

Engaging in psychological interventions: A Middle Eastern perspective

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Abstract

This thesis explores attitudes and decisions around engagement with mental health services of individuals in the Middle East. Paper 1 examined the attitudes towards mental health interventions of individuals living in the Middle East by systematically reviewing the literature. Thirteen quantitative studies were included and the findings synthesized using a narrative approach. The findings indicated that over half of all individuals in most studies considered seeking mental health treatment and that they would seek support first and foremost from their family and friends. Stigma was consistently found to negatively impact on attitudes towards mental health interventions. Other factors that impact on attitudes were also discussed and clinical implications highlighted.

Paper 2 was an empirical study which focused on families displaced by the Syrian conflict who have resettled in the UK. Four mothers' decision-making process to engage in a parenting group was explored in-depth using Interpretative Phenomenological Analysis. The aim was to gain an understanding of their subjective experience with regard to facilitators and barriers to engagement. The themes that emerged appeared to suggest a lack of connection, and yet wanting to connect with others. The sharing of experiences within a group setting were important to the women. They expressed uncertainty and had concerns about control within the group. Another theme was related to wanting help but feeling that services did not understand and accommodate their needs on a practical level. The data also highlighted a sense of abandonment by services on an emotional level. The mothers also reflected on feeling stuck which appeared to be a motivator to decide to take part in the parenting group. The intervention booklet was predominantly perceived positively. However, some of the mothers highlighted difficulties around implementation. These findings were discussed in light of existing literature and clinical implications included.

Paper 3 is a critical appraisal of the systematic review and qualitative study and offers reflections on the research processes.

Declaration of Interest

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning

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Paper 1: Attitudes of people in the Middle Eastern towards mental health interventions and seeking help: A Systematic Review

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For submission to the Journal: European Psychologist (Appendix A). Please note that in order to provide a more detailed account of the systematic review, the word count was based on University guidelines.

Abstract

Mental health services in Middle Eastern countries are less well developed compared to other parts of the world. Given the number of individuals affected by conflict in these areas, it is a pressing issue to develop more services and engagement strategies to tackle mental health problems. To better understand individuals' views on mental health interventions and barriers as well as facilitating factors for accessing mental health treatment, studies were systematically reviewed to assess (1) attitudes towards psychological interventions and help-seeking, (2) stigma and (3) intention to utilize psychological support. Studies were included if they were journal articles conducted in the Middle East, available in English language, and from peer-reviewed journals. Thirteen studies met criteria with a total of 6675 participants and were examined using a narrative synthesis approach. It was found that mental health treatment was a considered option for many individuals. Level of education, age, severity of symptoms, and recognition of need for help appeared to positively impact on individuals' attitudes towards mental health treatment. Stigma was consistently found to be related to negative attitudes. Initiatives to improve service utilization should consider raising awareness by targeted family and friends of those in need of psychological support and potentially aim to integrate mental health and general health for better access.

Key words (max 5): Middle East, attitudes, mental health, review

1. Introduction

It has been highlighted by the World Health Organization (WHO) that mental health (MH) services in the Middle East need to be further developed (WHO Profile on mental health in development: WHO proMIND, 2013). A recent assessment report in Jordan estimated that there are only two psychiatrists per 100,000 inhabitants (International Medical Corps, 2017). As part of the WHO Mental Health Gap Action Program (mhGAP), a national strategy was developed to increase the number of mental health services in Jordan (WHO proMIND, 2013). Other Middle Eastern countries face similar problems. Strategies for mental health service implementation and raising awareness of mental health have been proposed (e.g. WHO-Assessment Instrument for Mental Health Systems: WHO-AIMS, Iran, 2006; WHO-AIMS, Iraq, 2006).

Focusing on mental health services in the Middle East is important as this area is going through a challenging time due to many conflicts, large numbers of survivors of armed conflict and internally and externally displaced families, high unemployment rates and increasing poverty (United Nations High Commissioner for Refugees: UNHCR Global Appeal, 2018-2019). With the Syrian crisis alone 6.6 million individuals were internally displaced and another 5.1 million became refugees in neighboring Middle Eastern countries as of July 2017, including Egypt, Iraq, and Jordan (UNHCR, 2017). In 2018, the Islamic Republic of Iran and Lebanon are still some of the countries with the largest number of refugees (UNHCR Global Appeal, 2018-2019). Studying and supporting these communities in the Middle East is essential to tackle the difficulties they are facing.

Research shows that exposure to adverse events increases the likelihood of developing mental health problems, such as anxiety, depression and Post-Traumatic Stress Disorder (PTSD) (Fazel, Reed, Panter-Brick, & Stein, 2012; Steel et al., 2009). Systematic reviews on the impact of the Syrian conflict on refugees showed that already existing mental health problems worsened, and experiences of the crisis and issues in the resettlement

phase triggered MH problems (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016; Wells, Steel, Abo-Hilal, Hassan, & Lawsin, 2016). This suggests that there is a need for psychological interventions. Research in this area specific to Syria is sparse, but given that historically Syria and surrounding countries were a distinct region and that Syrians, like most other inhabitants in the Middle East, identify themselves as Arabs, exploring psychological support in this wider context is meaningful (Abbara et al., 2016).

Efforts to increase the number of MH services or developing pathways for individuals in need of support can only be fruitful if the target population accepts and accesses the given support. In fact, there are many barriers to accepting psychological support. For instance, many studies have shown that attitudes towards mental health in the Middle East can be negative (Al-Krenawi, Graham, Dean, & Eltaiba, 2004b; Gearing, Brewer, Schwalbe, MacKenzie, & Ibrahim, 2013) and stigma affects people's help-seeking behavior (e.g. Sewilam et al., 2015).

1.1. Attitudes and behavior

It was initially believed that attitudes predicted behavior. The link between attitudes and behavior in general has been studied in detail (e.g. see Armitage & Christian, 2003). Whereas there seems to be no reliable direct link between attitudes and behavior, research findings have led to different theories, one of which suggests that attitudes influence behavior indirectly as attitudes impact on behavioral intentions, perceived pressure from those around and perceived difficulty of executing the behavior (perceived behavioral control): the Theory of Planned Behavior (TPB: Ajzen, 1991). Therefore, it is meaningful to explore attitudes and these other factors that are known to be linked to behavioral outcomes in order to better understand these components that contributes to behavioral change. With the TPB in mind, in systematically gathering evidence on attitudes of individuals in the Middle East towards psychological interventions it is necessary to assess not just attitudes themselves, but also perceived social pressures,

such as stigma, and intentions to engage in psychological interventions in order to better understand the factors that impact on individuals' general standpoint and their behavior, i.e. whether they will engage with psychological interventions.

1.2. Aim

The aim of this systematic review was therefore to examine Middle Eastern individuals' attitudes towards psychological interventions. It is meaningful to explore attitudes, stigma (i.e. perceived social pressures), and intentions to utilize support (i.e. behavioral intentions), in line with the TPB, to better understand how individuals perceive psychological support and how these different factors impact their views and behavior on engagement with psychological support. The implications of the findings will help to further guide the development of engagement strategies aimed to improve mental health awareness and uptake of support for individuals from the Middle East in need of psychological interventions, both nationally and internationally.

Other reviews have examined studies to identify barriers and facilitating factors for effective translation and adaption of psychosocial support (Gearing, Schwalbe, et al., 2013). Included studies were published in and prior to 2010. Although there is some overlap in the factors examined in Gearing's review and this review (attitudes and stigma), the current review contains nine studies published after 2010. Given that programs such as the World Health Organization mental health Gap Action Program (WHO mhGAP) were released in 2013, it will be useful to re-evaluate the literature on attitudes towards psychological interventions. Furthermore, their review did not include intentions to engage in psychological treatment but is a useful indicator of individuals' beliefs about MH interventions.

This review highlights factors impacting attitudes towards MH treatment within the population and aims to capture a breadth of views from all ages, rather than focusing only on specific groups such as adolescents (Goodwin, Savage, & Horgan, 2016). It does not

aim to assess attitudes of staff members who may have a number of roles and hence may hold several different views (e.g. teachers, physicians, mental health nurses).

To better understand individuals' attitudes towards psychological interventions, the following objectives were examined: (1) To explore questionnaire-based attitudes towards mental health treatment/treatment preferences, (2) to examine how stigma impacts on attitudes and behavior, (3) to examine whether and what support individuals intent to utilize, and (4) to explore what factors impact on attitudes towards psychological interventions. The findings presented here should therefore aid decision making when developing strategies to further integrate psychological services and to increase access to services within the Middle East, as well as in host countries of displaced individuals.

2. Method

The structure of this systematic review was guided by an a priori protocol that was based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses criteria (PRISMA 2009 checklist: Moher, Liberati, Tetzlaff, Altman, & Grp, 2009).

2.1. Search Strategy and eligibility criteria

MEDLINE, Web of Science, PsycInfo and Scopus were systematically searched in August 2017 using the following inclusion criteria: (1) all years, (2) studies from peer-reviewed journals, (3) in English language, (4) studies focusing on general population samples living in the Middle East, (5) studies focusing on attitudes, beliefs, and views on psychological interventions and (6) with assessment of participant attitudes. Limits were set as 'English' and 'all journals'. Through the consultation with a university librarian the search words and strategy were checked.

Studies were excluded if they were not examining new data (i.e. literature reviews, overviews, guidelines or reflective papers). Studies examining attitudes of health care staff or other staff groups that are exposed to emotional or behavioral issues (i.e. teachers) were excluded. The search terms used were kept general to ensure a wide inclusion of

articles, especially given the publication gap on mental health topics in Arab countries (Jaalouk, Okasha, Salamoun, & Karam, 2012). They were combined using the 'AND' instructor in each of the databases (see Table 1).

Table 1 Search terms used in scientific databases.

Free search terms
1. Attitude* OR perception* OR belie* Or bias* OR mindset OR opinion* OR perspective* OR position* OR prejudice* OR stance* OR view*;
2. Psycholog* OR mental OR psychiatr* OR psychopatholog* OR distress OR emotion* OR feeling*;
3. Intervention OR treatment OR therapy;
4. Middle East OR Arab* OR Syria* OR Saudi* OR Oman OR Yemen OR Kuwait OR Iran OR Iraq OR Palestine OR Jordan OR United Arab Emirates OR Egypt OR Bahrain OR Qatar OR Lebanon OR Afghan*

Additional search terms initially used (i.e. 'wellbeing' OR 'well-being') were excluded after the initial search yielded only 102 studies. After exclusion, the search identified 1659 studies. References and citations from papers included in the study were also hand searched and revealed another four additional studies. Two of these were included in the study. As can be seen in **Error! Reference source not found.**, duplicates were removed, and titles and abstracts reviewed. 38 full text papers remained of which 13 studies met inclusion criteria.

The principal investigator reviewed all titles, abstracts and full texts. A second rater reviewed a random sample of 10% of titles, 10% of abstracts and 50% of the full texts to increase the reliability of selected studies.

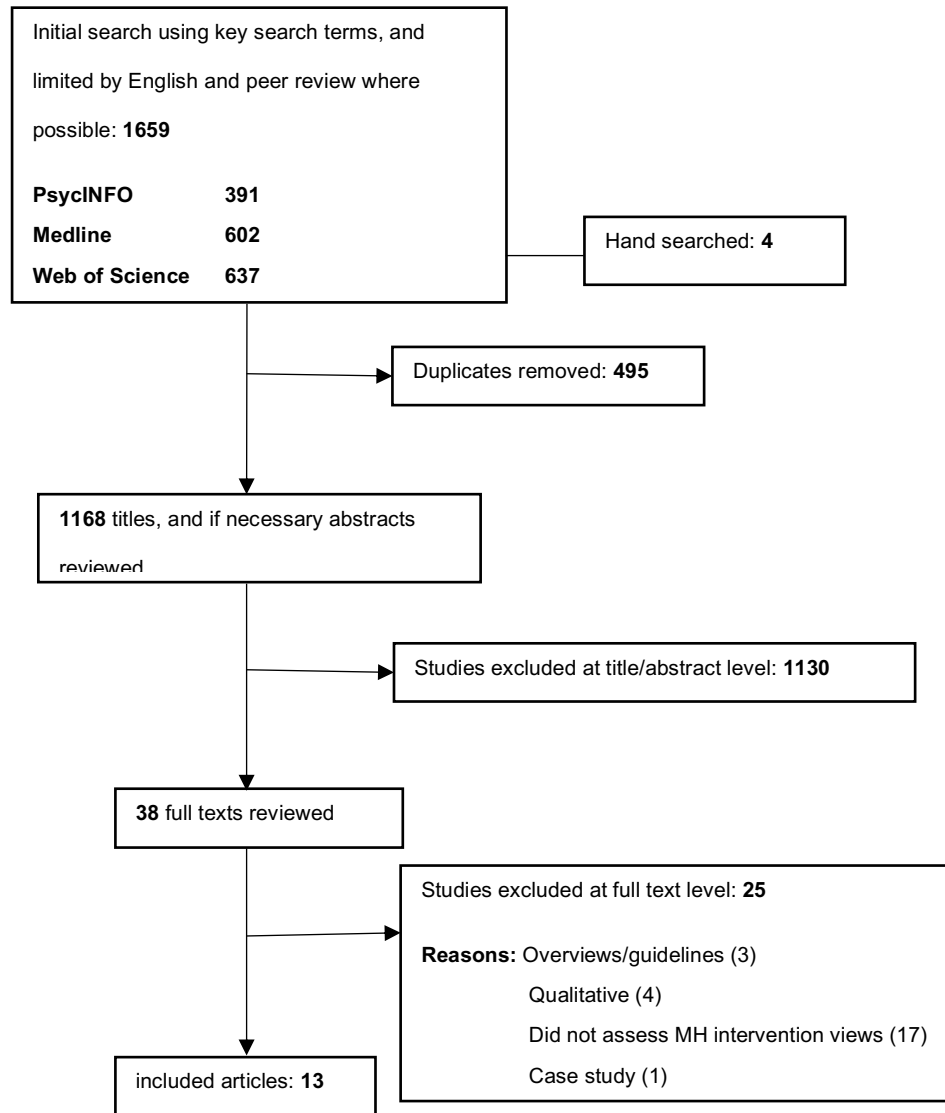


Figure 1 Flow diagram of search strategy

Kappa was calculated to measure interrater reliability and was found to be good ($\kappa=0.7$). As studies examining attitudes on psychological support use a multitude of approaches and focus on a range of aspects (e.g. attitudes towards specific mental health difficulties), it was decided during the full-text selection stage, to only include studies that used measures specifically designed to capture attitudes towards psychological help seeking (e.g. Fischer & Farina, 1995). It was also more feasible to synthesize only quantitative data. Studies that did not have measures of attitudes and qualitative studies were therefore excluded. Importantly, another review was known to be under way focusing on

the qualitative aspects of help-seeking in the Middle East (e.g. Sumra, Ulph & Calam, in preparation).

2.2. Characteristics of included studies

Study information was summarized in Table 2. The studies were published between 2004-May 2017. Most studies were descriptive and used correlational/regression designs.

Three studies were purely descriptive. Participants across the studies ranged between 11-74 years of age, with a total of 6675 respondents. Two studies used only female samples (Al-Krenawi, Graham, Dean, & Eltaiba, 2004; Thabet, El Gammal, & Vostanis, 2006) and in total more females than males were recruited (N=3891/2890). In two studies no age indication was given (Morawska & Sultan, 2016; Thabet et al., 2006), one gave a vague range (Zolezzi, Bensmail, Zahrah, Khaled, & El-Gaili, 2017) and one only gave means and standard deviations (Al-Krenawi, Graham, Al-Bedah, Kadri, & Sehwal, 2009). Eleven studies were conducted nationally and two cross-nationally. Middle Eastern countries included in the studies were from; Israel (6), Jordan (3), Gaza (1), United Arab Emirates (UAE) (1), Qatar (1), Iran (1), Oman (1), Lebanon (1), Egypt (1), Kuwait (1) and Palestine (1). Sample sizes varied, ranging from 73 participants (Basheti, Qunaibi, & Malas, 2015) to 1984 participants (Essau, Olaya, Pasha, Pauli, & Bray, 2013). Recruitment occurred in universities, health care settings, within the community or in refugee camps. Typically, snowball, cluster or convenience sampling methods were used.

Table 2 Study characteristics

No	Authors	Year	Aim/goal/research question	Country	N	Age range	Gender	Roles/settings	Sampling strategy	QATSDD
1	Al Ali et al.	2017	To examine factors that impact attitudes towards MH services.	Jordan	482	18-74	254 females, 226 males	Patients in primary health care setting	Convenience sampling	26 (62%)
2	Al-Krenawi and Graham	2011	To compare attitudes towards MH seeking patterns in Arab students.	Israel	195	18-30	109 females, 81 males	Arab students at Haifa University	Snowball sampling	17 (40%)
3	Al-Krenawi et al.	2004	To compare attitudes towards MH treatment among Arab Muslim female students.	Israel, Jordan, UAE	262	19-24	262 females	Muslim-Arab university students	Snowball sampling	19 (45%)
4	Al-Krenawi et al.	2009	To examine and compare attitudes towards MH help-seeking cross-nationally.	Israel, Egypt, Kuwait, Palestine	716	M=22.05, SD=3.58	436 females, 279 males	Arab university students	Snowball sampling	19 (45%)
5	Basheti et al.	2015	To examine refugees' psychological distress and views on health care services provided.	Jordan	73	19-60	29 females, 44 males	Alzatary camp for refugees	Survey random sampling	26 (62%)
6	Essau et al.	2013	To examine adolescents' knowledge and beliefs about depression and treatments and explore gender differences.	Iran	1984	12-17	993 females, 991 males	Urban and sub-urban schools	Cluster sampling	27 (64%)
7	Hornik-Lurie et al.	2014	To examine attitudes towards mental health treatment and impact of physicians on seeking treatment.	Israel	902	25-75	591 females, 311 males	Jewish patients in primary care clinics	Convenience sampling	23 (55%)
8	Maalouf et al.	2016	To estimate prevalence of mental health problems and help-seeking behavior.	Lebanon	510	11-17	224 females, 286 males	Sampled households in Beirut	Multistage cluster sampling	31 (74%)

No	Authors	Year	Aim/goal/research question	Country	N	Age range	Gender	Roles/settings	Sampling strategy	QATSDD
9	Morawska & Sultan	2016	To examine parents' attitudes towards children's emotional and behavioral problems and factors impacting on service utilization.	Oman	204	Parents' ages not given	160 females, 43 males	Community sample of parents with children aged 4-14 in Muscat	Cluster and snowball sampling	32 (76%)
10	Nurit	2016	To examine service utilization with regard to level of depressive symptoms, attitudes towards psychological treatment, physician referrals and accessibility.	Israel	509	66-92	260 females, 249 males	Jewish older adult community sample in Israel	National random digit dialing	30 (71%)
11	Shechtman et al.	2010	To examine if public and self-stigma impact on attitudes and intentions to utilize group therapy. To examine the extent of cultural factors on stigma and attitudes towards psychological treatment.	Israel	307	18-42	154 females, 153 males	Jewish and Arabic university students at three Israeli universities	Convenience sampling	32 (76%)
12	Thabet et al.	2006	To examine mothers' beliefs and attitudes of their children's MH problems and types of treatment.	Gaza	249	n/a	249 females	Mothers in refugee camp in Gaza	Cluster sampling	25 (59%)
13	Zolezzi et al.	2017	To examine knowledge, attitudes and beliefs about MH problems and treatment of university students.	Qatar	282	<18-30<	116 females, 114 males	UG and graduate students from Qatar University	Convenience sampling	19 (45%)

Note. UAE= United Arab Emirates, UG= Undergraduate

2.3. Quality appraisal

To assess the methodological quality of the included studies, the Quality Assessment Tool for Studies of Diverse Designs (QATSDD: Sirriyeh, Lawton, Gardner, & Armitage, 2012) was used (Appendix B). Quality assessment tools for randomized controlled trials or experimental studies were not suitable due to the designs used in the included studies. Although this review did not use a mixed-method approach, the QATSDD provided a good fit for the studies. The tool has shown good validity and reliability (Sirriyeh et al., 2012) and has been used in numerous published papers (e.g. Augestad & Jiang, 2015; Dias, Rodrigues, da Costa-Pereira, & Magro, 2013).

The QATSDD is comprised of 16 items. These items focus for instance on explicit theoretical frameworks, descriptions of research settings, procedures, and statistical assessment of reliability and validity of measurement tools. The items are rated on a 4-point scale as: 'not at all', 'very slightly', 'moderately' and 'completely' with a maximum score of 42. Scores of ≥ 30 indicate very good methodological quality. The ratings are based on scoring guidance notes given by the authors. For instance, for the criterium "Explicit theoretical framework", if it was not mentioned at all, score 0, if reference to broad theoretical basis is made, score 1, if reference to specific theoretical basis is made, score 2, etc. A second rater (qualified forensic psychologist), assessed 50% of the studies. Where discrepancies existed between raters these were reviewed and discussed as recommended by Sirriyeh et al. (2012).

Percentage scores were calculated by dividing each QATSDD score by the maximum score and categorized as: 75% and above= high quality; 50%-75% = good quality; 25%-50% = moderate quality (Augestad & Jiang, 2015). Papers ranged between 40%-76%, showing moderate to high methodological quality of papers (see Table 2). None of the studies were excluded on the basis of the quality assessment scores. However, the methodological quality of the studies was considered when interpreting the results.

2.4. Data extraction

Only relevant outcomes were extracted from the studies. These included (1) attitudes towards mental health treatment from questionnaires or indirectly using treatment preference, (2) stigma, and (3) considered utilization of MH treatment. Key findings for each study were presented in Table 3.

3. Data synthesis

Due to the different study designs, outcome measures and differing sample sizes identified by the search, a meta-analysis was not conducted. Instead, the data were synthesized using a narrative synthesis approach, informed by guidelines from Rodgers (Rodgers et al., 2009).

Questionnaires on attitudes towards seeking mental health support varied and included seven studies with existing, standardized scales. Six developed measures for their studies and one study used a clinical vignette. Although a number of studies used the same measure to examine attitudes (OSPH: Fischer & Turner, 1970), not all studies included mean scores and different factors were regressed. Therefore, comparisons based on their statistical analyses would not have been meaningful. Most of the extractable data examined factors impacting on attitudes rather than measuring attitudes directly. Stigma was measured in five studies with 4 different scales of which one used scales for public stigma and self-stigma (Shechtman, Vogel, & Maman, 2010). Intended utilization was expressed as percentage.

Table 3 Outcomes of studies with key findings in alphabetical order

Author	Year	Study design	Measure used	Attitudes/views towards psychological interventions	Stigma measure	Stigma towards psych. interventions	Considered utilization of MH treatment
Al Ali	2017	Descriptive, correlations, regressions	ATSFMHS CBMHP	Cultural beliefs about MH predicted lower help-seeking attitudes. Gender, age, marital status and level of education had no impact on attitudes towards seeking psychological support. Help-seeking preference did not predict attitude.	ATSFMHS	Higher perceived societal stigma was the best predictor of low help-seeking attitude in this study.	16% of sample would seek help from a MH professional. 66% would seek help from informal source (i.e. religious consultant, family member, close friend). 18% would not seek help.
Al-Krenawi	2004	Regression	OSPH	Age, time in higher education and being married were positively associated with attitudes towards seeking help. Nationality was not significantly related to help-seeking attitudes.		N/A	N/A
Al-Krenawi	2009	Regression	OSPH	Cultural differences found in attitudes - Kuwaiti subjects were higher in 'recognition of personal need' of therapy. Cultural differences in confidence in MH services – Palestinians had higher confidence than Israeli Arabs, Egyptians and Kuwaitis.	OSPH	Cultural differences in stigmatization beliefs, Palestinian and Israeli Arab subjects showed stronger stigma beliefs than Egyptian and Kuwaiti subjects.	N/A

Author	Year	Study design	Measure used	Attitudes/views towards psychological interventions	Stigma measure	Stigma towards psych. interventions	Considered utilization of MH treatment
Al-Krenawi & Graham	2011	MANOVA, univariate ANOVA	OSPH	Age positively associated with positive attitude. Higher age related to higher 'recognition of personal need' for therapy. Higher confidence in MH associated with higher recognition of personal need for therapy.	OSPH	Higher feeling of threat of stigmatization after psychological treatment correlated with lowered 'recognition of personal need'.	N/A
Basheti	2015	Descriptive, regressions	Authors own questionnaire	46% felt need for psychological support.		N/A	
Essau	2013	Z tests to examine age and gender differences	Clinical vignette	N/A		N/A	Average 66% would see psychologist and counsellor, more girls considered MH support to be useful. No age differences between 12-14 and 15-17year olds. Average 61% would seek help from GP, average 57% close family, 56% close friend, 16% would not seek help.
Hornik-Lurie	2014	Descriptive, regression	Readiness to seek MH treatment	Probability of positive attitude towards mental health treatment higher in women than men. probability of negative or uncertain attitude higher in adults over 65, and ages 25-34, patients with lower school education, those who were ultra-Orthodox, and those not feeling subjectively psychologically distressed.		N/A	54% willing. 33% uncertain. 13% unwilling.

Author	Year	Study design	Measure used	Attitudes/views towards psychological interventions	Stigma measure	Stigma towards psych. interventions	Considered utilization of MH treatment
Maalouf	2016	Descriptive, correlational	Authors own questionnaire about seeking MH treatment.	N/A		N/A	36% of parents whose children received a psychiatric diagnosis considered for their child to see a MH professional.
Morawska	2016	Descriptive	OSPH	<p>Negative attitudes towards seeking MH treatment as indicated by low interpersonal openness.</p> <p>Parents whose children scored in clinical range on the SDQ had higher 'recognition of need for help' than those who scored in the non-clinical range.</p> <p>Higher education levels were related to more positive help-seeking attitudes.</p> <p>Higher household incomes were related to more positive attitudes.</p>	OSPH	Parents tended to have negative attitudes towards seeking MH treatment as indicated by low stigma tolerance.	
Nurit	2016	Descriptive, regression	ATSPPHS	<p>Participants showed positive attitudes towards psychological treatment.</p> <p>Odds of using psychotherapy were higher in participants with higher depressive symptoms, positive attitude towards psychological treatment, GP referral, and accessibility of psychological services.</p>		N/A	N/A

Author	Year	Study design	Measure used	Attitudes/views towards psychological interventions	Stigma measure	Stigma towards psych. interventions	Considered utilization of MH treatment
Shechtman	2010	Path analysis, correlations	ATSPPHS-S	<p>Intentions to seek help were linked to attitudes towards help-seeking for both individual and group therapy.</p> <p>Older participants had more positive attitudes towards seeking psychological help.</p> <p>Women had more positive attitudes and intentions to seek help, compared to men.</p>	<p>Public stigma: Devaluation-Discrimination scale (DD).</p> <p>Self-stigma: Self-stigma of seeking help. scale (SSOSH)</p>	Self-stigma towards individual and group therapy were negatively correlated with attitudes and intentions towards individual and group therapy.	N/A
Thabet	2006	Descriptive	Questionnaire about seeking MH treatment	<p>Preferred types of treatment for their children:</p> <p>85% stated psychotherapy,</p> <p>63% stated medication,</p> <p>61% stated citings from the Quraan,</p> <p>15% would take children to a smoking setting to inhale Bokhour.</p>		N/A	<p>63% of parents stated they would seek help from psychologist/psychiatrist.</p> <p>70% would seek help from GP.</p> <p>52% would seek help from a social worker.</p> <p>4% would seek traditional Arab treatment.</p>
Zolezzi	2017	Descriptive	Questionnaire about seeking MH treatment	<p>Preferred types of treatment:</p> <p>69% stated Individual counselling</p> <p>68% stated medication,</p> <p>21% stated marriage</p>		N/A	<p>82% of sample considered asking for help from psychiatrist.</p> <p>85% would seek help from family member.</p> <p>47% considered help from GP.</p> <p>45% considered help from pharmacist.</p> <p>37% considered help from nurse.</p>

Note. ATSFMHS= Attitudes toward seeking formal mental health services; CBMHP= Cultural Beliefs about Mental Health Problems; OSPH= Orientations for seeking professional help; MH= Mental Health; ATSPPHS = Attitudes toward seeking professional psychological help scale; ATSPPHS-S= Attitudes toward seeking professional psychological help scale shortened version

3.1. Attitudes and seeking psychological support

Two studies clearly stated participants' attitudes towards mental health interventions. Whereas Morawska & Sultan (2016) found attitudes to be generally negative, Nurit and colleagues found the opposite (Nurit, Dana, & Yuval, 2016). One likely reason for these contradictory findings may be the population groups used. The former study examined parents' attitudes linked to their children's MH and the latter examined attitudes of older adults (>65). Nurit et al. discussed how 'perceived need' was an important factor impacting attitudes. It is possible that parents perceive their children's mental health problems as behaviours that they have parental responsibility for and therefore have lower perceived need for external support. However, personally experiencing mental health problems is likely to increase the perceived need for help and hence impacts positively on attitudes (e.g. Nurit et al., 2016). Severity of symptoms and perceived need of help are further discussed in Section 3.4.1.

Attitudes towards psychological treatment were examined by assessing preferred type of support in four studies (Al Ali, Alqurneh, Dalky, & Al-Omari, 2017; Essau et al., 2013; Salem, Saleh, Yousef & Sabri, 2009; Thabet et al., 2006; Zolezzi et al., 2017). Al Ali et al. (2017) reported the lowest preference for seeking mental health support, at only 16%, compared to 66% preferring informal support from family, friends, and religious leaders. Other studies also reported high rates of community/family support (Essau et al., 2013; Thabet et al., 2006; Zolezzi et al., 2017). In three studies over 60% of individuals reported a preference to seek psychological treatment, i.e. psychologist or counsellor (Essau et al., 2013; Thabet et al., 2006; Zolezzi et al., 2017). With the exception of Al Ali's study, general practitioners were important points of seeking support, with preferences as high as 70% (Thabet et al., 2006). Al Ali and colleagues reported that only 5% of their sample would seek help from a GP for mental health difficulties. The stark difference of help-seeking patterns in Al Ali's study compared to the other studies is interesting. All studies were conducted in different countries. Although it is possible that individuals in Jordan

were less likely to seek psychological treatment compared to individuals in Iran, Gaza and Qatar, there is no clear evidence for cultural differences. There did not seem to be a link between the findings and the year of publication, as it could have been hypothesized that more recent studies would show higher preferences of psychological treatment, given the mhGAP initiatives.

3.2. Stigma

Five studies assessed the role of stigma on attitudes, with regard to help-seeking and recognition of need for help (Al-Krenawi et al., 2009; Al-Krenawi & Graham, 2011; Al Ali et al., 2017; Morawska et al., 2016; Shechtman et al., 2010). All studies, although ranging in methodological quality, found that perceived stigma was related to more negative attitudes towards psychological treatment, lower intentions to seek help (Shechtman et al., 2010), and lower recognition of needing support (Al-Krenawi & Graham, 2011).

3.3. Considered utilization of psychological treatment

Considered utilization of treatment was examined in seven studies and findings were mixed. For instance, Al Ali et al. (2017) found that only 16% of the sample would seek psychological help, suggesting that to this date, attitudes towards psychological treatment are likely to impact utilization in some Middle Eastern areas. Other studies reported considered utilization of psychological treatment ranging from 36-82% (Basheti et al., 2015; Essau et al., 2013; Hornik-Lurie, Lerner, Zilber, Feinson & Cwikel, 2014; Maalouf et al., 2016; Thabet et al., 2006; Zolezzi et al., 2017). In three studies between 13-18% of people did not want to seek help at all (Al Ali et al., 2017, Hornik-Lurie et al., 2014, Essau et al., 2013). Highest considered utilization (82%) was in Qatar (Zolezzi et al., 2017).

3.4. Factors influencing attitudes towards psychological treatment

3.4.1. *Severity of MH problems*

Two studies examined symptom severity and attitude towards psychological treatment (Nurit et al., 2016; Hornik-Lurie et al., 2014). Both studies found that higher perceived

severity of problems was associated with more positive attitudes towards psychological treatment.

3.4.2. Attitude, age and marital status

Four studies assessed the association between attitudes towards psychological interventions and age. Al-Krenawi & Graham (2011) and Shechtman et al. (2010) found a positive correlation between these factors in Israel, indicating a potential link. With increasing age, attitudes towards psychological interventions and seeking help became more positive. Al Ali and colleagues (2017) did not find a link between age and attitudes in Jordan. Differences in findings could be due to cultural differences. Hornik-Lurie et al. (2014) reported that in a sample of 25 to 75-year-old individuals in Israel, those between the ages of 25-34 as well as those over 65 held more negative attitudes towards psychological support. This suggests a less linear relationship between attitudes and age. Both age range and sample size in the studies by Al-Krenawi & Graham (2011) and Shechtman et al. (2010) were much smaller than in the studies by Hornik-Lurie et al. (2014) and Al Ali et al. (2017), which may have led to the difference in findings. Furthermore, all four studies used different measures to examine the link between age and attitudes which could have had an impact on the results.

Being married was related to more positive attitudes towards psychological interventions (Al-Krenawi et al., 2004). However, older participants also showed more positive attitudes towards psychological services and as married participants tended to be older, marital status could have been an artefact rather than a significant factor that facilitated positive views. Al Ali et al. (2017) did not find marital status to impact attitudes and compared to Al-Krenawi et al. (2004) had a much larger sample size and better methodological quality. This further supports the possibility that marital status does not directly affect attitudes towards mental health treatment.

3.4.3. *Gender and level of education*

Four studies examined gender differences in attitudes towards seeking psychological support. Al Ali et al. (2017) found no gender differences. Three studies found women to have more positive attitudes than men (Shechtman et al., 2010; Hornik-Lurie et al., 2014; Essau et al., 2013). As the methodological quality of all four studies was good, this should not have impacted on the results. Age ranges and settings varied across studies but given that Hornik-Lurie's study was very similar in terms of age range and setting to Al Ali's study, these factors also do not appear to explain differences in findings. Perhaps, the diverse findings were due to cultural differences, with Al Ali's study being conducted in Jordan. It is also possible that differences were due to the use of different measures. In Hornik-Lurie's study a vignette assessed participants attitudes by asking them to imagine a friend with MH problems and then imagine themselves having that problem. In Al-Ali's study attitudes were measured using a questionnaire, without added context and perspective changes, which are likely to impact on participants' responses.

Five studies assessed the link between level of education and attitudes towards psychological interventions. The majority found that higher levels of education were associated with more positive attitudes (Al-Krenawi & Graham, 2011; Al-Krenawi et al., 2004; Hornik-Lurie et al., 2014; Morawska et al., 2016). This was shown in four different countries. However, in Al-Krenawi's studies, attitudes were compared between university students of different years rather than between different population groups. Al Ali et al. (2017) found no impact of education level on attitudes. Their study included a bigger sample and was not limited to university students. Hornik-Lurie used a similar recruitment strategy to Al-Ali. Perhaps, the difference in result was linked to the distribution of respondents with different levels of education. Participants in Hornik-Lurie's study were more evenly distributed, making comparisons between groups more meaningful. In Al-Ali's study only few participants (5%) were in the highest education level bracket, and most participants fell into the diploma/bachelor bracket (68%). Here, statistical power to detect

differences is much lower. Although household income was also positively related to attitudes, income typically depends on level of education and may therefore not be predictive of attitudes in its own right.

4. Discussion

The studies included in this review measured, mostly indirectly, attitudes towards psychological interventions in the Middle East. Methodological quality was moderate to high and measures to explore attitudes varied across studies. The findings of the studies were mixed. Some studies reported more negative attitudes towards psychological treatment (Morawska & Sultan, 2016), other studies showed more positive attitudes (Nurit et al., 2016). Most studies that examined treatment preference, preferred sources of help and considered use of services found that typically more than half of the sample would seek help from MH professionals (Essau et al., 2013, Hornik-Lurie et al., 2014, Thabet et al., 2006; Zolezzi et al., 2017). The findings also showed that individuals living in Middle Eastern countries would seek help for MH problems first and foremost from friends and family (Al Ali et al., 2017, Essau et al., 2013, Hornik-Lurie et al., 2014). Only a small percentage of individuals reported not wanting to seek any help (Al Ali et al., 2017, Essau et al., 2013, Zolezzi et al., 2017).

One of the most salient findings was that perceived stigma was consistently found to be negatively linked with attitudes towards psychological treatment and help-seeking (Al-Krenawi & Graham, 2011; Al-Krenawi et al., 2009; Al Ali et al., 2017; Morawska & Sultan, 2016; Shechtman et al., 2010). This is in line with other research, showing that stigma was an important barrier to seeking help (e.g. Gearing et al., 2012; Sewilam et al., 2015).

Studies that examined factors thought to impact attitudes on psychological interventions showed that higher severity of mental health problems had a positive impact on attitudes towards psychological treatment (Nurit et al., 2016). Findings were mixed for the impact of age (Al-Krenawi & Graham, 2011; Shechtman et al., 2010; Al Ali et al., 2017; Hornik-Lurie et al. 2014), level of education (Al-Krenawi & Graham, 2011; Al-Krenawi et al., 2004;

Hornik-Lurie et al., 2014; Morawska et al., 2016), and gender (Shechtman et al., 2010; Hornik-Lurie et al., 2014; Essau et al., 2013, Al Ali et al, 2017).

4.1. Seeking help

Surprisingly, despite national efforts in Jordan to increase mental health awareness (WHO Profile on mental health in development, 2013), Al Ali et al. (2017) showed the lowest percentage of individuals seeking help from MH professionals or their GP within this review. This suggests that, despite efforts to increase MH utilization in Jordan, access to services may still be hindered by negative attitudes towards psychological interventions. However, the findings also highlighted that many individuals would seek help from mental health professionals (Essau et al., 2013, Hornik-Lurie et al., 2014, Thabet et al., 2006; Zolezzi et al., 2017) but that family and friends were their first line of support (Al Ali et al., 2017, Essau et al., 2013, Hornik-Lurie et al., 2014). One question this raises is whether the findings point to a generally negative attitude towards psychological interventions or whether it highlights a natural step-wise increase in help-seeking, from talking to close family or friends about manageable difficulties to seeking other, more professional avenues of support with increasing severity of problems. Other studies, both in the Middle East and elsewhere that examined this found similar help-seeking pattern. For instance, qualitative studies of older adults in the USA and a sample of men and women in Egypt were or would seek help from the community, especially family and friends first, before seeking professional help (Kitchen Andren et al., 2013; Coker, 2005).

4.2. Stigma

The link between perceived stigma and negative attitudes towards MH treatment is in line with other studies and reviews in the Middle East and USA (e.g. Kitchen Andren et al., 2013; Gearing et al., 2012; Sewilam et al., 2015). Barney and colleagues showed that in a large Australian sample just under half of the individuals would be embarrassed to see a psychologist or psychiatrist (38% and 44%, respectively) (Barney, Griffiths, Jorm, & Christensen, 2006). Perceived stigma from others was equally high. They found that

higher self-stigma and perceived stigma reduced the likelihood of seeking psychological help. Similarly, in a qualitative study by Al-Darmaki and colleagues perceived social stigma as well as self-stigma was a barrier to seeking psychological help (Al-Darmaki, Thomas & Yaaqeib, 2016). Negative views about psychological treatment also tie in with cultural beliefs about mental illness. In a series of case studies in Israel, particularly the Persian participants perceived there to be more stigma for mental health problems, than participants from other cultural groups (Minuchin-Itzigsohn, Ben-Shaoul, Weingrod & Krasilowsky, 1984). They often expressed somatic symptoms as this was more acceptable than mental health problems. In addition, within a Muslim context a narrative exists that God will heal all problems (e.g. Thomas, Al-Quarni & Furber, 2015). If this is then perceived as the only way to seek help, accessing services may be viewed as “weak” or going against religious beliefs. Furthermore, supernatural beliefs about *jinn*s and the evil eye may also contribute to stigma (El-Islam & Ahmed, 1971; Thomas et al., 2015). On the other hand, Al-Darmaki and colleagues found that in female college students in the UAE mental health problems were not attributed to these religious beliefs but focused on bio-psycho-social explanations (Al-Darmaki et al., 2016).

The findings here and in the literature can guide the development of targeted engagement to raise awareness and reduce stigma, for instance by educating people about how holy scripts do not discourage seeking non-spiritual support.

4.3. Factors impacting attitudes towards psychological interventions

Some studies explored the effect of different factors on attitudes towards psychological interventions. Findings were mixed for the association between age and attitudes. It is possible that the younger generations are more open to psychological support, given easier access to knowledge and exposure to MH problems through the media (Schomerus et al., 2012). Certainly, within the literature the trend points towards a negative relationship between attitudes and age (Yuan et al., 2016). Individuals aged 65 and above may hold beliefs that problems such as depression are normal and expected

(Sarkisian, Lee-Henderson & Mangione, 2003). Kitchen Andren et al. (2012) found that stigma and self-reliance were important factors that hindered service utilization and impacted on attitudes towards MH treatment. Pepin and colleagues on the other hand found that amongst university students and older adults help-seeking was less impacted by stigma when the two groups were directly compared (Pepin, Segal, & Coolidge, 2009). More evidence is needed using large samples, wide age ranges and appropriate comparison groups, to examine the link between age and attitude towards MH treatment to better target strategies to improve attitudes and MH utilization.

The review also found that men held more negative attitudes compared to women. This is a consistent finding in the literature cross-culturally (e.g. Barney et al., 2006; e.g. Park, Jeon, Lee, Ko, & Kim, 2018; Pepin et al., 2009) It is possible that this is linked to a typically lower likelihood of men to utilize services (Möller-Leimkühler, 2002). In her review, Möller-Leimkühler suggests that factors such as under-evaluation, non-perception or symptom denial may impact men's lower help-seeking response.

Education seemed to impact on individuals' attitudes (Al-Krenawi & Graham, 2011; Al-Krenawi et al., 2004; Hornik-Lurie et al., 2014; Morawska et al., 2016). Although speculative, Yuan and colleagues suggest this may be linked to individuals with higher levels of education having a better understanding of mental health information and better access to such information (Yuan, Abdin, Picco, Vaingankar, Shahwan et al., 2016).

The positive link between symptom severity and attitudes towards psychological treatment is in line with other research which identifies this factor as a motivator to seek help (Li, Denson, & Dorstyn, 2018; Thompson, Hunt, & Issakidis, 2004). For instance, in Thompson et al.'s study, 66% of participants sought help because their symptoms became unmanageable and highlights that symptom recognition is crucial for seeking help. This supports the importance of raising MH awareness.

The findings presented here also suggest that more engagement strategies are necessary. Some initiatives have focused on training general health staff in MH and

provided a useful guide (International Medical Corps, 2017). The guide contains a proposed list of steps to implement this strategy, including (1) involvement of stakeholders, in terms of national policies, belief systems, (2) training of staff, (3) providing interventions, (4) basing practice on holistic integration, in terms of referral mechanism, treatment adherence, etc., (5) advocating program. Some of the advantages of this approach are better access, potentially earlier recognition of MH problems, and reduced stigma perception, given that individuals are seen in general health care settings rather than psychological or psychiatric settings. Although this strategy was used in African countries and in the Philippines, it could be equally relevant in Middle Eastern countries. It is also consistent with other recommendations (see Gearing et al., 2012).

4.4. Limitations

Although some studies found that age, gender and level of education were associated with attitudes towards psychological support (Al-Krenawi & Graham, 2011; Al-Krenawi et al., 2004b; Essau et al., 2013; Hornik-Lurie et al., 2014; Morawska & Sultan, 2016; Shechtman et al., 2010), this does not mean that these factors have a direct impact on actual utilization. None of the studies examined a potential mediating effect of attitudes on intention to seek help, in line with the Theory of Planned Behavior (Ajzen, 1988). Although findings on attitudes and factors impacting these are likely to be relevant for service utilization, they are unlikely to be the sole predictors and hence conclusions about the impact of the individual factors on attitudes and utilization were made tentatively.

The results on the link between considered utilization and attitude towards MH support varied (Al Ali, Alqurneh, et al., 2017; Basheti et al., 2015; Essau et al., 2013; Hornik-Lurie et al., 2014; Maalouf et al., 2016; Thabet et al., 2006; Zolezzi et al., 2017). It should be noted that there were many university students and graduates within studies. As several studies have found a link between level of education and attitudes towards psychological treatment (Al-Krenawi & Graham, 2011; Al-Krenawi et al., 2004b; Hornik-Lurie et al., 2014; Morawska & Sultan, 2016), the results may not be representative of the general

population. Although the methodological quality of the studies was moderate to high, sampling biases meant that individuals recruited were from specific populations, e.g. university students, or potentially had particular attitudes that made them more likely to participate (e.g. snowball sampling), thereby reducing the overall validity of their findings. It also reduces the generalizability of the findings. Nonetheless, if shifts in attitudes are present in some population groups, this could have a positive effect on other population groups over time.

Utilization of psychological treatment, although an important factor to assess, in part depends on availability and awareness of services. It was beyond the scope of this review to also examine these factors.

A question that this review could not answer was whether national and international programs to increase MH awareness and reduce stigma have led to change in attitudes. The studies were cross-sectional, making assessments of change over time impossible. In addition, as the review focused only on quantitative studies, insight into individuals' attitudes towards mental health interventions was only explored through questionnaire data. More in-depth accounts of this topic derived from qualitative designs, were not included due to other reviews highlighting these particular aspects (e.g. Sumra, Ulph & Calam, in prep).

Furthermore, the search for studies was limited to the English language and peer-reviewed papers. The search was also restricted to four search engines. Papers were also hand searched from reviewing references and citations of included studies. Due to time constraints it was not possible to hand search all papers that were found by the initial search. Therefore, relevant studies, studies in the grey literature and studies published in other languages were potentially missed.

4.5. Conclusion and clinical applications

This review summarized current findings in the literature on attitudes towards mental health interventions. Future studies that aim to examine attitudes towards MH would benefit by basing their research designs on models of attitudes and behavior, e.g. the Theory of Planned Behavior. This will allow for a grounded approach that will take into account the different aspects that impact on behavior, such as behavioral intentions, perceived behavioral control and perceived social pressures (Ajzen, 1991).

Future studies and especially longitudinal studies that use standardized measures to examine attitudes and other factors impacting on behavior can assess changes over time. This will have implications for MH programs, their focus and their effectiveness.

Although findings of this review were somewhat mixed, a large number of individuals considered psychological support as one of their options. However, stigma is and was a consistent barrier to utilization and impacts on individuals' attitudes (Al-Krenawi & Graham, 2011; Al-Krenawi et al., 2009; Morawska et al., 2016; Shechtman et al., 2010). Given the impact of stigma on attitudes towards psychological treatment and utilization, it will be important to continue efforts to raise MH awareness and base this education on the unique cultural perceptions that currently stop individuals from accessing the help they need. As individuals preferred to seek support in the first instance from family and friends, it is important to raise awareness of MH and available support through those links, addressing individuals to support their friends and family and suggest treatment options they can pass on.

5. References

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Paper 2: Factors impacting on Syrian parents' decision to engage in a parenting intervention in the UK: An Interpretative Phenomenological Analysis study

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Abstract

Through conflict, displacement and resettlement in a new country, displaced families are faced with many challenges that impact on their parenting. Research suggests that there is a need for parenting support and in response a brief parenting intervention ('Conversation Group') and linked booklet were developed. This qualitative study explores four Syrian women's experiences of deciding whether to engage with the Conversation Group in the resettlement phase of displacement in the UK. Prior to the interview, they received the booklet to familiarise themselves with the content. Focusing on their decision-making process, Interpretative Phenomenological Analysis (IPA) was used to analyse the data. Two superordinate themes emerged: Connection and Help-seeking. Participants expressed an absence/lack of and a need for connection and shared experiences. The group was felt to meet that need. However, participants were also uncertain, especially about other group members. Although some women had positive experiences of support, overall there was a sense of lack of services meeting the individuals' needs and feelings of abandonment. These experiences, as well as their perceived need for help impacted on their decision to engage in parenting support. The clinical implications of these findings include the importance of positive experiences with services and a responsibility for services to facilitate this. In offering group support it would benefit service users to receive information that reduces uncertainty about the group set up and members. Such information should also aim to highlight the sense of connection this group may offer. Considerations of cultural differences and language barriers are important and service users' needs (e.g. child care, work) need to be accommodated.

Key words: parenting; displacement; help-seeking; Interpretative Phenomenological Analysis; service user perspective; Syria

1. Introduction

Current wars and crises around the world mean that approximately 28 million children have experienced displacement (United Nations Children's Fund [UNICEF], 2016). Many reports have shown that exposure to armed conflict, loss, resettlement, uncertainty about family members, and uncertainty about the future can exacerbate and cause psychological problems in these children, such as anxiety, depression and post-traumatic stress (Cartwright, El-Khani, Subryan, & Calam, 2015; Dimitry, 2012; Papageorgiou et al., 2000).

Research suggests that parental and familial support can reduce the risk of the child developing mental health problems (Panter-Brick et al., 2011; Havighurst et al., 2013). These findings highlight the need to enhance parenting support to improve mental health of children and parents (El-Khani, Ulph, Peters, & Calam, 2018). Efforts to develop and facilitate such support is therefore vital in decreasing children's emotional and behavioural difficulties. Although findings from individuals living in the Middle East suggest negative attitudes towards mental health interventions and attached stigma (Morawska & Sultan, 2016; Sewilam et al., 2015), research that recently explored whether families in displacement would value parenting support, showed that overall families perceived the parenting advice as useful (e.g. Thabet, El Gammal, & Vostanis, 2006). An exploratory study gathered information from parents about the kind of support displaced parents living through conflict would value (El-Khani et al., 2018). This work formed the basis for developing parenting advice in the form of a leaflet. In order to distribute these to families a bakery that delivered bread daily to an area in North Syria distributed leaflets alongside bread to 3000 Syrians (El-Khani, Cartwright, Redmond, & Calam, 2016). Families were given feedback sheets to rate the usefulness of the information (return rate N= 1783, 59.5%). Feedback for the leaflet was very positive, with 78.5% (N= 1399) of respondents rating its usefulness to be high. However, respondents also felt that they would want more detailed information. In response, a more detailed booklet was developed with a single

session parenting intervention (“Conversation Group”) seminar designed to accompany and enhance this, with the aim to reach parents in need of such support for their children. The Conversation Group will be offered to displaced families in the resettlement phase of migration, which in this study will be defined as having settled in a new country. However, research suggests that displaced individuals typically face many barriers to engaging with services that could offer this kind of support. For instance, displaced individuals may be single parents, have low socioeconomic status, mental health problems and daily stresses (i.e. financial, family conflict, etc), low recognition of need for help, ethnic minority status, face practical barriers (e.g. transport, translator availability, timing of appointments), and may have negative attitudes towards mental health services (Nock & Ferriter, 2005; Picco et al., 2016; Snell-Johns, Mendez, & Smith, 2004; Staudt, 2007). All these factors have been found to be negatively associated with service engagement. Therefore, although the need for parenting support has been identified in the literature, it may be a challenge for families to access this support. Better understanding the experience of resettled families in engaging with parenting support is vital and perhaps necessary for improving access and engagement with such support. To date there appears to be no research that explores this issue (a) in terms of the decision-making process, (b) with individuals in the resettlement phase of displacement, (c) from the Middle East, and (d) where the treatment offered is a parenting group.

1.1. Aim

The aim was to explore in-depth the decision-making process of displaced parents from Syria resettled in the UK about whether to engage with the Conversation Group. Their experience of this process also served to highlight barriers and facilitating factors that could impact their decision to take part in interventions more generally. Participants’ views of the Conversation Group booklet specifically was also investigated. The findings of this study will contribute to a better understanding of the experience of being faced with the decision to engage in parenting support in the resettlement phase of displacement due to

conflict. This understanding has implications for engagement strategies to increase acceptability of group interventions.

2. Method

2.1. Recruitment

Convenience sampling was used in this study (Onwuegbuzie & Leech, 2007). As a hard-to-reach population group, recruitment relied heavily on third parties, i.e. charity workers who worked directly with the target population. Language barriers and uncertainty about research processes meant that charity organisers had better opportunities to inform potential participants about the study because they spoke Arabic and had formed good relationships with individuals. Charity organisers and volunteers approached potential participants with research flyers in English and Arabic (Appendix D). Where interest existed, interviews were scheduled. In total, 11 organizations were contacted in the North West of England, UK, either in person, via email or phone.

2.2. Eligibility

Participants were included in the study if they (i) were aged 18 or above, as being a very young parent may be associated with even more complex issues, beyond those associated with experiences of conflict and resettlement; (ii) had children between the ages of 4-14, as this was the intended age group for the intervention; (iii) had been living in the UK for 2 years or less, as this allowed face-to-face interviews at a time when displacement was a relevant issue; (iv) spoke Arabic or English and were from the Middle East; and (v) were able to understand the participant information and could give consent to take part, through translation if necessary.

2.3. Participants

Five participants were interviewed, although data from only four participants could be analysed. For one participant, it became apparent during the interview that she had lived in the UK for more than two years. Her circumstances were very different from the other

participants as she had not fled her country due to conflict. In line with the inclusion and exclusion criteria, her data was excluded from the study.

The remaining four participants were Arabic speaking women from Syria, displaced due to the conflict there. All four women lived in Syria with their families when the conflict began. One woman held a British passport but had lived in Syria all her life and did not speak much English before she came to the UK. She and her family had similar experiences in Syria and struggles as well as uncertainties about finding accommodation to the other women. Therefore, her data was included in the study.

2.4. Design

This study used Interpretative Phenomenological Analysis (IPA: Smith, Flowers & Larkin, 2009) with parents resettled in the UK. In the development of the study, service users with experience of mental health difficulties who were part of the Division of Psychology and Mental Health Community Liaison Group were consulted about the study design, procedure and considerations regarding the target population. As the aim was to explore in-depth participants' subjective experiences and their cognitions about making a decision to engage in a parenting intervention, IPA was identified as a suitable qualitative method (Biggerstaff & Thompson, 2008; Pietkiewicz & Smith, 2014). IPA allows the researcher to be brought into the sense-making of what the participant discloses during the interview, i.e. double-hermeneutics. The aim is for the researcher to interpret the data from the participant's point of view and in addition combine this with relevant psychological concepts (Pietkiewicz & Smith, 2014). In the semi-structured interviews, an interview schedule was used to guide the interview process (see Appendix E). The interview schedule was developed by the researcher under the supervision of an experienced IPA researcher. The questions focused first on opening up the conversation by asking about their experience of when they first became aware of the conversation group. They were then asked about who was involved in making the decision to engage in this group, their experience of the booklet, the kind of person who will ask for this type of support, their

feelings about group settings and finally what would change their decision. Where appropriate, follow-up questions were asked to allow an in-depth understanding of the participants' personal experience. The first interview transcript was checked by the experienced IPA supervisor to see if the questions elicited an in-depth account of her experience. As this was the case, no alterations to the interview schedule were made.

The Conversation Group was designed as a brief, single session for displaced families. To explore participants' views about the group, they received the booklet containing the content of the parenting intervention before the interview was held. The booklet covers how parents and children may feel as a consequence of displacement and includes advice about self-care and strategies to support children with their difficulties.

2.5. Measures

A questionnaire to gather demographic information was completed with participants after the interview (Appendix H). This questionnaire was previously used within the research group. Questions included level of education, details about their children, time spent in country of conflict, and details about their journey to the country of resettlement.

2.6. Procedure

Ethical approval was given by the University of Manchester (Appendix E). Participants first received information about the study and had time to ask questions. They then signed the consent form (Appendix F and G). Participants were interviewed in settings familiar to the participants, either community centres or their homes. A certified translator attended all interviews although one interview was conducted in English, with minimal input from the translator (participant 2). The translator had previous experience of translating for qualitative research.

In preparation for the interview, participants were given the booklet to read through in Arabic. As one participant ("Daniela") was not able to read through the booklet beforehand, the researcher gave her 10 minutes before the interview to spend time with

the booklet. Interviews lasted approximately 75 minutes and were audio-recorded. Debrief information was given to all participants with support contacts (Appendix I).

2.7. Data analysis

The researcher transcribed the English responses during the interviews verbatim. The data were then analysed in accordance to IPA guidelines (Smith et al., 2009). The following steps were taken: (i) Each transcript was read several times and initial thoughts were recorded in the margins, (ii) from the initial thoughts, emerging themes were developed by interpreting the underlying meaning of the text. This was done by asking the questions “What is happening for the participant?” and “What is the participant implying but not able to say?” whilst also including general psychological understanding, (iii) for each participant the emerging themes were clustered where patterns were identified, (iv) overarching themes across participants were developed and (v) through peer debriefing the reasons for the developed themes were discussed with an IPA expert to ensure quality assessment of the data (Guba & Lincoln, 1981).

Participants spoke about the booklet containing information about the content of the Conversation Group. IPA on these data proved not to be appropriate as these were superficial and not sufficiently in-depth. To ensure that the findings not only reflect the decision-making process when being offered parenting support, which typically highlights broader barriers and facilitating factors, but also reflect participants' view of the parenting booklet specifically, a Content Analysis was conducted. For this analysis, based on guidelines by Krippendorff (2004), all data specific to the parenting booklet were used. This means that any data that made direct reference to the booklet was included in the analysis. These data were read several times. Meaning units were then extracted that typically consisted of short phrases (e.g. “The ideas are very nice...”; “...helpful in guiding parents to take care of the feelings of their children”). These meaning units were then grouped and the common message within each category identified. The categories were

reviewed by a researcher with expertise in qualitative research methods to ensure quality assessment of the data.

3. Results

The four participants were all linked to the same charity organization. They are briefly introduced before presenting the results of their accounts. Pseudonyms were used to protect their identity.

Dima was a 40-year-old mother of two children, aged 5 and 10. She came to the UK 11 months prior to the interview and had been divorced. She held a university degree.

Although she understood some English, a translator was necessary.

Ayla, aged 49 had come to the UK 9 months prior to the interview with her four children, aged 13, 18, 20 and 24. Her husband had remained in Syria. She had been to high school and was the only participant who did not have a refugee status as she held a British passport. She had been attending an intensive English course for several months and was therefore able to do the interview in English.

Yara, a 43-year-old mother of six children had moved with three of her children, aged 8, 18 and 27 and her husband to the UK 24 months prior to the interview. Her other grown-up children lived in Turkey and a reunion of the family was not possible at present. Yara had no school education. She had only recently started learning English and therefore needed a translator.

Daniela, 30 years old, had been in the UK for 6 months. She and her husband came together with their three children aged 1, 10 and 12. Daniela had spent some time in high school and did not speak English.

3.1. Content Analysis

Using Content Analysis showed that participants described and experienced the Conversation Group booklet in one of three categories: (i) Positive connection with the booklet, (ii) implementation difficulties and (iii) focus on parenting.

3.1.1. *Positive connection with the booklet*

Extraction of data specific to the booklet revealed that 80% of comments about the booklet content were positive and appeared to highlight a connection with the booklet. For instance, mothers stated that the content was good (7 responses), e.g. “It’s good. It’s nice.” (Daniela). They found the booklet understandable (7 responses), e.g. “[booklet] explained a lot of things” (Ayla). Dima and Yara stated that they would want to share the booklet with other parents (3 responses), e.g. “I wish you can give it to every mother” (Yara). Yara expressed that the content reflected their experience (3 responses), e.g. “I thought it reflected a lot of what happened to us [refugee families]”. Each participant gave at least one positive comment about the booklet.

3.1.2. *Implementation difficulties*

Other data were related to implementation difficulties (5 responses) totalling twenty percent of the overall comments, e.g. “...it was very theoretical and difficult to implement, practically” (Dima); “...it’s difficult for you to change your life” (Ayla). These comments were made by Dima and Ayla. Yara did not give any negative comments about the booklet. Daniela was the only mother who stated that the content of the booklet was not new to her.

3.1.3. *Focus on parenting*

Dima and Yara commented on the booklet content that stood out for them the most with regard to parenting: advice about the behaviour and feelings of their children (9 responses), e.g. “This ... caught my attention and made me think about supporting the child, the behaviour” (Dima); “... it was helpful in guiding parents to take care of the

feelings of their children” (Yara). The other mothers did not comment on what stood out for them from the booklet. Given that Daniela had very limited time to study the booklet, it is unsurprising that she did not comment on this aspect. Ayla’s reflection about the booklet focused mainly on the length of the information and what information she would like to have in addition to the booklet. For her it was important to know more about the group members and facilitators. None of the comments related to the booklet were linked, within the narratives, to participants’ decision to take part in the Conversation Group.

3.2. IPA

For these women what was driving the IPA was the decision about being offered help. Two superordinate themes emerged: Connection and Wanting help. These and subordinate themes are shown in diagrammatic form below (see Figure 1). Each theme will be discussed in turn, by using original quotations from participants.

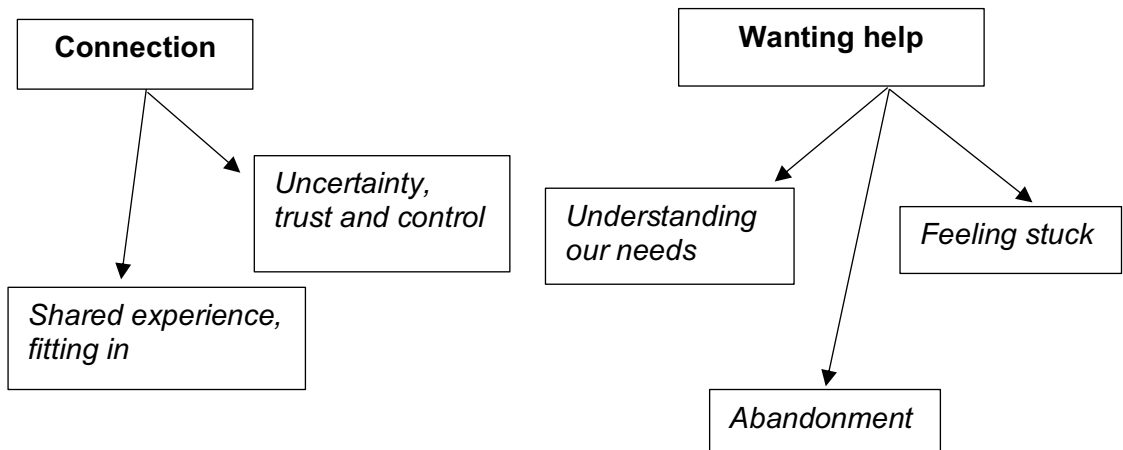


Figure 2 Superordinate themes (bold) and subordinate themes (italics)

3.2.1. Connection

Looking at all the accounts, the data appeared to suggest that there is a strong need for connection, and a sense of absence/lack of connection from both services and other individuals in the community. Connection is important for finding mutual understanding of

difficulties. However, they are also fearful of the group as a way to connect because of the uncertainty of the other group members.

3.2.1.1. *Shared experience, fitting in*

The data appeared to suggest that taking part in a group is not only useful to solve problems, it also fulfils a pressing need for connection and understanding, which is achieved by sharing experiences with like-minded people with similar narratives. For Ayla, finding people with shared experiences seemed to be very important in the search for connection. She expressed that it is the emotional connection and empathising, rather than practical support that she needs. Her use of the word 'never' (in capitals to show emphasis) appears to emphasize the sense of loneliness and disconnection without that shared experience:

Ayla: "...only the people who have the same feeling, they can share this things. Other people they can help you support you, a lot, but they will NEVER feel about, they will never have the sense, about the pain or about this suffering. Only who has the same situation."

Her account and the repetition of the word 'never' also appears to suggest that services may not be able to connect with individuals on the same level as individuals with shared experiences. Therefore, there are important benefits of bringing together people with similar experiences. Indeed, other participants also expressed the potential value of the shared experience in a group setting and the opportunity to learn from each other.

Yara: "...In the first group that I joined I learned things that I didn't know before."

Dima expresses how the group is seen as a potential way to process their experiences in a therapeutic way and develop new perspectives:

“It’s an opportunity ... to listen to other people’s problems that might be even more difficult ... to hear other people’s problems that might be more difficult and provide support for each other.”

The need to share their experiences with people in similar situations also appears to be an opportunity to have their voice heard again and hence to feel valued. Yara, who has attended a number of other groups described:

“...one of the things that I liked about the groups was that people were willing to listen to me whereas before I felt that no one wanted to listen, no one wanted to know.”

This is important, given that the data appears to suggest that their experience in the new country made them feel that at present, for example Dima mentioned “people in higher positions” (politicians) do not understand the difficulties displaced individuals have been going through. There is a sense of disconnection as she went on to say that “success” would be when such people hear their stories and it appears that there may be a need for their voices to be heard to improve policies and support. On the other hand, Ayla expressed experiences of being heard and valued. This experience appears to positively influence the decision to engage with the Conversation Group.

Ayla: “...they [local MP] always send me a letters and anything I want to ask they interested about this.”

Daniela did not express views on the sharing of experiences as useful or needed. Her account focused more on barrier to engaging with groups, for instance “The main problem that I have is language.” Language and cultural aspects appeared to make connecting

with individuals in the UK difficult. There was a sense of 'us and them' (Syria and the UK), creating a barrier to connecting and the use of 'definitely' appears to emphasise a permanent divide, a hurdle that cannot be jumped:

Dima: "...there is an issue of cultural differences and there are things that will definitely cause us to be separate in some senses."

How well-fitted the group appears is going to influence, to some degree, the decision to take part, especially in light of the women's need to connect. Yara spoke about other potential members as friends. In this way, she identifies with the other members as Arabs. Seeing other group members as friends may be linked to the fact that she knew a lot of the women in the groups through the charity organisation:

Yara: "...and she made this group for Arabs who are our friends and there weren't people who didn't speak Arabic."

Ayla spoke about other group members as strangers. The data appeared to suggest an uncertainty about how like-minded they would be and a worry of them being judgemental:

Ayla: "...it's strange because you don't know that person, the other personality, what they think about, they have their own ideas. Maybe they do not agree with you."

She could have been worried about group members being judgemental as in her narrative it appeared that her family did not necessarily understand her viewpoints and tended to be judgemental ("I didn't tell everybody because some people don't understand and they will start to say 'do this' or 'do that' ..."). She also did not spend as much time in the charity organisation as Yara and therefore perhaps did not know the other women as well as her.

Yara's experience of being in groups (e.g. well-being group) gave her a sense of belonging, connection. Whereas talking about their problems they would typically use 'I' (e.g. Ayla "...I don't have any place to go and only in this room with my children in the same room..."), her use of 'we' highlights a new-found community that she is part of.

Yara: "By the end of these lessons we changed to the extent that we were all thinking about what would make us happy, ... we made big lunch for everyone."

3.2.1.2. *Uncertainty, trust and control*

Across all narratives, the women expressed anxiety about the group and the uncertainty of what to expect. Some of them also spoke about trust in those who support them and felt in control. Daniela was the only one who predominantly spoke about uncertainty and lack of control. She did not talk about trust and was the only participant who stated that living in the UK was "*much more difficult than it was*". There was a sense of uncertainty in terms of her gains from the group as she contradicted herself by first saying she "[*does not*] know what she can benefit" from the group and later stated "*It's an educating way and we'll benefit*". As Daniela had only briefly looked at the booklet before the interview, her uncertainty could be linked to not being clear enough on what the group can offer. Uncertainty about group settings was also expressed by Yara who stated:

"When I first entered the group I felt a bit fearful but then I found that it wasn't that bad and it wasn't something to be afraid of"

She was "*fearful*" and "*afraid*" when she first joined a group because she had an expectation that people would be "unjust" and untrustworthy.

Yara: "...I was worried that they would force me to do something I didn't want to do ... or they would make me do something in an unjust way."

There was a sense of having to protect oneself from potential harm on Ayla's account too:

"Some people ... afraid ehm they always maybe something bad will happen. Maybe somebody will hurt, maybe somebody will hurt me, maybe they will speak about that on media,..."

Here it appears that Ayla was talking about how other people may feel. Towards the end she changed from saying 'they' to 'me'. This appears to suggest that she has the same worries as the individuals she talked about. Although she recognised the importance of trust ("*...you must trust people.*"), the worry about others breaking her trust played on her mind, both in close proximity ("*... someone will take this information and speak in front of everybody...*") and in the wider community through the media. This reflects a level of vulnerability which was visible in all accounts.

Dima's data also seemed to highlight a barrier of trust linked to cultural and religious differences.

"...it's not about us not wanting to be or disliking being around other people of different nationalities like English or Chinese, but for me, it's being around like-minded people with the same religion. So that there can be more closeness in the relationships."

The data suggests differences in social distance whereby less trusting, close relationships can be formed with individuals from other backgrounds.

Although worries about the group were expressed, there was also a sense of empowerment (use of “I decided”) that helped Yara for instance to decide to act and join groups. She “started getting courage” with each group she joined and this made her feel in control.

Ayla had attempted joining other groups but could not due to time constraints but had also had many positive support experiences. She stated “...So I decided to be, to see you.” Due to being flexible in arranging an interview date, she was able to engage with the research. The use of “I” suggests an internal drive that made both of them the agent of their decision. The rest of their data suggested that they felt in control not only of the decision but also knew they would have control within the groups. There was a sense of knowing what their rights are and that their decisions within the group would be accepted.

Yara: “I felt that in joining, if I wanted to say something then I could. If I didn’t want to say anything then I could...”

This empowerment and sense of control was something they had the opportunity to experience already. This appears to have impacted on them developing trust and security.

On the other hand, Daniela, who had been in the UK the shortest amount of time compared to the other participants, seemed uncertain about whether she would be given control. She appeared to place the control onto others by saying “making you talk” and appears to be linked, at least in part, to her recent arrival.

Daniela “... if ... people are left free to speak about the issue that concerns them, it’s better than making you talk in front of people.”

3.2.2. *Wanting help*

Participants' decision to take part in the Conversation Group seemed to be linked to experiences with services and highlighted a perceived lack of services understanding and meeting the women's needs. This could impact the decision whether or not to engage with the parenting group. There was a sense of abandonment whereby the individuals felt that services were uncaring. The narratives also gave a sense of being stuck, which highlighted the perceived need for help and reflected on the readiness to ask for help.

3.2.2.1. *Understanding our needs*

There were other considerations that impacted participants' decision-making. Across participants, needs were identified that services could not accommodate and consequently stopped them from engaging. This included an inflexibility around scheduling appointments where participants had multiple needs such as caring responsibilities. There is a sense in the data that the uniqueness of the person ("I am", I have") does not fit with the generically organized events:

Dima: "... I am a single parent, I have got my children on my own and it is sometimes difficult to come to these events that have been organised."

Another issue, that was discussed mainly by Daniela and had extreme significance for her was the need for a translator. Daniela's data seemed to suggest that her biggest priority with regard to any service contact is whether a translator will be provided ("*The first thing I think about when I go anywhere is the translation*"). This emphasises the general importance of communication and the need for services to meet this need. Furthermore, Daniela stated:

“Because there wasn’t a translator at the GP we couldn’t see the doctor and now they’ve given us another appointment for the [date] which is in a long time, her [daughter] situation is getting worse every day.”

This highlights the unavailability of translators for some, giving rise to uncertainty as to whether this need is going to be met in the future.

Despite two other participants needing a translator, their narratives did not focus on translator needs. It is unclear whether this was due to different experiences or whether those interviews simply took other directions.

The lack of accommodating the women’s needs appeared to create an ‘us and them’ divide.

Ayla: “Yeah, they make groups. But I don’t have time to sit. Because I I I’d like to do that but I didn’t have time to go there.”

There is a sense that ‘they’ represent services that try to deliver support. However, the individual (‘I’) cannot take up this support, despite wanting to. Ayla repeated “I don’t have time...I didn’t have time”, which appears to highlight a frustration with the inflexible to deliver support that fits the individual. Yara commented:

“I tried to register at the college and enrol myself on one of their courses but I found that I couldn’t because of the times, the school times of my child.”

Her account indicates that despite proactive efforts to engage with the services, she was not able to pursue her goal. She was not offered alternatives or given support to accommodate her caring needs. The divide between “us and them” also features in her narrative (“I” and “their courses”).

3.2.2.2. *Abandonment*

Looking at all the accounts, it appeared that participants experienced feelings of abandonment, and not feeling heard, in addition to the more practical challenges highlighted in the above theme. From the women's accounts there was a felt sense of helplessness and being devalued by others. For instance, Dima stated that *"no one spoke to me. She just left."* as she described her experience with a social worker. From the rest of her account it appeared that there was a mismatch of expectations which made her feel abandoned.

Dima: "...there is no one available to help so it's difficult to find someone you can ask or would provide help."

Other participants also experienced services as abandoning by not providing the support they needed, leaving them helpless.

Daniela: "At the end when I did go [to the GP] I found that they hadn't brought me a translator."

Daniela's and Dima's accounts highlight their dependency on others, e.g. services, and the difficulty to problem solve when they feel that no one is there to help them.

Abandonment was also expressed by Ayla when discussing her experience regarding children and the involvement and effort provided by services, and in this circumstance schools. She said: *"Never and nobody care about them [children]."* Ayla stating that *"nobody"* cared when talking about services appears to suggest a sense of isolation and

not being worthy of care. In addition, Dima, very emotionally, described that she feels refugees are a burden to the country:

"...we feel that we are imposing ourselves on the country, and that is a very difficult feeling to be feeling. [crying]"

There is a sense from the work "imposing" of feeling unworthy of help and 'needy'.

"Imposing" also appears to highlight her view that others perceive refugees as unrightfully forcing themselves onto the country. It raises the question of whether people in the UK have made her feel this way. It is, however, unclear.

On the other hand, Yara did not express any abandonment but instead described her experiences as very positive. Her experiences were marked by people helping her and not giving up, stating:

"...people here didn't stop supporting us and they gave us help here in the centre."

Yara sounded surprised when talking about this. It seemed to highlight an expectation that people would not be as helpful or not persist in helping for as long as they in fact did.

3.2.2.3. *Feeling stuck*

From the accounts of the women it seemed that the decision-making process also involved a perceived need for help. There is a sense in the data of a gap of knowledge or lack of experience with a certain problem which parents therefore want to seek help for.

Daniela expressed how *"...sometime there would be a specific problem that they don't know how to resolve."*

Ayla reflected on the helplessness that parents may feel in terms of their parenting (*"they [parents] are stuck"*). This may be an internal motivation to engage with support.

Ayla: "...some other parents they really need help, they have some problem with their child and they are stuck. They don't know what shall they do. And they want to come to this conversation group to find a way for them."

Ayla used the phrase "other parents" as if wanting to differentiate between herself and them. It is 'them' who need to seek help. This appears to highlight that a level of readiness is necessary to seek and accept help. This internal readiness was also reflected on by another mother:

Dima: "Someone who has the willpower to change... Someone who is flexible... And who is willing to accept other people's ideas."

These attributes reflect a sense of personal strength that is required to make changes ("willpower") and an ability to take on new perspectives. Ayla also expressed an openness to learning and accepting new ideas "...I can eh know new ways, new skills, new things.". The repetition of 'new' suggests a keen interest in finding new strategies and highlights the parent's agency, wanting to learn strategies that help her to independently support her children and be empowered. Learning new skills is an important part of what Ayla and other participants want from the Conversation Group.

Ayla, on the other hand, also describes how people with low motivation may not take the decision to engage with parenting support:

"...some people they don't like to change anything from their souls because they think they are only right. And they will not accept something new."

This highlights an issue with acceptance of advice and a fear of trying out new ideas. This can hinder the decision to take part in a parenting intervention. It was not clear from the

data whether these issues were linked to cultural differences, personality traits, trust issues or other barriers. One factor that may be important is the perceived benefits from joining a parenting group.

Yara: "She [charity worker] said to us that this group would be good for you and it would eeh improve your psychological wellbeing..."

Yara had experienced other psychology-related groups. It appears that her experience was in line with what the charity worker said about psychological support being helpful. This previous experience impacted on Yara's decision to take part:

"When I saw them here and I trusted them I was happy to join their study... I started getting courage and wherever there is a group I go and join."

4. Discussion

This study was the first to explore Syrian women's experience of deciding whether or not to take part in a parenting intervention during their resettlement phase in the UK. The themes that emerged highlighted factors that impact on decision making, such as a lack of, and yet a need for, connection with others, especially others with similar experiences. These reflected general, rather than intervention-specific aspects of decision-making and give us useful insight into newly resettled Syrian refugee mothers' internal processes that impact on their engagement with support. So far, no research has examined Syrian refugees' experience of making decisions to engage with support in the UK. The women emphasised feelings of uncertainty, were concerned about confidentiality and described issues around trust. Furthermore, help-seeking emerged as a theme with the women expressing both practical and emotional issues related to services. They also reflected on

the perceived need for support. All of these aspects were suggested to impact these women's decision to engage with the Conversation Group. Furthermore, the women in this study felt connected with the content of the Conversation Group booklet.

4.1. Shared experience

For instance, the importance of shared experience was highlighted by the participants and findings in the literature support this notion. Worrall and colleagues reviewed different types of support groups and found that they facilitate inclusion (Worrall, Marks, Yuan, Lloyd, & Ramjan, 2018). Given the need for connection for individuals in the resettlement phase of displacement, this would benefit group members and perhaps should be highlighted when developing engagement strategies for support groups. Furthermore, other research has identified that another facilitating factor for individuals to join groups is the value of a safe space, learning from and supporting each other (Mytton, Ingram, Manns, & Thomas, 2013). On the other hand, the same authors also highlighted that concerns about group dynamics and other group members have been identified and fit with the data in this study.

4.2. Empowerment, control and abandonment

The data also highlighted the importance of empowerment and control. In a mental health context, empowerment and a sense of control are positively associated with recovery (Nelson, Lord, & Ochocka, 2001). These factors allow an individual to become proactive and self-sufficient. On the other hand, if control is seen as external, for instance if the individual feels forced to attend a parenting group or feels the control is in the sole hands of a group facilitator, this may lead to non-engagement and withdrawal (Rothbaum, Weisz, & Snyder, 1982). This may link to styles of dealing with resettlement (Colic-Peisker & Tilbury, 2003). They suggested that there is an "achievers and consumers" style. Refugees in this bracket tended to be active in pursuing goals, such as learning the language, finding jobs or study. They were empowered. The other style that was found to be more passive towards resettlement was coined "endures and victims". These

individuals had to deal with uncertainties about the well-being of their families back home, and had waited for long periods of time in temporary housing for more stability. They also focused more on their losses compared to individuals in the other bracket. Their levels of resilience were strongly reduced (Colic-Peisker & Tilbury, 2003). The authors stated that these styles did not neatly fit the individuals. Similarly, these styles do not fit neatly with the individuals of this study. However, these styles highlight different behavioural responses that certainly impact individuals' decisions to engage with services and may be linked to empowerment, perceived control, motivation, attitudes and experiences. This highlights that resettled families have different needs. Similarly, feelings of abandonment and feeling that their voice was not heard by services and the government may be linked to these different styles. Their sense of distrust could have a detrimental effect on their decision to take part in a parenting group as trust is a vital component in the help-seeking process (Rowe & Calnan, 2006).

Those who felt more empowered may also have felt less abandoned and able to speak up. On the other hand, those women who felt that no one cared about them may have had experiences of not being heard and could have stopped them from expressing their needs.

4.3. Language

Language ability appeared to be a factor differentiating the styles in Colic-Peisker & Tilbury's study (2003). Participants in this study also reflected on the difficulty of communication and the need for translators. It was suggested that failure to provide translators within services could lead to individuals withdrawing and disengaging. It also may reduce the likelihood of accessing services in the future. Deng and Marlowe (2013) interviewed refugees from South Sudan. Their thematic analysis also highlighted an issue with language which stopped families from accessing support. Participants were unsure what services were offered and how they could help the families. Language and literacy difficulties were also identified barriers in Mytton et al.'s review (2013). It is therefore vital

that group information and facilitation of groups is done in the mother tongue of the group members if possible. Where there is no such facilitator available, reliable access to translators is necessary. In addition, it seems vital to promote uptake of language courses for individuals in resettlement as this will likely decrease isolation, increase independence and empowerment and allow integration (Colic-Peisker & Tilbury, 2003; Gearing et al., 2013).

4.4. Perceived need of help

Perceived need of help emerged as a theme. This factor, amongst others, has been identified in the literature as a predictor of help-seeking behaviour (Li, Denson, & Dorstyn, 2018). However, even if a need for help is identified, barriers such as stigma can negatively impact on the decision to engage with services (Morawska & Sultan, 2016). Although stigma did not emerge as a theme. Potentially this was due to this topic not being included in the questions asked, but nonetheless may have influenced individuals' decision to engage with support.

The data in this study further reflected a need for readiness and being open to learning new skills and learning from others appeared to be a facilitating factor in deciding whether to engage. Fear of disclosing information to others and less open attitudes towards learning appeared to impact more negatively on decision-making. This fit with the Transtheoretical Model and Stages of Change (pre-contemplation, contemplation, preparation, action and maintenance: Prochaska & DiClemente, 1983). Participants appeared to be at different stages with some having insight into their mental health and the impact this has on their children, knowledge of the gains from group support, previous positive experience and a willingness to learn. Therefore, if group support is perceived as beneficial, individuals are more likely to engage in future groups. However, the challenge is to help individuals move from the pre-contemplation and contemplation stage to the preparation and action stage. In summary, this may be achieved by building trusting relationships, taking time to listen, giving information about mental health and offering

language and community support to facilitate integration, enhance empowerment and improve engagement with services.

4.5. The Conversation Group booklet

The data in this study highlighted broad themes related to making a decision about taking up psychological support, despite participants being asked specifically how their experiences were linked to their decision-making about the Conversation Group. The data about the Conversation Group booklet elicited responses about the content, which were predominantly positive. Participants understood and liked the advice presented in the booklet. This suggests that the information and language used were targeted at the appropriate level for the recipients and was congruent with their views.

Some participants had tried to implement ideas from the booklet and found this difficult. Although there was not enough information given by participants about the reasons for these difficulties, these findings potentially highlight the need to address parents' concerns and barriers to implementing the advice during participation in the Conversation Group.

Participants' opinions about the booklet content within the interviews were not linked to their decision to engage in the Conversation Group. This was most likely due to the limits of the interview questions and participants focusing on more general aspects of the decision making process.

4.6. Clinical implications

Given that no other studies have yet examined the experience of Syrian refugees when deciding to engage with parenting support in the UK, the findings here have several clinical implications. At the same time, it is important to note that the findings are based on a small sample of mothers. Therefore, the suggestions made here will need to be further investigated to allow assessment of their generalisability.

One of the messages highlighted was the importance of previous experiences. Those participants with positive experiences of groups were keen to join other groups. It is

paramount for clinicians, as well as researchers, to not underestimate the impact their contact with women has on their future help-seeking behaviour. Every contact with services is vital in facilitating engagement for support in the future. Furthermore, giving individuals information about parenting groups, ideally through people they know and trust already, such as staff in charity organisations they are affiliated with, and giving control to the individual to make their own decision is important.

The Conversation Group booklet was accessible for these particular women. In addition, information about the parenting groups should ideally include details about who other group members will be as well as what will happen in the group, to help relieve at least some of the uncertainty individuals may experience and to ensure they know that they will “fit in”. It is vital to create a safe environment for people to be able to connect. Especially when staff working with displaced individuals advertise parenting support, it may be useful to have open discussions about it so that individuals can explore their concerns and see who else may be interested. This will impact the decision as to whether or not to take part in the parenting intervention.

In terms of cultural differences, the participants indicated it would be ideal if facilitators are from similar religious or cultural backgrounds. This is, if done sensitively, likely to increase the sense of connectedness.

This study also highlighted that when services are perceived as not being able to accommodate the needs of service users, these individuals will be forced to prioritise their needs. They may then potentially refrain from seeking help for their own and their children’s emotional well-being.

Lastly, the perceived need for help and readiness for support depends, in part, on the individual’s own personality and experience. However, it will also be influenced by where they are in the motivation of change cycle (Prochaska & DiClemente, 1983), and by how likely they are to perceive the support offered as suitable and appropriate. It is therefore important to have clear information leaflets to highlight what the parenting group’s aims

are. Services should also consider their role in delivering support as there may be limits, as highlight in this study, to what services can offer (i.e. practical support) and where support may not be accepted due to a perceived lack of understanding of the experiences individuals in displacement have been through. It should also be considered if and how implementation difficulties can be addressed.

4.7. Limitations

One issue that arises from working with diverse populations is the language barrier. Using translators is one way to address this issue. However, it is the study's most prominent limitation. This is because the meaning of certain concepts in one language do not translate perfectly into another and therefore part of the meaning can get lost (Oxley, Günhan, Kaniyattam & Damico, 2017). To reduce the impact of these issues, a translator was chosen who was certified, who had worked in research settings in the past and who was recommended by an Arabic speaking colleague. However, ideally the interviews should be held and recorded in the native language and translated later on by two translators (Smith, Chen & Liu, 2008). This was not possible in the current study and as such the approach adopted was means that the results need to be interpreted with caution.

In IPA, the aim is to keep the sample size small and focus on an in-depth analysis (Turpin et al., 1997). Typically, for easy-to-reach populations, IPA studies include 6-8 participants. Due to the underrepresentation of the target population and the fact that they are a hard-to-reach group, it was only possible to interview four participants in the given time-frame. Nonetheless, it is not unusual for published IPA studies to have even smaller sample sizes (e.g. Rivituso, 2014; Solli, 2015) and so the current sample size appeared appropriate.

Although the questions in the interviews and the impact participants' experiences had on their decision to take up support were always referred back to the Conversation Group, the data that emerged and that had real depth was not necessarily specific to the

parenting intervention but highlighted more generic experiences. In this lies a strength of this study because had the approach been to focus only on the booklet and the content, it would have neglected the non-specific factors that individuals in displacement are exposed to and consider when engaging with an intervention. The data about the intervention itself was brief and did not have the depth needed for IPA. This was due IPA aiming to interpret individuals' experiences whereas views on the booklet were concrete. However, by using Content Analysis on this more surface level data, it was possible to capture information specific to the parenting intervention.

The interviewees in this study included only mothers. Although fathers were offered participation, none took part. There may be a number of reasons for this. Fathers can be more difficult to recruit (Bayley, Wallace, & Choudhry, 2009) and in the recruitment process, more women were available to discuss the study. It is a limitation of this study that no experiences of fathers on the decision-making process were explored. Future studies could investigate if differences exist between mothers and fathers in terms of the decision-making process and how the family structure impacts on the decision.

Participants were recruited from help organizations. All participants who were interviewed came from one charity. This charity offered different groups, included a creche and offered general support (e.g. housing, translation, finance). Other organizations either did not get in touch or, in the case where participants were suggested, they did not fit the inclusion criteria. Had parents from other organizations been interviewed, perhaps they would have described different narratives compared to the mothers included in the study.

Nonetheless, the data did include different perspectives with some mother's narratives capturing more uncertainty and barriers and other mothers' more empowerment and positive experiences.

4.8. Conclusions and future research

Given the large number of displaced families in Western countries and the identified need for parenting support, this study contributed to widening our knowledge about the

decision-making processes of a small number of displaced mothers from Syria with regards to engagement. Although their experiences cannot be used to make generalisations, the study highlights potential avenues for improving engagement strategies.

Future larger-scale studies that aim to explore engagement and effectiveness of parenting groups for individuals in the resettlement phase of displacement should consider the factors identified in this study, i.e. the importance of connection and shared experience as well as the importance of services to understand and accommodate individuals' needs, to examine if these factors can be generalised. The findings highlighted areas that services and individuals working with this population group can develop and improve to increase engagement strategies.

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Paper 3: Critical Appraisal of the systematic review and qualitative study

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Preface

In this paper, not intended for publication, the overall research process for the systematic review and the empirical study are appraised. This includes reflections on the choice of methods as well as the challenges faced within this field of research.

1. Conducting the Systematic Review

1.1. Finding a suitable topic to review

What follows is a subjective account of the trainee's journey on deciding on the topic. The research conducted by the trainee focused on Syrian families displaced by conflict and their experience of engaging in a conversation group designed to deliver parenting advice. Previous research in this area had focused on the pre-settlement phase of displacement, i.e. when individuals and families are in refugee camps and other temporary accommodation. Within this context, it had been identified that, amongst the pressing needs for food, shelter and safety, parents expressed the desire to receive parenting advice (El-Khani, Cartwright, Redmond, & Calam, 2016; El-Khani, Ulph, Peters, & Calam, 2018). This was a result of the children displaying new emotional and behavioural difficulties that parents did not necessarily know how best to manage.

The trainee initially wondered if parenting support would also be a priority when families who have fled conflict are resettled in a new country. Therefore, the initial scope for the systematic review focused on research identifying the need for parenting support for refugee families in the different phases of displacement from flight through to resettlement. However, research in this particular area proved to be very sparse. As a result, the scoping then focused on identifying stressors that impact on children in the resettlement phase, with the view that this would highlight whether family support at this stage would be appropriate. Once again peer reviewed research in this area was almost non-existent. Articles focused more on the direct impact of conflict and the impact of displacement but did not often focus on stressors for families and children once resettled.

Finally, the trainee considered that even if displaced families from the Middle East wanted to receive parenting support, there may be barriers to accessing this help. In order to refine the scoping, the trainee focused on attitudes of Middle Eastern individuals on psychological interventions to understand better the current cultural views and perceptions. Understanding Middle Eastern narratives on mental health is also informative when working with individuals living in Western societies as it can guide integration and adaptation of psychological support for this population group (e.g. Gearing et al., 2013). As there were no recent reviews on this specific topic, the trainee had found a suitable area to review.

1.2. Inclusion and exclusion criteria

Inclusion criteria are useful to ensure that the papers selected reflect the research aims and take into consideration factors that can impact the overall findings. Whereas some criteria were straightforward (e.g. papers written in the English language due to the constraints of the project, peer-reviewed articles), other criteria were more difficult to decide on. For instance, the trainee reflected on the role of care professions, both health and education. Given the increased exposure to emotional and behavioural difficulties in these professions, and the training received, it was felt that attitudes towards psychological interventions of these staff groups may potentially be unrepresentative of the population as a whole. It would be interesting to examine their beliefs and views on mental health and interventions. However, for the purpose of the review conducted by the trainee, it felt important to capture the perspective of individuals who may access mental health interventions. Therefore, papers exploring attitudes from health staff or teachers were excluded. Papers were also excluded if the participants have moved to non-Middle Eastern countries. This was done because exposure to belief systems in those countries and experience with support there may have caused differences in attitudes to those not exposed to non-Middle Eastern belief systems and experiences.

Finally, a decision had to be made about whether to include both qualitative and quantitative papers or only one type. Given that the initial scoping of ideas yielded minimal results, it was initially decided to not specify the type of method used. However, the search strategy identified numerous studies with qualitative and quantitative methods. To create a clearer approach to reviewing the studies and allow better comparison, it was decided to focus on the method yielding the most studies, i.e. quantitative studies.

1.3. Methodological quality assessment tool selection

Many different assessment tools were available to examine the methodological quality of research papers. After comparing a number of validated assessment tools in terms of fit between required information and type of studies in the review, the trainee decided to use the Quality Assessment Tool for Studies of Diverse Designs (QATSDD: Sirriyeh, Lawton, Gardner, & Armitage, 2012). This was done for several reasons: (i) assessment tools that are typically used for research designs such as randomised controlled trials and cohort studies did not fit. This is because the papers used in the current review were descriptive or correlational in nature. Therefore, using these types of quality assessment tools would not capture the relevant quality criteria. (ii) Despite the QATSDD being a mixed method tool, the quantitative questions appeared to capture the relevant quality criteria, (iii) the QATSDD had clear scoring guidance notes that made it transparent for the two appraisers to know how to score each paper. (iv) The QATSDD was well published and had good validity and reliability (Sirriyeh et al., 2012) as discussed in Paper 1.

1.4. Assessing attitudes

Within the main text of the systematic review, it was discussed how attitudes, amongst other things, influence behaviour. In choosing to examine quantitative studies, the trainee had to extract data linked to attitudes from clinical vignettes, standardised or idiosyncratic questionnaires. However, despite the fact that the studies set out to examine attitudes, they almost exclusively measured attitudes indirectly or were focused on aspects that influenced attitudes. Analysing the data was therefore challenging, as measures varied

across studies and where the same measures were used, the focus of what was measured differed. For instance, although a small number of studies used the Orientations for Seeking Professional Help (OSPH) questionnaire (Fischer & Turner, 1970), the studies did not all display the results individually, hence making meaningful comparisons difficult. For these reasons, it would have been meaningless to analyse correlation coefficients. Instead, results were summarised in written form and the data analysed using a narrative approach. This process highlighted a few key points. Although some studies used standardised measures, other studies did not include any but relied only on idiosyncratic measures, e.g. vignettes, or recorded only descriptive data. In order to better review evidence in the literature, it will be important for future studies to include standardised measures and report the outcomes in a standardised way. Particularly, if studies aim to examine the factors that impact on attitudes and behaviour, they should consider existing theories and models of attitude and behaviour in order to draw conclusions based on theoretical frameworks. For instance, if factors have been found to mediate the effect between attitudes and behaviour, the conducting of mediation analyses may be necessary.

The trainee also felt that it was difficult to draw concrete conclusions from the findings presented, due to the fact that some studies only presented descriptive data and comparisons could only be made tentatively. Perhaps, in order to review change in attitudes over time, it would be useful to replicate some of these studies and outline how they compare with previous findings.

2. Conducting an Interpretative Phenomenological Analysis (IPA) study

2.1. Recruitment

From the outset it was clear that the recruitment process was going to be difficult.

Therefore, the trainee initially attended a meeting for individuals displaced by conflict in Manchester to become more familiar with this population group, to engage in conversation

with them and group leaders to find out about the difficulties these individuals experience when resettling. This was useful in getting a broader understanding, at least on a practical level, of what it meant to seek asylum in this country, the uncertainty of whether asylum would be granted, the uncertainty of where they would be relocated to as it became clear that individuals would often move within the country, sometimes several times, with the individuals being powerless about these decisions. Furthermore, official paperwork and deadlines to return them put individuals under enormous pressure and increased anxiety. Language barriers often mean that asylum seekers do not understand the forms or when they need to be returned. Difficulties also exist where individuals need to engage in a chain of processes that depend on each other (e.g. needing an address to open a bank account and needing a bank account to apply for accommodation). Understanding more about the processes individuals have to go through brought the trainee somewhat closer in her understanding of the experiences of participants.

The trainee also reflected on the fact that the route on which a person in displacement reached the new country would influence how he or she perceived the host country, how welcomed they would feel (i.e. legal vs illegal entrance) and how much support they would receive. Consequently, the individuals taking part in research studies may form only a subgroup of displaced individuals that had more positive experiences. Furthermore, people's language skills in the new country would determine how isolated and insecure they feel.

Through supervision with researchers experienced in working with this population group, the trainee learned that effective recruitment typically involved contacting third parties (e.g. charities). Given refugees' experiences it is understandable that barriers exist that reduce the likelihood of them from engaging with services and research. The trainee therefore contacted numerous organisations to ask for their help in recruiting participants. Despite the offering of help, only one organisation enabled the trainee to visit the support centre and speak to individuals in displacement. On reflection, it was through the direct

meeting of people as well as the positive messages from the organiser about the research, that made it possible for the participants to agree to take part in the study. Importantly, the participants received the message that it was within their own control to participate. This empowerment, after multiple experiences of powerlessness, may have had a positive effect on the women. Interestingly, all the women attended the interviews without the fathers. This was partly because the participants were divorced, or the husband was still in Syria. Perhaps there was an unspoken expectation that because the topic was parenting, it was the mothers that the trainee needed to speak to. However, it was not specified or mentioned in conversation that only mothers could participate.

Cultural differences were also considered by the trainee to identify potential barriers to engagement and to ensure that the research experience they would receive was positive. The experience participants have in a research or clinical context, in hindsight, needs to be paramount for researchers and clinicians, because it was very clear from the trainee's interviews with participants that their previous experiences and that of their family and friends influenced their decision-making process for other support or research opportunities. It made the trainee aware of the researcher's and clinician's responsibility and influence on refugees' help-seeking behaviour. Needless to say, it is vital for people working with this population to conduct their research in an appropriate manner, treat participants with respect, be transparent and spend time getting to know each person.

Organisationally, one difficulty was the planning of interview dates, as the trainee not only had to coordinate a time convenient for herself and the participant, but this also had to fit in with the charity centre's room availability and the availability of the translator. Therefore, some delays in interviewing participants were experienced.

2.2. Using a translator

The trainee had not worked with a translator before and saw this as an opportunity to gain experience in working with people through translation. It is in the nature of IPA that language is an important aspect used later on in the analysis. Therefore, it was vital to

discuss the process of translating as closely as possible to what was said with the translator. For instance, it was discussed that everything should be translated in the first person, rather than in the third person. Despite these discussions with the translator, at times the trainee was unsure if translations of “them” were meant in the literal sense (people other than the participant) or whether the participant was included in this “them”. This meant that the interpretation of these particular sections had to be done even more tentatively.

Furthermore, it is not possible for any translator to convey exactly what is said. Languages have different ways of expressing certain experiences, and some expressions do not translate exactly into other languages. It was helpful that the trainee was bilingual, as this meant she was perhaps more aware of the limitations of translation compared to monolingual speakers. This knowledge also helped the trainee to pay more attention to the emotions expressed by participants non-verbally and integrate this information where possible into the transcript.

Given the importance of an experienced translator, and the limited availability of research colleagues who had experience of both doing qualitative research as well as speaking and translating into and from Arabic, it was necessary to hire a translator. Despite reasonable fees, the payment was an issue due to the limited research funds available. It was only possible to complete the study because extra research funds from one of the trainee’s supervisors was accessible. This not only caused stress and uncertainty about the study completion but also meant that, especially the last interview, was conducted under time pressure. This interview was not felt to be as in-depth as the other interviews because there was a set time in which the interview had to be completed. One learning point from this experience was that budgeting for translators needs to take into account more than the time for the actual interview as they can take longer and for instance in this study a questionnaire had to be completed afterwards as well.

2.3. Why Interpretative Phenomenological Analysis (IPA)?

There are many qualitative methods to study a given subject. The type of method used depends on the research question, similarly to quantitative research methods. The trainee's study aimed to explore the experience of making a decision about engaging in a parenting group. Approaches that examine concepts to develop a new, more generalised theory, as would be the aim in a Grounded Theory approach (Charmaz, 1996) were therefore not suitable. Although Thematic Analysis (TA) is based, in part, on phenomenology, it does not capture the participant's personal experience and underlying meanings in the same way as IPA does. TA typically also requires a larger sample size than IPA. IPA differs from other approaches in that it aims to analyse the data in a way that stays as close as possible to the content, ideally without fitting a particular theoretical framework. Instead, it aims to apply psychological understanding to guide interpretation (Smith, Flowers & Larkin, 2009, p. 105). As such it is, apart from meeting the requirements of the research question, a method useful to learn as a trainee clinical psychologist. Furthermore, IPA differs from other approaches as it explores subjective meanings of experiences and with that highlights social cognitions (Biggerstaff & Thompson, 2008).

Learning to structure interviews in an IPA style was very different from clinical interviews and required practice with the research supervisor familiar with IPA and using a practice interview and feedback on the initial interview to refine the skills such as staying as informal as possible, not reflecting back if possible and continually going back to the initial question and asking again until the topic is completely saturated. In addition, both what the interviewer and the interviewee say need to be broken up into chunks small enough for the translator to remember and therefore changes the dynamics of the conversation to some degree. However, it was felt that the participants were comfortable carrying on their stream of thought, perhaps due to exposure to translators previously.

3. Reflections on clinical implications

Working with individuals displaced by conflict has been very enjoyable as well as at times emotional. Gaining insight into their stories and experiences highlighted the level of resilience these individuals have. The interviews in particular also highlighted needs and barriers for individuals to access services. For instance, their dependence on translators when in contact with services and the uncertainty of whether such support will be available has clinical implications as individuals. Unless the need for a service is great, such as needing to be seen by a GP for physical problems, individuals may not access support out of fear that they will not be provided with a translator and therefore not be able to communicate their needs. Given refugees' financial situation, most individuals would want to be certain that spending money on travel will mean they get the support they need. It is therefore vital for clinicians to be as organised as possible to ensure that translators are available for appointments. Such appointments, where possible, could be arranged in settings close to the individual's home, to reduce the financial burden (i.e. travel expenses).

Choosing translators will also need to be done with care, considering factors such as accents spoken in different regions, the possibility of the translator knowing the client, especially when from a small community, cultural considerations (e.g. gender of translator/clinician, location for appointments, time of day/year, clothing). The more positive the interactions are with services, the more likely it is that displaced individuals will access support in the future and will share their positive experience with other displaced individuals who may need support.

Through the interviews it was also highlighted that individuals felt isolated and wanted to form new connections. It may therefore be useful for clinicians to signpost clients to organisations where they can meet other people in displacement (e.g. charities, religious places of worship). This potentially will have a positive impact on their sense of identity, sense of belonging and ultimately their well-being.

Lastly, given that individuals in each culture have different narratives around mental health, it is helpful if clinicians approach this topic with curiosity to understand each client's narrative, and consider how best to work together and develop and use a shared language.

4. Dissemination

Paper 2 highlights a number of clinical implications. It is vital that these findings are shared with those providing services and support for individuals in displacement.

Therefore, the trainee will attend a Manchester-wide meeting that is joined by many organisations working with refugees. The findings of Paper 2 will be presented there and a summary sheet of the findings, including the clinical implications will be given to attendees. The findings of both studies will also be uploaded onto the trainee's research group's website and the trainee's own Research Gate website to enable wider access.

Finally, a summary sheet will be developed and translated into Arabic in order to give this to the women who participated in the study.

5. References

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Appendices

Appendix A – Journal: European Psychologist author's guidelines

- References in APA style (6th edition)
- Abstract max. 250 words
- Max. 5 key references
- Figures and tables should be numbered in Arabic numerals
- Max word count: 7500 (including tables, figures, abstract and references)

Appendix B – Quality Assessment Tool for Studies of Diverse Designs

Criteria

1. Explicit theoretical framework
2. Statement of aims/objectives in main body of report
3. Clear description of research setting
4. Evidence of sample size considered in terms of analysis
5. Representative sample of target group of a reasonable size
6. Description of procedure for data collection
7. Rationale for choice of data collection tool
8. Detailed recruitment data
9. Statistical assessment of reliability and validity of measurement tools
10. Fit between stated research question and method of data collection
11. Fit between research question and method of analysis
12. Good justification for analytical method selected
13. Evidence of user involvement in design
14. Strengths and limitations critically discussed

0= not at all

1= very slightly

2= moderately

3= complete

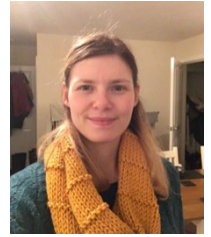
Appendix C – Journal: Social Science and Medicine author's guidelines

- 1) Peer-reviewed original research articles and critical or analytical reviews in any area of social science research relevant to health. These papers may be up to 8,000 words including abstract, tables, and references as well as the main text. Papers below this limit are preferred.
- 2) References can be in any style or format as long as the style is consistent.
- 3) There are no other strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.

Appendix D – Research flyer

Would you like to help with research looking at parenting advice for refugees?

My name is Kathleen Baess. I'm a Trainee Clinical Psychologist at The University of Manchester. My research is looking at the decisions parents make about taking part in a conversation group, which aims to help by sharing ideas about improving parents' and their children's wellbeing.



We know families have to adapt to a new way of life when they settle in a new country. Often, they also have to cope with distressing experiences from the past. All these changes can present challenges. Getting the right kind of support can be important for the wellbeing of both parents and their children.

If you are a refugee parent and want to take part, this is what will happen:

- We will give you information about the conversation group.
- You can decide whether you want to take part in this group or not.
- We will then arrange to meet somewhere convenient for you.
- I will interview you, together with an interpreter if you like, **about the decision you made, whether or not to attend the conversation group.**
- This will take around 1h30min.

This aim of this study is to learn how to help families to get the best support possible to improve their own health and their child's wellbeing.

To take part you have to:

- be a refugee from the Middle East
- have lived in the UK for less than 2 years
- be a parent
- be over the age of 18
- speak Arabic or/and English
- at least one of your children must be between the age of 4-14

If you tell me in the interview that you would like to take part in the conversation group, we will arrange this for you. Parents will meet once, in a small group, with a presenter and interpreter. Ideas about how to help parents and children feel better will be discussed. We are offering this to Arabic-speaking refugee parents who have come to the UK in the last two years.

Please get in touch with me for further information. I look forward to hearing from you.

Dr Kathleen Baess

Email: kathleen.baess@postgrad.manchester.ac.uk, Tel: 07925 818237

Under the supervision of: Prof Rachel Calam (Rachel.calam@manchester.ac.uk) and Dr Fiona Ulph (Fiona.ulph@manchester.ac.uk)

هل ترغب المشاركة للحصول على نصائح تربوية خاصة بالوالدين للأهالي اللاجئين؟



أنا اسمي كاثلين بايس وأعمل متدربة في علم النفس السريري في جامعة مانشستر. يركز بحثي على مسألة القرارات التي يتخذها الأهالي للانضمام إلى الجلسات الحوارية مع فريق البحث الذي يهدف إلى مساعدة وتحسين وضع كلاً من الوالدين والأطفال على حد سواء من خلال تبادل ومشاركة الأفكار.

إننا نعلم أنه يوجد بعض العائلات التي عليها أن تتأقلم مع أساليب حياة جديدة عند استقرارهم في بلد جديد وغالباً ما يكونوا قد مروا بتجارب قاسية في حياتهم الماضية ومن الواضح أن مثل هذه التغييرات تخلق تحديات لذلك فإن الحصول على الدعم الصحيح والمناسب هو أمر ضروري لسلامة كلاً من الأطفال وأهاليهم.

إذا كنت لاجئاً ولديك أطفال وترغب بالمشاركة معنا في هذه الدراسة فهذه هي الخطوات:

- سنقدم لك معلومات حول فريق البحث
- ومن ثم عليك أخذ القرار بشأن الرغبة في المشاركة أو عدمها
- ثم علينا تحديد المكان المناسب للقاء فريق عمل البحث
- سأجري معك مقابلة - مع وجود مترجم إن أحببت - ونكون المقابلة حول القرار الذي اتخذته بالانضمام أو عدم الانضمام إلى مجموعة الحوار.
- تستغرق الجلسة الحوارية حوالي ساعة ونصف

تهدف هذه الدراسة إلى فهم كيف يمكن مساعدة الأهالي للحصول على الدعم المناسب لتحسين وضعهم ووضع أطفالهم الصحي والمعيشي

للمشاركة يتوجب أن تتوفر فيك الشروط التالية:

- أن تكون لاجئاً من الشرق الأوسط
 - أن تكون قد عشت في المملكة المتحدة لمدة أقل من عامين
 - أن تكون أباً أو أمّاً
 - أن يكون عمرك أكثر من 18 عاماً
 - أن تتكلم الإنكليزية أو العربية
 - أن يكون عمر أحد أولادك ما بين 4-14 عاماً
- إذا وافقت خلال المقابلة على المشاركة مع فريق البحث للانضمام إلى الجلسات الحوارية فسوف نقوم بترتيب الأمر معك. سوف نلتقي مع الأهالي مرة واحدة ضمن فريق صغير مع وجود مترجم وسوف نناقش معكم بعض الأفكار التي ستساعد كلاً من الوالدين والأطفال على حد سواء. يقوم فريقنا بتقديم هذه المساعدة للأهالي اللاجئين العرب الذين قدموا إلى المملكة المتحدة خلال العامين الماضيين.

للحصول على المزيد المعلومات يمكن الإتصال بي كما يلي:

د. كاثلين بايس

البريد الإلكتروني: kathleen.baess@postgrad.manchester.ac.uk

رقم الهاتف: 07925 818237

تحت إشراف:

Rachel.calam@manchester.ac.uk برفسورة رانشل كالام

Fiona.ulph@manchester.ac.uk د. فيونا ألف

Appendix E – Interview Schedule

Note. Questions in **bold**, prompts in *italics*.

We're interested in knowing about how people decide about taking part in something like a conversation group. What I would like you to do is tell me the story about you making the decision about whether to go to the conversation group. We'll do some activities to help you tell your story. Feel free to tell me what you thought and felt at any point during our discussion.

(1) Can you take me back to when you first became aware of the conversation group and tell me about how you felt about it?

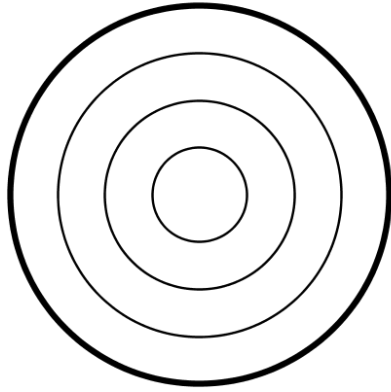
Who introduced you to the programme? What did you think of that person?

How was the programme explained to you? What did you think the parenting support would be?

(2) Can you tell me what your first reaction was when you were told about the conversation group?

What went through your mind? How did you feel?

(3) I'd now like to hear who was involved in helping you make the decision about whether or not to go by drawing everyone who played a part into a circle. People whose influence was strongest will be closest to the centre. People whose influence is weaker would be in the outer circles. You may not have actually talked to them, but might have thought about what they would think.



(4) Can you tell me more about what these people said or what you thought they would say and think?

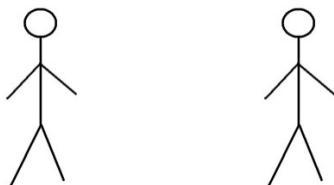
Why were they involved? How did they become involved?

(5) Take me back to when you looked at the booklet. I'm wondering whether you could tell me more about how you felt when you looked through the booklet.

Where were you? What went through your mind? Tell me about who you wanted to show it to? What did they say?

(6) Try to imagine that this is a person (on the left) who needs this kind of parenting advice. What do you think this person is like?

What do you think their parenting is like? What is their relationship like with their wider family and community?



(7) When you look at this person (on the left), can you see yourself as that person?

- If not, can you write some words around this second person (on the right to show what you are like?

(8) The conversation group involves a group of people sitting and talking. Tell me what you think about being in that group setting.

(9) Could you tell me if you feel there is anything that would have changed your mind about your decision?

Appendix F – Ethical approval

Ref: 2017-2376-3709 11/08/2017

Dear Ms Kathleen Baess ,Dr Fiona Ulph, Prof Rachel Calam

Study Title: Decision making about parenting advice for refugee parents.

University Research Ethics Committee 4

I write to thank you for submitting the final version of your documents for your project to the Committee on 10/08/2017 16:14. I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

Please see below for a table of the title, version numbers and dates of all the final approved documents for your project:

This approval is effective for a period of five years however please note that it is only valid for the specifications of the research project as outlined in the approved documentation set. If the project continues beyond the 5 year period or if you wish to propose any changes to the methodology or any other specifics within the project, an application to seek an amendment must be submitted for review. Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. [Amendments](#)
2. [Breachesandadverseevents](#)
3. [Notificationofprogress/endofthestudy](#)

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a UREC Feedback Form. Instructions for completing this can be found in your approval email.

We wish you every success with the research. Yours sincerely,



Dr Timothy Stibbs
Secretary to University Research Ethics Committee 4

Appendix G – Participant Information Sheet

Decision making about parenting advice for refugee parents resettled in the UK

Participant Information Sheet

You are being invited to take part in a research study as part of a postgraduate student project for the Doctorate in Clinical Psychology. Before you decide whether you would like to take part in the study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information sheet carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?

The study will be conducted by Kathleen Baess, Trainee Clinical Psychologist under the supervision of Professor Rachel Calam, and Dr Fiona Ulph (Faculty of Biology, Medicine and Health, The University of Manchester, Second Floor, Zochonis Building, Brunswick Street, Manchester, M13 9PT).

Title of the research

Decision making about parenting advice for refugee parents resettled in the UK.

What is the aim of the research?

Families across the world are forced to leave their homes and country of origin due to conflict. When they resettle in different countries such as the UK, families have to adapt to this new way of life, often whilst also coping with distressing experiences that may have occurred in the past. Raising children in a new country can present challenges and getting the right kind of support can be important for the wellbeing of both parents and their children. We want to learn more about how refugee parents might make decisions about whether or not to take part in a conversation group about parenting. This will help to find the best ways of supporting refugee parents in their parenting role. The aim is to learn how to help families to get the best support possible to improve their own health and their child's wellbeing.

Why have I been asked to take part?

You have been asked to take part because you are a parent who has left your country with your family due to conflict and resettled in the UK.

What would I be asked to do if I took part?

A researcher will ask you some questions and our interpreter may be present if you find it difficult to communicate in English. We will talk about your experience of making a decision about whether or not you want to take part in a conversation group. We want to find out what things you consider and who is involved when making this decision. We want to hear all about your perspective on this decision, no matter what you decide. The interview will take up to two hours and will be audio-recorded. At the end we will ask you a few questions about yourself.

We will also ask whether you give permission for us to re-contact you in the future for other research studies our research team is conducting. If you agree to this you may be contacted by a researcher from the team if we are doing other projects that you may be interested in taking part in. If this was the case, we would talk to you about the project, and you would be free to agree to take part or not, without giving a reason. We would not contact you within the first 3 months after you have taken part in this project. You will be free to change your mind and ask us not to contact you at any time.

What are the risks of taking part?

There are no more than minimal risks associated with this research. We will ask you questions about making a decision about a parenting intervention. If, however, you do not feel comfortable answering certain questions, you do not have to. It is up to you to decide what you tell the researcher. You do not have to discuss with the researcher anything you might find intrusive or upsetting. However, if through responding to interview questions you find that you become upset, the interview can be stopped if you wish. If after the interview you would like to discuss further any issues discussed during the interview, we can direct you to appropriate services.

What happens to the data collected?

The data collected will be stored confidentially and securely at The University of Manchester. Both telephone and face-to-face interviews will be audio recorded and stored securely at the University of Manchester. The information will be used to widen our knowledge about what makes parents, displaced by conflict, want to take part in a parenting conversation group and things that makes parents not want to take part. The findings of the study will also be shared with to academics, refugee organisations and health and educational professionals and services to help them give the best parenting support to families. Anonymised interview transcripts (with no identifying information) may be shared with other researchers known to the research group for research or teaching purposes.

Will my data be confidential?

Yes, all information collected will remain confidential at all times. A number will be assigned to you and your name will not be used when we store the information. Your data including audio-recordings will be kept confidentially and securely using this number at The University of Manchester. Your data will be kept for a minimum of five years and may be used for further research or secondary data analysis. The only people who will have access to your individual identity and your data are the research team.

With your permission, we may use direct quotes from your interview, but your name will not be used and therefore you will not be personally identified and will remain anonymous. The only exception to your data not remaining confidential is if you tell the researcher something that concerns him or her regarding your safety, your child's or children's safety or another person in

your family is at risk. In such a circumstance, we may be duty bound to tell someone the information. This person may be someone who is not a member of the research team. We will tell you initially if we need to share the information with someone else.

Do I have to take part?

This study is voluntary, so you do not have to participate in this study. If you decide to take part and subsequently change your mind, either before you start the study or during, you can withdraw without giving any reasons. Once the analysis of the data has been initiated, you can no longer withdraw your data.

What is the duration of the research?

The study will last up to 2 hours. We will book an appointment to see you for up to 2 hours to allow time to obtain consent from you and give you the opportunity to ask any further questions you might have before being interviewed.

Where will the research be conducted?

The study will take place in a private room at The University of Manchester, at a community centre, or over the telephone/video software (i.e. Skype or FaceTime).

Will the outcomes of the research be published?

When we have seen all participants taking part in the study, we will provide you with a summary of what we have found out. The results from the research may be presented at national and international conferences and may be published in academic journals. They will also be used as part of an educational project (Doctorate in Clinical Psychology). The results may be presented to refugee organisations and agencies and other health and educational professionals and services and a report containing the results may be provided to them. **You will not be personally identified in any reports or publications of the research.**

Will I be paid for participating in the research?

We will pay for your travel expenses to and from the University or community centre (max. £10). You will not be paid for your participation in this research.

Who has reviewed the research project?

The project has been reviewed and approved by The University of Manchester Research Ethics Committee, which is an independent group of people whose role is to protect your safety, rights, wellbeing and dignity. The Committee has confirmed that they think the research is ethical and safe to do.

Contact for further information

For any further information about the study please contact kathleen.baess@postgrad.manchester.ac.uk or the main study supervisors, Prof Rachel Calam (rachel.calam@manchester.ac.uk) and Dr Fiona Ulph (fiona.ulph@manchester.ac.uk)

What if something goes wrong?

If you have a concern about any aspect of the study, you should speak to the research team. You can contact Rachel Calam by phone on 0161 275 8755 or by email rachel.calam@manchester.ac.uk . You can also contact Fiona Ulph: Fiona.ulph@manchester.ac.uk, and Kathleen Baess: Kathleen.baess@postgrad.manchester.ac.uk

If there are any issues regarding this research that you would prefer not to discuss with members of the research team and/or you would like to make a formal complaint about the conduct of the research, please contact the Research Governance and Integrity Team by either writing to 'The Research Governance and Integrity Manager, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester M13 9PL', by emailing: Research.Complaints@manchester.ac.uk, or by telephoning 0161 275 7583 or 275 8093.

اتخاذ قرار المشاركة للحصول على نصائح تربوية خاصة بالوالدين للأهالي اللاجئين في المملكة المتحدة

معلومات عن البحث للمشاركين

أنت مدعو للمشاركة في دراسة كجزء من مشروع طالبة دراسات عليا للحصول على درجة الدكتوراه في علم النفس السريري. قبل أن تقرر المشاركة في هذه الدراسة من المهم أن تعرف لماذا يتم عملها وعلى ماذا تتضمن. الرجاء أخذ الوقت المناسب لك في قراءة ورقة التعليمات هذه وناقشها مع الآخرين إذا رغبت بذلك! خذ وقتك في تقرير ما إذا كنت تريد المشاركة في الدراسة أم لا، مع كامل الشكر لقراءتك هذه الورقة.

من الذي سيجري الدراسة؟

سيتم إجراء الدراسة بواسطة كاتلين بايس وهي متدربة في علم النفس السريري تحت إشراف كلاً من البروفيسورة راينشل كالام والدكتورة فيونا الف (كلية الأحياء، والطب والصحة/ جامعة مانشستر/ الدور الثاني من مبنى زوكنيس/ شارع برنزويك/ مانشستر، M13 9PT)

ما هو عنوان البحث؟

اتخاذ قرار المشاركة للحصول على نصائح تربوية خاصة بالوالدين للأهالي اللاجئين في المملكة المتحدة

ما هو هدف البحث؟

يوجد عائلات حول العالم أُجبروا على مغادرة بلدانهم بسبب الصراعات. عندما يستقرون في دول أخرى كالمملكة المتحدة يتعين على هذه العائلات أن تتكيف مع أساليب الحياة المختلفة، وفي الغالب عليهم أن يتأقلموا أيضاً مع التجارب القاسية التي قد مروا بها في الماضي. إن تربية الأبناء في دولة جديدة من الممكن أن يحمل الكثير من التحديات والحصول على الدعم المناسب في هذا السياق هو أمر هام جداً لسلامة الآباء والأبناء. نريد من خلال هذا البحث أن نتعرف أكثر حول كيفية اتخاذ الوالدين اللاجئين قرار المشاركة أو عدم المشاركة للانضمام إلى الجلسات الحوارية الخاصة بالنصائح التربوية، سيساعد ذلك على إيجاد أفضل الطرق لدعم الآباء والأمهات اللاجئين عند ممارسة أدوارهم الأسرية. تهدف هذه الدراسة إلى معرفة كيف يمكن مساعدة العائلات للحصول على أفضل دعم ممكن لتحسين صحة الوالدين وسلامة أطفالهم.

لماذا تمت دعوتي للمشاركة في هذه الدراسة؟

تمت دعوتك للمشاركة لأنك أحد الأهالي "أب/ أم" الذين غادروا وطنهم مع عائلتك بسبب الصراعات والنزاعات وقدمت للإقامة في المملكة المتحدة.

ما الذي سيطلب مني إذا وافقت على المشاركة في الدراسة؟

سوف تقوم الباحثة بطرح بعض الأسئلة عليك وإذا كان لديك صعوبة في التواصل باللغة الانكليزية فإنه سيكون هناك مترجم لتقديم المساعدة. سوف نتحدث خلال اللقاء عن تجربتك في كيفية اتخاذ قرارك حول المشاركة أو عدم المشاركة في الجلسات الحوارية. كل ما نريده هو أن نستوضح ما هي الأمور التي أثرت في قرارك ومن هم الأشخاص الذين أثروا على صنع قرارك. نود سماع وجهة نظرك حيال كيفية اتخاذ قرارك سواء وافقت على المشاركة أو لا. سوف تستغرق المقابلة حوالي الساعتين وستكون مسجلة صوتياً وفي نهاية المقابلة يمكن أن نوجه إليك بعض الأسئلة الخاصة بك.

سوف نطرح عليك إمكانية إعطاءنا الموافقة على التواصل معك في دراساتنا البحثية المستقبلية التي يقوم بها فريق من الباحثين لدينا وسيتواصل معك أحد الباحثين في فريق العمل في حال موافقتك على ذلك، وعند الموافقة سوف نتواصل معك ونتحدث عن المشروع وسيكون لديك كامل الحرية للمتابعة معنا أو عدم المتابعة دون أي حرج أو الحاجة إلى تقديم أي عذر. لن نتواصل خلال الأشهر الثلاثة التي تلي مقابلتك الأولى وسيكون لديك كامل الحرية لتغيير قرارك في أي وقت تشاء بأن تطلب منا عدم الاتصال بك حين ترغب بذلك.

ماهي المخاوف المترتبة على المشاركة معنا؟

ليس هناك مخاوف تذكر سوى تلك المتعلقة بالبحث ، سنوجه لك أسئلة تحتاج إلى اتخاذ قرار بشأن بعض التدخلات الخارجية المتعلقة بالأباء والأمهات وإذا شعرت خلال أي مرحلة من مراحل الحوار بعدم الرغبة في الإجابة على أسئلة معينة فلك الحرية التامة في ذلك، كما أن لك كامل الحرية في اختيار ما تريد الإجابة عليه فلا يتوجب عليك أن تجيب على أي سؤال تعتبره تطفلياً أو مزعجاً، وإذا شعرت بشيء من الاضطراب أو الانزعاج خلال المقابلة فإنه بإمكانك عدم المتابعة. أما إذا أردت بعد المقابلة أن تتابع أي من الأمور التي تمت إثارتها أثناء الحوار فإننا سنقوم بتوجيهك إلى الجهة المختصة بذلك.

ماذا يحدث بالبيانات التي سيتم جمعها؟

سوف تخزن البيانات التي نجمعها في مكان سري وآمن في جامعة مانشستر حيث سيتم تسجيل المحادثة الصوتية واللقاء الشخصي صوتياً وتحفظ بشكل آمن في جامعة مانشستر. سوف يتم الاستفادة من المعلومات لتوسيع معرفتنا بالأسباب التي تدفع الأباء والأمهات إلى تغيير مكان إقامتهم أثناء الحروب وإلى الأمور التي تشجعهم على المشاركة في مثل هذه الحوارات الجماعية أو لا تشجعهم عليها. إن النتائج التي سوف نتوصل إليها سوف يطلع عليها كلاً من الأكاديميين (الفريق التدريسي) ومنظمات اللجوء والأخصائيين والدوائر المعنية لمساعدة الأسر في تقديم أمثل الطرق لدعهم. يمكن أن يتم تداول نسخ المقابلات بين الباحثين لأسباب بحثية أو تدريسية ولكن لن تحوي نسخ المقابلات المتداولة إسماء عليها ولن تحوي أية معلومات شخصية يمكن منها معرفة صاحب المقابلة.

هل سيتم التعامل مع بياناتي بشكل سري؟

نعم ، إن كل المعلومات التي سيتم جمعها ستحفظ بشكل سري وآمن. سوف يعطى لإسمك رقماً وسوف يستخدم اسمك عند القيام بحفظ المعلومات فقط، كما أن كلاً من بياناتك بما

في ذلك تسجيلك الصوتي سيحفظ بشكل آمن وسري تحت الرقم المعطى لإسمك في جامعة مانشستر. سيتم الاحتفاظ بالمعلومات لمدة زمنية لا تقل عن خمس سنوات وسوف تستخدم لأبحاث أخرى أو لتحليل البيانات الثانوية. إن الأشخاص الوحيدين الذين يملكون صلاحية الإطلاع على هوية الشخص صاحب المقابلة وبياناته هم فريق الباحثين فقط.

هل علي أن أشارك في هذا البحث؟

إن هذه الدراسة هي دراسة تطوعية، فلذلك لست ملزما بالمشاركة بها وإن قررت المشاركة ومن ثم غيرت قرارك سواء كان ذلك قبل البدء بالبحث أو أثناءه يمكنك الإنسحاب دون إعطاء أي تبرير أو عذر، ولكن بمجرد صدور نتائج البيانات فلا يحق لك أن تسحب بياناتك.

ما هي مدة البحث؟

إن مدة المقابلة سوف لن تتعدى ساعتين ولكن سوف نقوم بترتيب لقاء لرؤيتك لمدة ساعتين لنتيح لك زما كافيا للموافقة ولنتيح لك فرصة للاستفسار عن أي أمر قبل البدء بالمقابلة.

أين سيتم اللقاء؟

سوف يتم اللقاء في غرفة خاصة في جامعة مانشستر أو في أحد مراكز الجالية أو عن طريق أحد برامج الاتصال مثل سكايب أو فيس تايم.

هل ستم نشر نتائج البحث؟

عند إتمام مقابلة جميع المشاركين يمكن أن نزودك بملخص عما توصلنا إليه كما يمكن لنتائج البحث أن تعرض في المؤتمرات الدولية والمحلية كما يمكن أن تنشر في المجلات الأكاديمية، كما يمكن أن تستخدم في المشاريع الأكاديمية كرسائل الدكتوراة في علم النفس السريري، ويمكن أيضا أن تعرض نتائج البحث في منظمات اللجوء والصحة والمراكز الاختصاصية والتعليمية، ولن تكون هويتك معروفة أو ظاهرة في أي من التقارير أو البحوث المنشورة.

هل سيدفع لي مقابل مشاركتك في هذا البحث؟

سوف يدفع لك تكلفة القودم والذهاب من وإلى الجامعة أو من وإلى مركز الجالية بما لا يتجاوز/10/ جنيهات استرلينية ولكن لن يدفع لك مقابل مشاركتك في هذا البحث.

من هي الجهة التي اطلعت على هذا المشروع البحثي؟

إن هذا البحث تمت مراجعته والموافقة عليه من قبل لجنة أخلاقيات البحوث في جامعة مانشستر وهي عبارة عن مجموعة مستقلة مسؤليتها حماية سلامتك وحقوقك وكرامتك، وقد أقرت هذه اللجنة أن هذا البحث أخلاقي وسليم وقابل للتطبيق.

للحصول على معلومات إضافية

يمكنك الاتصال للحصول على أية معلومات إضافية حول هذا البحث بالباحثة كاتلين بايس على البريد الإلكتروني: (kathleen.baess@postgrad.manchester.ac.uk)

أو المشرفتان الرئيسيتان المسؤولتان عن البحث:

برفسورة راتشل كالام : (rachel.calam@manchester.ac.uk)

د. فيونا ألف : (fiona.ulph@manchester.ac.uk)

ماذا لو حصل خطأ ما؟

إذا كان لديك أي توجس اتجاه أي أمر متعلق بالبحث فيمكنك أن تراجع فريق البحث حيث يمكنك أن تتحدث هاتفياً مع البرفسورة راتشل كالام على الرقم (0161 275 8755) أو التواصل عبر البريد الإلكتروني على العنوان: (rachel.calam@manchester.ac.uk)

كما يمكنك أن تتواصل مع الدكتورة فيونا ألف على العنوان الإلكتروني: (fiona.ulph@manchester.ac.uk) أو التواصل مع كاتلين بايس على البريد الإلكتروني (kathleen.baess@postgrad.manchester.ac.uk)

إذا كان هناك أي أمر متعلق بهذا البحث ولا ترغب بمناقشته مع فريق البحث أو إن أردت تقديم شكوى حول مجريات البحث يمكنك الاتصال بفريق إدارة البحوث والسلامة عن طريق مراسلتهم على العنوان البريدي التالي:

The Research Governance and Integrity Manager,

Research Office, Christie Building,

The University of Manchester, Oxford Road, Manchester, M13 9L

أو مراسلتهم إلكترونياً على البريد الإلكتروني (research.Complaints@manchester.ac.uk) أو الاتصال بهم هاتفياً على الرقم

(0161 275 7583) أو الرقم (0161 275 8093)

Appendix H – Consent form

**Decision making about parenting advice for refugee parents
resettled in the UK**

CONSENT FORM

If you are willing to participate please complete and sign the consent form below.

Please initial

1.	I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2.	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to any treatment/service.	
3.	I understand that the interview will be audio-recorded.	
4.	I agree to my data being retained indefinitely for further research and/or secondary data analysis related to the parenting experiences and support needs of refugee parents. This includes anonymised data being shared with other researchers working with the research group for research or training purposes.	
5.	I understand that my name will not be used and I will not be personally identified in any reports or publications of the research. I agree to the use of anonymous quotes from the interview or focus group.	
6.	I agree to my contact details being securely stored and being re-contacted by a member of the researcher in the future (after a minimum of 3 months). I understand that I am free to withdraw this consent at any time.	
7.	I agree to take part in the above project.	

Name of participant

Date

Signature

Name of person taking
consent

Date

Signature

اتخاذ قرار المشاركة للحصول على نصائح تربوية خاصة بالوالدين للأهالي اللاجئين في المملكة المتحدة

استمارة موافقة

إذا كانت لديك الرغبة بالمشاركة من فضلك أكمل بيان الموافقة التالي وضع توقيعك في أسفله:

1- أقر بأنني قمت بقراءة المعلومات المرفقة مع المشروع وكان لدي الوقت الكافي لفهم المعلومات وطرح الأسئلة وتلقي الإجابات بشكل وافٍ.
2- أتفهم أن مشاركتي في هذه الدراسة هي مشاركة طوعية وأن لدي الحرية التامة للانسحاب في أي وقت دون إعطاء أي سبب ودون إلحاق ضرر بأي طرف.
3- أوافق على أن المقابلة سوف يتم تسجيلها صوتياً.
4- أوافق على أن يتم الاحتفاظ ببياناتي إلى أجل غير مسمى للاستفادة منها في أبحاث لاحقة وفي تحليل البيانات الثانوية المتعلقة بخبرات الوالدين ولدعم حاجات الأباء والأمهات اللاجئين وهذا من جهته قد يستدعي مشاركة الباحثين العاملين ضمن فريق البحث للبيانات لأهداف بحثية وتدريبية دون معرفة الهوية الشخصية لصاحب البيانات.
5- ما أفهمه هو أن اسمي لن يستخدم ولن يتم معرفتي بشكل شخصي في أي من التقارير والمنشورات البحثية وأوافق على الاقتباس من محتوى المقابلة دون الإشارة إلى صاحب المقولة.
6- أوافق على ان يتم الاحتفاظ بعناويني وأرقامى بشكل آمن لكي يتم الاتصال بي مرة أخرى من قبل أحد الباحثين خلال فترة زمنية لا تقل عن ثلاثة أشهر بعد أول مقابلة، كما أنه لدي الحرية للانسحاب في أي وقت.
7- أوافق على المشاركة في هذا المشروع.

اسم المشترك: _____ التاريخ: _____ التوقيع: _____
اسم الشخص الذي حصل على الموافقة: _____ التاريخ: _____
التوقيع: _____

Appendix I – Family Demographics Questionnaire

Participant ID:				Date:	____	____	____
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Family Demographics Questionnaire

This questionnaire collects information about you and your family. Please read and answer each question.

1. Your age when the conflict started: (Years)

2. Your age today: (Years)

3. Your gender: Male/Female (please delete or circle as appropriate)

4. Your current marital status:

Married Divorced/separated Single
 Cohabiting Widow/Widower

Other relevant information:

5. Your highest level of education:

primary school or less some high school completed high school
 trade/technical college qualification university degree post-graduate degree

6. Your partner's highest level of education (if applicable)?

primary school or less some high school completed high school
 trade/technical college qualification university degree post-graduate degree

7. Are you working outside the home right now?

yes, full time yes, part time not working, but looking for a job
 home based paid work (child care, sewing, internet or phone-based work, etc)
 not working (includes stay at home parents, retired)

8. Is your partner working outside the home right now (if applicable)?

yes, full time yes, part time not working, but looking for a job
 home based paid work (child care, sewing, internet or phone-based work, etc)
 not working (includes stay at home parents, retired)

Participant ID:				Date:	__ __	__ __	__ __ __ __
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9. How many children do you have?

.....

Please provide further details about each of your children.

Child	Date of Birth	Age When Conflict Started	Age Today	Gender	Relationship to Child
1.					
2.					
3.					
4.					
5.					
6.					

10. Which ethnic or cultural group do you most strongly identify with (e.g., Asian, Caucasian)?

.....

11. What is your country of origin?

.....

12. Is your country of origin the same country as where the conflict you lived through was?

.....

13. *Where* were you living (city / town / village) and *who* with before the conflict began?

.....

14. How long had you lived there?

.....

15. When the conflict started did you and those you lived with stay there before moving to the UK?

.....

.....

Participant ID:				Date:	__ __	__ __	__ __ __ __
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15a. If no, where did you and the others you lived with go before coming to the UK?

.....

15a(i). Did you live anywhere else after that before coming to the UK? If yes, please list.

Location 1

Who with How long (months)

Location 2

Who with How long (months)

Location 3

Who with How long (months)

Location 4 How long (months)

Who with How long (months)

16. When did you move to the UK and where from?

.....

17. How did you get to the UK and who with?

.....

18. How long have you lived in the UK (in months)?

.....

19. *Where* did you live (city / town) and *who* with when you first arrived in the UK?

.....

20. Have you moved since then? If yes, i) *how many times*, ii) *where to* (city / town) and iii) *who with*?

.....

Participant ID:				Date:	__ __	__ __	__ __ __ __
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20. Continued

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21. Further information / comments

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Thank you for your time.

Appendix J – Debrief form

Decision making about parenting advice for refugee parents in the UK

University of Manchester

Debrief

Thank you for taking the time to talk to us. We appreciate your help. When the research is complete, you can have a summary of the results if you wish. Please let Kathleen know the best method of contacting you if you want a summary. Your contact details will be kept in a secure place and no third parties will have access to your information.

Sometimes, the things that are talked about can make people feel emotional. Below is a list of organisations that offer support should you need it:

Samaritans

Confidential support for people experiencing feelings of distress or despair.

Phone: 116 123 (free 24-hour helpline)

Website: www.samaritans.org.uk

Refugee Action

To assist refugees in conditions of need, hardship and distress, advice and support to asylum seekers who are dispersed without choice to the North West, East Midlands, South Central and South West Home office regions.

Website: www.refugee-action.org.uk

Parenting: Family Lives

Advice on all aspects of parenting including dealing with bullying.

Phone: 0808 800 2222 (Mon-Fri, 9am-9pm. Sat-Sun, 10am-3pm)

Website: www.familylives.org.uk

For emergencies

Should you feel distressed and need help straight away, ring 999.

اتخاذ قرار المشاركة للحصول على نصائح تربوية خاصة بالوالدين لأهالي اللاجئين في

المملكة المتحدة

خلاصة

شكرا جزيلاً لوقتكم الذي اخذته لكي تشارك في هذه الدراسة وتحدث إلينا، نحن نشكر ذلك عالياً. عندما يكتمل البحث سوف يكون بإمكاننا أن نعطيكم خلاصة عن النتائج التي توصلنا إليها إن أحببت ذلك، نرجوا منك أن تخبر السيدة كاتلين بأفضل طريقة يمكننا فيها التواصل معك إن أردت الحصول على خلاصة الدراسة. عنوانك ورقم هاتفك سوف تبقى سرية ولن يتم كشفها لطرف ثالث مطلقاً. في بعض الأحيان، تتسبب المواضيع التي يتم التحدث عنها في إثارة عاطفية للناس. يوجد في الأسفل قائمة بالمنظمات التي يمكن أن تقدم المساعدة في حال حاجتك إليها:

ساماريتانس (Samaritans)

خدمات سرية للناس الذين يشعرون بضيق ويأس

الهاتف: 116 123 (خط مساعدة مجاني دائم-24 ساعة)

ريفيوجي أكشن (Refugee Action)

لمساعدة اللاجئين في ظروف الحاجة والصعوبات واليأس ولتقديم المشورة والمساعدة لطالبي اللجوء الذين يشعرون باليأس وليس لديهم خيارات في مناطق شمال غرب ، شرق وسط ، جنوب وجنوب غرب انكلترا.

الموقع الإلكتروني: www.refugee-action.org.uk

بارينتينغ: فاملي لايف (Parenting: Family Lives)

نصائح للوالدين في شتى المجالات متضمنة حالات التعامل مع التسلط

رقم الهاتف : 0808 800 2222 (الاثنين إلى الجمعة من الساعة 9 صباحاً إلى 9 مساءً، يومي

السبت والأحد من الساعة 10 صباحاً إلى 3 بعد الظهر)

الموقع الإلكتروني: www.familylives.org.uk

في حالات الطوارئ

إذا شعرت بالحزن الشديد وكنت بحاجة للمساعدة اتصل فوراً برقم الطوارئ 999