

What are the barriers to accessing psychological therapy in Qatar

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ABSTRACT

Introduction: 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 access are likely to vary across countries and cultures and could be better understood. This paper aimed to identify perceived barriers to accessing psychological therapy for people living in Qatar in the Middle East.

Methods: A mixed methodology known as concept mapping was used to investigate the views of mental health clinicians and policymakers. Participants were invited to brainstorm the issue (qualitative data), then sort these barriers into groups (clusters), and rate them in terms of perceived importance (quantitative data).

Results: Fifteen clinicians and 11 policymakers took part in this study. A nine-cluster concept map was produced with the following titles; *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.*

Discussion: We concluded that 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: All authors declare that they have no conflict of interest.

Keywords: barriers, psychological therapy, concept mapping, mental health, mixed methods, health services research

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 some parts of the world, as many as three quarters of the people who could potentially benefit from treatment go without (Jorm *et al*, 2017; 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, up to a third of all countries worldwide still have no such policy or plan in place, or it goes largely unimplemented (Saxena *et al*, 2007, Winkler *et al*, 2017). This is despite agencies and governmental organizations in non-Western countries increasingly turning to Western established evidence-based practices and empirically supported treatments when seeking to treat mental illness (Gearing *et al*, 2013).

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 (e.g. Kessler *et al*, 2005). Other barriers to accessing treatments provided by mental health services therefore clearly exist. Amongst the barriers to accessing

Barriers to accessing psychological therapy in Qatar

psychological therapy 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, and these are often inflated in developing countries. Saraceno et al (2007) investigated the barriers to improving mental health services in low and middle-income countries, finding continued resistance to the decentralization of services (particularly moving to primary-care based services), 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 to providing care for individuals experiencing mental health problems.

While barriers to accessing psychological therapy exist globally, they are, of course, not identical between countries. For example, within Middle East Arab countries, Gearing et al., (2013) reported collating a total of 78 barriers to successful treatment implementation. These were extracted from their systematic review of 22 psychosocial or mental health studies in Middle East Arab countries 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 a preference for seeing traditional healers (Al-Krewani et al, 2004; El-Islam, 2005), as well as the impact of

stigma. This included 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 as a result of accessing mental health services (Al-Krenawi & Graham, 1999; Shalhoub-Kevorkian, 2005). This potential to not marry is significant within Arabic cultures given that marriage is traditionally seen as an obligatory milestone in a woman's life, therefore, not marrying could be a further source of stigma and shame. Barriers relating to community and systems included issues associated with access and availability of 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). Gearing and colleagues reflect on the need for mental health interventions in the Middle East to give consideration to culturally specific contexts such as within this region, including; the overriding value placed on family membership (these countries tend to be 'collectivist' cultures which refers to valuing the needs of a community over those of the individual), the role and status of women, stigma associated with mental health symptoms, a preference for indigenous healing, and the lack of formal mental health interventions in many Arabic countries. Despite these potentially helpful suggestions for effective strategies to improve treatment implementation, there remains a paucity of reliable evidence to support the argument for cultural adaptation of mental health interventions (Rathod et al, 2017). It is also important to note that although it is likely that barriers to effective treatment implementation are similar to the barriers to accessing treatment, they are not conceptually the same.

Barriers to accessing psychological therapy in Qatar

Qatar is a small country located in the Gulf of Arabia, sharing a land border with Saudi Arabia. Most of its population identify as Muslim and the country is governed by a mixture of civil and Sharia law due to its Islamic heritage. The traditional culture of Qatar is that of a typical collectivist Arabic society (AlHaj, 1987; Barakat, 1993), with these communities historically value collective good over the individual, and social stability over social change. There is a tendency to adhere strictly to social morals and values as well as the principles of gender segregation (Hall, 1981).

The country ranks the highest in the world for its gross domestic product per capita, due to its vast natural gas reserves. It has experienced considerable economic growth in recent years, topped by winning the right to host the 2022 FIFA World Cup. As a result, the population of Qatar has changed substantially in recent decades. For example, in the last 20 years its population has grown fivefold to around 2.4million, with 87% being expatriates on short-term work contracts (CIA World Factbook, 2019). 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 labour migrants (Klahed and Gray, 2019).

Recent analysis from the global burden of disease dataset has found that in Middle Eastern countries such as Qatar the burden from mental health disorders is higher than it is in other parts of the Western world (Charana et al, 2017). Furthermore, this burden has increased over the past 20 years. Whilst potentially a crude measure of mental well-being, especially in Qatar where epidemiological data is limited, these statistics emphasise that this area of healthcare requires substantial resource investment if these

countries are to manage the growing burden that mental ill-health can place on the country and its population.

With this growth in both population and ill-health has come the need to rapidly develop Qatar's health care services. Despite this growth, Sharkey (2017) reported that spending on mental health care represented only 0.34% of all healthcare expenditure, a rate that is seven times lower than spending in developed Western countries. This suboptimal spending has been observed across low, middle and high income countries within the region (Okasha et al 2012; Charana et al, 2017). Sharkey also noted that most of this spending within Qatar went on in-patient services within the one mental health hospital situated in Doha, Qatar's capital city. The most recent WHO Mental Health Atlas reported that Qatar has 1.66 psychiatrists, 10.94 nurses and 1.26 psychologists per 100,000. This contrasts with countries such as the UK that have an average of 13 psychiatrists, 52 mental health nurses and 4 psychologists per 100,000 population (WHO, 2014). Qatar has a '*National Mental Health Strategy*' in place (Supreme Council of Health, 2013; Sharkey, 2017), which outlines the modernisation of mental health services in Qatar. It highlights the role of evidence-based practice (including psychological therapy), as a central step in the provision of services.

In order to successfully scale up and develop mental health services across Qatar, the barriers to accessing treatment, and in particular psychological therapy, need to be identified. Extrapolating barriers from other countries within the Middle East such as those identified by Gearing et al (2013) is insufficient, given the unique nature of each country within the Middle East. The aim of the current study is therefore to gain an

understanding of the barriers to accessing psychological therapy in Qatar as viewed by stakeholders with unique perspective within the country.

METHODS

This study was undertaken by a team of three clinician researchers. Author one is a counselling psychologist originally from the UK who lived in Qatar for a number of years. Author two is a clinical psychologist acting as external supervisor and author three is a British nursing academic also living and working in Qatar. Further support was provided by author one's clinical supervisor within Qatar, a counselling psychologist originally from Sudan, trained in Egypt and the UK. Data collection was performed by author one between June 2016 and January 2017. Throughout the data collection and analysis process, we reflected on our unique position as 'westerners' living within an 'eastern' society and how that might influence our interpretation of the data. Leech and Onwuegbuzie's (2010) Guidelines for Conducting and Reporting Mixed Research in the Field of Counseling and Beyond were followed throughout this project.

Study context/setting

Mental health care in Qatar is predominantly provided across public (Hamad Medical Corporation – HMC) and private hospital settings. Within HMC, there is one 'psychiatric hospital' for the whole country, with 80 beds for individuals 14 years and over. These wards are staffed predominantly by nurses with generic nursing qualifications. The hospital also has an outpatient clinic for individuals within the public system to see psychologists and psychiatrists. There are also a handful of private hospitals within Qatar, some with a psychiatrist running private outpatient clinics.

Some populations may access psychological assessment and therapy via clinicians working in international schools and Universities in the country. Finally, there are some clinicians that work privately from their own homes with referrals being made informally by ‘word of mouth’ and who are not overseen by the State.

Participants

There are several different stakeholder groups that are well placed to help identify barriers to accessing mental health care. These include 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, including the potential need for an interpreter in order to ensure that participants fully understood the tasks they were required to complete. This was not possible with the resources available to this study. Additionally, a research project was being completely concurrent to the recruitment of this study that interviewed service users and their carers resulting in the potential for these participant groups to feel overburdened. It was therefore felt that this study would be best placed to consider the views of two other important stakeholder groups (Green & Aarons, 2011) involved in mental health services within Qatar; clinicians (group one) and policy makers (group two).

Group one – clinician inclusion criteria;

- currently providing psychological therapy privately or in public health care settings within Qatar, or
- had done so within the last three years, and
- the ability to speak, read and write in fluent English.

Group two – policymaker inclusion criteria;

Barriers to accessing psychological therapy in Qatar

- Working at a managerial level having input into policy around mental health in Qatar (for example providing consultancy to the development of the mental health strategy), or
- Provide consultation to organisations in Qatar that run mental health services, or
- Had worked in one of the above roles within the last three years, and
- the ability to speak, read and write in fluent English.

Proficient English language skills were required given the requirement to undertake the tasks in English. We feel that this did not restrict our recruitment sample because as a result of the large number of nationalities working in the health systems in Qatar, the language used predominantly is English. This means that everything is communicated in both Arabic and English and that official documentation is written in English and Arabic e.g. consent forms.

Sampling strategy

We recruited participants using a chain referral sampling technique (Biernacki & Waldorf, 1981), a purposive sampling method. Recruitment of group one (clinicians) involved approaching personal contacts who met the above inclusion criteria that might be interested in taking part and inviting them to pass on the contact details of the first author within their networks (Biernacki & Waldorf, 1981). We used the same methodology to recruit participants to group two (policy makers), beginning by approaching personal contacts who had had input into designing or influencing mental health services in Qatar at an organisational or policy level and inviting them to pass

on details, thus extending the network of individuals reached. We continue recruitment until we reached our planned sample sizes.

Study Design

This project involved concept mapping, a mixed methods approach that uses qualitative procedures (in this case predominantly interviewing), to generate statements. These are then extracted, ranked, clustered, and ultimately analysed using quantitative methods. From this conversion to numerical data a visual representation of the findings is produced (e.g. Johnsen, Biegel, & Shafran, 2000). A benefit of using concept mapping is that it allows participants to answer the question in their own words, rather than using a survey with predetermined statements. The approach recognises that groups may hold different views to each other and acknowledges the added value that addressing these differences can bring when interpreting results. That is, in this study, using concept mapping allowed us to assess the level of agreement between clinicians and policymakers with regards to the perceived barriers to accessing psychological therapy.

The type of concept mapping used in this project refers to a sophisticated mixed-methods analysis first developed by Trochim (1989b).

Data collection within concept mapping essentially consists of two parts, the *generation* of statements and the *structuring* (prioritising and clustering) of these statements.

a) Statement generation.

First, participants are asked a focus question, in this case; ‘*what are the barriers to accessing psychological therapy in Qatar?*’ Participants are required to generate as many statements as possible that they felt answered the question.

An example of a statement answer to this question is “there is not enough

therapists”. Once all brainstorming sessions were complete, statement consolidation takes place, whereby duplicates are eliminated and similar statements merged. The final list of statements forms the basis of the second part of the process.

b) Statement structuring.

Participants are provided with each individual statement and asked to perform two separate tasks: 1 – ranking the importance of each statement (prioritising) and 2 – putting the statements they feel go together into groups (clustering).

The prioritising task involves 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 requires participants to sort the statements into clusters based on their perceived similarity. In order to avoid researcher-labelling bias, participants are also asked to assign a descriptive title to each of the clusters. Participants use all the statements to create between two and ten clusters with a maximum of 40 statements in each cluster (Severens, 2012).

Specific concept mapping computer software was used into which participant responses are collated and subsequent data analysis performed, namely Ariadne (Severens, 2012).

It is methodologically acceptable to have different participants complete the generation and structuring parts of concept mapping, if consideration is given to ensuring that the background and experiences of the participants is similar (Jackson and Trochim, 2002), as was completed here.

Data collection procedures

Statement generation – In the current study, participants brainstormed answers to the focus question through a variety of approaches in order to maximise the potential for participants to be involved (Rosas and Kane, 2012). This included the first author running small focus groups and one-to-one interviews with participants whereby they were required to come up with as many answers to the focus question as possible. Additionally, participants could take part in this section by sending a list of statements via email.

Statement structuring – During the second state of the data collection, we invited participants who had taken part in the brainstorming task as well as others who were new to the process to meet face-to-face to undertake the structuring tasks. This involved participants being given a deck of cards, each with a separate statement written on it and a pen and paper to record the prioritising scores and clustering groups. After this was completed, the first author uploaded participant responses to the Ariadne software. It was also possible for participants to undertake the tasks online, inputting the data directly into the Ariadne software via a secure weblink.

Data analysis

Data analysis forms the next stage of concept mapping, termed by Trochim as *representation*. This section involves all data being entered into a specialist computer software program called Ariadne (Severens, 2012). This software 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 program analyses the data using a pre-determined combination of multivariate statistical techniques, specifically PCA and cluster analysis. This analysis places all statements being positioned on the map with the

distance between them representing how often participants sorted them together into the same group. The concept map is therefore a graphical illustration of the relationships among statements. The result of the cluster analysis produces a series of concept maps, consisting of between two and twelve clusters. The final stage of Trochim's concept mapping analysis involves the research team (including participants where possible to preserve the participant led data-analysis process) evaluating potential cluster solutions (e.g. 8 clusters, 12 clusters) in terms of the extent to which each fitted the data, considering their meaning and conceptual interpretation and subsequently selecting the most meaningful concept map as the final solution.

Finally, in order to gain a sense of which barriers are felt to be most important, statement rating information is incorporated into the statement clusters. Overall cluster ratings are averages of the ratings for each item in each. They are represented visually on the map by the thickness of the cluster lines. These maps can be created for the overall participant group as well as for separate stakeholder groups. For example, once the final map has been produced, comparisons between groups can be made by aggregating importance ratings for each group so that there is a map that represents all participants, while also allowing differences in importance ratings between stakeholder groups to be identified. Differences in these aggregated importance ratings can subsequently be statistically analysed using independent sample T-tests.

Sample size

Recommended minimum numbers of participants for a successful cluster analysis and principle component analysis (PCA) used within Concept Mapping vary: Trochim (1989a) recommended between 10 and 20 participants while Severens (2012) suggested

a minimum of eight to ten participants. Analysis with relatively small numbers is possible because the number of statements is also an important variable within the analysis. Rosas and Kane's (2012) pooled analysis of concept mapping studies found that the internal reliability of results increased with a larger sample size, they advised a minimum of 20 participants overall. We therefore aimed to recruit between ten and fifteen participants for each group (20-30 in total) to undertake the statement structuring tasks. Data collection for the generation stage involved recruiting until data saturation occurred, i.e. participants were not brainstorming any new statements.

Ethics

Ethical approval was obtained from the University of the West of England Research Ethics Committee prior to recruitment starting (HAS/16/03/120). 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 (MRC1341/2016).

RESULTS

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 task ceased at sixteen as participants were not generating any additional items therefore data saturation had been reached (Holloway & Wheeler 2010). This decision was supported

Barriers to accessing psychological therapy in Qatar

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).

INSERT TABLE 1 ABOUT HERE

The Structuring task. Twenty-six individuals (fifteen clinicians and eleven policymakers) participated in the prioritising and clustering tasks, nine of whom had also been part of the generation task. Seventeen new participants only took 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. 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), thus representing similar characteristics to the groups who participated in the generation task.

INSERT TABLE 2 ABOUT HERE

Statement generation task

From the brainstorming sessions a total of 251 statements were produced. This was reduced to 80 distinct statements by EB. These can be seen in Table 3.

INSERT TABLE 3 ABOUT HERE (OR AS AN APPENDIX IF REQUIRED)

Cluster map creation

A series of concept maps were created, ranging from the simplest two-cluster map to the most complex eighteen-cluster map. A team of three (author one, author three and a participant) evaluated each of the concept maps, judging the nine-cluster map to be the most meaningful interpretation of the data.

Cluster descriptions and ratings.

This part of the analysis involved giving each cluster in the final solution a name, retaining the titles suggested by participants where possible. The 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, the x-axis representing ‘organisational-to-individual’ and the y-axis representing ‘interpersonal-to-intrapersonal’.

INSERT FIGURE 1 ABOUT HERE

Cluster 1 - 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/illegal in Qatar (e.g. suicide)”).

Cluster 2 - impact of the family 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*”.

Cluster 3 – cultural implications 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, for example “*people access traditional healers for treatment of mental illness*” and “*a belief that problems should be dealt with within the family*”

Cluster 4 - stigma impacting on reality is represented by just one statement, “*the fear of losing one’s job because of having therapy*”. The title was chosen because it captures the local situation.

Cluster 5 - 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, for example “*a concern that therapists don't understand traditional/cultural explanations*”.

Cluster 6 - 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. Statements included “*therapists have to be found through word of mouth - can't advertise*” and “*Being a therapist/psychologist isn't a desirable career for a Qatari local*”.

Barriers to accessing psychological therapy in Qatar

Cluster 7 - local (mis)understanding of therapy, is made up of four statements that refer to how the population in Qatar understands psychological therapy, for example, “*a lack of understanding of confidentiality*” and the required attendance at weekly, scheduled appointments. It had a mean importance score of 2.85.

Cluster 8 - 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*”).

Cluster 9 - 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.

Table 4 shows these clusters 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. These scores were consistent when both clinician and policymaker groups were examined independently as well as together.

INSERT TABLE 4 ABOUT HERE

Comparison of the two stakeholder groups

No significant differences were found for the first eight clusters. Despite the low numbers, 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 ($M=2.60$, $SD=0.81$) than the policymakers ($M=2.05$, $SD=0.47$); $t(23) = 2.20$, $p=0.04$.

DISCUSSION

This study aimed to identify the perceived barriers to accessing psychological therapy for mental health problems in 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 were grouped into nine distinct 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 that were originally devised in developed health care systems into Middle East Arab countries as related to ‘cultural context’. 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. It reinforces the need to explore and engage local cultural beliefs and values to order to ensure the effective adaption and translation of mental health treatments from Western societies. The proximity of these three clusters (stigma, culture and the family) to each other on the concept map helps us see visually just how interlinked the three concepts are considered to be. Indeed, there were numerous times when participants wanted to place statements in two or all these clusters. This suggests the need to consider stigma,

family and culture almost collectively when reviewing how barriers to accessing psychological therapy in Qatar may be overcome.

El-Islam's (2008) conclusion that cultural beliefs and practices can be crucial in shaping an individual's perception and management of mental health problems is supported by our present findings. The current study offers further insight into why accessing psychological therapy for managing mental health problems in Arabic culture may be resisted. We know there is a current lack of evidence supporting the efficacy of culturally adapted mental health interventions (Rathod et al, 2017). Culturally adapting mental health interventions to a country such as Qatar would benefit from a structured approach whereby service users and their extended family members are extensively consulted before an intervention is decided upon. Its efficacy would then need to be rigorously tested, ideally using a non-adapted intervention as the comparison group (Rathod et al, 2017). This model of intervention development would be a useful next step towards ensuring global access to relevant and culturally appropriate psychological treatments.

One possible way of adapting therapies that could be beneficial in Arabic collectivist cultures may be by involving family members in an individual's therapy to the extent that they are considered 'co-therapists', as proposed by El-Islam (2005). This proposal warrants further unpacking however, given 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). 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 health problem. Given that

participating in therapy involves engagement and often being physically present in contexts where it is known a stigmatising illness is managed, the family may work to maintain their isolation in order to prevent their health needs becoming apparent to the wider community. To attempt to engage family as ‘co-therapists’ may therefore be difficult because it would involve challenging societal norms around preserving family status (Barakat, 1993; Lay, 2005). Possible clashes between family and patient’s expectations would also need to be carefully managed. Further work is required to explore this and how services may work best to manage these complex dynamics.

It was interesting that, despite potential resistance to receiving treatments that were developed in Western cultures, the barriers in the ‘East meets West’ cluster scored relatively low. This suggests that potential cultural clashes were not perceived to be a barrier to clients accessing psychological treatment. This was explained by some participants as being the result of the rapid urbanisation of the country and culture, bringing with it increased exposure to Western ideologies, including ‘being in therapy’.

On the other side of the concept map were clusters related to organisational factors; *workforce and training* and *structural problems within the country*. These included several barriers that related to Qatar-specific issues with providing psychological therapy. For example, currently there are limited psychologist, mental health nursing, or therapist training programs in Qatar as well as complex licensing for therapists making it very difficult to work independently in private practice. Those 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. Indeed, registration or licensure are far from universal (Fairburn &

Patel, 2014). However, the combination of scarcity, inconsistency and stigma in Qatar undoubtedly compounds problems around access to therapy and consequently requires strategic intervention from Government level entities if the country's Mental Health Strategy is to be realised.

Broadly, the barriers identified here fall in to two categories; organisational and individual issues. The ranked importance of the clusters suggests that as a first step to helping individuals access treatment for mental health problems, cultural attitudes, including those of a stigmatising and discriminatory nature, need to shift. Once this shift occurs, it is likely that the number of individuals willing to access services will increase. When this happens, the country will need to re-think the health service infrastructure in order to successfully manage this shift in demand. 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.

Given the relative importance attributed to stigma in the current study, it could be argued that one way of achieving a shift towards openness to managing mental health problems in Qatar may be to develop and run an anti-stigma campaign aimed specifically at a family-orientated, collectivist culture. This focus is supported by our findings around the need to addressing the views of the wider family and community and acknowledge how influenced an individual may be by the concerns of others (Lay, 2005). Mental health staff on the ground in Qatar, such as psychiatrists, nurses and

psychologists, particularly those from Arabic societies themselves, may be well placed to develop such an intervention. 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.

Finally of note, 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 country. It may also of course, be a reflection of the relatively small number of participants in the study preventing statistically significant results.

LIMITATIONS

This study was limited by its sample size and it cannot be viewed as representing all clinicians working in mental health in Qatar or all individuals involved in policy development. It also does not consider the views of service users, 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. However, we feel this gives breath to our findings as mental health services typically aim to treat a multitude of diagnoses within one setting.

Furthermore, this study inevitably does not address the views of individuals who do not engage in psychological therapy for mental health problems. This, again, may impact on the findings and conclusions we have made.

CONCLUSIONS

The findings from this study offer some understanding of how clinicians and policymakers 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 support services when making decisions about service development and how best to meet the needs of patients and their extended 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.

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Table 1 Descriptive statistics of participants in the brainstorming task

	Clinicians (n=10)	Policymakers (n=6)	Total participants (n=16)
Age			
20-29 years	1 (10.0%)	0	1 (6.3%)
30-39 years	2 (20.0%)	0	2 (12.5%)
40-49 years	5 (50.0%)	1 (16.7%)	6 (37.5%)
50-59 years	1 (10.0%)	4 (66.7%)	5 (31.3%)
60+ years	1 (10.0%)	1 (16.7%)	2 (12.5%)
Gender			
Male	3 (20%)	4 (66.7%)	7 (43.8%)
Female	7 (70%)	2 (33.3%)	9 (56.3%)
Academic qualification			
Degree	1 (10.0%)	0	1 (6.3%)
Masters	5 (50.0%)	2 (33.3%)	7 (43.8%)
PhD	4 (40.0%)	3 (50.0%)	7 (43.8%)
Other (post masters)	0	1 (16.7%)	1 (6.3%)
Profession			
Counsellor/Psychotherapist	3 (30.0%)	0	3 (18.8%)
Psychologist	4 (40.0%)	1 (16.7%)	5 (31.3%)
Psychiatrist	3 (30.0%)	1 (16.7%)	4 (25.0%)

Barriers to accessing psychological therapy in Qatar

Nurse	0	4 (66.7%)	4 (25.0%)
Other	0	0	0
<hr/>			
Ethnicity			
MENA	4 (40.0%)	2 (33.3%)	6 (37.5%)
Western Countries	5 (50.0%)	4 (66.7%)	9 (56.3%)
Africa	0	0	0
South Asia	1 (10.0%)	0	1 (6.3%)
<hr/>			
Years working in MH			
mean	14.2	28.3	19.5
SD	11.7	2.87	11.62
<hr/>			
Place of work			
HMC	6 (60.0%)	3 (50.0%)	9 (56.3%)
School/University	1 (10.0%)	0	1 (6.3%)
Private provider of healthcare	1 (10.0%)	1 (16.7%)	2 (12.5%)
Other in Qatar	2 (20.0%)	0	2 (15.4%)
Outside of Qatar	0	2 (33.3%)	2 (12.5%)
<hr/>			
Number of years worked in Qatar			
Mean	3.0	3.5	3.14
SD	1.6	0.58	1.35
<hr/>			

Barriers to accessing psychological therapy in Qatar

Table 2 Descriptive statistics of participants in the clustering and prioritising tasks

	Clinicians (n=15)	Policymakers (n=11)	Total participants (n=26)
Age			
20-29 years	1 (6.7%)	0	1 (3.8%)
30-39 years	4 (26.7%)	0	4 (15.4%)
40-49 years	6 (40.0%)	5 (45.5%)	11 (42.3%)
50-59 years	4 (26.7%)	6 (54.5%)	10 (38.5%)
60+ years	0	0	0
Gender			
Male	3 (20%)	6 (54.5%)	9 (34.6%)
Female	12 (80%)	5 (45.5%)	17 (65.4%)
Academic qualification			
Degree	1 (6.7%)	0	1 (3.8%)
Masters	11 (73.3%)	6 (54.5%)	17 (65.4%)
PhD	3 (20.0%)	4 (36.4%)	7 (26.9%)
Other (post masters)	0	1 (9.1%)	1 (3.8%)
Profession			
Counsellor/Psychotherapist	5 (33.3%)	0	5 (19.2%)
Psychologist	9 (60.0%)	2 (18.2%)	11 (42.3%)
Psychiatrist	0	1 (9.1%)	1 (3.8%)
Nurse	0	4 (36.4%)	4 (15.4%)
Other:	1(6.7%)	4 (36.4%)	5 (19.2%)

Barriers to accessing psychological therapy in Qatar

Child Life Therapist	1 (6.7%)	0	1 (3.8%)
Operational management	0	1 (9.1%)	1 (3.8%)
Physician	0	2 (18.2%)	2 (7.7%)
Project manager	0	1 (9.1%)	1 (3.8%)
<hr/>			
Ethnicity			
MENA	4 (26.7%)	3 (27.3%)	7 (26.9%)
Western Countries	9 (60.0%)	8 (72.7%)	17 (65.4%)
Africa	1 (6.7%)	0	1 (3.8%)
South Asia	1 (6.7%)	0	1 (3.8%)
<hr/>			
Years working in MH			
mean	15.1	19.8	17.1
SD	9.2	10.8	10.0
<hr/>			
Place of work			
HMC	8 (53.3%)	8 (72.7%)	16 (61.5%)
School/University	2 (13.3%)	0	2 (7.7%)
Private provider of healthcare	1 (6.7%)	1 (9.1%)	2 (7.7%)
Other in Qatar	4 (26.7%)	0	4 (15.4%)
Ministry of Public Health	0	2 (18.2%)	2 (7.7%)
<hr/>			
Number of years worked in Qatar			
Mean	4.0	4.8	4.4
SD	3.7	5.0	4.2

Barriers to accessing psychological therapy in Qatar

Table 3. List of all statements generated

Statements	Cluster	Mean importance score
1 - No psychologist/therapist training programs in Qatar	Workforce and training	3.35
2 - Lack of anti-discriminatory legislation	Structural problems within the country	2.81
3 - Therapists have to be found through word of mouth - can't advertise	Workforce and training	2.96
4 - There are not enough therapists	Workforce and training	3.58
5 - Therapists are not necessarily well trained	Workforce and training	2.96
6 - No clear international training route for therapists/psychologists (like for medical training)	Workforce and training	3.19
7 - People hold traditional explanations of mental illness such as 'evil eye' or possessed by spirits	Cultural implications	3.35
8 - People access traditional healers for treatment of mental illness	Cultural implications	2.85
9 - The stigma associated with mental illness	Stigma	4.35
10 - There are no 'answers' available yet to tackle stigma	Stigma	3.27
11 - A fear of being labelled	Stigma	4.12
12 - A fear of having your or family member's chances of getting married affected	Impact of the family	3.96
13 - A belief that problems should be dealt with within the family	Cultural implications	3.81
14 - The needs of the family are put before own needs (collectivist culture)	Cultural implications	3.54
15 - Therapy is seen as sharing family secrets rather than speaking with someone	Impact of the family	3.15
16 - The law still criminalises seek help for 'haram' behaviours (e.g. suicide)	Impact of the family	3.42
17 - Lack of understanding of confidentiality	Local (mis)understanding of therapy	3.35
18 - Difficulty in recruiting psychologists/therapists to work in Qatar	Workforce and training	2.96

Barriers to accessing psychological therapy in Qatar

19 - Mental health and therapy is not prioritised by Government	Structural problems within the country	2.65
20 - Qatar is a small community - fear of being recognised or bumping in to therapist	Impact of the family	3.46
21 - Cost – of private therapy, transport to appointments etc.	Structural problems within the country	2.27
22 - Therapy isn't covered under private health insurance	Structural problems within the country	2.35
23 - Fear of losing job because of having therapy	Stigma impacting on reality	3.19
24 - Unethical private practice – e.g. therapists seeing client groups they aren't qualified to see	Workforce and training	2.15
25 - No licensing/registration for private therapists in place	Workforce and training	3.62
26 - A person's job takes priority in Qatar which may interfere with attending therapy sessions	Structural problems within the country	2.81
27 - Lack of research into what therapy works here	Structural problems within the country	2.92
28 - Language barriers - many different languages spoken in Qatar	Workforce and training	2.62
29 - No interpreters available	Structural problems within the country	2.08
30 - Fear of bringing shame on family	Impact of the family	4.19
31 - Logistical difficulties: traffic, transport issues etc.	Structural problems within the country	1.62
32 - Preference to self-medicate	Stigma	2.58
33 - Limited community based services	Structural problems within the country	3.58
34 - Therapists lack therapeutic abilities to deal with cultural diversity	Cross-cultural therapy	3.15

Barriers to accessing psychological therapy in Qatar

35 - No national level education about what mental health problems	Structural problems within the country	3.62
36 - Qatar not yet in the right place for accepting psychological services (new country)	Local (mis)understanding of therapy	2.46
37 - A lack of data on the use of services (epidemiology)	Structural problems within the country	2.46
38 - The expected presence of a male member of the family in therapy sessions preventing women expressing themselves openly	Cultural implications	3.00
39 - Men don't see therapy as for them	Impact of the family	2.65
40 - Services are only accessed when the family can't cope any longer	Impact of the family	3.23
41 - Therapy is a Western concept	East meets West	2.54
42 - a lack of understand of mental health problems	Stigma	4.12
43 - Employment/HR issues e.g. only full time work available or not able to have 2 jobs	Structural problems within the country	2.08
44 - A lack of understanding of what therapy is	Local (mis)understanding of therapy	3.50
45 - A concern that therapists don't understand traditional/cultural explanations	Cross-cultural therapy	2.69
46 - Problems are suppressed rather than tackled	Stigma	3.46
47 - Preference to see mental illness as a physical illness (somatization)	Stigma	2.92
48 - Medical model and paternalistic care still prevails	Structural problems within the country	3.42
49 - Some psychiatrists have negative views of therapy	Workforce and training	2.77
50 - Other professionals not understanding what therapists do	Workforce and training	3.00
51 - The difficulty in successfully delivering culturally sensitive psychological therapy	Cross-cultural therapy	2.96
52 - Inequalities in minority populations e.g. LGBT, multiple disabilities or older adults	Structural problems within the country	3.12

Barriers to accessing psychological therapy in Qatar

53 - A lack of joined up working between services	Structural problems within the country	3.27
54 - A lack of care pathways for specific diagnoses	Structural problems within the country	2.96
55 – The local population feel hostile towards expatriates ‘taking over their country’	East meets West	2.19
56 - A person's cultural baggage might unconsciously impact on their behaviour	Cultural implications	2.38
57 - Being a therapist/psychologist isn't a desirable career for a Qatari local	Workforce and training	2.46
58 - People perceive that if you are mentally unwell it means you are weak	Stigma	3.23
59 - People perceive that if you need to see a psychologist then you are mad	Stigma	3.27
60 - Clients would prefer to take medication to 'take the problem away' rather than talk	Stigma	3.35
61 - clients are disappointed that therapy doesn't offer an instant fix	Stigma	2.58
62 - Unclear referral processes	Structural problems within the country	2.65
63 - Therapists are anxious about who they see	Workforce and training	2.08
64 - People in Qatar aren't used to an appointment based system instead of turning up and being seen	Local (mis)understanding of therapy	2.08
65 - A reliance on what is in the Qur'an rather than newer understanding about how the mind works	Cultural implications	3.27
66 - People are only willing to attend therapy sessions when there is a drama/crisis	Stigma	3.12
67 - Some services are seen as only being accessible if you are taken there by police or doctors	Structural problems within the country	2.12
68 - People don't trust the government or police	Structural problems within the country	2.54
69 - Showing need/dependency on others is shameful	Impact of the family	2.81

Barriers to accessing psychological therapy in Qatar

70 - some behaviours that may benefit from therapy are unacceptable/illegal in Qatar (e.g. suicide)	Stigma	3.73
71 - Everything is 'God's willing' - In'shallah	Cultural implications	3.23
72 - There is nobody in Qatar permanently driving the need for psychological therapies	Structural problems within the country	2.35
73 - Group work isn't possible as people don't want to talk in front of others	Impact of the family	2.88
74 - Clients don't want to be seen as a patient who is ill	Stigma	3.00
75 - Issues of anxiety, depression, trauma are not concepts discussed within the culture	Cultural implications	3.46
76 - Society wants to keep mentally ill people away from rest of society	Stigma	3.08
77 - Experts' pushing their own agendas not considering the needs of the population	Structural problems within the country	2.35
78 - Under 18's need to have parental consent to access treatment	Structural problems within the country	2.19
79 - Fear of discrimination from family, friends & others	Stigma	4.08
80 - Clients don't want to accept a diagnosis	Stigma	3.00

Table 4: Independent samples T-test analysis comparing the mean importance scores of the two stakeholder groups.

Cluster	All Participants (n=26)			Group 1 – Clinicians (n=15)			Group 2 – Policymakers (n=11)			T-test result (p- value)
	Rank	Mean (SD)	95% CI	Rank	Mean (SD)	95% CI	Rank	Mean (SD)	95% CI	
1 – Stigma	1	3.37 (.50)	3.17 – 3.57	1	3.38 (.51)	3.10-3.66	2	3.34 (.51)	3.00-3.68	0.84
2 – Impact of the family	2	3.31 (.55)	3.09 – 3.53	2	3.29 (.45)	3.04 – 3.54	3	3.33 (.68)	2.87 – 3.79	0.84
3 – Cultural implications	3	3.21 (.59)	2.97 – 3.45	3	3.25 (.54)	2.95 – 3.55	~4	3.15 (.67)	2.70 – 3.60	0.67
4 – Stigma impacting on reality	4	3.19 (1.39)	2.63 – 3.75	4	3.00 (1.51)	2.16 – 3.84	1	3.45 (1.21)	2.64 – 4.26	0.42
5 – Cross-cultural Therapy	5	2.94 (.98)	2.54 – 3.36	7	2.79 (.85)	2.32 – 3.26	~4	3.15 (1.14)	2.38 – 3.92	0.35
6 – Workforce and training	6	2.90 (.46)	2.71 – 3.09	6	2.91 (.36)	2.71 – 3.11	6	2.93 (.33)	2.71 – 3.15	0.94
7 – Local (mis)understanding of therapy	7	2.85 (.40)	2.69 – 3.01	5	2.93 (.83)	2.47 – 3.39	7	2.73 (.52)	2.38 – 3.08	0.48

Barriers to accessing psychological therapy in Qatar

8 – Structural problems within the country	8	2.65 (.71)	2.36 – 2.94	8	2.63 (.33)	2.45 – 2.81	8	2.68 (.50)	2.34 – 3.02	0.72
9 – East meets West	9	2.37 (.73)	2.08 – 2.66	9	2.60 (.81)	2.15 – 3.05	9	2.05 (.47)	1.73 – 2.37	0.04*

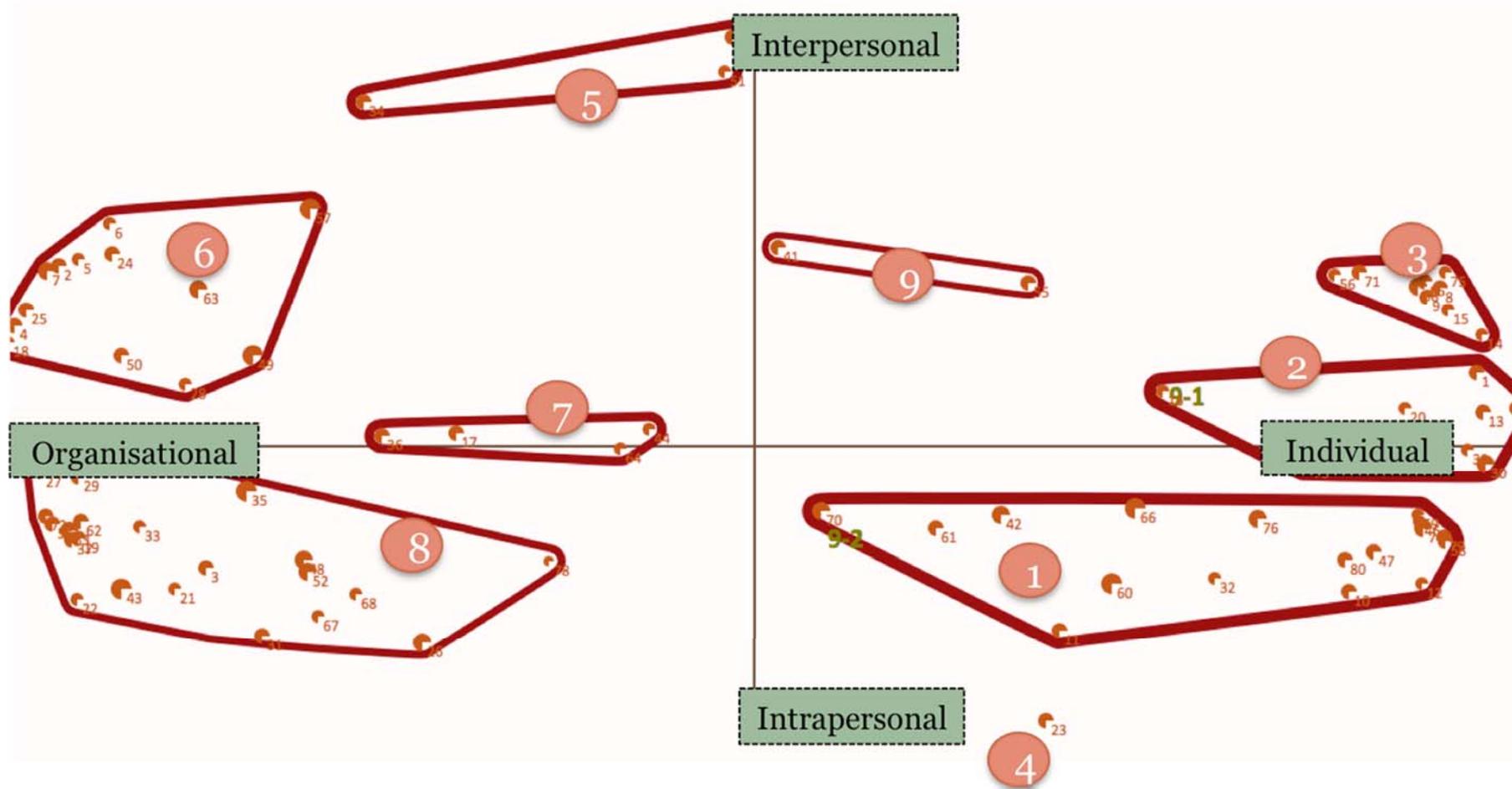


Figure 1: concept map showing clusters

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