A narrative exploration of people's experiences of mental ill-health and accessing mental health services in the Kingdom of Saudi Arabia

Nada AL-Attar
Ph.D. student, School of Health Sciences
University of Nottingham

Supervisors

Professor Catrin Evans
Dr Theodore Stickley
Dr Anne Felton

2023

Abstract

In the Kingdom of Saudi Arabia (KSA), there has been a rise in the number of people experiencing mental health difficulties, however, it is notable that people are reluctant to seek professional help. Whilst there may be cultural, economic, social, legal, and policy barriers, it is unclear to what extent people do not access services because of the stigma associated with the label of a mental illness.

Mental ill-health presents a global challenge, complicated by the fact that cultural beliefs and behaviours associated with mental ill-health can come between people experiencing difficulties and their receiving appropriate treatment. Furthermore, there is little qualitative research which gives voice to people's experiences of being diagnosed and receiving treatment from services. In respect to Saudi culture, the existing research indicates that there is often a strong stigma associated with people with mental health difficulties and especially with those who seek help at psychiatric institutions. Furthermore, "courtesy stigma" is experienced within families of those affected and whole families are often regarded as being affected by "Jinn" (possession). Since mental health problems are regarded as taboos, such beliefs have been found to negatively impact families and this may cause people to not access professional help (structural sigma) and instead they may rely upon faith-healing or other traditional methods.

This study aimed to explore people's experiences of mental ill-health and of accessing and using mental health services in the Kingdom of Saudi Arabia. It employed a narrative inquiry research method with the following objectives:

1. To enable mental health service users in KSA to speak about their experiences of mental health difficulties and accessing services

2. To discover possible barriers that people experience in accessing mental health services in the KSA

3. To identify how stigma associated with mental health difficulties may have affected people's lives

4. To consider the influence of cultural and religious beliefs on people's understanding of mental illness and the impact this has on service access and use.

This study adopted a qualitative, narrative approach to explore people's accounts of experiencing mental distress and using services in KSA. Recruitment was through a community-based national organisation: "Saudi Schizophrenia Charity Association" (SSCA), which is in Riyadh, the capital city. Interviews were conducted with 20 Saudi mental health service users. Narrative, un-structured interviews were used to give opportunity for people to narrate their own stories of their experiences of receiving a mental health diagnosis and subsequent treatment. The data obtained from the interviews were systematically analysed using a critical narrative analysis process.

This research found a number of key themes concerning access to mental health services in KSA and the importance of faith healers as a mental health resource and cultural artefact. These related to widespread stigmatisation; socio-economic problems, including financial and social issues; psychological distress and mistrust or suspicion of medical assistance; the lack of belonging and the absence of family assistance and support and family relationships. The study findings suggest that in KSA, a culturally tailored approach that takes account of religious and traditional as well as conventional medical treatment, may optimise outcomes for people accessing mental health services. This study makes an original contribution to the existing knowledge on the experiences of people who use mental health services in KSA and helps to identify the barriers to accessing mental health care services. In the Kingdom of Saudi Arabia, a culturally tailored approach that takes account of religious elements as well as the medical model may encourage people with mental health issues to access mental health services.

Acknowledgements

I praise ALLAH, for blessing & facilitating me to complete this thesis. The Prophet Mohamed (PBUH) said: 'Those who do not thank people, they do not thank Allah''. I wish to thank myself for my patience and doing a hard work during my PhD journey. First and foremost, I want to express my gratitude to my supervisors, Dr Theo Stickley, Dr Anne Felton and Professor Catrin Evans for their essential guidance, unwavering support, and patience throughout my PhD studies. Their vast expertise and wealth of experience have inspired me throughout my academic study and daily life. Great thankful also to College of Nursing at King Saud University for supporting and funding my PhD study. Special appreciation to my dad for his inspiring and encouragement to continue my PhD and believing on me. I dedicate my work in my thesis to his soul, May Allah have mercy on him. I would like also to thank my family (My Husband and my children) for their patience, without their tremendous understanding and encouragement in the past few years, it would be impossible for me to complete my study. Further grateful thanks to the president and staff member of the Saudi Charity Society for Schizophrenics Patient for their help & cooperation during data collection time and the greatest appreciation to the participants of this study for their participation in this research

Abbreviations

BSA	British Sociological Association.
CNA	Critical Narrative Analysis
GBD	Global Burden of Disease
GCC	Gulf Cooperation Council
GHQ	General Health Questionnaire
KSA	Kingdom of Saudi Arabia
MCPT	Macro Cultural Psychological Theory
MHA	Mental Health Act
MHCL	Mental Health Care Law
MOE	Ministry of Education
MOH	Ministry of health
MOM	Ministry of Media
OCD	Obsessive Compulsive Disorder
PBUH	Peace Be Upon Him
PCC	Population, Concept and Context
RMHCL	The Regulation of Mental Health Care Law
SCFHS	Saudi Commission For Health Specialties
SCSS	Saudi Charity Society for Schizophrenics patients
SMHPC	Saudi Mental Health Promotion Centre
SRA	Ethical Guidelines
WHO	World Health Organisation
ZPD	Zone of Proximal Development

Contents

Chapter 1: Introduction and Background 1

1.1 Structure of the thesis 2

1.2 Background to the Study 7

1.3 The Development of Mental Health Care Services in the KSA 9

1.4 Saudi Cultural Beliefs and Mental Health Help-Seeking Behaviour 12

1.5 Barriers to Using Mental Health Services (Social, Economic, and Legal) 13

1.6 Conclusion 16

Chapter 2: Literature Review 17

2.1 Introduction 17

2.2 Historical and Cultural Foundations of Saudi Society 17

2.2.1 Population and Cultural Symbols 18

2.3 How Cultural Identity Theory Relates to Saudi Culture 19

2.3.1 Religion 19

2.3.2 Saudi Society 20

2.3.3 Cultural Context 23

2.3.4 Barriers to Access 25

2.4 Scoping Review Method 26

2.4.1 Identifying the research question 27

2.4.2 Study Selection 29

2.4.3 Collating, Summarising and Reporting the Results 30

2.4.4 Characteristics Included 31

2.5 Classifying Themes 31

2.5.1 Prevalence of Mental Illness in the KSA..... 32

2.5.2 Mental Health/Illness Stigma 33

2.5.3 Attitudes, Perceptions and Knowledge 34

2.5.4 Understanding Mental Illness amongst Arab Muslims and Saudi people..... 35

2.5.5 Availability and Accessibility of Mental Health Services 37

2.6 Discussion 39

2.7 Identification of Research Gaps 41

2.8 Significance of the Study 43

2.9 Research Aim and Objectives.....43

Chapter 3: Theoretical Framework 45

3.1 Introduction 45

3.2 Vygotsky: an overview.....46

3.2.1 Vygotsky's Assumptions 46

3.2.2 Vygotsky's Macro-Cultural Psychological (MCP) Theory 49

3.3 Macro Cultural Factors/Forces in Saudi context 52

3.4 Macro-Cultural Psychological Theory and the KSA 55

3.4.1 Perceptions of Mental Illness within the Saudi Context 58

3.4.2 Religious Impact on the Cultural Identity of Saudi Arabians 62

3.4.3 Gender Factors within the KSA 64

3.4.4 The Meaning and Influence of the Family Network within the KSA 66

3.4.5 Access to Mental Health Services in the KSA 68

3.5 Conclusion 69

Chapter 4: Methodology and Methods 71

4.1 Introduction 71

4.2 Philosophical Underpinning 72

4.2.1 Interpretivism 73

4.2.2 Narrative Theory and Constructionist Approach74

4.2.3 Constructivist Approach 77

4.3 Trustworthiness in Narrative Research.....80

4.4 Narrative Analysis Method 83

4.5 Ethics in Narrative Research 85

4.5.1 Reflective Ethics 87

4.5.2 Ethical Considerations 88

4.6 Study Design.....89

4.6.1 Access to the Participants 90

4.6.2 The Impact of the Research on the Identity of the Researcher 91

4.7 Ethics and Safety of the Participants 95

4.7.1 Consent..... 95

4.7.2 Payment..... 96

4.7.3 Safety of the Participants..... 96

4.8 Method of the Narrative Interview.....96

4.8.1 Unstructured interview Process..... 97

4.8.2 Participants' Selection 97

4.8.3 Recruitment and Eligibility Criteria 98

4.9 Sample size.....99

4.10 Transcription 100

4.11 Critical Narrative Analysis (CNA) 101

4.12 Reflexivity within Stage One of CNA 108

4.12.1 Reflection on my Upbringing, Knowledge and Experiences 111

4.12.2 Reflection on my Data Collection Journey . 112

4.12.3 Reflection on my Values, Beliefs, and the Content of People's Narratives 114

4.13 Analysis of Data 118

4.14 Writing up the Analysis.....119

4.15 Conclusion 120

Chapter 5: Findings 122

5.1 Introduction 122

5.2 Service Users' Narrative Experiences.....123

5.2.1 Critical Narrative Analysis: Faris 123

5.2.2 Critical Narrative Analysis: Bashar 129

5.2.3 Critical Narrative Analysis: Kareem 134

5.2.4 Critical Narrative Analysis: Hameed..... 139

5.2.5 Critical Narrative Analysis: Mansour 145

5.2.6 Critical Narrative Analysis: Yasir 150

5.2.7 Critical Narrative Analysis: Othman 156

5.2.8 Critical Narrative Analysis: Mdawy 161

5.2.9 Critical Narrative Analysis: Salmah..... 165

5.2.10 Critical Narrative Analysis: Awaad 169

5.2.11 Critical Narrative Analysis: Amal 172

5.2.12 Critical Narrative Analysis: Rami 176

5.2.13 Critical Narrative Analysis: Bayan..... 180

5.2.14 Critical Narrative Analysis: Monerah 184

5.2.15 Critical Narrative Analysis: Mashayer..... 188

5.2.16 Critical Narrative Analysis: Khalaf..... 191

5.2.17 Critical Narrative Analysis: Nader..... 195

5.2.18 Critical Narrative Analysis: Bandar 198

5.2.19 Critical Narrative Analysis: Adam 203

5.2.20 Critical Narrative Analysis: Majed..... 207

5.3 Common Themes extracted from Twenty Stories 212

5.4 Analysis 216

5.5 Conclusion 218

Chapter 6: Discussion.....223

6.1 Introduction 223

6.2 Cultural Identity and Religion: Social Attitudes and Stigma Negatively affect Help-Seeking Behaviour ..225

6.3 When Religious and Spiritual Beliefs are Ignored, Mistrust leads to a Suspicious Dependence on Medical Assistance.....232

6.4 Socio-Economic Problems, interfere with Accessing and Using Mental Health Services 235

6.5 The lack of a Sense of Family and Social Belonging exacerbates Mental Health Difficulties 239

6.6 Challenges for Saudi Society.....241

6.7 What this Study Adds.....249

6.8 The Study's Recommendations 253

6.9 Where do I go from here?.....255

6.10 Strength and Limitations of this Study....255

6.11 Conclusion 257

Chapter 7: Conclusion 259

7.1 Introduction 259

7.2 How theory has facilitated my Inquiry.....263

7.3 The Original Contribution of the Research 265

7.3.1 The Potential of Using a Narrative Approach in Mental Health Nursing Practice 267

7.4 The Original Contribution to Nursing Practice in the KSA 269

7.5 Relevance for Future.....271

7.5.1 The Implications for Research 271

7.5.2 The Implications for Mental Health Nursing272

7.5.3 The Implications for Service Development and for Policy 275

7.6 Knowledge Transfer and Dissemination from the Current Research 276

7.7 Personal Reflection and Way Forward 277

Chapter 8: References 280

Chapter 9: Appendices: 303

Appendix A: Charting tables for the included studies 303

Appendix B: Study tables, boxes, and figures .331

Appendix C: Ethical approval letters 340

Appendix D: Study information sheet and Consent form 342

Appendix E: Example of participants transcript352

Chapter 1: Introduction and Background

The impetus for the current research stems from an incident that occurred during my nursing career. I was working as a senior mental health nurse in Riyadh in the Kingdom of Saudi Arabia (KSA), the place of my birth, where I was supervising undergraduate students in the patient zone of a Riyadh Psychiatric ward. On one occasion I noticed a man who appeared to be quite angry and who also displayed feelings of shame; he was not intending to draw attention to himself, as he was only there to accompany his wife to a clinic follow-up appointment. The lady entered the clinic and was then left to sit in the waiting area after a short period of time. However, I noticed that she had started crying, and I could not help but ask about the cause of her distress. She told me that she did not want to go to the clinic again because she was ashamed and embarrassed, not only for herself, but also for her husband, relatives, and family. At the time I tried to reassure her, but she was disheartened as she felt herself to be a burden on her family; it transpired that the whole family was trying to hide the fact that she was experiencing psychological problems and never wanted to disclose this to anybody, as it would bring humiliation upon the family. Subsequently, I began to realise that this was an all too familiar situation in KSA.

This experience provided motivation to emotionally and intellectually question and explore the relationship between the stigma associated with people with mental health problems in the KSA, and the personal, societal, religious and cultural experiences behind any issues they may have experienced with regards to 'help-seeking' behaviours in relation to accessing mental health services. Listening to this woman's story led to the conclusion that these

experiences were seldom heard by the public or the research world. This, therefore, resulted in the consideration of a narrative approach for the current research. Since such stories are seldom heard, it would be beneficial to focus upon people's stories as an emancipatory act to collect these stories of Saudi citizens and provide them with a voice. Accordingly, emancipatory narrative research has been viewed as a deliberate act of transforming respondents' lives by opening up new subjective possibilities (Wolgemuth and Donohue, 2006; Greenfield, 2010).

1.1 Structure of the thesis

Throughout the current thesis, I have been drawn towards a cultural inquiry in order to help me to understand the cultural and social contexts for the difficulties that people encounter once they, or a member of their family, experience mental health difficulties. The research led me to discuss how Saudi citizens who have mental health problems, and their families might be influenced by religious beliefs (social institution) and other socio-cultural factors (cultural artefacts and cultural concepts) in accessing and using mental health services. The aim of this study is to explore people's experiences of mental ill-health and of accessing and using mental health services in the KSA.

The particular area of interest on this journey was to obtain further comprehension of the role that 'traditional' approaches (i.e., faith-healers) have in delaying people from seeking professional help. It became evident that as a nurse, delaying seeking such help often resulted in further deterioration of people's mental health. Another aspect of interest was the issue of people initially engaging with services, but then withdrawing for fear of the effects of medication and mistrust of healthcare providers. Moreover, a further major social influence was observed to be the impact of stigma on individuals and

families of those individuals experiencing mental distress (White et al., 2017).

In order to begin to address these issues, the current study firstly presents a brief social background to Saudi society and introduces the prevalence of mental ill-health in the KSA, while the literature review identifies some of the barriers in accessing and using mental health services. The literature review helped to determine the gap in the research that this study seeks to fulfil, which can be appreciated through the following research objectives of the study:

1. Give people an opportunity to relay their experiences of mental health issues and access to services.

2. Discover barriers people may have faced during their mental health journey.

3. Identify how stigma may affect people's lives and how it is has affected them and their families.

4. Consider the cultural influences and traditional beliefs on people's understanding of mental health difficulties and how these impact upon their access and use of mental health services.

A version of the scoping review conducted for the current study has been published prior to submission (AlAttar et al., 2021). Different psychosocial theories were scrutinised that may be appropriate to apply to this study. I was drawn to Vygotsky's Macro Cultural Psychological Theory (MCPT), as it appeared to have all the components that could help to further understand Saudi society; but importantly it may also help to more deeply understand why people have such negative experiences when enduring mental distress, which results in seeking help for their condition. Chapter Three, therefore,

introduces MCPT as the theoretical framework to underpin the study. In the chapter, to the aim is to identify macro cultural factors that may make Saudi people feel reluctant to access professional mental health care and how that might impact upon their wellness and normal lifestyle. These cultural factors have a crucial effect on peoples' responses to the access and use of mental health services. It could be noted that in Saudi culture, religious and traditional beliefs are so engrained that culturally informed behaviours, such as denial, secrecy, and 'shameful' visits to faith-healers predominate. People are more inclined to attribute the aetiology of mental distress to be evil spirits (jinn) than they are to attribute to complex psychosocial understandings. As Saudi culture is intrinsically bound by traditional beliefs, stigma has become so prevalent that any significant advancement in social understanding of mental distress seems to require substantial progression.

In the methodology chapter, the selected methodology and methods helped to elicit, analyse and interpret people's stories. The voice of mental health service users is so rarely heard in KSA, and thus, the aim is to endeavour to conduct a competent, quality study in order to allow some of these voices to be heard. When I was first led to narrative methodology by my supervisor, it occurred to me that a qualitative, narrative research study that provides a voice to mental health service users had never been conducted in the KSA. I was initially excited because I realised that I was facing a distinctive opportunity to make an original and worthwhile contribution to this body of knowledge. However, I was also daunted for different reasons: firstly, because a qualitative research project, such as this had never previously been attempted and I would not know what difficulties lie ahead; and secondly, I wondered whether Saudi society actually wanted to hear the voices of mental health service users. Ultimately, I felt both stimulated and challenged by the work ahead.

When I first came to England to study, I had no idea what kind of research I would undertake; I had assumed it would be more 'scientific' than what I ended up with. Mental health nursing, though, is an art, as well as a science (Norman and Ryrie, 2013), and I felt privileged to be able conduct this kind of study.

When I began reading the narrative research literature, I was surprised at the use and strength of the authors' personal voices. I needed to adjust to this way of being as it conflicted with any previous training, I had received in regards to conducting research. However, doing qualitative research made sense to me, as I could provide a personal context to understand the topic. Riessman (1993) refers to this as 'locating myself' and suggests that it is beneficial for an author and narrative researcher to reflect on their own context and the impact it has on narrative creation. This context has greatly helped me in emphasising the importance, not just for the story and how it is told, but also the way in which the listener can impact upon the narrative – something researchers refer to as 'co-creation' (Frank, 1995).

In the methodology chapter, I use the narrative approach, which has a crucial role in providing people with a voice, as it allows the twenty participants to narrate their stories during the unstructured interview. I transcribed each of the stories and then analysed them by using Langdridge's (2007) critical narrative analysis method. Additionally, I provide more details of my personal views, which are an important component of the Critical Narrative Analysis (CNA) framework. Accordingly, reflexivity is part of the ongoing attempt to demonstrate clarity and rigour in this study. Specifically, Langdridge's (2007) CNA is the analytic framework chosen, which is described as a "framework for reading text", relying on Paul Ricoeur's work that combines phenomenological philosophy and hermeneutics

(Ricoeur and Thompson, 1981; Ricoeur, 2010). CNA was selected for its appropriateness in eliciting contemporaneous meaning from interview narratives. CNA offers a useful six-stage framework (Langdridge, 2007), and are explored in detail in the methodology chapter. The following is an overview of where each stage has been applied in the current study:

Stage 1: A critique of the illusions of subjectivity (which is discussed in the theory and methodology chapters).

Stage 2: Identify narratives, narrative tone and rhetorical function.

Stage 3: Determine the Identities and Identity work.

Stage 4: Thematic priorities and relationships (Stages 2,3 and 4 are situated in the findings chapter).

Stage 5: Destabilising the narrative (in the discussion chapter).

Stage 6: Synthesis (in the conclusion chapter).

The findings chapter identifies that in the KSA, cultural factors and traditional beliefs incorporate both religious elements as well as medical mental health approaches and along the journey of treatment, a more tailored and personal approach emerges as preferable.

In the discussion chapter, stage 5 of CNA is explained, with additional reflections on the study's progress, together with the strengths and limitations of the methodology. I then apply Vygotsky's macro cultural psychological theory to destabilise the narratives and reveal some of what is hidden behind what was said. I also examine how socio-cultural factors influence stigma and how stigma affects individuals with mental health issues and how these factors may

contribute to the stigmatisation of people with mental health issues and their families, which extends throughout Saudi society. Moreover, it is identified that the original contribution the current study makes to the existing knowledge about how people experience mental distress in the KSA and how they experience access to services.

In the conclusion chapter, Stage 6 of CNA is used to synthesise the study, with the findings summarised and the study's transferability and implications discussed in regards to service users' experiences in accessing and using mental health care in the KSA. The intention is also to explain how the research questions were answered with some recommendations for future research.

1.2 Background to the Study

The World Health Organization (WHO, 2009) estimates that approximately 25% of the global population faces mental and behavioural health issues (World Health Organization, 2009). This burden is estimated to account for 12% of the worldwide cases of severe mental illness (Ahmed and Ezzedine, 2014). The Bureau of Labor Statistics (2017) highlights that in the USA approximately 33 million adults suffer from behavioural and mental health challenges. Comparatively, in the UK, there are an estimated 9 million persons experiencing diagnosable mental health problems (Minas and Cohen, 2013).

There are growing fears at the increasing number of people affected by mental health difficulties who seek medical help. In contrast, in the USA individuals who start treatment often do not complete their recommended treatment plans (Shim et al., 2012). What is more, stigma is identified as the main barrier to accessing treatment plans in Australia (Reavley and Jorm, 2012). Meanwhile, other potential barriers in the KSA include: economic, social, legal, and policy barriers (Almalki et al., 2011). Separately, a report from

the Gulf Cooperation Council (GCC) Member States undertaken by Hickey et al. (2016) found that more than 25% of the Gulf countries' population has experienced mental health challenges. Among the surveyed population, 65% had experienced stigma, while 40% had suffered a negative social impact due to their mental health situation (Hickey *et al.*, 2016).

In the KSA, the situation is similar with a presence of mental health problems projected to be up to 20% of primary care clinical visits (Almalki et al., 2011). Furthermore, a ten year retrospective study reported that about 37% of patients experience social stigma (Al-Zahrani et al., 2013). However, doubts towards effective mental care and social stigma still persist across Saudi systems (El-Gilany et al., 2010; Griffiths et al., 2014; Alyousef, 2017). From the 53% of those individuals who experienced mental health conditions in the KSA, 21% reported to have stopped or had avoided going to social events, as they were afraid of how they may have been treated (i.e., structural stigma, (Goffman, 1963)). Additionally, 17% were noted to have been discouraged by family members or relatives from going outside (i.e., courtesy stigma, (Goffman, 1963)). The majority (76%), however, sought help from close friends, while 24% preferred not to inform anyone of their condition (Shahrour and Rehmani, 2009). Indeed, people may feel stigmatised by their local communities, or they may fear being judged because of breaking their cultural norms when they attempt to seek mental health care without the awareness and support of their families and community (i.e., structural stigma). Due to the insidious complexity and seriously damaging effects of stigma, the concept is explored in greater detail in the following chapter, which informs the findings and discussion of the current research.

1.3 The Development of Mental Health Care Services in the KSA

The health care system in the KSA is a publicly funded system in which the Saudi government provides all health services for its citizens under the umbrella of the Ministry of Health (MOH). While the Kingdom's health laws attempt to assure equitable and accessible healthcare for all citizens, the continual population expansion has placed a strain on the sustainability of free healthcare services. Thus, the development of private medical facilities and hospital sector privatisation offer a solution to assist the Saudi government to maintain free health care (Carlisle, 2018). Nevertheless, it is not clear if it is a deliberate government policy to encourage privatisation, as the private hospitals are fewer than the governmental ones. However, the MOH remains the primary provider of diagnostic, curative, rehabilitative, and palliative healthcare services in Saudi Arabia.

In terms of mental health services in the KSA, the state continues to provide free and fully funded care with additional government institutions. In addition, there are private psychiatric and psychological services in various private sector hospitals and health centres, as well as psychiatric clinics. In the early 1980s, the KSA had just two mental facilities, and psychiatric training was only available up to diploma level (Becker, 2004; Koenig et al., 2014). In the late 1980s, Saudi physicians who wanted to work as psychiatric consultants had to complete their postgraduate studies overseas; almost all of the specialist psychiatrists and nursing personnel were non-Saudis who spoke English and the mental health care was medication-focused (Al-Subaie, 1989).

In 1983, the Saudi MOH began decentralising mental health services, and by 2014, there were 21 regional psychiatric hospitals, which were supplemented by free-standing private psychiatric clinics and other psychiatric clinics based in many of the country's 125+

private general hospitals (Carlisle, 2018). In 2006, there was a national mental health policy in place, which comprised speciality programmes for addicts, children and adolescents, the elderly, and counselling services in general medical settings. Hospitals, though, continue to be the major specialised providers, resulting in many communities' mental health care being delivered primarily by general health care physicians (Becker, 2004; Koenig et al., 2014).

Mental health services in the KSA are subsequently mapped out through a document known as the Mental and Social Health Atlas, which includes initiatives intended to improve mental health services and to seek to streamline the delivery of mental care services between families, caregivers and patients (Qureshi et al., 2013). One of the main areas of development is the policy legislation, where key changes to Health Care Services have been introduced (Al-Habeeb and Qureshi, 2010). For instance, the KSA government passed the Mental Health Act (MHA) (2010), which aimed to improve people's access to care, and to ensure optimum care to the targeted population (Al-Habeeb and Qureshi, 2010). This MHA was adopted to ensure that the KSA meets global guidelines on mental health services in line with the WHO standards (World Health Organization, 2009). Another crucial step taken by the KSA government to improve mental health service delivery is through advancements in financing and resource allocation (Griffiths et al., 2014; Alyousef, 2017).

The WHO recommends funding to be a powerful tool that lawmakers are able to embrace in order to develop and shape the quality of mental health services (Hsu and Alden, 2008). Considering these recent developments, the KSA is deemed to be on course in its efforts to improve mental health care within the country and services in terms of funding, personnel, materials, and other resource allocations (Kazdin and Rabbitt, 2013). The intention of such an

approach is to ensure that people with mental health problems are not ostracised from society, victimised or denied care (Griffiths et al., 2014; Koenig et al., 2014). Despite all the above developments of mental health services in the KSA, it is common for those who access mental health services to be seriously affected by the attitudes and responses of family members and friends, and consequently become subject to structural stigma. Such stigma encompasses cultural norms, one's identity, well-being and is a strong force that often prevents people from accessing mental health services (Hatzenbuehler, 2016).

Human rights groups also work to ensure that these persons are not segregated while seeking employment, housing, and education (Griffiths et al., 2014). In particular, the KSA has the Regulation of Mental Health Care Law (RMHCL) (2016) that defines the following rights for people with mental health problems:

- The patient has the right to be treated in a healthy and humane environment where their dignity is upheld. The patient should be regularly updated on the developments and the progress of their treatment. The patient should also be protected from all forms of degrading treatments including corporal and moral punishment.

- The law also respects the freedom of patients and their spiritual health and receive faith-healing in accordance with Sharia law (Holy Quran and prophet Muhammed instructions) if the patient or relatives so demand.

- The patient can also file complaints against the institution or any party within the facility without consequences to the quality of treatment afforded to them or prejudice (RMHCL, 2016).

In an effort by the KSA to reduce mental health stigma, the Mental Health Care Law (MHCL) (2014) set a monetary fine and/or imprisonment for any medical practitioner who intentionally provides a report of false statements regarding the mental condition of any person for the purpose of admitting them to or releasing from hospital (MHCL, 2014). However, there is no known initiative in the KSA to educate the population in mental health matters which especially involves faith healers or spiritual leaders in their awareness work. Nevertheless, healthy and humane environments can be extended to the family and special circles of patients. Indeed, as the KSA is a religious kingdom, spiritual leaders can be used to educate the people in regards mental health.

1.4 Saudi Cultural Beliefs and Mental Health Help-Seeking Behaviour

In Saudi culture, there is often a strong stigma attached to people with mental illness and those who seek help from psychiatric institutions (Amri and Bemak, 2013; Ciftci et al., 2013). Stigma is not just limited to individual patients, but also stretches to the patients' families, in terms of "courtesy stigma" (Goffman, 1963; Hsu and Alden, 2008; Gaebel et al., 2016; Alattar et al., 2021). Separately, there is a robust belief association between mental health disorders/issues and evil eyes, spirit possession, loss of faith (Hart, 2016; Rassool, 2018). There is an allied 'taboo', about such beliefs and these negatively influence families and individuals, and thus, they generally refrain from seeking help (Amri and Bemak, 2013). Griffiths et al. (2014) note that one of the causes of their fears is the shame that their families might be subjected to the notion that they are spiritually weak (Hussein, 2014). In the KSA, the social stigma that surrounds people with mental issues is profound, and it could directly affect help-seeking behaviour (Amri and Bemak, 2013; Alyousef, 2017). For instance, Ciftci et al. (2013) claim that Islam is a source

of strength and healing, and mental health is not an exclusive condition; however, people with mental issues are often considered to be ‘insane', implying that such persons must have lost their spiritual path and faith in Allah (Ciftci et al., 2013; Jelaidan et al., 2018).

Some cultural beliefs encourage individuals with mental health difficulties to ‘toughen up’ and confront their problems (Vanaleesin et al., 2010). Such a phenomenon is especially true for men who are expected to act strongly in order to support their families. In contrast, women are rarely likely to internalise similar stigma levels when seeking help. They can, though, be heavily influenced by the opinions of their families when they choose to seek help and whether or not they continue their medical treatment (Vanaleesin et al., 2010). As the stigma against these groups is high, help-seeking is often limited to men, as most women continue without essential health care support and often struggle with their problems without professional help (Wirth and Bodenhausen, 2009). The relationship between mental health and culture is of great importance and, as a result, scholars emphasise the vital role that culture plays in influencing help-seeking behaviour, specifically in formulating approaches to reduce the barriers that patients face when accessing mental health services (Yang et al., 2007).

1.5 Barriers to Using Mental Health Services (Social, Economic, and Legal)

People with mental illness in the KSA are commonly faced with several challenges when using health care services, and experience economic, legal, and social barriers. For example, fewer than 40% of mentally ill patients seek professional care and some of the reasons for such barriers have been linked to social and cultural problems (Abu-Ras, 2014). These sociocultural barriers include being

discouraged by family members from seeking medical help, as self-stigma relates to being a burden to the family, in addition to the public stigma about being cursed, which are two common barriers that hinder patients from accessing care services (Abdullah and Brown, 2011; Mak and Cheung, 2012; Alyousef, 2017). In contrast, as stigma is engrained across cultures and affect persons from different backgrounds, avoidance protects against shame or the fear of being ostracised by the public (El-Gilany et al., 2010; Jelaidan et al., 2018).

In addition, the cost of insurance premiums and treatment in private psychiatric clinics, largely limits access to mental care for many people (Abdullah and Brown, 2011). As a consequence, lack of financial resources may prevent many people from seeking services, while for others inconsistent or inadequate finances result in incomplete medication and care (El-Gilany et al., 2010). In some cases, people with insurance cover can also find it challenging to access services when their cover expires, given the costly nature of mental care services (Yang et al., 2007). The costs and potential costs of psychiatric treatment clearly affect entire families; while the decision whether to choose private treatment greatly depends upon affordability and the circumstances of the family.

Due to the widespread lack of public awareness and mental health education (El-Gilany et al., 2010), there is minimal, if any policy-framework to guide people on how to seek services, which in turn, plays a negative role in influencing who accesses the information. If such frameworks existed, this may help in enabling the public to encourage people experiencing mental distress to seek medical help and reduce the neglect that so many people experience. At present, people are deterred from seeking medical help due to the stereotyping and negative cultural beliefs associated with mental illness (Rubin et al., 2016). Theoretically there are protective rights

in KSA (MHCL, 2014); however, victimisation, blaming and stigma all create barriers to people seeking professional help (Al-Zahrani et al., 2013).

Most Saudis who have mental health issues prefer to visit private clinics by either paying for the service per visit or by registering with medical insurance companies, which include treatment for mental distress. By using private clinic services, it is likely that people are attempting to avoid being stigmatised by others in their surrounding community (i.e., structural stigma), as private clinics tend to be more discrete and can be accessed at preferred times, rather than set 'clinic hours'. By contrast, accessing a freely provided government clinic could take a considerably longer time to arrange a first appointment, and it is clearly more of a 'psychiatric clinic'. Indeed, by and large, people who are unemployed or on a low income, usually attend government-provided services.

In 2014 the KSA's MOH improved mental health services across the country by combining mental health care into primary health care centres. However, studies have shown that some people are reluctant to use this system, despite the prevalence of mental illness in the KSA (Koenig et al., 2014; Alamri, 2016). The literature on the number of patients with mental illness provides inconsistent figures on the prevalence of the problem among the Saudi population, which was the main impetus to undertake the current research (Alibrahim, 2010). Other studies demonstrate a relationship between stigma, cultural barriers to health care, and stereotyping with reduced patient outcomes and a reduction in the number of people seeking medical help. However, this has not been investigated in the Saudi setting (Abdullah and Brown, 2011; Ciftci, 2013). Nonetheless, recent studies confirm the existence of negative attitudes toward mental illness within the Saudi population, which indicates the possible reluctance

to seek mental health care (Jelaidan, 2018; McCrae et al., 2019). This proposed research, thus, aims to bridge the existing literature gap on what factors influence the desire for people to seek formal help, and provide a voice to people's experiences.

1.6 Conclusion

In the current study the aim was to understand in-depth the full picture of Saudi citizens who have mental health problems with regard to their decisions about seeking early professional help. In addition, it was hoped to be possible to determine the type of help-seeking behaviours that they prefer to follow before, with and after they access and use mental health services. This exploration should involve people's families, relatives and friends' roles in formulating and directing their relatives in their help-seeking behaviours. To do that, the scoping literature review in the following chapter will identify the various studies which explain how people with mental health problems in Arabic and Muslim countries understand and deal with mental distress. Furthermore, I will seek to explore the challenges of cultural, traditional, religious and social factors that they have faced, or which they continue to face when accessing and using mental health services in the KSA.

Chapter 2: Literature Review

2.1 Introduction

Minimal research is available regarding the experiences of people who access mental health services in the Kingdom of Saudi Arabia (KSA). Therefore, the current review seeks to understand the experiences of mental health stigma in the KSA; to analyse the possible barriers people may experience when accessing mental health services and seeking health care; to investigate the influence of cultural and religious beliefs on people's understanding of mental health problems; and to identify the research gaps in the literature. Firstly, a cultural perspective on Saudi society is presented, including history, religion and other forces at work that create difficulties and barriers for people experiencing mental distress. Subsequently, a systematic scoping method is introduced to provide the rationale for the study through reviewing the relevant published empirical research.

2.2 Historical and Cultural Foundations of Saudi Society

The KSA has a unique cultural identity, although there are many similar points shared with its Islamic neighbours. It is commonly referred to as *Al-Mamlakah al-Arabiya as-Saudiyah* and is the motherland of the Arab people and the Islamic religion (Long, 2005). The cultural identity of the inhabitants of Saudi Arabia is primarily Arab Muslim, and this identity is shared with millions of others beyond the Kingdom's borders (Moaddel, 2016). The KSA also occupies the most considerable portion of the Arabian Peninsula; and the Kingdom's name connects the geographical and cultural identity ruled by the Al Saud dynasty (Long, 2005). The country identifies itself as a modern nation with its own national culture.

2.2.1 Population and Cultural Symbols

The KSA has historically recorded a constant increase in population. In 1992, the population was 17 million people (Long, 2005); which has now doubled with a large majority living in urban areas (General Authority Statistics KSA, 2020). Yamani (2004) postulates that the KSA's national culture acknowledges its modern achievements as epitomised through a national airline, thriving agriculture in the irrigated desert, petrochemical installations, skyscrapers, modern highways, and shopping malls with ice skating rinks and artificial waterfalls. The national culture is also embraced through artistic dimensions, such as epic poems recounting historical events of individual tribal affairs and *ardah*, which is a type of folkloric performance characterised by men dancing and waving swords in the air (Niblock, 2004; El-Shamy, 2018). Culturally, both men and women wear distinctive clothing that conforms to Muslim dress codes and prescribes decency for both genders, although most importantly for women.

Despite its numerous cultural symbols, the most powerful Saudi images are those connected with Islam (Silvey, 2004*;* Alkahtani et al., 2021). Similarly, the ritual celebrations that actively capture the imagination and the attention of Saudis are the holy pilgrimage (*haj*) to Makkah, the month of Ramadan, and the Muslim feasts of *Id al-Fitr* and *Id al-Adha,* which occur in conjunction with the pilgrimage and again after the end of Ramadan (Salem, 2017). Additionally, private wedding celebrations, expressions of condolences, and funeral participation are also regarded as significant rituals within Saudi society (Long, 2005; Gauvain, 2012). Arguably, the KSA has one of the most rigid cultural identities in the world from early childhood and incorporates complicated values and moral factors.

2.3 How Cultural Identity Theory Relates to Saudi Culture

Cultural identity is the feeling of belonging to a specific group. An individual's cultural identity involves self-perception related to aspects of his or her nationality, religion, ethnicity, and social class (Guitart, 2011; Hall, 2014). As identity is established by and derived from interaction with others, it has been perceived as both fluid and dynamic. Its substance, in addition to being transmitted from one generation to another, is also transferred from a member of a particular culture to a newcomer (Hall, 2014). Every cultural identity is enmeshed in a web, illustrated by the multifaceted and multidimensional relationship between social structure and identity (Livesey, 2004; Brooks et al., 2015). Even though individuals or social entities are surrounded by a variety of social forces, however, their options regarding choices and capacity to make decisions are limited. Livesey (2004) also notes that the identity of every culture is recognised through the consistency in values, standards, and behaviours of its members. Most importantly, the KSA is an Islamic state, and therefore, all of its national and cultural activities are founded on and dictated by Islamic law (Sharia).

2.3.1 Religion

In the KSA, religion has shaped the cultural identity of the Saudi people. A majority of Saudis are Sunni Muslims, and Sunni Islam is the established religion, making all religious institutions eligible for government support (Moaddel, 2016; Rinaldo, 2021). Saudis believe that their religion sprang from the Arabian town of Makkah, where a Hashimite branch merchant of the Quraysh tribe, the Prophet Muhammad (*Peace be Upon Him*), began preaching a series of revelations believed to have been given to him by God through the Angel Gabriel. Muhammad denounced Makkah as polytheism and upheld monotheism (Yamani, 2004; Burge, 2020). This created enmity between him and the town leaders, as the town's economy

primarily relied on numerous pagan shrines and the sacred structures around a black meteorite. He was invited to Yathrib (Medina) in 622 and the move, known to Muslims as *hijra,* marked the onset of the Islamic era (Long, 2005).

After Muhammad's death in 632, the adherents of his doctrine compiled the *Quran* from the words they perceived as coming directly from God (Donner, 2012; Moaddel, 2016). Other teachings and words interpreted as the understandings of Muhammad and his companions and witnessed by those who personally knew him became the *hadith*. The *Sunna* recounts Mohammad's deeds and utterances, and the three (Quran, Hadith and Sunna) comprehensively form a guide to the mystical, moral, and social life of a Sunni Muslim (Yamani, 2004; Bowering, 2015). The KSA is ruled by an Islamic monarchy, where Sunni Islam is considered the formal state religion. Despite Prophet Muhammad's preaching of Islam, he also recognised and accommodated the religious opinions of Christians, Hanifs, and Jews, who at the time inhabited the Arabian Peninsula. In fact, he considered their scriptures as part of God's word, destined to significantly contribute to Islam (Yamani, 2004; Khalidi, 2009). Hence, other monotheistic believers are mentioned in the Quran. During Muhammad's time, all monotheists (Jewish and Christians alike) were allowed to live by their religious laws, and if they acknowledged the position of *dhimmis people* they were excused from military service (Turner, 2010; Considine, 2021).

2.3.2 Saudi Society

In the last twenty years, the KSA has witnessed a substantial growth in the development of technology and urban infrastructure, including the construction of numerous hospitals, clinics, universities, colleges, and schools, which has resulted in free medical care and education for Saudi citizens (Ouda, 2016). Moreover, development has led to shopping malls, suburban neighbourhoods with single-

family houses, and satellite communications (Goldstone, 1998). Extensive oil revenues have also brought enormous wealth to the Kingdom; however, all this wealth has produced certain issues, as The Kingdom struggles to preserve its social and spiritual heritage while still reaping the benefits of modernity and Western influence. Accordingly, since the 1990s, the government has strived to develop technology while preserving and supporting Saudi society's core values. The KSA's foundation is built upon religion and an 18th-century reform movement that advocated for purity and simplicity and was supported by the early Islamic community. These origins have tethered the KSA to its Islamic traditions, making it difficult for leaders to make decisions that relate to modernity (Moaddel, 2016; Considine, 2021).

Despite economic change, the strength of traditional opinion has grown at a rapid rate. Religious conservatives engage in a debate with modernisers regarding the kinds of technology to adopt and the best ways to utilise the Kingdom's vast affluence. Nonetheless, the majority agree that the Kingdom's modernity should reflect Islamic customs and values (Abdullah et al., 2006; Kayed and Hassan, 2010). For decades, the KSA was torn between embracing the changes of the developed world and preserving the traditions of the third world (Wahass and Kent, 1997; Goldstone, 1998). Close to a third of the populace reside in rural areas away from the effects of urbanisation, with some people living as nomadic and seminomadic herdsmen and others as oasis agricultural labourers. Public amenities, such as schools and hospitals, though, were historically located away from the rural areas, making access difficult for the rural population (Hamdan, 2005; Long, 2005). For many rural dwellers, challenges, including lack of knowledge and incentive, physical distance, illiteracy, and bureaucratic obstacles, separated them from the resources of the burgeoning society in the country.

The population of the KSA was also a reflection of cultural contrasts. From one perspective, people felt required to abide by the stipulations of the Quran and the teachings of Prophet Muhammad that traditionally govern Islamic societies; while comparatively, there were diverse interpretations as to what these teachings demand. A faction of Saudi society pushed for traditions to adjust to contemporary circumstances, while other segments of society advocated for an alignment of present circumstances with tradition (Blanchard, 2010). The tension, however, was more pronounced in the role of women in Saudi society; conservatism was inclined towards a complete separation of women from men, particularly in public life, and focused on teaching domestic skills to women. Others favoured the transformation of 'separation values' into 'modesty ideals', presenting an opportunity to expand women's skills in both work and education (Hamdan, 2005; Abu-Ras, 2014).

Politically, even though the KSA depends on the US military, the need to declare cultural independence from the Western world has grown. What is more, as the Kingdom abandons traditional ties with other Arab countries to embrace and accommodate Western alliances, the importance of its role as a leading Muslim state among the Islamic nations has even greater significance (Moaddel, 2016). It is also postulated by Moaddel (2016) that the KSA has embraced modernity at a level that is in line with most of the Western world. Societal changes have focused on benefiting women, in contrast to previous practices that marginalised women in areas such as religion and politics. Economic and social frameworks have improved significantly for women under the current regime, culminating with the historic decisions to lift the driving ban on women (Silvey, 2004; Topal, 2019). Nevertheless, despite this significant step towards gender inclusion and equality, with Saudi women accessing better levels of education,

they still need to be adequately represented in the labour market in the near future to help shape the economic future of the country.

As a result of these social changes, in January 2016 plans were made to implement Crown Prince Mohammad bin Salman's major reform initiative, which is referred to as *Vision 2030* (Habibi, 2019). The reform plan would completely redesign the economic system of the KSA by supporting and improving other economic areas, such as tourism. Millions of pilgrims travel to Makkah and Medina every year, making religious tourism the second most important source of income in the country (Yamani, 2004; Kouchi et al., 2018; Timothy, 2020). Redesigning the economic system, therefore, can be achieved through expansion of cultural and leisure tourism. Moreover, the reforms include opening cinemas and opera houses, which will directly expand culture through the entertainment sector.

In the KSA, change is traditionally created from the top down when it seems likely that society will accept the changes. With nearly 70 percent of the population under the age of 30, many Saudi citizens have studied abroad and are influenced by various global cultures, who now want to lead freer and more open lives (Thompson, 2017; Habibi, 2019) . The Crown Prince, Mohammad bin Salman, sees himself as the ambassador of this young society and welcomes the reforms that will apparently redefine Saudi society. The goal is to make Saudi society culturally inclusive, regardless of gender, while also preserving the Kingdom’s entrenched societal structure that has enabled its survival in spite of global influences (Thompson, 2017). This will enable the blend of cultural tradition combined with modernisation through various fields.

2.3.3 Cultural Context

In the KSA culture, seeking care from psychiatric institutions is often stigmatised, not only for patients but also for their families who experience ‘courtesy stigma’ (Goffman, 1963; Birenbaum, 1992; Hsu

and Alden, 2008; Amri and Bemak, 2013; Andersson et al., 2013). There is a strong connection between mental health problems and concepts of the 'evil eye', spirit possession and/or lack of faith (Hart, 2016; Rassool, 2018). There are many allied taboos that negatively influence families and individuals, which results in them refraining from seeking help (Amri and Bemak, 2013; Jelaidan et al., 2018). Many individuals with mental health issues fear the shame that seeking help may bring to their families and the perception of spiritual weakness (Hussein, 2014; Alamri, 2016). Thus, in the KSA the social stigma is profound and directly affects help-seeking behavior (Jelaidan et al., 2018). While people may find the Islamic faith to be a source of strength and healing, people with mental health issues are often considered to be 'insane' or 'mad', and in the Saudi context, people may also be regarded as having lost their faith in Allah (Ciftci et al., 2013; Wesselmann et al., 2015).

Certain cultural/traditions in the KSA encourage people with mental health issues to handle their problems on their own and be strong (Vanaleesin et al., 2010; Abdullah and Brown, 2011). This is especially true for men, who are expected to be strong and support their families. In contrast, Saudi women are more likely to internalise stigma when seeking help, and can be easily secluded at home whilst seeking health care (Vanaleesin et al., 2010). Help-seeking, therefore, is often limited to men, as most women go without essential health care and often bear their problems without professional aid (Wirth and Bodenhausen, 2009; Clement et al., 2015). The relationship between mental health and culture is crucial and scholars emphasise the vital role that culture plays in influencing help-seeking behaviour, advising practitioners to formulate approaches to reduce the barriers that patients face when accessing mental health services (Yang et al., 2007; Choudhry et al., 2016).

2.3.4 Barriers to Access

Accessing mental health care services in the KSA can present numerous challenges, and people with mental illness may suffer from various economic, legal, and social barriers (Abu-Ras, 2014). These obstacles include discouragement from seeking medical assistance by family members and the belief that mental illness places a burden on families. Such barriers, coupled with public/social stigma and the notion of being 'cursed,' are widespread and hinder individuals from receiving care (Abdullah and Brown, 2011; Schierenbeck et al., 2013). Since stigma is widespread and affects people regardless of their background, avoiding help-seeking can protect individuals from the shame and/or fear of being ostracised (El-Gilany et al., 2010).

The cost of treatment, especially long-term, also greatly restricts people's access to mental care (Abdullah and Brown, 2011). A lack of money prevents some people from seeking help altogether, while for others it may mean incomplete medication and care (El-Gilany et al., 2010; Clement et al., 2012). Furthermore, people with insurance cover can have problems accessing care when their cover expires (Yang et al., 2007; Schierenbeck et al., 2013). The lack of legal framework in the KSA can also present a barrier for people seeking access to mental health services (El-Gilany et al., 2010). This can particularly affect those who are less aware or educated. The implementation of a legal framework could help reduce neglect of psychiatric patients and encourage people to seek medical care, despite the existence of socio-cultural artefacts and societal stigmas (Rubin et al., 2016).

Even though there are protective rights in place in the KSA (MHCL, 2014), fear of being socially shunned still prevents many people from seeking professional help (Al-Zahrani et al., 2013; Stuber et al., 2014). Studies have shown the impact of stigma, stereotyping, and cultural barriers on healthcare and patient outcomes, with fewer individuals seeking medical assistance. However, this issue has not

been thoroughly investigated in the Saudi context (Abdullah and Brown, 2011; Ciftci, 2013). The proposed research aims to fill the gap in the literature by identifying the factors that influence the decision of patients to seek or not to seek formal help, as well as the role that stigma may play in this dynamic.

2.4 Scoping Review Method

Scoping reviews can be used to identify key concepts, unlike other reviews that address relatively specific questions. Little research describes the experiences of those in mental health care in the KSA. Thus, to establish a literature review a systematic scoping method was conducted, with primary consideration of published empirical studies conducted in the KSA, but also relevant studies of Muslim populations. The review sought to characterise the nature of research that has been undertaken to understand the experiences of mental health stigma in the KSA. This included exploring the potential barriers facing those accessing mental health care, outlining the influences of cultural and religious beliefs, and identifying current research gaps. A review question guided the literature search strategy: *What research has been undertaken relating to stigma and its impact on people needing to access mental health services in the KSA?*

Scoping reviews are beneficial when examining new evidence when it is still unclear what other, more specific, questions should be addressed (Arksey and O'Malley, 2005). In the current study the Arksey and O'Malley six-stage methodological framework was adhered to (see Table 1) and the PRISMA framework.

Table 1: Scoping Review Framework Steps (Arksey and O'Malley, 2005)

Stage No	Stages of conducting the scoping review
1	Identifying the research question
2	Identifying relevant studies
3	Study selection
4	Charting the data
5	Collating, summarising, and reporting Results
6	Consultation (optional)

2.4.1 Identifying the research question

According to the population, concept and context (PCC) elements of the inclusion criteria (Algoso et al., 2016), the review question generated three manageable parts (see Table 2), and keywords were also identified (see Table 3).

Table 2 : Elements of the Inclusion Criteria (Algoso et al., 2016)

Population	Mental health/ill patient/public people
Concept	Experiences of stigma and seeking help from mental health services
Context	Mental health services in the KSA

Table 3: Search Keywords

Keywords
Mental illness; mental health; mentally ill people; people with mental illness; mental illness stigma; accessing mental health services; barriers to accessing mental health treatment; mental disorders; coping behaviour; mental health discrimination; social acceptance; community attitudes; help-seeking behaviour; faith-healing; major depression; mental illness in Saudi Arabia; traditions in Islam or religious beliefs; social interaction; religiosity, culture or Muslims, spirituality

The keywords were linked by the Boolean operator 'OR' between each element in PCC, and the main result of each PCC element was combined with 'and' to reach the total amount of articles, titles and abstracts. Using the keywords provide in Table 3 the relevant articles were found using the following databases: MEDLINE, CINAHL, Pub Med, PsycINFO, Web of Science, Psyc ARTICLES. No restriction was applied concerning the type of research study. From the results, using the inclusion and exclusion criteria in Table 4, different articles and journals were selected. Meanwhile, articles published before 2002 were excluded in the interests of focusing on contemporary research. Only papers published in English were included because academic articles produced from original research in the Arabic language are always submitted and published in English in both local and international journals.

Table 4: Literature Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Paper focused on related key terms • Paper published only in English • Papers published in peer-reviewed journal • Articles from 2002 or later (literature reviews, qualitative and quantitative research) • Relevant title or abstract	• Paper not in English • Papers not relevant to research topic • Articles older than 2002 • Non-peer reviewed, discussion pieces, commentaries and editorials

2.4.2 Study Selection

2414 studies were exported to reference manager EndNotex8; when duplications were removed this dropped to 1,230. The remaining 1190 reference lists and bibliographies of all the retrieved studies were screened against the inclusion criteria and after filtering, 143 references were screened for titles and/or abstracts relevant. Of the 143, 69 studies were excluded, and for the 74 remaining papers, full text articles were obtained and assessed for inclusion criteria. Ultimately, 28 articles met the full inclusion criteria and were thus included. Figure 1 below illustrates the selection process:

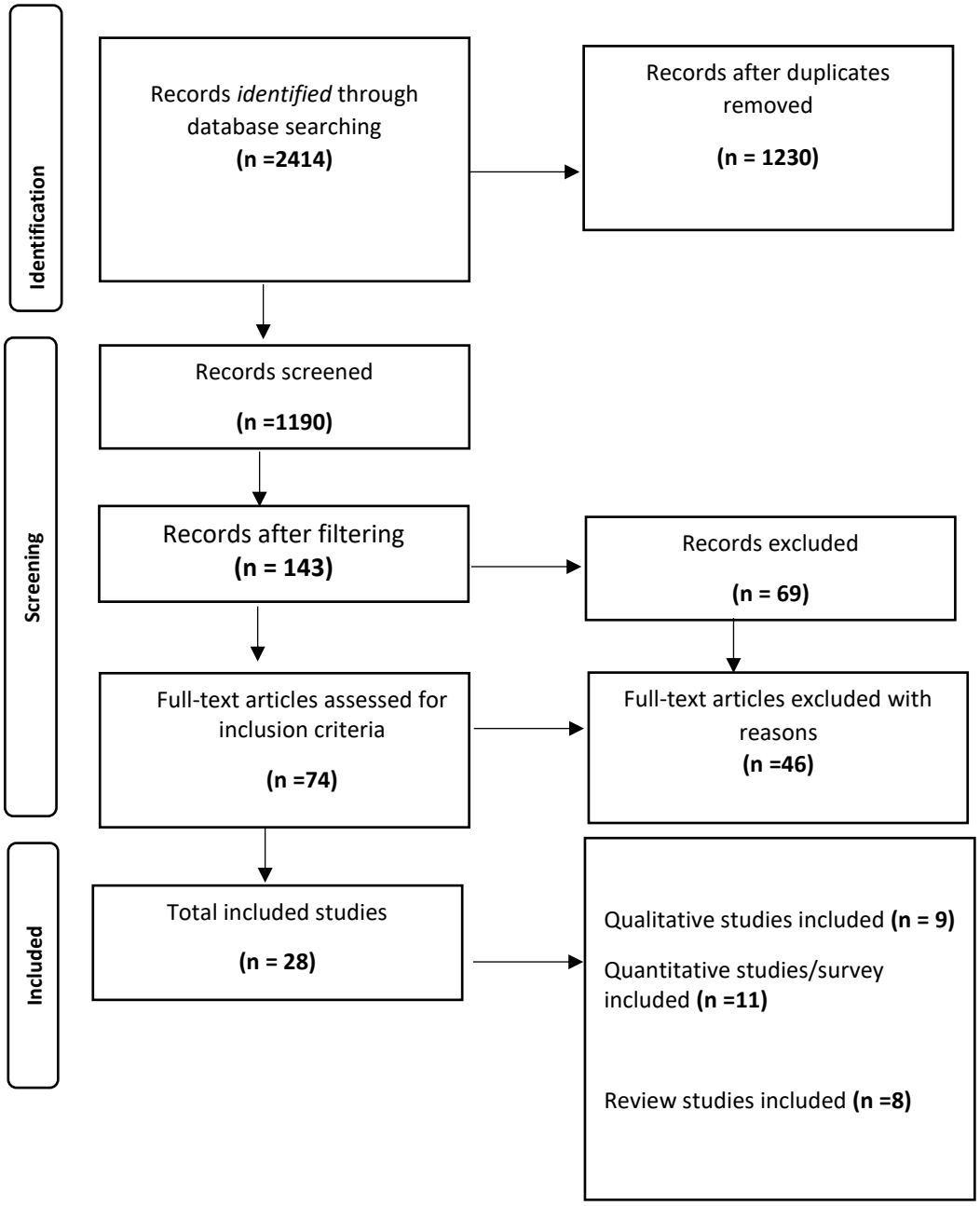


Figure 1: PRISMA flowchart of literature identification process (Page *et al.,* 2021).

2.4.3 Collating, Summarising and Reporting the Results

Of the final selection of 28 studies, eleven were quantitative studies, nine were qualitative studies and eight were review articles. All the selected studies were condensed to determine the research area and identify where the research gaps potentially lie. As the research question for the current study is broad, it is difficult to compress the different domains (culture, religion and beliefs and

behaviour) into one, as all may influence access to mental health services. Indeed, all selected studies were conducted in settings such as mental health facilities, public areas, schools and universities, which all shared various themes (see Table 5).

2.4.4 Characteristics Included

Most of the research comprised empirical studies (qualitative and quantitative methods), and there were also literature reviews and secondary data analysis (included as review studies). Patton (1990) argues that qualitative research commonly uses purposeful sampling to enhance the understanding of the context. For example, one study used qualitative methods to investigate the positive effects of religious components in treating stress in Muslim countries (Raza, 2016). Six Muslim women completed semi-structured interviews; all were university students or of strong religious persuasion, and therefore, outcomes may not apply to other Muslim women who may be more representative of the general population, or the non-religious. Overall, appraising the studies promotes research quality and permits cross-referencing. However, a scoping review does not require quality appraisals (JBI, 2015).

2.5 Classifying Themes

The included studies were classified by theme (see Table 5).

Table 5: Main Themes

Themes Extrapolated from Included Studies
1- Prevalence of mental illness in the Saudi Arabian community
2- Mental health/illness stigma
3- Attitudes towards and perceptions of mental illness and mentally ill people
4- Understanding mental illness among Arab Muslims and Saudi people (cultural and religious influences)
5- Availability and accessibility of mental health services in the KSA

2.5.1 Prevalence of Mental Illness in the KSA

Government agencies require accurate statistics of the prevalence of mental illness for a population group in order to plan and provide services for that particular group. However, no detailed records of the prevalence of mental disorders in the Saudi community are available. Recent studies, though, have tried to fill the gap (Al-Sughayr and Ferwana, 2012; Al-Qadhi et al., 2014; Al Atram, 2015); specifically, two of the studies (Al-Sughayr and Ferwana, 2012; Al-Qadhi et al., 2014) quantify the prevalence of mental illness among different age groups in Saudi society and in various settings. Al-Qadhi et al. (2014), interviewed patients between 18-65 years, who attended three large primary care centres in the KSA. Data were collected using the validated interview questionnaire for analysis. Personal data regarding age, income, past medical history, area of residence and social habits were also collected during the survey.

Comparatively, Al-Sughayr and Ferwana (2012) randomly selected 354 students from two female and two male high schools in Riyadh from a housing compound area, where mental health issues in adolescents were linked to experiences of social, psychological and biological transitions. The General Health Questionnaire (GHQ) was used as a self-administered screening instrument. In general, both studies identified significantly higher depression scores in females, particularly married women (Al-Sughayr and Ferwana, 2012; Al-Qadhi et al. 2014). Al-Qadhi et al. (2014), in particular identified higher instances of severe mental disorders than men. However, the second survey was restricted in sample size and locations; thus, they may not have addressed the research question adequately (Al-Sughayr and Ferwana, 2012).

Separately, Al Atram (2015) assessed the rate of diagnosed mental disorders amongst those aged over 65, in a combination of

rural and urban areas in the KSA. Results show that psychiatric symptoms were absent in 40% of those over 65 in the countryside, with 15% of the population for those aged above 65 in the city (Al Atram, 2015). Thus, 85% of over-65s in urban areas were deemed to have mental health problems. Nonetheless, all three studies indicate a lack of reliable and accurate research evidence concerning the prevalence of mental health problems in the KSA, especially regarding specific age groups.

2.5.2 Mental Health/Illness Stigma

The stigma of mental health problems has become entrenched. One theoretical overview of that stigma provides a useful taxonomy of four kinds of stigma: public or social stigma; stigma by association ('courtesy stigma'); self-stigma; and structural stigma (Goffman, 1963). These various types of stigmas are described in three studies (Almutairi, 2015; Sanden et al., 2015; Sewilam et al., 2015); where stigmatisation was found to be highly prevalent, particularly in cases where mental illness was culturally attributed to alcohol abuse. Stigma seems less prevalent for other disorders, such as depression and psychosis, although many people still replace medical practitioners with traditional healers in order to avoid stigmatisation.

A recent study by Jelaidan et al. (2018) sought to evaluate the background and attitude of the general population throughout the KSA regarding attitudes to mental illness. They implemented a cross sectional study and analysed data from 5850 participants aged 18 and up across the KSA via an electronically distributed questionnaire. The results demonstrate that 96.9% believed that psychiatric patients were considered to be insane and to have weak personalities, with such negative attitudes preventing people from accessing help. Almutairi (2015), though, suggests statistics concerning the prevalence of mental illness in the KSA to be inaccurate, with insufficient research having been undertaken, as mental illness is still

perceived as a taboo subject. Indeed, the controversy and taboo associated with mental health stigma in the KSA have served to restrict the research; structural and cultural barriers, and the prevalence of traditional faith-healers, have restricted access to treatment and its efficacy.

2.5.3 Attitudes, Perceptions and Knowledge

Four of the papers reviewed considered people's behaviour in regards to and perceptions of mental illness according to background and knowledge (Alshowkan et al., 2015; Alrahili et al., 2016; Dawood and Modayfer, 2016; Abolfotouh et al., 2019); while one examined newspaper media in the KSA to identify how newspapers report mental disorder in the country (McCrae et al., 2019). These studies found that stigma acted as a barrier, although shame also influenced quality of life amongst those experiencing mental distress. People experiencing mental health difficulties face the dilemma of whether to disclose or conceal their diagnosis and experiences, although this may be a global issue.

One study by Abolfotouh et al. (2019) found that of 650 surveyed citizens, less than a quarter of Saudi participants claimed that they would not be embarrassed if their friends knew that they were receiving professional help for mental health difficulties. This is compared to 81% of Belgians and 90% of Spanish respondents in regards to the same question. Separately, in a survey of 3,464 citizens on public attitudes, 72.2% believed in conventional and/or spiritual treatments for mental health difficulties (Dawood and Modayfer, 2016). In addition, McCrae et al. (2019) identified that newspaper stories that had advocacy and concerns as their main theme presented a more positive approach to those with mental health difficulties. However, a third of the articles studied associated mental illness with dangerous aspects.

Furthermore, families experienced numerous burdens caring for mentally ill patients through financial, physical, and emotional burdens, stigma and blame, disruption, dissatisfaction with immediate family, patients' failure to adhere to treatment and lack of support from the authorities, which were major issues (Von Kardorff et al., 2016; Bril-Barniv, 2017). Alrahili et al. (2016) also claim that the concept of depression in the KSA may be adversely influenced by people's superstitious beliefs regarding mental illness, which limits their willingness to understand any of the concepts. Consequently, there is limited comprehension of causes, the need for treatment or that depression can be significantly treated.

2.5.4 Understanding Mental Illness amongst Arab Muslims and Saudi people

Mental illness in the KSA is best understood in the context of culture and religion. Correspondingly, studies have found understanding of mental illness to be hinged on religious and cultural aspects (Al-Habeeb, 2003; Al-Solaim and Loewenthal, 2011; Obeid et al., 2012; Pargament and Lomax, 2013; Halawani, 2014; Alosaimi et al., 2015; Raza, 2016). In the KSA, culture can affect the understanding of mental illness; consequently, a plethora of explanations, beliefs and misconceptions, such as possession by jinn's, 'evil eye', magic and faith-healing have arisen and prevail in the country, despite a high level of education for the general population (Al-Habeeb, 2003; Obeid et al., 2012). Faith-healers purport to cure mental illness, even though the often have scant knowledge and have been found unable to correctly discern the three so-called spiritual disorders (jinn's, evil eye and magic) in psychiatric patients (Al-Habeeb, 2003).

Research is crucial to discern the effects of traditionalism and religious beliefs on concepts of mental health (Alosaimi et al., 2015). In the current study, almost all of those with mental illness who used

a faith-healer relied primarily on faith-healing, with a high likelihood of further visits. In general, ,any of those using faith-healing without accessing medical help had depression and other forms of psychiatric disorders (Alosaimi et al., 2015). Interestingly, such strong trust in faith-healing services has provided academics with opportunities to study the psychosocial factors that facilitated trust in those healers. Further, exploring the role of religion in obsessive compulsive disorder (OCD) among females in the KSA, Al-Solaim and Loewenthal (2011) concluded there was a relationship between OCD and religion, although each was distinct, and religion was not considered to be a causal factor in OCD. However, it was noted that religious adherence generated behaviours similar to those of OCD (Al-Solaim and Loewenthal, 2011).

Wider research has indicated the crucial role of religion and spirituality when these are integrated into the care of mentally ill people (Koenig, 2009; Nolan et al., 2011; Pargament and Lomax, 2013; Halawani, 2014; Raza, 2016). Some have argued that religious components provide coping mechanisms for people with mental health problems, enabling comfort and hope. What is more, psychiatric diagnosis and assessment generally incorporate an understanding of the practices, beliefs and values that define patients' worlds, while spiritually-integrated treatments encourage patients to draw upon their religious resources (Pargament and Lomax, 2013). However, the evaluation of Islamic spiritual treatments and their benefits suggests that these rely substantially on religion playing a pivotal role in the life of the respective patient being treated (Raza, 2016). Accordingly, Islamic culture and religion has a direct impact on the mental well-being of individuals in the KSA, and leads a great number of those suffering mental health problems to favour non-pharmacological interventions and, subsequently, use spirituality and religion in their treatment (Halawani, 2014).

2.5.5 Availability and Accessibility of Mental Health Services

In the Saudi context, use (or not) of mental health services might be associated with or directed by various barriers and/or facilitators that are placed in the person's path by service providers or religion and their own coping strategies. Obstacles might include religion, cultural beliefs regarding mental illness, understanding of the disorder, carers' awareness, the nature and availability of mental health services, early/late diagnosis, and unwillingness to engage with services, as well as the fear of stigma (Koenig et al., 2014; Jelaidan et al., 2018). All of these were identified in the papers reviewed for this study (Almoshawah, 2010; Koenig et al., 2013; Koenig et al., 2014; Ahmed, 2016; Alamri, 2016; Alshowkan and Kamel, 2016; Staiger et al., 2017). Significantly, none of the studies provide a voice to people who have experienced mental distress first-hand; although one recent study by McCrae et al. (2019) acknowledges the need for public narratives of those experiencing mental health difficulties. In the last 30 years, mental health care in the KSA has progressed, despite political, social, religious, and cultural challenges. However, some aspects remain in need of immediate attention (Koenig et al., 2013). Religion, family and culture greatly affect the understanding of mental disorders, and could be considered barriers to, or facilitators of, access to mental health services in the KSA (Koenig et al., 2014; Staiger et al., 2017).

From the perspective of those caring for people with mental health issues, health services have identified various barriers, including beliefs regarding: mental illness; the centralisation of mental health services; the use of alternative treatments and traditional healers; and the failure of policy-makers to prioritise mental health (Jelaidan et al., 2018). For reasons of stigma, most potential patients decline support from mental health services, deeming them to be just for 'mad people' (Alamri, 2016). Another, apparently widespread issue in the KSA is a lack of available and

accessible mental health provision, although the review claiming this is based on one study (Alamri, 2016). However, the issue of low service uptake remains alarming and should be rigorously investigated in the Saudi Arabian context.

The review by Ahmed (2016) proposed the early detection of mental illness through implementing an action plan for the integration of mental health services in primary care. It suggested that mental healthcare awareness sessions be integrated to increase awareness of mental health problems at an early stage, and thus, create the possibility for secondary treatment (Ahmed, 2016). This view is supported by the report by the World Health Organization (WHO) (2008), which states that the integration of optimal mental health care into primary care is essential to facilitate access to next-tier treatment and facilities for patients. Further, it may help to address inequitable access to facilities, the cost of treatment and low awareness, leading to the treatment of more under-privileged people (World Health Organization, 2008). Meanwhile, a focus group of nursing students discussed the care of people with mental health problems, concluding that the chief impediments to provision of optimal care by nurses were generated by factors specific to nurses, the clinical supervisor and the general clinical environment (Alshowkan and Kamel, 2016). It is, thus, important to ensure professional training for caregivers, in order to reduce the contextual factors that interfere with the delivery of optimal care.

The evaluation of the current challenges for mental health services in the KSA, in terms of awareness, effectiveness and the roles played by psychiatrists, was provided by Almoshawah (2010). In that particular study, 90% of psychiatrists showed a strong awareness of issues facing mental health services in the KSA, although they lacked clear understanding of their own roles and responsibilities, as well as

that of the services they worked for in the fight against stigma (Knaak et al., 2014).

2.6 Discussion

There has been significant research into mental illness in industrialised western nations, while in the KSA (along with many other countries) it has been limited (Al-Ahmadi and Roland, 2005). The KSA has only recently introduced frameworks to drive the enhancement of mental health facilities; hence, there is less understanding of treatment modalities, which might affect service use (Alamri, 2016). However, there is a higher tendency to stigmatise and discriminate against those with mental health problems in the KSA than in western nations (Lauber and Rössler, 2007). There is also much social disapproval and devaluation of families of people with mental health problems in the KSA, which results in many secluding relatives at home (Aloud and Rathur, 2009). This is in stark contrast with western nations, where family support for sick people is generally high and social disapproval is less significant for many families (Rüsch et al., 2005). In the KSA the Mental Health Law was only instituted in 2014 (MHCL, 2014) and then regulated more recently (RMHCL, 2016). It may be some time before it can be used effectively as a platform from which people's voices may be heard, and until it becomes an essential component of Saudi mental health care law and policy.

As with other Islamic countries, religious beliefs and practice have both positive and negative connotations and implications for mental health in the KSA, due largely to the centrality of religion in the lives of many people. Any programme developed to care for those with mental health issues in the KSA must, therefore, incorporate religion and spirituality to encourage help-seeking behaviour and optimal use of services. Correspondingly, in their international study, Nolan et al. (2011) claim that conventional mental health services can be enhanced by prioritising the traditional, religious and spiritual

elements and context in patient improvement programmes, and by incorporating guidelines and frameworks that align with the spirituality of the patient to deliver optimal care. If used carefully and appropriately, religious components are able to augment the coping mechanisms of mentally unwell patients by providing comfort and hope.

Subsequently, advances have been made in developing effective mental health treatments, which have contributed some way to addressing the problem (Corrigan et al., 2014). However, various factors still impede care-seeking and, in particular, stigma may directly affect mental illness and associated support systems, provider networks and community resources. As a result, the most important strategies to mitigate the adverse impact of stigma include enhanced mental health literacy, cultural competence, and family engagement campaigns (Corrigan et al., 2014). This important factor has been acknowledged in a recent major study in the KSA, which calls for increased public education strategies (Jelaidan et al., 2018). Reluctance to adhere to treatment, though, may be at least partly due to factors other than stigma; for instance, unemployed people with mental health issues have been shown to face barriers in the form of conditions and structures in healthcare provision, discrimination and mental health literacy, as well as stigma (Alyousef, 2017; Staiger et al., 2017).

In the KSA, mental illness is the largest cause of disability among young people (Mathews et al., 2011). It is, therefore, important to understand the association between different levels of stigma and the help-seeking intentions of the young. Research shows that young people who believe that mental illness is a sign of personal weakness, and who exhibit a preference for social distance, are less likely than others to seek professional help (Yap et al., 2013). It has been suggested, however, that ceasing to refer to 'label avoidance'

might help to promote help-seeking behaviour (Corrigan, 2016; Dawood and Modayfer, 2016). Around the world, various mental health policies have been adopted and implemented with a view to facilitating the use of mental health services (Golberstein et al., 2008). By evaluating the variables through the use of a model of help-seeking pathways for the Arab Muslim population, research has shown that the relevant beliefs and superstitions are fuelled by a lack of knowledge regarding mental illness and formal health services, and holds these to be root causes of the issues (Aloud and Rathur, 2009). Further, social contact may be considered to be one of the most robust means of intervention through which to improve stigma-related knowledge (Thornicroft et al., 2016).

The literature on health-seeking behaviour points to a lack of knowledge on mental health issues across all age-groups. Nevertheless, none of the available research provides data aggregated by age-group and such data is precisely what is required in order to offer targeted care programmes and interventions specific to each age group. In regards to the KSA, there are numerous structural barriers to the availability of and access to mental health services. The nature of facilities themselves urgently require improvement; while the management of mental health facilities should also be prioritised, and key roles need to be identified in order to provide a systematic framework for the delivery of care.

2.7 Identification of Research Gaps

The literature review has found that few studies have been conducted in the Arab and Middle East countries that directly address the aims of the current review, which reveals a significant gap in the literature pertaining to factors that directly and indirectly affect the perceptions and attitudes of Saudi Arabian people towards mental health and related services. Overall, there is minimal knowledge about first-hand factors that inhibit access to proper health care by

those experiencing mental health issues. While some progress has been made towards an understanding of the reasons behind such reluctance to engage with services, such as social, cultural, and religious beliefs, much remains to be explored in mental health research, especially in terms of people's perceptions, beliefs and understanding.

The Saudi government has made attempts to reform and has attempted to change the situation. However, to overcome the substantial barriers to accessing services more needs to be undertaken in the KSA to improve the public's perception of mental illness, for example by creating community-based care centres, encouraging, and supporting affected persons and changing the cultural narrative around mental illness. Education and anti-stigma campaigns need to be developed and further training needs to be developed for mental health professionals who need to offer greater support in this area.

The prevalence of mental illness in the KSA is not clear due to stigmatisation and other cultural factors, which reflect reasons behind people's reluctance to access and use mental health services. However, people seek medical help after a long journey of seeking traditional help. Further, the scoping review encompassed various settings for the research reported in the KSA that ranged from mental health facilities, schools, universities, etc. Whilst the review recognises variations in the data reported in the literature, such as differences between age groups and gender, the most significant and stark difference is people's access to health and education between rural and urban settings. Hence, there is clearly the need for more research in order to identify areas of social inequalities. Meanwhile, the most significant gap in the literature is the absence of service users' voices. Gathering and broadcasting patients' stories through this current review might help to reduce stigmatisation and encourage

more families and people with mental health issues to seek mental health care, rather than remain silent for fear of being victimised.

2.8 Significance of the Study

The current study hopes to make a new and original to the existing knowledge on mental health in order to explore people's experiences to access mental health services treatment. In addition, the literature review has found that few similar studies have been conducted in the Arab and Middle East countries. In the context of Saudi Arabia, it appears that no similar studies have been published concerning the people's experiences of accessing mental health services in the KSA. Moreover, no previous studies have discussed people's experiences through using a narrative research approach. Hence the current research is an opportunity to add to the body of knowledge by enabling people to have a voice to tell their own stories of their mental health/illness experiences.

2.9 Research Aim and Objectives

The current study aims to explore people's experiences of mental ill-health, as well as their access and utilisation of mental health services in the KSA through a narrative inquiry research method.

1. To enable mental health service users in the KSA to speak about their experiences of mental health difficulties and access to services.
2. To discover possible barriers that people experience in accessing mental health services in the KSA.
3. To identify how stigma associated with mental health difficulties may have affected people's lives.
4. To consider the influence of cultural and religious beliefs on people's understanding of mental illness and the impact this has on service access and use.

The following chapter provides a theoretical perspective of some theories that help connect concepts of mental health stigma with personal, societal, cultural, and religious experiences in regards to mental health services access, with specific emphasis placed on the context of the KSA.

Chapter 3: Theoretical Framework

3.1 Introduction

In the preceding chapters, the historical background was identified, together with the cultural and traditional beliefs of Saudi people especially concerning the concept of mental health and related issues. This then resulted in contemplating a potentially relevant theoretical framework that could explore the cultural and social factors within the KSA in relation to mental health (White et al., 2017). After a lengthy discussion with my supervisors, we evaluated various theories to find the theoretical framework that was most suited to my research questions. It was of great importance to consider the social and cultural factors that influence people's upbringing, values, and beliefs that in turn may affect whether they choose to access services. Specifically, Vygotsky's Macro-Cultural Psychological Theory (MCPT) was chosen as the most fitting framework to answer the research questions relating to mental health, stigma and society in an Islamic context.

The theory locates perceptions of mental health within social, cultural, and societal contexts, especially in societies with strong cultural forces, such as social institutions, artefacts and cultural concepts, as in the KSA (Vygotsky, 1978; Ratner, 2011 a,b,c,d; Ratner and El-Badwi, 2011). This theoretical framework was chosen, as it is focuses on human development reliant upon upbringing and the socio-cultural norms and values learned from families and groups that are transferred from one generation to the next. All of these grounded sociocultural factors will undoubtedly be impact upon individuals' behaviours and perceptions toward understanding and dealing with uncommon difficulties, such as mental health issues.

3.2 Vygotsky: an overview

Lev Vygotsky (1896-1934) was a psychologist and lawyer from Moscow. It is widely recognised that his theories have become the foundation of much cognitive development thinking and theory, especially what has become known as the theory of psycho-social development. Furthermore, much of Vygotsky's work has a wide, inter-disciplinary application and has made a major contribution to socio-cultural psychology (Luria, 1935). Unfortunately, most of Vygotsky's research was not published when he was alive due to ill-health that interrupted his output of publications (Luria, 1935). However, prior to his death, certain works were published by Vygotsky's collaborators and students, including Luria, Leontiev and others, who comprised his research group and were guided by him in their research of psychological phenomena from multiple perspectives (Leontiev and Luria, 1976; Luchkov, 1981; Kozulin, 1986; Leontiev, 2005). Accordingly, whilst appraising and drawing upon Vygotsky's MCP theory, the current study further draws upon the work of these subsequent academics. Following his death, Vygotsky was declared to be one of the most prominent psychologists from the Soviet Union, particularly by Russian students from the post-Stalin era of the 1960s-1980s (Fraser and Yasnitsky, 2015). Furthermore, he has remained one of the most cited researchers in the area of psychology and has become a cult hero for several modern philosophers and professionals in both Russia and the larger world psychoeducational community (ibid).

3.2.1 Vygotsky's Assumptions

Vygotsky theorised that an individual's development depends primarily on social factors and on the knowledge and skills learned from family institutions, groups, and cultures. He refers to 'elementary mental functions' of awareness, feeling, memory and perception, which eventually develop into more complex and efficient

mental processes/strategies, known as 'higher mental functions', through communication within the socio-cultural environment. Structured as a set of mutual interpersonal social relations, these help to describe the transition into the identity of an inward relationship between family, relatives, friendship interactions and relationships relating to the social factors by forming the basis of the human personality's social structure (Vygotsky, 1998).

Vygotsky further assumed that innate abilities, such as perception and attention form the foundation for the development of more complex mental processes, such as problem-solving and thinking. He believed that it is through social experiences and cultural practices that individuals can develop upon these elementary mental functions and transform them into higher mental functions. Hence, Vygotsky viewed social and cultural factors as essential in shaping the way individuals think and process information. Vygotsky proposed that culture refers to knowledge held by books and experts, transmitted through language; suggesting that people learn from others who are more experienced and who support their learning. For instance, in addition to active learning from family and others, the individual also learns passively by absorbing the attitudes and behaviours of those around them in their social settings (Vygotsky, 1998).

In addition, Vygotsky developed a concept referred to as the Zone of Proximal Development (ZPD). This concept relates to identifying an individual's mental progress and explains the relationship between learning and development. According to Vygotsky, this represents the difference between an individual's own capability and the ability that they are able to obtain with the support of a qualified instructor. Therefore, the ZPD is the difference between one's actual level of development as determined by individual

problem-solving and one's potential level of development as measured by problem-solving under other guidance or collaboration with more capable people (Vygotsky, 1998; Shabani et al., 2010).

Additionally, a further proposition of Vygotsky is the significance of scaffolding, which is a concept that provides a supportive structure within which individuals can learn. This is seen as the central role of family and community, with a gradual withdrawal of support as the individual develops confidence and understanding (Vygotsky, 1998). He later proposed other approaches that explained psychological development in terms of emotive changes (Ratner, 1991; Ratner, 2000). Vygotsky believed that all psychological events are shaped and influenced by cultural and cognitive factors. He did not accept the existence of innate, natural, or pre-existing forms or substances of psychological events that are independent of cultural and cognitive organisation. Instead, he viewed human development and mental processes as being shaped by cultural and social experiences, and he emphasised the role of social interactions in cognitive development.

Consequently, he concluded that the widely accepted difference between basic psychological forms and cultural psychological content is erroneous (Ratner, 2000); and what was required was the *"transfer to the identity of an inward relation of social order"* (ibid., p.169). Furthermore, Vygotsky insisted that understanding psychology requires a thorough understanding of social order. Cultural influences affect all elements of psychological functioning (both in form and content). As Vygotsky stated, "…*the form and content of thought are two factors in a single whole process, two factors internally linked to each other by an essential, not accidental, bond"* (ibid., p.38). This process relates directly to how people develop and mature in their cultural context, and Vygotsky's sociocultural theory views human development as a socially mediated process in which children acquire

their cultural values, beliefs, and problem-solving strategies through collaborative dialogues with more knowledgeable members of society. This leads to the role of Vygotsky's ZPD, which can relate to the Saudi context for the current study.

Understanding the macro-factors of Saudi culture, especially in relation to concepts of mental health identifies the powerful influence of religion and superstition, and subsequent stigma. Whilst attempts to combat stigma amongst adults is laudable, consideration also needs to be provided to attitudes developed in childhood. Subsequently, this learning and developmental changes could go through entire lives for as long as people have the capability and the potentials to learn and to change. Correspondingly, it is argued that the psychological processes are both unconscious and conscious (Vygotsky, 1998). Consciousness interferes, or facilitates, between stimulus and response; it is the 'mental space' of psychological phenomena, such as perception, emotion, memory, thinking, motivation, identity, language, and cumulative experiences (ibid).

3.2.2 Vygotsky's Macro-Cultural Psychological (MCP) Theory

Vygotsky's MCP theory, referred to as 'socio-cultural theory' emphasises the essential role of social interaction in cognitive development and understanding (Vygotsky, 1978; Ratner, 2019), underpinned by the belief that culture plays a crucial role in the process of 'sense-making'. The main emphasis of this theory is that society may be shaped through understanding how socio-cultural factors influence people's cognition, as well as social development. Broadly speaking, culture is seen as being comprised of social markers, such as language, ethnicity, religion, geographical origin, upbringing, individual life experiences, socioeconomic class, gender, age, group history, and education (Ratner, 2011a). Furthermore, Vygotsky proposed that learning has a significant function in

constructing the process of developing a *"socially structured psychological structure, specifically human"* (Vygotsky 1978, p.90). Thus, people's development is largely influenced by their social and cultural environment; hence, their development may be difficult to comprehend without looking at their social and cultural context, as mental processes originate in social processes (Vygotsky, 1978). Mental processes and behaviours are shaped by the social norms, beliefs, and practices that exist in a person's community/society, and, therefore, it is difficult to understand an individual's development without considering their social and cultural context.

Vygotsky detailed a psychological theory of culture founded on the basis of macro-cultural factors, some of which are cultural concepts, cultural artefacts, and social institutions (Ratner, 2014). These ideas were initially established by Vygotsky, and then further developed by Ratner, which include learned and shared norms, beliefs, values, and life practices within groups that guide thinking, actions, and decisions in consistent ways (Ratner, 2013). Meanwhile, macro-cultural psychology is defined as a psychological phenomenon embedded and rooted within macro-cultural factors (Ratner and El-Badwi, 2011; Ratner, 2019). It is argued that high psychological processes are the result of humanity's historical evolution, and macro-cultural factors are conceptualised as psychological phenomena (Wertsch and Tulviste, 1992). Similarly, Vygotsky's theory explains how psychological phenomena stem from macro-cultural factors, how they are objectified within them, how they solidify and sustain macro-cultural factors, and how they ultimately embody their features (Vygotsky, 1998).

From this, it can be seen that macro-cultural psychology is a broad psychological theory that takes into account individual socio-cultural variations within macro-cultural foundations and in biological

processes (Vygotsky et al., 1997). Individuals residing in indigenous or small-scale societies are highly dependent on the structure of the specific social groups they belong to when it comes to the degree of development as regards decision-making (Vygotsky, 1986; Sirgado, 2000). For example, within the Saudi context, some tribal Saudi societies might be dependent on their relevant social group regarding their decisions whether or not to access mental health services (Ratner and El-Badwi, 2011). In such societies the organisation of macro-cultural factors may follow a coherent and dependent system that leads people who have mental health difficulties to struggle to protect their own treatment choices and decisions (Vygotsky, 1986). The cultural norms and values associated with the social group can impact individuals' decisions regarding accessing mental health services. Accordingly, the organisation of macro-cultural factors (e.g., social institutions, artefacts, and cultural concepts) may follow a distinct system that can lead people with mental health issues to face difficulty in making choices and decisions about their treatment.

Macro-cultural psychological theory explains why macro-cultural factors are the main basic predictors, illustrative constructs, and descriptors of psychological phenomena (Ratner, 2013). Therefore, they are viewed as internal constructs that dominate all other constituents of and influences on well-being, as opposed to being viewed as external influences on the well-being of individuals. For instance, it was the gap in identifying the role of social and historical origins shaped by culture on mental health processes that encouraged the crafting of this the MCP theory (Ratner, 2013). While discussing how culture informs beliefs and behaviour, macro-cultural factors are crucial, as culture is utilised throughout life in the exploration of culturally informed health beliefs, help-seeking behaviour, and treatment for mental health problems (Holzinger et al., 2012). Thus, macro-cultural factors could be regarded as essential

formative influences on psychological well-being, possessing the most direct and speedy influence (Ratner, 2014).

Ratner (2011a) pioneered a cultural psychological model for social reform that integrates culture and psychology, which addressed the lack of a unified psychology theory. Subsequently, it claimed that identity is embedded in macro-cultural factors, such as social institutions, artefacts, and cultural concepts (Guitart and Ratner, 2011). Understanding identity requires an understanding of the history, society and culture that affect the particular ways in which people define themselves (Esteban-Guitart and Moll, 2014). This concept is referred to as macro-cultural psychology (Ratner, 2013), which is defined as the study of psychological experiences that are embedded in macro-cultural forces/factors, such as social institutions, artefacts and cultural concepts (Ratner, 2011a; Ratner, 2011b; 2011c; 2011d).

3.3 Macro Cultural Factors/Forces in Saudi context

As in any society, social institutions, cultural artefacts, and cultural concepts define Saudi society. Whilst being rooted in religion and born through historical conflict, they are essentially political in the sense that they are contested and influenced by vested interests. It could be said that mental ill-health disrupts the consensus behaviours that determine the 'normal' cultural identity of Saudi citizens based upon religious piety, practice and duty. Further, Vygotsky claimed that individual development cannot be understood without reference to the social and cultural context within which it is embedded (MacLeod,2018). Similarly, Ratner (2011) argues that one cannot understand theories of human identity from a cultural psychological perspective without giving account to cultural identity, as it is embedded in macro-cultural factors. The following section will focus upon the cultural identity of Saudi society and focus upon these factors.

The macro-cultural factors in the context of Saudi society encompass the three main elements mentioned above: institutions, artefacts and cultural concepts (see Figure 2). Each of these elements further encompasses sub-factors that are embedded in them. For instance, cultural artefacts are objects, symbols, or practices that reflect and embody the values, beliefs, and norms of a particular culture, such as, religious symbols and traditional practices. Cultural concepts, on the other hand, are abstract ideas or mental representations that are used to categorise and understand the world. These are often shaped by cultural beliefs and values and can include attitudes, perceptions, and understandings of mental health, illness, and stigma. In the context of mental health, the distinction between cultural artefacts and cultural concepts is important because cultural artefacts can influence cultural concepts and attitudes toward mental health, while cultural concepts can shape people's health beliefs and behaviours related to mental health and treatment seeking.

The social institutions include religion, family and gender; the cultural artefacts involve: Saudi society's cultural identity, norms, values, traditions and beliefs, where the society is the centre of learning and for people to engage to practice and apply what they learnt through social interactions. Meanwhile, the cultural concepts incorporate people's understanding, attitudes and perceptions toward the concept of mental health-ill and stigma. Amongst those using mental health services in the KSA, help is most usually first sought from faith healers prior to accessing mental health services. Figure 2 illustrates the various components of macro-cultural factors

in the context of the KSA in more detail.

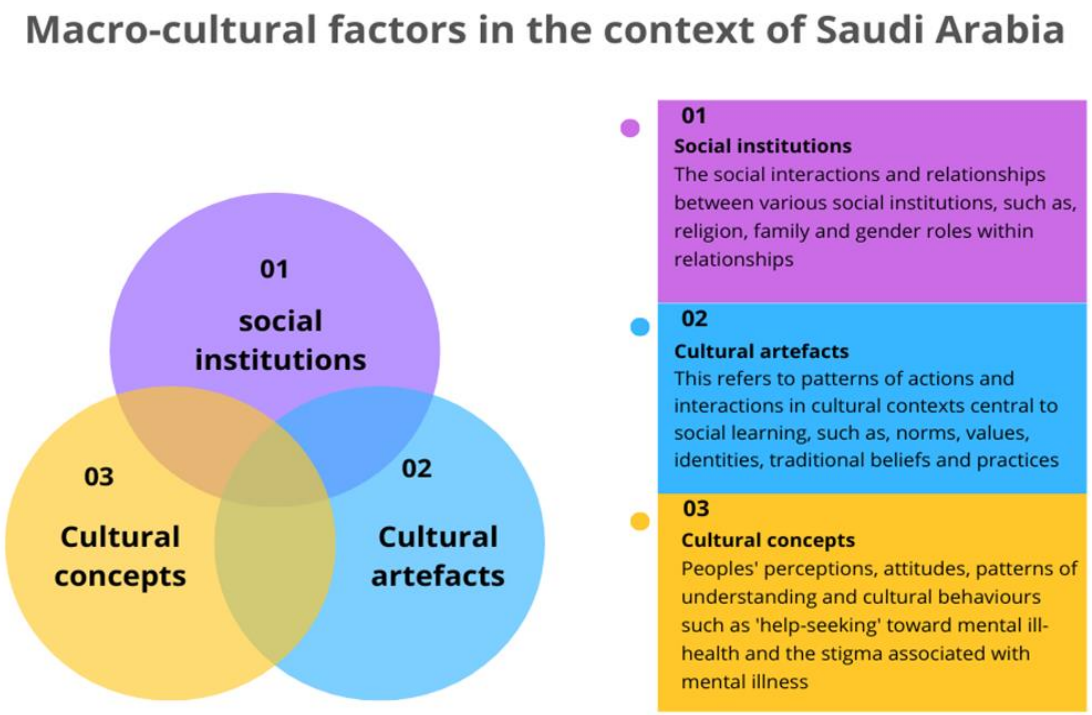


Figure 2: Macro-Cultural Factors in the Context of the KSA

In relation to sociocultural artefacts in the KSA and indeed all Arab/Muslim countries, the Holy Quran is the most powerful spiritual and cultural object. The Quran is the book that all Muslims are expected to read verses from five times a day when praying, or when they are ill or when they require help from ALLAH. Furthermore, the KSA is considered the centre of Islam for all Muslims because of the existence of the city of Makkah. All religious artefacts in the KSA pay homage to the five pillars of Islam which are: faith, prayer (the ritual prayer required of every Muslim five times a day for the rest of their lives); Zakat (the act of giving a portion of a rich Muslim's wealth to those in need for the rest of their lives); Sawm (the act of fasting during the holy month of Ramadan); and Hajj (the sacred pilgrimage to Makkah required of every Muslim at least once in their lifetime if it is within their means). Culturally, therefore, those who experience

mental health difficulties are expected to find peace and healing through religious observance of the Islamic tradition and its cultural practises. However, for those with profound mental health issues, it becomes difficult to conform to sociocultural norms, and they subsequently experience increased social exclusion as they are often considered religiously weak and easily susceptible to jinn or spiritual possession because they have lost their faith.

As people attempt to understand their own psychotic or neurotic experiences, from their religious beliefs, they attempt to understand their illness in an accepted sociocultural frame, and subsequently, it is common to seek help from faith healers to gain relief from their mental distress. Overall, as the KSA is an Arab Islamic society, they have unique cultural artefacts that influence their understanding, behaviour, and decisions regarding mental illness, as such artefacts are embedded in their behaviours and form their identities.

3.4 Macro-Cultural Psychological Theory and the KSA

Macro-cultural factors within Saudi society might be overlapped when identifying the cultural impact on people's attitudes toward mental health problems and their attitudes to people suffering from mental health issues. This might appear in the form of the type of coping style and social support that Saudi people have undertaken, and the kind of help that they may seek which is determined by the cultural meaning/health beliefs to which Saudi people are attached (Jelaidan et al., 2018; Alyahya et al., 2020; Tanhan and Young, 2021). Culture determines the meaning that Saudi people attach to their illness, with the meaning varying in terms of how the individual perceives their own experiences of distress and illness (Ratner, 2013). Further, this meaning may be given to mental illnesses or other experiences leading, in turn, to deep-rooted attitudes and beliefs. These attitudes are often formed as a result of their culture in form of cultural concepts, artefacts and social institutions (Berry et al., 1997).

Within the KSA, and indeed other Muslim countries, the cultural meaning of mental illness has significant consequences related to the attitudes and beliefs surrounding mental health. These include cultural beliefs and norms that shape the understanding of mental ill-health, which in turn impact how people perceive and experience mental illness. This may lead to stigma, which can prevent individuals from seeking help and their access to appropriate treatment for their mental health concerns. Correspondingly, the cultural meaning of mental illness could contribute to negative attitudes and discrimination towards those with mental health issues, which result in isolation, shame, and a lack of support.

These consequences are frequently serious and potentially lead to extreme distress in those experiencing mental health issues and who fail to receive appropriate interventions and are stigmatised (Amri and Bemak, 2013; Jelaidan et al., 2018; Alattar et al., 2021). MCP Theory makes it possible to explore the complex association between religion and mental health, given that Islam, as a religion, is a major factor that influences mental health. As believers of Islam are required to read the Holy Quran and pray extensively (cultural artefacts) when feeling unwell, seeking mental health treatment is often considered to be a last resort. These practices show how Saudi people's beliefs are dominated by religion in their health behaviours. Thus, amongst Muslim communities, individuals are likely to first seek God (Allah) to alleviate their problems with prayer and seek faith-healers, before seeking official medical assistance. Furthermore, the misunderstandings surrounding mental illness symptoms and management may further delay access to treatment.

Stigma that stems from traditions and cultural understanding also plays an important role in mental health, the major constructs of which, within the Saudi Arabian context, include stereotypes,

prejudice, discrimination attitudes. Moreover, regarding the MCP Theory, social institutions, such as religion, family, gender roles, and stigma mingle with other sociocultural factors that largely impact upon people's understandings and acceptance of mental health issues, in addition to whether they choose to seek help or not (Okkels et al., 2017; Alyahya et al., 2020). Furthermore, the family, thus, can be considered to be the most important social institution within the KSA, when it comes to influences concerning how people with mental health difficulties respond to their respective situation.

Cultural factors such as these, mould understanding of mental illnesses within the KSA. Further, the cultural concept of the evil eye, spirits, or jinn within Saudi culture is reinforced by religious traditions and cultural artefacts (Islam and Campbell, 2014). These result in people frequently ascribing their mental health distress to jinn, particularly in the presence of hallucinations (Lim et al., 2018). Within the Holy Qur'an, jinn are described as having been created by Allah, being mentioned several times in different places, particularly within the Al-Jinn chapter. Jinn additionally play a prominent role within the Hadith, evoking the belief amongst Islamic people that they strongly interfere with humans (Al-Habeeb, 2003; Obeid et al., 2012; Islam and Campbell, 2014). This perception is frequently relevant in relation to mental illness, especially when the symptoms of such illnesses include obsessive-compulsion, hallucinations, and flashbacks of traumatic events, physical pain, insomnia, aggression, suicidal thoughts, nightmares, sensed presence, headaches, brooding, sadness, and anxiety (Lim et al., 2018). These associations negatively impact upon people's willingness to access and use mental health care services in the KSA.

In relation to Saudi culture, and in particular conceptions of mental ill-health, Vygotsky's MCP theory, has much to offer when attempting to answer the two key questions of:

1] How does Saudi culture impact upon the perception and attitudes towards mental health issues of Saudi citizens and on how people understand and react to individuals with mental health issues in the KSA?

2] How does this also impact upon the perceptions and attitudes regarding accessing and using mental health services in the KSA? (White et al., 2017).

In order to respond to these questions, this section focuses on key macro-cultural factors in Saudi society, which inform psychological well-being and development, and further, to simultaneously inform the understanding of how mental illness and well-being is perceived by Saudi society. The following sections illustrate how social institutional factors in the Saudi context, such as religion, family and gender are manifested with people's cultural concepts and artefacts. Such as, cultural identity, perceptions and attitudes, and how these impact people's understanding toward mental ill-health and stigma, which in turn influence, direct and inform their health behaviours in the access and use of services.

3.4.1 Perceptions of Mental Illness within the Saudi Context

During the European Middle Ages and as a result of the oppressive socio-political climate endured at the time, incidents of mental illness were high, with those battling mental illness being subjected to solitary confinement and restraint (Butcher et al., 2010; Im and Meleis, 2021). However, with the development of medical science during the 19th and 20th Centuries, Western culture witnessed the emergence of modern theories of psychopathology, with a

classification system and theoretical frameworks applied. Research and treatment of mental diseases expanded significantly and important developments within that era set the groundwork for contemporary pharmacological and psychotherapeutic methods utilised in the tackling of mental illness (Haney, 2003; Polanczyk et al. , 2015).

As with other Arabic countries, Saudi citizens are at a crossroads in their thinking regarding mental health in potentially following the socio-cultural, traditions and religious thinking in understanding and dealing with mental health problems (Okasha and Karam, 1998; Thoits, 2011); or embracing Western thinking around the medical model, in conceptualising and dealing with mental health issues. Despite scientific advances into the nature of mental disorder, the Western concept of mental health is contested, even within Western society (Thoits, 2011). Therefore, it becomes doubly contested, when contrasted with Eastern thinking, especially that which is so deeply rooted in Saudi society (Thoits, 2011; Jelaidan et al. , 2018).

Some Eastern cultures maintain the belief that mental illnesses are products of demonic, jinn-like possession and supernatural forces (Okasha and Karam, 1998). Such cultural concepts, traditional beliefs and cultural artefacts (especially the Holy Qur'an) are largely maintained by the Muslim religion as a robust social institution, particularly in the context of the KSA (Al-Habeeb, 2003; Thoits, 2011; Jelaidan et al., 2018). As a result of these traditional beliefs, the affected individuals and their families are more likely to seek help from religious sources, such as a faith-healer, in an attempt to free the troublesome spirit (Al-Habeeb, 2003; Amri and Bemak, 2013). This obviously reflects how religious institutions are deeply embedded in Saudi people's cultural beliefs, which impacts their health

behaviours in seeking treatment. Vygotsky's theory can be applied to these cultural constructs to affect social behaviours in limiting effective 'higher mental functions'; thus, leaving people who are stigmatised in virtual social subjugation.

In the KSA, it is widely accepted that the stigma surrounding seeking help in regards to mental health and being seen to have mental health issues is widespread (Clement et al., 2015; Avasthi, 2016; Baba et al., 2017; Gaebel et al., 2017). People with mental health difficulties frequently possess various negative emotions and difficult thoughts and associations concerning seeking help and being afforded treatment. This stigma is further perpetuated by religion, as highlighted across global research, not only in the context of the KSA, but also in other countries and cultures (Taylor and Brown, 1988). Correspondingly, Macro-Cultural Psychological Theory (MCPT) can be used to demonstrate the link between stigma, psychological distress, and the burden of mental illness on families or caregivers (Mak and Cheung, 2012). Even though Vygotsky did not use the language of stigma in his theory (Vygotsky, 1986), he discussed the social consequences of disability and the disadvantages that disabled people experience. In a way, Vygotsky preceded the understanding of such social interactions as cultural artefacts within the Saudi context, which Goffman later developed in the concept of stigma in his book Stigma: Notes on the Management of Spoiled Identity (Goffman, 1963).

In general, Western culture can be described as individualistic, whilst Eastern culture is collectivist. In the latter, which applies to the KSA context, individuals view themselves as interdependent (i.e., the interconnectedness between people and the relationships with each member of the group plays a central role in each individual's identity). This goes some way to explain the rationale behind delaying access and using mental health treatment within the KSA context in which

individuals depend on social agreements (extended family, relatives, and community as social institutions). Contrastingly, those within Western culture view themselves as more independent, and therefore, people with mental health issues are more often perceived differently from those within the KSA, due to the fact that they do not conform to group norms (Pescosolido et al., 2013). The variations in social behaviour and cognition impact how mental illnesses reveal themselves and affect people's lives (Angermeyer, 2006; Stuber et al., 2014), and are not dissimilar between Western and Eastern cultures.

The cultural self-view within Eastern culture places greater emphasis on relationships, whereby individuals in groups are mutually dependent upon one another, and these are reinforced by Saudi language and attitudes (Yang et al., 2007; Schierenbeck et al., 2013). This collectivist way of social being expects common understandings of behaviour and conformity. In a culture such as the KSA, individuals experiencing mental distress may be perceived as not conforming to group norms by not 'fitting in' or for acting differently to their peers, frequently leading to other members of the group being unwilling to regard them as part of the group. Furthermore, people experiencing mental health problems within the interdependent (Eastern) culture may respond differently to illnesses; they may favour staying silent and focus their attention on themselves to avoid coming across as different to others within their group, rather than communicating to others about how they feel (Yang et al., 2007; Schnyder et al., 2017). Thus, within Eastern cultures, the fear of stigma may be more intense than in Western cultures (Alyahya et al., 2020).

Statistically, Saudi people with mental health issues are less inclined to report symptoms of mental distress to friends and family who can help them than those within Western cultures (Ratner and

El-Badwi, 2011; Jelaidan et al., 2018). Meanwhile, the development of individual attributes, as well as the need for self-actualisation are encouraged within independent (Western) cultures (Wahass and Kent, 1997; Bruner,2001; Itai, 2008). This leads to individuals being more apt to seek professional help for their own well-being without necessarily consulting friends and family members. Due to this, it has been argued that social stigma is likely to have less of an impact on individuals within Western culture (Pescosolido et al., 2013).

A group's level of understanding of cultural and social elements may impact on an individual's choice as to whether or not to seek treatment (Corrigan and Rao, 2012). Vygotskian theory explains the impact of socio-cultural education (upbringing) on people's behaviours/attitudes when following their group or society's behaviours (i.e., cultural concepts and artefacts) towards mental illness and subsequently seeking non-professional help. There are however great variations across the KSA, and some communities are more traditional than others in their attitudes and beliefs towards mental ill-health. There have been a number of statutory initiatives to attempt to increase public understanding of mental health difficulties, as well as to reduce the effects of discrimination, stereotypes and stigma (Wahl and Aroesty-Cohen, 2010) and in recent decades there is evidence of increased academic understanding of the psychosocial effects of mental illness but this increased understanding has had little effect when close to home (Jelaidan et al., 2018).

3.4.2 Religious Impact on the Cultural Identity of Saudi Arabians

It is widely acknowledged that Saudi Arabians possess strong spiritual and cultural identities, as evidenced by their religious traditions and artefacts (Abu-Ras, 2014; Hussein, 2014; Alamri,

2016). Furthermore, Saudi culture, is experiencing significant transition through modernisation (Jelaidan et al., 2018). This process of modernisation has been a direct challenge to some traditional beliefs and practices including attitudes to mental ill health. Adoption of modern thinking has involved an amount of social learning and change with regards to traditional attitudes versus modern/Western attitudes, especially in relation to mental health awareness. As culture is so significantly embedded within the lives of Saudi people, the question arises concerning the way in which cultural identity moulds perceptions regarding mental health issues, alongside how these can be managed within contemporary Saudi society (Guitart and Ratner, 2011) and social learning may occur in order to change negative attitudes.

Therefore, an exploration of Saudi identity may provide both potential insight into Saudi cultural identities and other social institutions factors such as, the role of religion, and the emphasis placed on corresponding values, morals, and traditions, which are communicated and passed down from one generation to the next. For significant attitudinal change to occur, there needs to be significant shifts in policies and practices in the educational systems of mental health professionals to facilitate greater peer acceptance and learning of new and challenging ways of thinking about mental health in order to create a broad social acceptance (Jelaidan et al., 2018). The Zone of Proximal Development (ZPD) can, thus, be overtly developed firstly amongst those who are in mental health training and education and secondly in wider society in order to help bridge understanding about the relationship between cultural issues and mental health in the KSA.

Special attention is afforded to the concept of social stigma and how it is reflected and enacted through social interactions, which can change among different demographics, such as gender. This inquiry

also takes into account personal experiences of people in terms of their attitudes and beliefs towards mental health and the access to and use of mental health services (White et al., 2017).

3.4.3 Gender Factors within the KSA

As with many Muslim countries, the roles of men and women are clearly demarcated. Within the Saudi culture specifically, women are primarily defined as mothers and wives, and are likely to place family needs before their own (Ratner and El-Badwi, 2011). Furthermore, men are frequently acknowledged to be the decision-makers; thus, women are generally not permitted to make health care decisions (Koenig et al., 2014). This lack of relative autonomy for women may exacerbate mental health problems. Indeed, considering many of those facing mental health issues are women, gender factors play a significant role in the prevalence of mental health disorder within the KSA (Alahmadi, 2010).

Gender divisions within the KSA are engendered within socialisation in childhood, interactions with others, social constructions of work and family roles of both men and women (social institutions) (Alamri, 2016). These interactions are also reflected in behaviours, attitudes, and emotions (Ratner and El-Badwi, 2011). All of these variations are reflected in people's health, and influence help-seeking and caring behaviours, access to and use of mental health services (Afifi, 2007; Abdullah and Brown, 2011). This impact can be seen in various ways; for instance, if a Saudi woman is socialised to believe that seeking help for mental health issues is a sign of weakness in a male-dominated society (Al-Subaie, 1989), she may be less likely to seek help when she needs it. Similarly, men may be labelled as "unstable" by peers, family members and their local communities that will inevitably discourage men from seeking help for

mental health issues; they may also be less likely to access mental health services.

Indeed, the gender division in Saudi culture can be thought of as a religious and socio-cultural factor in regards to MCPT. Accordingly, women who experience mental distress in Saudi culture require specific cultural orientation/adaptation, which means that mental health services and educational approaches need to be adapted to fit the cultural and social context due to these various aspects. Further, the cultural orientation measures may help Saudi women to express the difficulties that they potentially face in taking decisions to access mental health services and to continue their treatment. Saudi women may face unique challenges when it comes to accessing mental health services due to the social and cultural factors that influence their behaviour and decision-making. For instance, the Saudi government might consider adaptation measures, such as gender-specific care, which provide mental health services that are sensitive to the unique needs and experiences of women, rather than focusing solely on medical treatment (AlKrenawi and Graham, 2016). This could be conducted through incorporating religious and cultural values and practices into mental health services and by involving family members in the mental health treatment process, as they may play a significant role in supporting women who are experiencing mental distress.

Whilst there is ongoing work to improve access to and quality of mental health services in the KSA, there is still a requirement for continued efforts to address cultural and social barriers that may prevent individuals, particularly women, from seeking help and engaging in treatment. Gender divisions within the KSA can have a complex and multifaceted impact on people's health, and addressing these issues requires a comprehensive approach that considers the

cultural, social, and institutional factors that contribute to these divisions.

Saudi citizens could benefit from the progress of their society by learning how to determine whether they embrace and absorb this evolution and learn how to let go of attitudes and beliefs that hold people back socially. This, however, requires the kind of social learning and development identified in Vygotsky's ZPD. Indeed, what the KSA needs is grass roots, community-level collaborative guidance amongst family members, friends, trainee, peers, etc. There is no evidence, though, of research studies to implement and explore such initiatives in the KSA. Comparatively, in Western nations, there are thousands of examples of community-based efforts for local people to learn, understand and change their attitudes and beliefs regarding mental illness. Most of these involve people with 'lived experience', who can narrate their own experiences and stories. Subsequently, the current study aims to use a narrative approach to illustrate how people with mental health issues could benefit from sharing their stories of accessing and using mental health services in order to help others further understand the complex issues facing mental health services and wider society in the KSA nowadays.

3.4.4 The Meaning and Influence of the Family Network within the KSA

When it comes to culture in KSA, familial matters are of high importance: family processes and family structures impact human functioning in the context of health/illness (Ratner, 2013). The internal quality of family functioning is a crucial determinant of mental health (White *et al.*, 2017). To understand a person suffering from mental health difficulties, it is imperative to understand the family (Okasha and Karam, 1998; Fatori and Polanczyk, 2020). As in all cultures, the family may be harmful or a supportive influence upon a person experiencing mental distress (Alahmadi, 2010). Moreover,

Saudi family cohesion may play a crucial role as a protective factor; the socio-cognitive reconstruction of disappointment and resentment toward a family member similarly often translates into guilt for having distressed the parents/relatives (Ratner and El-Badwi, 2011). In the KSA, the family is the most significant social institution, where individuals tend to socialise within the circles of family alliances and the family unit (Ratner and El-Badwi, 2011). It is in the family context that people usually form and retain their identity.

Family members, therefore, play an essential role in how individuals with mental health issues respond to their condition and seek treatment (or not), (Jelaidan *et al.*, 2018). Conversely, when denial occurs amongst the families of people who experience mental health difficulties, they likely experience stigma; thus, exacerbating the problem (Koenig, 2009). Bizarre features and mixed emotions lead to shock reactions and denial, and despite the strong family bonds that characterise Saudi society, religion, traditions, and courtesy stigma lead to low social support from the family for the person with mental health issues. Furthermore, the family itself may also experience discrimination, prejudice, and social stigma, with the level of support received from the family frequently being influenced by misunderstandings and low levels of awareness concerning the causes and symptoms of mental illness (Jelaidan *et al.*, 2018). Subsequently, families may be surrounded by conflicting beliefs regarding mental illness, as they conflate symptoms of mental illness with jinn or possession, or they might be frightened from disconnections from the extended family. Rather than seek help, professional help is often avoided due to this. As a result, Saudi family members may prevent their relatives with mental health problems from seeking appropriate professional help, accessing and using mental health services (Alyousef, 2017; Chaturvedi, 2019).

3.4.5 Access to Mental Health Services in the KSA

The accessibility and utilisation of mental health services within the KSA is heavily influenced by cultural factors of social, family and spiritual origin and function, as aforementioned, due to the fact that attitudes, behaviour patterns, and beliefs toward mental illness vary across cultures and are governed by cultural rules (Kleinman, 1980; Alyahya *et al.*, 2020). Indeed, religious provision frequently influences beliefs concerning the causes and nature of mental illnesses, thus shaping the attitudes that individuals possess towards those experiencing mental health issues (Koenig, 2009). Such attitudes demonstrated by the public, directly influence the rate at which those with mental health problems experience social stigma. Furthermore, as with other societies, the onset of mental health issues are inevitably linked back to social class, income, ethnicity, education and gender (Williams *et al.*, 1997). Higher educational achievement is concomitant with low levels of mental disorders, explained by the fact that education frequently enhances people's perceptions and skills, instilling better coping mechanisms of individuals and affording important structural advantages, which results in people's improved mental health and the accessibility of mental health care services if required (Livingston and Boyd, 2010). Even though a higher level of education may also be associated with wealth and freedom from poverty (Teo, 2014). It has been further asserted that education makes a considerable contribution to human capital, which may ultimately mediate the ability to navigate health services (Halpern-Manners *et al.*, 2016).

3.5 Conclusion

Cultural concepts, artefacts and Saudi social institutions play a critical role in mental health, possessing a wealth of both positive and negative aspects, which all collectively shape and support specific psychological attributes. As it is embedded in the lives of the people, cultural identity moulds how mental health issues are perceived and managed (Im *et al.*, 2017). Multiple theories potentially form the basis of a theoretical framework that provides an explanation as to how culture influences mental health within the context of the KSA, as well as the challenges experienced within mental health treatment. Correspondingly, due to its capacity to explicate—culturally and socially—the details of individual and interpersonal psychological dynamics, Vygotsky's MCPT has been selected as the most appropriate source in regards to explaining mental health problems within the KSA; further, a person's well-being may be influenced by a network of cultural factors when seeking an understanding of mental illness as a disorder.

Vygotsky presents a psychological theory of culture, centred on several macro-cultural factors as concepts, cultural artefacts, and social institutions. In such a culture, people may need to express their experiences and provide opportunities for their voices to be heard. Vygotsky (1978) believed that the social environment, culture, and people were important components of learning. In the KSA, the social order has been moving through a period of change in recent years and it is imperative that citizens learn and adapt to these changes for long-held beliefs and traditions to be challenged in relation to concepts of mental health and illness. Whilst there have been rapid developments in technology, education and healthcare, social attitudes have not maintained this rate of change and 'macro-cultural' forces of negative attitudes based upon religion and superstition continue to dominate beliefs and attitudes about mental illness.

Saudi citizens could benefit from the progress of their society by learning how to determine whether they embrace and absorb this evolution and learn how to let go of attitudes and beliefs that hold people back socially. This, however, calls for the kind of social learning and development identified in Vygotsky's ZPD. Indeed, what the KSA needs is grass roots, community-level collaborative guidance amongst family members, friends, trainee, peers, etc. There is no evidence of research studies to implement and explore such initiatives in the KSA. Comparatively, in Western nations, there are thousands of examples of community-based efforts for local people to learn, understand and change their attitudes and beliefs regarding mental illness. Most of these involve people with 'lived experience', who can narrate their own experiences and stories. The current study aims to use a narrative approach to illustrate how people with mental health issues could benefit from sharing their stories of accessing and using mental health services in order to help others further understand the complex issues facing mental health services and wider society in the KSA today.

Chapter 4: Methodology and Methods

4.1 Introduction

Narrative inquiry is an interpretive approach in social sciences and involves using storytelling, whereby the story becomes the object of study through focus on how individuals or groups make sense of the events and actions in their lives (Mitchell and Egudo, 2003). Narrative research has increasingly been used in healthcare in research involving patients, healthcare professionals, and in nursing education (Hurwitz et al., 2004; Holloway and Freshwater, 2007; Joyce, 2015). Storytelling requires a teller and a listener, with Riessman (2008, p.21) stating that for narrative to prosper there "…*must be a community (audience) to hear and for audiences to listen; stories must weave together communities' identities, politics and histories*".

Mishler (1986) and Riessman (1993) argue that narrative research elicits information about areas of experiences which are narrated by the participants and analysed in dual layer of interpretation. Firstly, the research participants (story-tellers) interpret their own lived experiences through narratives by constructing the events of a story. Secondly, the researcher interprets the construction of that narrative, which may often involve summarising long passages, discovering the narrative structure of the story, creating vignettes or analysing for themes. This process is usually based on the outcome of an interview (Mitchell and Egudo, 2003). Narrative research is a form of qualitative research and according to Holloway and Freshwater (2007), narrative stories are continuous and have a common form of construction consisting of a storyline, a cast of people, and a stated issue. Holloway and Freshwater define the plot as an identifiable set of events, and narratives are always about something, such as disease, disability,

recovery, or everyday experiences. Additionally, as a researcher, it is important to elicit and capture the participants' narratives, as a structured interview approach does not facilitate story-telling of experiences. Comparatively, by using an unstructured interview method, participants have a great deal of influence over the process (Holloway and Freshwater, 2007).

The terms 'narrative' and 'stories' in clinical and nursing settings can be used interchangeably (Frid et al., 2000). It is recommended that the researcher uses phrases such as: "*What is your story?"* to gain deeper knowledge about the person than asking more structured questions (Hall and Powell, 2011). Exploring a person's individual narrative may help to place their experience in context and provide depth to its meaning. Several authors see narrative research as both an art and a science (Holloway and Freshwater, 2007; Ritchie and Lewis, 1993; Sandelowski, 1991): art because of the creative skills ingredient; and science because the approach is both methodical and systematic. Moreover, narrative research enables individuals to understand their experienced health and well-being in their social environment, as they interpret it, including their self-belief-oriented narrative (Ntinda, 2020).

4.2 Philosophical Underpinning

This study aims to explore the experiences of people with mental health issues and their access to mental health services and treatment programmes in the KSA and to discover their experiences when facing possible cultural barriers (whether religious or social), and how they interact and deal with these challenges. As a psychiatric nurse, it is understood that listening to people's stories is valuable when helping patients to be able to cope with their problems; however, this requires support through policy and regulation. The interest in narratives is based on providing people with the

opportunity to narrate their experiences of accessing and using services. Whilst doing this, the researcher is deliberately creating a platform for people's voices to be heard (Frank, 2002). Accordingly, a researcher is required to formulate the research within a chosen paradigm (Doyle et al., 2016) which cannot necessarily be empirically proven or disproven, because all assumptions are conjecture and different paradigms necessarily contain differing ontological and epistemological positions (Scotland, 2012). To have different assumptions underpins a particular research approach and is reflected in the methodology and methods.

4.2.1 Interpretivism

As qualitative research involves the act of studying the verbal accounts of others and subjects these accounts to select forms of analysis which are then synthesised and summarised by the researcher, the research process involves a great deal of interpretation; such research is said to be in the Interpretivist tradition. The act of interpretation itself may become a focal point for research through reflexivity, which has been especially acknowledged in nursing research (Hardy et al., 2002; Holloway and Freshwater, 2007). While positivism emphasises the explanation of human behaviour, interpretivism seeks to understand it. This development in the history of this research is often attributed to the scholarly works of Max Weber (1864-1920) and the approach has become known as 'Verstehen': an empathic or participatory understanding. In the current research, this process is referred to as 'giving voice' to participants, as there is no evidence of people providing opinions of their experiences of mental health services in the KSA in present research (Lebow, 2016). Interpretivism not only implies the researcher interpreting the social world in regards to the research, but also the participants' interpretation of that world (Alvesson and Sköldberg, 2009). Furthermore, the researcher's work is interpreted

within theories of knowledge of their own discipline. Largely through the work of Roland Barthes (1977), narrative research gradually became incorporated into the social sciences and more latterly in healthcare research (Lavers, 1995).

As will be discussed later in this study, Critical Narrative Analysis (CNA) will be used (Langdridge, 2007). This particular model of analysis facilitates the discussion of the complex relational implications of social science research, especially the role of the researcher. This is most relevant to the current study, due to my role as a mental health nurse in the KSA and how this affects my preconceived ideas and how I may be perceived by the participants. Accordingly, Malterud (2001, p.443) states that what researchers "*…choose to investigate, the angle of investigation, the methods judged most appropriate, and the framing of conclusions*" are all affected by the researcher's background and position. In conjunction, the researcher will endeavour throughout the research to be transparent in these processes of analysis and interpretations and constantly reflect upon personal background and positionality in terms of discipline and epistemological understandings (Johnson and Duberley, 2003).

4.2.2 Narrative Theory and Constructionist Approach

The narrative 'storytelling' and listening approach positions narrative research largely within the postmodernist paradigm (Mitchell and Egudo, 2003). Postmodernism questions the modernist philosophical assumptions of rationality and universal truth, as well as the application of scientific empirical methods, to solve problems where multiple perspectives are offered as an alternative to scientific problem-solving methods. As a result, the current research will provide participants with an opportunity to give voice to their stories (Creswell, 2007). The researcher will be the listener and during the

interview, the audience. Indeed, the research becomes a two-way process; both during the interview and the later analysis. Firstly, the researcher carefully listens and prompts the story-telling; and secondly, she interprets the transcribed narratives. The researcher is, therefore, involved in the construction through listening, asking questions and prompting, as well as using her skill in analysis. During all of the construction processes, the researcher brings her own values, opinions, life experiences and judgements. Subsequently, the narrator and the researcher are co-constructing the narrative (Watzlawick, 1984; Crotty, 1998;).

In the current study, the researcher's role is not only to co-construct a narrative, but also to construct meaning in collaboration As Crotty highlights (1998, p.42), *"meaning is not discovered, but constructed"*. This construction warrants the adoption of a reflexive position. Throughout the study, I kept a research journal and every aspect of the research was scrutinised. The contents were shared with my research supervisors who asked questions from many perspectives. Correspondingly, I brought personal beliefs, ideas and values to the research, which inevitably impacted upon the research, and thus, reflection was necessary upon the 'How? What? and Why?'; as well as to synthesise these questions and subsequent answers into the analysis and subsequent write up.

Research skills are required during interpretation, which are achieved through listening. The researcher must be reflexive in acknowledging her own values, beliefs, social backgrounds and assumptions, as these may prove to be influential factors. As the researcher and participants share the same culture, this emphasised that the researcher would keep an ongoing reflective journal and diary during the research process. In addition to asking secondary questions to participants during the narrative interview for more

clarifications by asking individuals to sometimes clarify or to explain widely certain events in their stories. However, much of this form of prompting is not recommended, as it might affect the narrative events that participants have constructed thoroughly. Hence, sensitivity is fundamental regarding the dynamics between the researcher and the participants. Within interpretivist assumptions, knowledge is more subjective, requiring that the researcher demonstrates direct involvement with the respondents to garner insight into their views (Rossman and Rallis, 2003).

Importantly, there must be direct engagement with the participants to gain insight and understanding of their experiences and perspectives underpinning the interactions. As a theoretical perspective, interpretivism is recognised as seeking to understand and explain human and social reality (Crotty, 2009). In the current study, recognising and understanding personal biases and assumptions is critical, as consideration will be directed towards many different factors and elements that could restrict help-seeking behaviours, such as community, culture, family and faith. Attention should also be directed to this issue (i.e., the researcher's own biases) to ensure accuracy and trustworthiness in the research process.

In implementing this research, it was important to be mindful of the theories that I had previously studied to underpin the thesis. Vygotsky's sociocultural theory was of relevance, as it views human development as a socially mediated process, with most of the people interviewed having experienced long periods in institutional care. It was interesting to know how doctors and nurses influenced that patients' perceptions of their (the patient's) mental illness. Furthermore, the very act of interviewing the participants provided a sense of doing something that was out of the ordinary for the interviewees; they perhaps have never been asked to tell their stories

outside of a clinical context. I felt like an educator/facilitator in my role of researcher, entering the zone of proximal development with the client. In the moment of interview, the participants had the opportunity to momentarily transform their identity from illness/weak identity to the empowering service users' identity of narrator of their own story.

4.2.3 Constructivist Approach

A narrative approach comes under the umbrella of social constructivism (or constructionism), which holds that people's lived experiences reflect the complexity and comprehensive understanding of key events during their lives (Ntinda, 2020). Such narratives in this type of design are suitable for the representation of biographical experiences (Flick et al., 2004). Therefore, through a constructionist position, I attempted to understand the lived experience of mental distress and historical experience of the participants in the current study. Despite the cultural homogeneity of the Saudi population, every participant has their own identity, especially regarding personal communication and interaction processes and experiences, within the context of Saudi society. Ricoeur (1987) asserted that narratives are fundamental in people's lives, adopting the view that people position themselves as humans through considering one's self as one element of the story. Ricoeur, though, is seen to adopt a different view to other philosophers in the field, as is emphasised when considering that he viewed the cosmological and phenomenological time as aligned, which he defined as 'human time'.

In Saudi society, and especially in mental health care, there is insufficient focus on individual identity. As the current study is based on a social constructivist perspective (i.e., participants' narratives reflect the way in which they construct their experiences), the religious, cultural, and social construction of Saudi people as mental

health service users is crucial to understand their experiences. Especially interpreting how they narrate and perceive their social experiences and, how they interpret these events in the light of Vygotsky's theories. In the light of both interpretive and constructionist paradigms, throughout the research I sought to facilitate story-telling, and to be mindful of their co-constructed nature in the recording and analysing. Later in this chapter there will be a discussion into how both approaches form together with regards data collection and analysis.

Critical Narrative Analysis (CNA) provides the researcher with an opportunity to explore and assess the concept of identity formation and construction, and also to reflect on their own experiences of identity formation and reformation throughout the process (Holloway and Freshwater, 2007; Castellanos, 2014). There is the potential for educational outcomes too, as the participants also can learn new things about themselves. Furthermore, this approach provides them with a voice and facilitates the process of construction and reconstruction, establishing space for renewal and closure (Freshwater, 2000). A further reason for selecting a narrative approach is that there are links between culture formation according to Vygotsky's theory and narrative. A significant connection between MCPT and narratives is that both provide attention to exploring people's cultural factors that describe their experiences through having their voices heard.

The process of sharing experiences potentially enables the subjects to transform their 'illness story' into a 'service user/survivor story' (Moran et al., 2011). This adds to the transformation of identity from a person who is perceived as being ill to one who accesses and uses the services and who moves on from illness. Outside of the Saudi context, the method of using people's experiences in formal roles

transforms that which is often viewed as stigmatised into something that can be considered as a strength and a quality. This could present and facilitate a change in identity, from one based more on embarrassment and indignity to one that is likely to be formed from pride and self-respect. Even though this would be seen as a western and individualised approach, this might work in the same way within the Saudi context. However, participants might take longer time to reach the positive transformation of their identities due to societal and cultural bonds that demand robust loyalty.

According to Ricoeur (1987), the identities of individuals are constructed narratively though their stories, and identity is at the core of mental health (Goffman, 1990). The telling of these stories may be empowering and emancipatory, as they provide individuals with the opportunity to share their experiences and shape their own identity. Indeed, narrative can further help transform traumatic experiences into valuable ones (Moran et al., 2011; Austin et al., 2014). For these reasons, a narrative approach has been chosen for this study, as it allows individuals to take control of their own story and potentially achieve a sense of empowerment. Moreover, nursing can be a crucial source and essential part of the idea of empowering and a source of giving hope, when the narrative approach is learned to assist people in their mental health journey. A narrative approach in nursing involves utilising the individual's own stories and experiences to help people understand life-processes and make meaning of their mental health challenges. By taking a narrative approach, nurses can help individuals regain control over their lives and their treatment behaviours. Later In the thesis, the mutual relationships between mental health nursing and narrative will explore, and how narrative is significant to improve mental health nursing, which undoubtedly reflects on people's understanding in accessing health care.

4.3 Trustworthiness in Narrative Research

In specific regards to trustworthiness, which is seen to underpin narrative inquiry as a research methodology, it is highlighted in the work of Polkinghorne (2007) that there are four different issues:

- Firstly, the limits of language when it comes to ascertaining the degree of intricacy and depth of experienced meaning;
- Secondly, the limitations associated with reflection when it comes to highlighting the various layers of meaning that are viewed as present beyond awareness;
- Thirdly, people's overall resistance as a result of social inclination to entirely highlight the complexities associated with the experienced meanings of which they were aware; and
- Fourthly, the degree of complexity recognised by the fact that it is common for texts to be co-created by an interviewee and an interviewer.

In regard to the first of these concerns, it is noted in the work of Kleres (2010) that intelligible language, in addition to other aspects, namely prosodic identifiers (e.g. self-interruption, hesitancy, intonation and stammering), can help to untangle emotions, both positive and negative, in addition to helplessness or agency. Thus, when there is a pattern of such markers of negative self-feelings, followed by prosodic identifiers inferring positive self-feelings, it then may be implied that the narrative is being created in such a way that a relief-centred story is being told.

When it comes to examining the second issue, it is clear when reviewing the work of Polkinghorne (2007) that in regards to reflection, the narrative researcher needs to keep a reflexive 'check' on their own beliefs, suppositions and values in order to favour the

narrator. This could happen unintentionally by the researcher during phases of analysis. To mitigate this challenge, I kept a diary to record my interpretations and I did my best to be a good listener during the interview. Clandinin and Connelly (2000) demonstrate in their research that narrative inquirers are not detached recorders of another person's experience, owing to the fact they may be seen to be experiencing an experience (Clandinin and Connelly, 2000. p.81).

The narrator and narrative inquirer are recognised by Wolgemuth and Donohue (2006) as equally important when it comes to achieving greater depth of meaning and understanding. This is satisfied through inquiry of discomfort, alongside the pedagogy of discomfort, which involves the inquirer posing questions with the aim of garnering information relating to assumptions and beliefs, as well as to suggest different approaches through which subjects could believe, and to aid subjects to recognise and identify their own inconsistencies, whilst also challenging the overall constancy and solidity of the subjectiveness displayed by the individuals (Wolgemuth and Donohue, 2006, p.1034). In this regard, Polkinghorne (2007) further suggests that narrators would benefit from having no time restrictions when it comes to completing reflective investigations into the meaning of individuals' emotions. This concept is particularly relevant to nursing research and in the concept of reflective practice in nursing (Choperena et al., 2019; Esterhuizen, 2019).

In tackling the third issue highlighted by Polkinghorne (2007), notably that of people's overall resistance as a result of social inclination to entirely highlight the complexities associated with the experienced meanings of which they were aware, it is highlighted in the work of Wolgemuth and Donohue (2006) that a paradox may be seen to arise as a result of feelings of discomfort that Correspond directly with the transformational experience of narrative inquiry,

which requires comfort. In this vein, the authors posit the view that the narrative and inquirer need to feel at ease when it comes to communicating their assumptions, beliefs, and vulnerabilities, which subsequently aids in establishing a space in which they are able to experience ambiguity, discomfort and transformation (Wolgemuth and Donohue, 2006.p.1030). In a comparable vein, the study by Ackerman and Maslin-Ostrowski (2002) suggests providing different viewpoints in a setting where judgements are not present so as to ensure a more wide-ranging vision of reality can be given, whilst also allowing a participatory way of thinking to be experienced (Ackerman and Maslin-Ostrowski, 2002. p.120). Moreover, comfort can also be aided by completing several interviews, which goes some way to encouraging transparency and openness between the narrator and the inquirer (Seidman, 1991; Polkinghorne, 2007). In this regard, metaphor use is also seen to be valuable when it comes to expressing emotions and in creating intimacy that otherwise might not be easily achieved (Kleres, 2010).

When addressing the concerns from Polkinghorne's (2007) fourth issue of trustworthiness, it was recognised by the fact that it is common for texts to be co-created (or co-constructed) by an interviewee and an interviewer. Researchers are cautioned against presenting the narratives they had expected, and this encourages researchers to undertake openness and transparency in order to ensure anything unusual or unexpected in the stories can be accepted and, therefore, examined. In the current study the researcher was aware that when participants narrated their stories, they were aware of the researcher as the audience, but they were also listening to themselves and what they were narrating in the moment, which allowed them to review, re-evaluate and re-construct their narrative. This phenomenon was articulated by Frid et al (2000, p.697) who claimed that *"…a person's narrative creates an approximation of*

something that occurred previously, although it is not simply a repetition, but a "reformulated description".

Through interpreting the narratives, my knowledge of interpretation methods has developed and that the new understandings informed interpretation of the study topic. In this regard, Riessman (1993) highlights that, in narrative inquiry, data coherence and persuasiveness need to be considered as above credibility, owing to the fact that data are both context-relevant and subjective. Persuasiveness can be established when the experiences of the storyteller feedback confirm theoretical claims. Nonetheless, it is important to remember that this should not come at the expense of the nuanced voices of the narrators (Clandinin and Connelly, 2000). Furthermore, Riessman (1993) and Helkkula and Pihlström (2010) emphasise that when considering other alternative interpretations of data, this can further enhance persuasiveness (Helkkula and Pihlström, 2010). In addition, Riessman (1993, p.66) claims that "…*persuasiveness ultimately rests on rhetoric of writing, on literary practice and reader response and what may be the most persuasive interpretation of the narrative text at one historical moment may not be later"* and the researcher's interpretation can be precarious.

4.4 Narrative Analysis Method

There are various types of narrative analysis, some of which centre on the content of the stories, whilst others are more concerned with meaning; however, some consider both aspects equally. Stories may be viewed as a window through which reality is knowable and where stories are analysed with the use of theory-derived concepts, including thematic analysis, or concepts taken from data, such as through grounded theory. Furthermore, stories may be considered to be socially situated knowledge constructions in their own right, placing emphasis on the differences, texture, depth and messiness of

experienced life (Polkinghorne, 1988). Analysis in narrative involves deriving meaning from the stories, which occurs throughout the research process as a whole (Van Laer et al., 2014). For instance, this relates to following constant comparatives in an ongoing way in the current research (systematic) from continuing reflexion during sampling selection and recruiting down to the analysis process of comparing and contrasting.

In the current study the emphasis is placed on the co-construction of meaning between the interviewer and the interviewee. Accordingly, the processes of data collection and analysis are merged to become one. For example, during in-data collection the study aim and objectives were clearly stated in the information sheets given to participants, and they were also retold in the opening statement on their interview day. Secondly, the narrative was automatically influenced by researcher feedback, as during the interview participants were asked questions to narrate their stories, while verbal or non-verbal feedback was sometimes used, which may or may not have been considered by participants as feedback to amend their narratives (co-creation process). Thirdly, after listening to the audio recordings, I became aware of my own perspective following the transcriptions of participants' stories. Meanwhile, the recordings were listened to twice to correct any errors in transcription and to recall some journals notes taken after each interview. During this stage (transcribing) the research question acted as a filter to determine which components of the story would be examined. The choice of CNA as the analytic framework for this research necessarily informed the structure and organisation of the analysis.

Importantly, narrative analysis handles stories as knowledge, which subsequently provides insight into the narrator's own social reality (Etherington, 2013), and which further communicates a sense

of the experiences of the individual in-line with its richness, texture, messiness and depth; this is achieved by reflecting on the words and phrases used. When ensuring transparency regarding the relational nature of the study, however, as well as the ways in which the stories are told and shaped through tools of co-construction and dialogue, some of my own dialogue is included. Furthermore, a reflective layer in relation to the positioning of the researcher is also provided. What is more, in order to maintain transparency and rigour in the analysis, a journal was kept for continuous reflection following interviews and during the analysis. These reflections were subsequently shared with the research supervisors.

4.5 Ethics in Narrative Research

As a result of the social nature of a wealth of narrative research works, there is always the potential that subjects can be negatively impacted as a result of their involvement in a narrative study. This can arise in several ways, either directly, such as by being identified as a participant in the study, or indirectly, as a result of the effects of a research report on the lifestyle, culture or other aspect of the subject's life. To circumvent these issues, or at least minimise them to the greatest possible extent, researchers are well positioned to establish a more complex and amalgamated narrative to ensure the preservation of the subjects' anonymity.

The researcher of a narrative study should ensure awareness regarding the potential for the relationship they develop - notably between themselves and the participants - as needing to be mutual and equal. Hence, the researcher should not be the only one to gain from the completion of the study; rather, they should provide some kind of value to the respondents (Lenfesty et al., n.d.). How I managed the dual role as researcher and mental health nurse was by firstly explaining to each participant that although I was indeed a

mental health nurse by background, the role in the interview was that of researcher. The process of the interview was carefully explained prior to asking any question, and each participant was given the opportunity to ask any questions they might have had. It was also evident that there was the potential for participants to become emotional in the telling of their stories, especially as this study sought to give voice to people having mental health issues. Nonetheless, none of the participants appeared to have found the interview distressing; it was deliberately chosen beforehand not to dwell or ask further questions about their past mental distress, as it was not the intention of the research to elicit strong emotions, only honest recollections. Further, the staff members at the SSCA charity (medical, mental health professional, security and emergency) where the study was located were very supportive of the interviews being conducted. An arrangement was made that if I felt unsafe in any circumstance, there was a bell phone to ring. The staff checked in before and after each interview, although participant confidentiality was maintained throughout.

Regarding the support for the participants to maintain their safety in the research process, it is important to escalate concerns appropriately depending on the nature of the concern and the context in which the study is occurred. For instance, if any of the participants expressed thoughts of self-harm, suicide, or harm to others, it would be necessary to contact the relevant person in-charge of the institution. In any such eventuality, it would be important to consider the ethical implications of any actions, including maintaining confidentiality and avoiding harm to the participant, while also prioritising their safety and well-being. Additionally, the power dynamic in the relationship with the participant had to be considered, and it was continuously hoped that a respectful and equal relationship

would be maintained. As it transpired, there were no concerning moments throughout the interviews.

4.5.1 Reflective Ethics

In regards to reflection, consideration was directed towards the potential effects of the research on my own identity. For example, there existed the potential for emotional and psychological impact whilst conducting the current research on mental health in the KSA, as it may well challenge cultural norms and confronting stigma surrounding mental illness. Much of this process concerns individual beliefs and perceptions, which, when questioned, can easily stimulate defensive responses. As there is a need to develop an in-depth understanding of individuals' experiences, no other method besides interviews could facilitate this, with back-and-forth dialogue, questions and discussion facilitating the gathering of a wealth of rich information (Crouch and McKenzie, 2006). As a mental health nurse and academic lecturer, I ensured that when it came to interview the subjects involved in the study, the relevant experience and knowledge in the mental health field was utilised. Overall, the interviews undertaken were unstructured in nature, which was recognised as fundamental because narrative involves discourse and probing; a structured interview, which involves adhering to a pre-set list of questions without the opportunity for either the interviewer or interviewee to steer away from what is outlined ahead of the interview, would not facilitate understanding and is, therefore, not seen to be compatible with a narrative approach (Holloway and Freshwater, 2007).

Importantly, reflective listening was also ensured; this involves following the thoughts and feelings of the interviewee, and accordingly gaining insight into what the subject is communicating from their own perspective and without the interviewer's own bias.

Reflective listening may be seen to be a special type of listening that involves keen attention to the content of the narrative in order to ensure that the participants feel heard and understood, and that their experiences and perspectives are accurately represented in the research (Dahlberg and Dahlberg, 2020). Hearing and understanding are imperative, with regular reassurance being given to the speaker that they are being heard and understood, such as using positive response statements, such as 'I see', or body language (e.g. nodding the head) (Katz and McNulty, 1994).

Following the completion of all twenty interviews (which were audio-recorded with the consent of the participants), transcription and analysis took place. This was seen to be the most advantageous approach to ensuring no data were missed: note-taking was considered to have the risk of distracting the subjects or making them feel like they were 'under the microscope', rather than allowing them to enjoy free-flowing conversation. Audio-recording allows the interviewer and the interviewee to focus on what was being said, which is critical in the case of narrative methodology (Riessman, 1993).

4.5.2 Ethical Considerations

Before proceeding to the research data collection, the current study was submitted to the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee and the approval was gained with the reference number of 56-1707. Further, approval was obtained from the Saudi Schizophrenia Charity Association (SSCA), in Riyadh Capital City, the KSA with a reference number of 1137 (see Appendix C). The important ethical considerations of interviewing the participants in the study were confidentiality, anonymity, safety and privacy to protect the

respondents, and all the information acquired from them during the research process (SRA, 2003; BSA, 2004).

In the interview process, the interviewees were informed of the importance of confidentiality, anonymity and privacy, and especially that the content of the interview would not be discussed with the staff at the charity. Nonetheless, the purpose of the study was clearly communicated to each participant (Smyth and Williamson, 2004; Ritchie et al., 2013) and communicated them about my role and their role during the interview (Waller et al., 2015). The participants were also informed that their participation would have no effect on them (as participants in this research if they preferred/wanted to withdraw from the study at any time) this would not affect their joining to charity's services or on the benefits they have from SSCA charity, where the study interview held. It was also made clear that I would not speak to any other agency involved in their care. Participants' data (documents, audio files and notes) were held securely in a locked cabinet and computer-held data were held securely and password protected. Ethical conduct, though, did not stop following the consent of the participants, as it was an ongoing process throughout the study process.

4.6 Study Design

The qualitative, narrative methodology used was partly based on the determination to reduce the distance between researcher and participant. The literature review revealed that previous research in this area (narrating mental health-illness experiences) lacked a participative perspective, which affected the sophistication and richness of the data collected and, therefore, the conclusions of those studies. It is common for qualitative studies to be viewed as relatively low-risk compared to more interventionist quantitative studies (Ritchie and Lewis, 1993). However, qualitative studies require that

participants engage in a process that can involve personal investment and revelation, which may generate negative experiences, and feelings of shame or other emotional responses when divulging deeply personal and sensitive information (Holloway and Freshwater, 2007). Therefore, this needed to be managed by providing a welcoming and safe space for the interview, as well as ensuring that there was support at the ready for either the researcher or the participant if it were to be required. Furthermore, I deliberately did not focus upon potentially sensitive aspects of the stories and retained focus upon the aims of the study.

There is a tension between the informal nature of storytelling during an interview and the more formal aspects of analysis of the data. Thus, it was important to respect the subjectivity of the participants and not subsume it under any personal interpretation or the particular social theoretical framework used. Further, it was emphasised that the importance of being mindful of the important part of the ethical consideration of the methodology is in the analysis of data. As Langdridge (2007, p.140) stated, "*subsuming the subjectivity of the participant beneath that of the analyst and the particular social theoretical hermeneutic being employed"*.

4.6.1 Access to the Participants

The current study was conducted in the Saudi Schizophrenia Charity Association (SSCA), which is in Riyadh Capital City, the KSA. The SSCA is a private charity that works by spreading knowledge and awareness of mental ill-health by introducing the extent of the problem and cooperating with the authorities concerned to improve the life and integration of this group into society. Even though the SSCA is referred to as the 'Saudi Schizophrenia Charity Association', the charity actually works with people with many diagnoses of mental health issues. The SSCA was not selected, therefore, because of any

specific diagnosis, it was chosen because it is the only charity in the KSA which offers community-based support to mental health service users and their families and delivered outside of mental health statutory services. This service is vital in supporting people by providing several programmes that assist Saudi people with mental health difficulties and their families to integrate and cope within the community. Accordingly, people's narratives of having mental health problems/difficulties and their experiences of accessing mental health services have provided the basis of the current study. Consequently, narrative in-depth interviews were undertaken with a group of people who suffered from mental health problems and were using the services of the charity and statutory services.

Power and Relations

4.6.2 The Impact of the Research on the Identity of the Researcher

In stage one of the critical narrative analysis (CNA), which is a critique of the illusions of subjectivity, the initial thought I had was: '*Is it fair to bring my own values and beliefs into my research study?'* (Langdridge, 2007). However, I realised that regarding the study of Langdridge's' CNA approach, it was possible to understand that acknowledging and reflecting upon experiences as a mental health nurse and lecturer is an integral part of the analysis process in the context of researching users of mental health services (Langdridge, 2007, p.140). The concept of *"illusions of subjectivity"* is also applied in this context (Langdridge, 2007, p140). As a mental health nurse and academic lecturer, I also have knowledge and experience in the mental health field and used this in the research when interviewing people. However, the concern as a researcher was whether using the position of authority as a researcher and interviewer may lead the participants to view somebody who has knowledge and understood what they were talking about in the light of professional experience;

as a result, they might not wish to openly share their accounts. Therefore, I was friendly and flexible with the participants in order to establish a strong rapport and develop a *'sensitivity towards each other'* (Russell and Kelly, 2002, p.75); as well as *'foster an I and-thou'* atmosphere (Buber and Kaufmann, 2013) that allowed the promotion of humanity between me and the respondents (Holloway and Freshwater, 2007). It was hoped that this relationship might generate an important empathy; although comparatively it was thought that it might be difficult to build such an effective researcher-participant relationship while interviewing male subjects, as some barriers may form, such as cultural and religious restrictions when being interviewed by a female researcher (i.e., feeling shy about talking with a female, or perceptibly not accepting female authority).

It was important to consider how Saudi male participants' cultural norms and social factors might function during the interview sessions. Bringing participants' religious cultural background into the interview was crucial, especially as I was strongly aware of and understands Saudi culture. The interview sessions were run smoothly and made into a comfortable experience for participants whilst bearing in mind the learning of Vygotsky's MCPT assumptions. This was done through respecting Islamic religious beliefs and customs, Arab's norms and values and Saudis' moral and cultural values. This was mostly achieved through carefully chosen language throughout the interview process and making a concerted effort not to judge anyone for their preferred beliefs and values. It was imperative that I maintained respectful professional relationships between the participants and myself.

For example, polite language was always used to address the participants and any language that could be perceived as disrespectful was avoided. I further avoided using inclusive or technical language,

such as gender-specific pronouns, to make all participants feel welcome and respected or jargon language that could confuse or alienate the participants. Other measures used before and during the interview were that a welcoming and relaxed atmosphere in the charity interview room was created by adjusting the lighting, temperature, and seating arrangements. Furthermore, necessary pauses and silences were incorporated to provide the participants with time to think and respond, showing active listening skills by making eye contact and nodding, whilst avoiding any judgement against the participants, together with their beliefs and values.

It transpired that most of the study participants were males (14 out of 20), who told their stories openly without creating barriers associated with gender. This may have happened due to my awareness of such problems and due to attempts to reduce restrictions as much as possible, as well as being flexible and friendly. As a mental health nurse, it is known that it is difficult to step outside one's own personal range of knowledge, experience and beliefs and view the relationship from an alternative perspective; hence, I inevitably brought my own assumptions into the research, as '*the researcher does not find the narratives, but instead participates in their creation'* (Riessman, 2008; Crossman, 2021, p.119). However, it was important to explore other people's experiences of accessing and using mental health services in the KSA with interest in learning participants' experiences and their means of access and use of mental health services. As a researcher, through taking the narrative approach, it was important to be aware of potential bias, although I was mostly concerned with providing people with a voice and listening to their experiences. Accordingly, CNA accommodates bias and facilitates the researcher to be reflexive to acknowledge presuppositions and 'illusions of subjectivity'. These stories offered a subjective perspective on experienced reality by the participants.

Finally, the aim was to consider the subjective accounts and was interested in phenomenological perspectives of the truth, despite people's stories (and the researcher's) never being completely objective, as narratives are also contextualised by culture and time (Holloway and Freshwater, 2007).

Consequently, reflexivity could be used to establish the trustworthiness of the research and to enhance the quality of the study. Indeed, I was aware of the significance of reflection into the relationship with the participants and on their own reactions toward the interview, which was subsequently used to inform the development of the study. This reflexive interest helped to understand my personal perspective and my way of thinking, and this reflexive understanding was able to help to form an emancipatory effect for the research participants as well (Habermas, 1978).

During the interview dialogues I considered the participants' stories with all the elements of emotions and meanings without ignoring my own position and feelings (Riessman, 2008). The coherence and meanings were interpreted, which pulled the parts of the story together. This method supported trustworthiness and made sense of the events. Hence, this analysis process became a co-construction of the narrative with ongoing reflexivity and critical self-awareness crucial to the quality and construction of the meaning of the research. Recently, self-awareness has been recognised as an essential component of reflexivity in narrative research (Holloway and Freshwater, 2007). Through narrative inquiry, reflexivity and self-awareness could significantly help to assess personal abilities, competencies and limitations, as well as to help to obtain feedback on one's own personal performance (Holloway and Freshwater, 2007). Various sources could assist in providing the required feedback, such as discussions with supervisors, a research diary and a reflexive

journal to help inform the Stage One analysis (‘illusions of subjectivity’). For instance, reflective notes were taken immediately after each interview, as it was difficult to take notes during interviews to prevent disturbing stream of participants’ stories. However, notes were also written, together with a diary and journal, retrospectively afterwards during the stage of data collection and analysis. This has been achieved by returning to all the previous notes and journal to read and re-read them frequently to explicit the hidden or uncovered meanings and context or to reflect upon my personal values and beliefs.

4.7 Ethics and Safety of the Participants

4.7.1 Consent

As part of the research ethics’ approval, I developed the participants’ information sheet and translated it into Arabic. The participants were contacted by the professional at SSCA via a phone call to provide the research with information, aim and to obtain their permission. Those who agreed to participate were invited to the SSCA location as part of their monthly routine visit. At this meeting, the agreements to attend a one-to-one interview were obtained after reading and discussing the information sheet. It was crucial that all participants were able to understand the purpose of the study, as this would ensure that they could provide informed consent to participate after a clear explanation in regards to their right to withdraw from the study or to stop the interview at any time. In addition, the participants’ mental and emotional conditions were discussed with the charity administration to make sure that all participants were not mentally or emotionally fragile to participate in the current study (see the inclusion criteria in Table 6).

4.7.2 Payment

Grocery coupons were provided to all participants in appreciation for their participation. Some of the participants were reimbursed their Uber fares to encourage them to be part of this study, especially those who had no cars, unable to drive or were unable to pay for alternative transport. However, this was not the case for most participants who owned their own cars and were able to drive to the charity premises.

4.7.3 Safety of the Participants

To guarantee the safety of the participants, I was able to contact the health team from the charity's clinics (comprising individuals with knowledge and professional backgrounds in psychiatric and mental health nursing, social work and psychology) if there were any issues, such as participant stressors that may occur during the interview sessions. The interviews, therefore, were conducted in convenient safe and private locations within the charity premises. In addition, in terms of my safety, relevant safety measures were taken during the interview session. The charity offered a security bell phone in the interview room in case help was required, and a security man was outside the interview room all the time (more details of the recruitment and interview process, including anonymity and confidentiality of participants are presented in box 1).

4.8 Method of the Narrative Interview

The participants were encouraged to convey their experiences in the form of a story or a narrative. A life-story method was adopted as a means of facilitating the material appropriate for narrative analysis. Therefore, open questions were used to enable the participants to relate as much information as possible regarding their experiences of access to mental health services in the KSA.

4.8.1 Unstructured interview Process

Box 1: Recruitment and Interview process

- The participants were contacted by SSCA's professional person through a phone call to provide the research information aim and obtain their permission.
- The participants who agreed to share in the study were given a preferred appointment time to visit the SSCA location (the charity).
- On the day of interview, I established rapport with the participant to create a comfortable environment and put the participant at ease. I welcomed the participants and offered them a seat and welcoming drink (Arabic coffee with dates, water or juice).
- At this meeting, agreement to attend a one-to-one interview was obtained after reading and discussing the information sheet.
- At the beginning of the interview, the participants were given time to read the information sheet (appendix D) again and ask for clarification if required.
- I then informed the interviewee of the importance of confidentiality and stressed the anonymity of names and data and assured that no feedback would be given to the care team, in or outside the charity premises for other purpose than the research.
- The participants were then asked to sign the consent form (appendix D4) after a clear explanation regarding their right to withdraw from the study or stop the interview at any time during the research.
- The participants were then given a brief introduction to the study and asked to narrate their experiences of their diagnosis as a 'mentally ill' patient, as well as how they used mental health services and anything that might facilitate or act as a barrier to their access to mental health services treatment during their journey of mental health difficulties.
- I conducted the interview in a conversational manner, to allow the participants to speak freely and without interruption. However, sometimes I used prompts to encourage them to share more information or to clarify a point.
- At the end of the interview, I thanked the participants for their time and contribution to the research.

4.8.2 Participants' Selection

The study population for the current research was comprised of people who experienced mental health problems (14 males and 6 females). The research was open to any of the service users of the charity who had not been in hospital for the previous six months and

who were deemed to have capacity to provide consent to participate in this study. The idea for not including people who had experienced a recent hospital admission was that of the research supervisors and the rationale was to avoid interviewing anyone who may possibly have been mentally or emotionally fragile. The service users were invited because they had experienced mental health difficulties and accessed and used mental health services. The research sought to explore the perceived reality of participants' experiences, and to hear from them regarding the possibility of feeling stigmatised by being diagnosed. The participants narrated their experiences: how they discovered they had mental health difficulties; the symptoms they had experienced; their reaction to both their experiences of those difficulties and the effects of being diagnosed; whether they immediately sought help via mental health treatment; and their attitudes and beliefs towards mental illness and accessing mental health services. A typical interview had an opening question, such as: "*Tell me your story about experiencing mental health difficulties…."*; whilst I sometimes prompted participants on the topics identified, with the interview remaining narrative in style.

4.8.3 Recruitment and Eligibility Criteria

Table 6: Participant Eligibility Criteria

	Inclusion criteria
	People with mental health problems
	• An adult, either with or previously diagnosed with any type of mental health problem, with the capacity to provide consent. • Is accessible (living in Riyadh city, where the charity is located). • No specific age or gender. • Only service users who had not been in hospital for the previous six months to avoid interviewing anyone who may possibly be mentally or emotionally fragile.

Exclusion criteria
• The study excluded any participant who was deemed not to have the capacity to give their consent. • Any person who had had a hospital admission (for mental health difficulties) within the previous six months.

4.9 Sample size

Sample size is generally important in most research studies as a reflection of generalisability. In narrative research, sample size is of less importance, as each narrative is free-standing. Holloway and Freshwater (2007, p.66) argue that a researcher should be committed to the fact that narrative research is inductive in nature and arises from *"specific instances to general statements rather than the reverse"*. They also clarify sampling and sample size, and suggest that the sample size does not need to be large, as it is based on the depth of the inquiry (Holloway and Freshwater, 2007). In the current study, the sampling method was convenience. This was because the participants were all recruited from one city (where the researcher lived as this meant that she able to access the participants more easily). In addition, the participants were all users of (and recruited via) the SSCA service. Despite that, this does not mean that these participants' experiences are 'atypical' when compared to the majority as each experience is unique and specific. Although the point of access was related to convenience, individual participants were not specifically chosen to take part and the study was open to any service users of the charity to participate. The fact that the participants were affiliated with the SSCA charity and located in one city raises the possibility that their experiences may be different from those who have not sought help from the charity or those who are in different geographical areas within the KSA. However, the fact that the study was open to any service users of the charity helps to reduce the potential for bias.

The research was conducted with twenty participants: Saudi people with mental health issues, regarding their life-experiences of their mental health disorder; the actual numbers were pragmatically determined. Indeed, the decision to select 20 participants was deemed to demonstrate a suitably sized study for a PhD study, which was made to capture the different voices that were convenient to the aim of the study; this decision was also supported by Sandelowski (1995, p.179):

> "*Determining adequate sample size in qualitative research is ultimately a matter of judgment and experience in evaluating the quality of the information collected against the uses to which it will be put, the particular research method and sampling strategy employed, and the research product intended*."

4.10 Transcription

As the interviews were conducted in the Arabic language, each of them was transcribed into written Arabic, with no attempt made to note any nonverbal 'gestures'. This transcription method is common in phenomenological research and is contrasted with more detailed transcription in discourse and conversation analysis. Langdridge (2007) argues whether the researcher should erase speech fillers, such as 'ums' and 'errs', and whether the narrative might be altered if colloquialisms or abbreviations were to be removed. I decided to remove all of these 'fillers', as they did not add to the narrative; rather they distracted from the meaning of the written word. The narrator's original quotes were also retained in the main text in italics and anything in note form in parentheses was clarified or explained for personal own use later in the analytic process. Additionally, I endeavoured to remain true to the principles of critical narrative analysis and stayed: "as close to the speech of the participant as possible" (Langdridge, 2007, P.74). In accordance, the audio data

were saved for use during the analysis stage to ensure accuracy and to allow potential checks for any incongruities in the written transcript.

Regarding ethics, the data were stored on personal password protected computers, while names and recognisable places were anonymised in the transcripts. The audio recordings were listened to in conjunction with the transcripts to ensure accuracy and to enable recollection of some of the non-verbal nuances. The audio recordings were saved on a password protected computer and erased from the original device. Once anonymised, all of the (Arabic) transcripts were directly translated by a professional English translator from Arabic to English in full. For quality, rigour and credibility purposes the English transcripts were subsequently reviewed by a fellow professional who is qualified in mental health nursing (PhD-associate professor psychiatric and mental health in King Saud university), and who is fluent in both languages (Arabic and English) (Birbili, 2000; Halai, 2007). Each line of transcription was numbered to enable referencing of quotations in the analysis, ensuring accuracy and rigour in the process. English transcripts were used in the analysis simply because the entire study would be written up in the English language. Subsequently, once in English the transcribed interviews in the English language became the 'dataset' for the current study. All subsequent analysis was conducted on the dataset in English.

4.11 Critical Narrative Analysis (CNA)

A CNA was undertaken on the data, guided by the theoretical framework devised by Langdridge (2007). This form of critical narrative analysis combines phenomenologically informed narrative approaches with critical theory to examine the ways in which narratives are constructed and how they reflect and reinforce power relations in society (Langdridge, 2007). Critical theory is a social and

political philosophy that critiques and transforms society and culture by examining power structures and domination. It seeks to understand the underlying forces that shape social and political relationships in order to promote social justice. As a phenomenological approach, the method respects individual subjectivity, and the narratives people provide regarding their experiences, which are taken as important accounts of human experience, beliefs and values.

This approach was selected for various reasons: firstly, CNA is an effective process, which utilises intellectual suspicion and critiques to raise questions about people's narratives (including the researcher's reflection of their values and beliefs). The CNA approach assumes that individuals always speak from a perspective, tradition, socio-cultural, or religious stance. Rather than viewing these positions as contradictory or mutually exclusive, a critical narrative analysis considers them to be complementary and open to interrogation (Stacy et al., 2016). Secondly, phenomenology and critical theory, according to CNA, inform each other (Langdridge, 2007). Thus, applying this form of analysis, enabled investigation into both how participants experience mental health problems and how issues of access to and use of mental health services play a role in those processes by providing a voice in the narrative approach. Thirdly, there is no published research in the KSA that has used narrative research methods to analyse the stories of people's experiences of mental health and to use mental health services in the KSA. Fourthly, the opportunity to conduct a critical narrative analysis on the data was informed by Vygotsky MCP theory, which helped to interrogate the cultural context of the study.

Furthermore, CNA involves employing a 'hermeneutic of suspicion'; a phrase invented by Ricoeur (1970) and later evolved by

Gadamer (1975), which presumes that all description is interpretive and that it is the researcher's role to use suspicion as a type of inquiry to uncover the underlying or hidden truths in narrative. Langdridge (2007, p.136) distinguishes two types of hermeneutics of suspicion: digging beneath the surface to find the hidden significance; and imaginative hermeneutics of suspicion, which in the current study uses Vygotsky's macro-cultural theory as a critical lens to generate "imaginative variation", while maintaining the narrative voice of research participants. I have used reflexivity on a regular basis to evaluate the researcher's own personal stance as a co-creator and audience to the narratives being told. The methodology and epistemological stance require investigation into one's own beliefs about the nature of mental health and stigma in the KSA and people with mental health issues. Overall, the CNA approach comprises six stages, which are presented below:

Stage 1: A critique of the Illusions of Subjectivity

I co-constructed and co-created the narratives after acknowledging my role and my own, beliefs and values in relation to the participants' narratives elicited through interview (Mitchell and Egudo, 2003). I was reasonably familiar with the subject area, but engaged with this through reflection on personal values and beliefs that identify one's own "illusions of subjectivity" to learn about one's self and the subject area, even before beginning to learn from the data (Langdridge, 2007). This stage consisted of reflexive writing about my position and experience that influence the captured narratives after reading, and re-reading through the dataset (the English transcription). This enabled the possibility to think about the meanings of the narratives in light of personal filters created by personal beliefs, values and prejudices based upon both personal and professional experiences, as well as ensuring openness to the text to explore the relationship and interpretation of the text in relation to

the participants. This reflexive process enables transparency and rigour in the analytic process.

Stage 2: Identifying Narratives, Narrative tone, and Rhetorical Function

This stage involves reviewing the transcripts to identify distinct narratives within the texts relating to the objectives of the study (Stacey et al., 2016). As an interview may contain one or more narratives, the researcher needed to read through the text/s and try to identify and describe the narrative(s). This was partially conducted by firstly identifying the tone – a form of listening beyond the text. It was also important to answer questions, such as 'what is difficult?', 'what is important to the person?' 'what is repeated and why?'. This provides insight into the meanings being expressed by the narrator and may reveal background information regarding the stories being told that are not necessarily apparent in the content of the text.

As an analyst in this stage, I read through the text again to identify master or grand narratives, asking myself questions, such as 'what message is the participant wanting to get across?' 'how does the narrator locate themselves in the story?' 'what is the plot in their story?'. It became possible to discover that most stories have more than one narrative, which was observed by finding new beginnings, characters or shifts to new events. Although I had the English transcripts to analyse, it was important to periodically refer back to the Arabic original to appreciate nuances in the narratives that may have been 'lost in translation'. There is no CNA in Arabic, and thus, in one way this was potentially the first study to have ever conducted this approach amongst an Arabic cohort of research participants. Therefore, the support, feedback and the scrutiny of the process by the supervisors was extremely important and added to the rigour and reliability of the study.

Once the narrative tone of each transcript had been established, I considered the narratives in the light of 'health narratives' identified by Frank (2002), such as transition-restorative, chaotic and quest narratives. This provided a way to consider the nature and meaning of each narrative and to identify the function of the narratives by defining what kind of stories have been told. Attention was paid to various rhetorical devices, such as metaphors and similes, or by using defensive justifications or opinions or positions that people adopted in their narratives (Langdridge, 2007, p.137). At this stage of the analytic process, I felt humbled by personal experiences as a researcher. Indeed, it must be noted that this form of research that is based upon the stories of people in society that feel marginalised is almost unheard of.

Stage 3: Identities and Identity work

This phase seeks to identify the 'self-being' that was present in the narrative, and to identify how participants construct and present their identities (Langdridge, 2007). As each narrative was read and re-read in both Arabic and English, it was possible to identify the identity claims made by each participant, especially in relation to the institution of mental health services and wider social institutions of the KSA. In this part of the analysis, it was crucial to identify how story tellers identify, express or describe themselves, and particularly in relation to their culture. This process was built upon the process of identifying rhetorical tone and function in Stage 2. Riessman (2008) offers insights in how to identify identity claims in narratives by asking questions such as: *In what kind of story does the narrator place themselves? How do they position themselves in relation to the audience? How does the audience position themselves in relation to the narrator? How does the narrator position other characters in relation to themselves? How do they position themselves in relation to themselves?.* These kinds of questions were asked in the light of

Vygotsky's MCP theory, as the responses were analysed with the use of social artefacts, together with cultural beliefs and concepts in their choices and decisions to access and use mental health care as a social institution. It is evident that Saudi culture is dominated by religion, although it was surprising that each participant professed more than one identity when it came to align themselves with contradictory models of western medical and faith models during their treatment process, while choosing to access mental health services in the KSA.

Stage 4: Thematic Priorities and Relationships

The researcher must identify the major (common) themes in the text without losing a sense of the narrative being told (Langdridge and Butt, 2004). The analytical processes were captured initially for all the participants (Castellanos, 2014), which was followed by a comparison of the themes identified from each narrative to consider the relationship between them (Merriam, 2002). It is critical to keep in mind the Stage One process and think about one's own views and beliefs regarding the topic. After working through the text, it was important to review, summarise and itemise all the ideas separately, in order for me to try to organise these ideas into clusters of meaning (Langdridge, 2007). All of this process provided guidance to run this stage of analysis smoothly, especially when working with the transcripts systematically and using qualitative thematic principles to approach the data by selective reading to discover key themes (Van Manen, 1990). At that point, I made entries in my research diary to reflect on my own ideas, values and beliefs in relation to the analysed stories. As emerging themes were identified, it became possible to begin clustering and categorising them, and to then determine the relationships between them (Langdridge, 2007, p.139). In total, ten initial themes were identified; and after further analysis (using NVivo software), and checking with the supervisors, four common themes were identified (see Section 5.3 in the findings chapter).

Stage 5: Destabilising the Narrative

In this phase, I engaged directly in a critique of the text by employing a critical theory (or theories) to interrogate the data (Langdridge, 2007, p.139). Accordingly, a phenomenological position arguing for a transcendental subject that can situate it outside all ideological positions is arguably naïve (Langdridge and Butt, 2004). As people, we are not only physically situated and contingent, but also socially, culturally and politically situated and contingent (Ricoeur and Thompson, 1981). At this stage I needed to complete the CNA circle, by returning to imaginative suspicion rather than turning on myself (Langdridge, 2007). To apply this stage of CNA, the text was scanned in light of Vygotsky's theory incorporating Ricoeur and Thompson's (1981) work. It was critical to engage with the narratives not only to discover the under-the-surface meanings, but also to make sense of what has been narrated using the 'imaginative suspicion' to interrogate the text. I endeavoured to uncover how the participants' narratives were relevant to the research questions. The complexities of the reliance on faith-healers and the impact of stigma were interrogated as significant barriers that could hinder people from accessing and using mental health services. It became important to understand the depth of these complexities in regards to Vygotsky's theories. The details of applying stage five of CNA will be presented in the discussion chapter.

Stage 6: Synthesis

The production of a synthesis of the study outcomes, which involves the researcher developing an analytical summary for all key narratives and themes, was based on the analysis conducted in the preceding steps. The final stage of CNA was applied in the conclusion chapter, which aimed to synthesise the findings in light of the chosen theories, and to identify the voices of the service users who were

participants in the study. The details of applying stage six of CNA will be presented in the conclusion chapter.

4.12 Reflexivity within Stage One of CNA

As outlined by Langdridge (2007, p.134), the first stage involved reflexive work on the personal experience that impacted the specific narrative. This reflection on my own values and beliefs was crucial, as it helped determine the '*illusions of subjectivity*' (Langdridge, 2007, p.140). CNA required exposing personal bias to make sense of the construction of the narrative captured, which helps to add clarity through thoroughness to the utilised technique. Stage one of the analyses would be to apply Ricoeur's (1970) term: '*hermeneutic of suspicion'* (Keane and Lawn, 2015); which was later developed by Gadamer (1975), which anticipates that all description is interpretive, and it is the researcher's job to utilise suspicion as a form of inquiry to uncover the deeper or hidden realities in the narrative.

As a researcher, reflexivity was used throughout the study and it was possible to develop awareness that the demand of frequent reflection is crucial, as in stage one, I endeavoured to critique my own values, beliefs and other perspectives as an audience and co-creator to the narratives that were being told. During this stage, my own beliefs were explored regarding the people who had experiences of accessing mental health services in the KSA, and how possible barriers, such as stigmatisation and other cultural and religious beliefs, could influence the access and use of mental health services in the KSA.

Additionally, it was expedient to put into perspective some factors concerning what it is like to be a Saudi female PhD nurse researcher in the UK in the 21st century studying mental health service users in the KSA. Being a Saudi female nurse pursuing a PhD

in a foreign country is not an easy experience, as it involves going against cultural norms that have a long-standing history of little support for the education of women (Miehls and Moffatt, 2000, pp.339-341). Nonetheless, recently there have been a number of changes, as over the last few years Saudi women have been given greater responsibility in society, as they have become part of a consultation body via The Shourah Council (Arabnews, 2017). In this body, there are thirty women members (out of its total membership of 150); and more recently, Saudi females have attained jobs as officer guardians (Arabnews, 2021). Thus, Saudi women can voice their opinions in the same way as the other male members.

Since the female involvement in the 2030 Vision, which was launched in 2016 by Crown Prince Mohammed bin Salman, the education of women in the KSA has received a great deal of attention, which has allowed Saudi women to make definite strides toward achieving their ambitions in different fields (Quamar, 2020). Saudi women have emerged, both at local and international levels, and have excelled in the fields of culture and specialised research with their achievements setting records. In accordance, Saudi women have recently been given highly responsible positions in public and private sector enterprises. The 2030 Vision now depends mostly on the workforce, rather than on oil that was the basis of the economy in the KSA and "*the Saudis finally understand that the economy will not diversify or reform without bringing women into the workforce*" (Arabnews, 2017).

As I consider myself to be a well-educated Saudi female with professional skills, I am in some small way helping to close the gap of education and economics as well, especially in recent times, as most of the barriers are removed from Saudi women's way of life. For instance, Prince Bin Salman has already proposed that one of those

obstacles – the longstanding ban on women driving – be abolished. As such barriers are removed, this enables women to keep their jobs, while saving money that was previously spent on chauffeurs (DAY, 2018). Consequently, the mental health field is quite involved, specifically in the amount of research work required in the KSA. However, it is an exhilarating feeling for a woman to be at the forefront of mental health research, coming from a country whose psychiatric research field has been underdeveloped for most of the last century (Koenig et al., 2014 .p113). In the 21st century there is now great hope for girls and women of Saudi origin who aspire to study and enter various careers, as it is becoming increasingly easier for women to pursue higher education abroad.

On a more socio-political aspect, for a long time the KSA has lagged behind on matters concerning mental health services, with almost no policies or legislation dedicated to this area up until the second half of the 20th century (Koenig, 2013; Koenig et al., 2014). This has been the result of inadequate research work in this specific field owing to religious and cultural perspectives on issues of mental illness. People in the country had a history of viewing mental illnesses from an external locus of control, in that such illnesses were beyond their capacity of aid, thus prayer and hopeful optimism about getting cured through 'inshallah' prevailed as a solution (Koenig et al., 2014 .p113). This is because they are mostly dominated by their religion and cultural norms, rather than medical treatment.

The function of this stage is to present details of some of the assumptions and biases that inescapably come with the researcher's analytic position as the primary researcher of the current study (Langdridge and Butt, 2004; Langdridge, 2007). Hence, the involvement of subjectivity in the research might be represented through two facets that have a direct bearing on what was observed,

organised, written and interpreted. The first, from personal experiences as a female researcher, meant that it was possible to be prone to imposing some personal feelings and experiences on the participants' transcripts. However, before commencing the study, I endeavoured to maintain balance by focusing purely on the participants' input. The second potential subjective influence would undoubtedly be experience of studying and working in the KSA. Owing to my cultural background, the subjective experiences, opinions and collective knowledge gathered over the course of my life put me in a somewhat compromised position in terms of partiality (Gergen, 2000). Being of Saudi descent, carrying out PhD research work in the field of mental health services might have predisposed me to lay emphasis on certain aspects of the participants' experiences that possibly resonate more.

4.12.1 Reflection on my Upbringing, Knowledge and Experiences

I am a Middle Eastern Arab, Saudi woman; a PhD researcher in Mental Health Nursing at the University of Nottingham, the UK (on a scholarship from King Saud University, the KSA). Before developing into this, I was my father's favourite daughter, who loved his songs and stories. These were not limited to bedtime stories, but were delivered all through the days of the week and the weekends as well. These stories were tales of the past and the culture and attracted me a lot, and I was with him in a fertile imagination of pictures, events and emotions. I grew more passionate about listening and reading stories when my beloved dad gifted me a series of reading books and audio stories every year during primary school. From all this, I learned to be a good listener, but unfortunately, I am not so good at telling others the stories. As a result, I was worried that this might affect my ability to retell my participants' narratives. I should be aware of script analysis to specify the underlying meaning clearly. Additionally, when

I was young, I did not realise that people's stories might lead to the things we were looking for: solutions to their problems, or at least initiatives.

Throughout my personal life I have always been a good receiver for other people's problems and stories. For example, as the oldest daughter in my family, I have always been the solution-finder for my younger siblings' problems. I think as I was reared as a responsible individual from an early age, this led me to be a good listener and, as many people in my life have said to me, a good analyser. I occasionally deal with other people's issues, and I have had many such experiences with students and staff during my work on the psychological counselling committee in my work at the King Saud University and as an academic counsellor. All of this has been reflected in my current research, through the story of the woman who had stimulated me in many ways, and which is the basis of this research. Even though she left me and did not expand on her story as a mental health patient, she made me more eager to hear more about those who are like her. However, I realised later through my supervisors that people's stories might open up and the things we were researching change, together with solutions to their common problems, certain developments or at least initiatives. In fact, what I had been doing for years was helping people spontaneously or professionally; I can see it now as a specific thing which needed more critical intellectual skills.

4.12.2 Reflection on my Data Collection Journey

In practice, twenty participants were interviewed: fourteen males and six females, all of whom were Saudi citizens who had accessed and used mental health services in Saudi Arabia. They were recruited via the SSCA charity and were all adults over the age of eighteen. Through listening to 20 stories through my research

interviews, I found myself sympathetic to the participants, but, as in the past, I struggled to find solutions to their complex problems. I subsequently realised that undertaking research is different to dealing with people's stories, which depended on their individual needs. However, this is not the case when undertaking narrative research, where finding the solutions or making the required change is a specific critical and intellectual analysis skill, which applies the 'hermeneutic of suspicion'. I describe myself as being caught between a sense of responsibility and a sense of empathy, and I can say that empathy is the catalyst and inspiration for the sense of responsibility and not being biased, that I hope will be the result in a clear picture at the end of this research.

As a researcher, the need to remain impartial and to present the material collected as objectively as possible is an obligation that is rarely, if ever, achieved. In my study, gender bias would seem to be inescapable, as the focus of the study puts the researcher in the same category as her participants as my feeling of empathy with the female participants that could potentially create a bias (Sarbin, 1986). Achieving impartiality on a matter that directly affects you, or has affected you, would seem quite a challenge, not only to the readers but also to the researcher (Gergen, 2000). The findings of the study cannot, therefore, escape an interpretation that circumvents the self-evident meaning to find traces, if not chunks, of bias (Langdridge, 2007).

In a situation where the participants' experiences draw similarities with the researcher's subjective experiences, it is quite easy for the interpretation and presentation of findings to be compromised due to instances of overlapping accounts (Smith, 2011). For instance, having a personal account of a relative who struggled with a mild form of mental illness and the effect that had on the

extended family unit, could be taken as pivotal in compromising the objectivity of the research, to an extent. Even though the relation was distant, a prior knowledge of mental health and the use of mental health services from a first-hand account play a small role in defining the direction of the study for a researcher such as me. Incorporating a hermeneutic of suspicion into the analysis of the narrative of my study has, therefore, been a crucial eye-opener to the possibilities of subjectivity in my work that I would not have factored in otherwise.

4.12.3 Reflection on my Values, Beliefs, and the Content of People's Narratives

As reflection is the first stage in critical narrative analysis, it is useful and fair for me to reflect on my own context of values, beliefs, fears and presuppositions during the process of the storytelling in terms of co-relation engagement. In fact, it challenges me to examine and understand the participants' narratives and the extent of their stories to the socio-cultural context of why? how? and who? I noticed that, as a researcher, I easily engaged with the participants' stories and quickly became absorbed into their own worlds, but maybe I am deluding myself. What gave me such feelings? I asked myself for a while whether this might be due to the sense of giving the participants a professional researcher's knowledge. All of that might have left me comfortable in that situation as, to some extent, this is my world and culture. During the interview sessions, I discovered their regions of origin through recognising their various Saudi accents, which I thought might build my prejudice toward them even before they started their narratives.

I based my learning experience on psychological theories, for instance: the socio-cultural and historical contexts that shape individuals and the creation of knowledge, and that this knowledge is the result of a complex combination of social and historical factors,

and social contact is based on language, norms, cultural, and historical settings (Hutchison, 2008). However, prior expectations are not always accurate. In my interviews, people from the western area (stereotyped as flexible, with broad minds) mentioned in their narratives that they had sought traditional, herbal treatments alongside faith-healer treatments, and had delayed accessing and using mental health services for, on average, one to eleven years.

In contrast, the findings from the participants from the southern area, who are traditionally simpler, generally uneducated people living in a huge, rural area largely dependent on agriculture, had not sought herbal or traditional treatments. This surprised me, but they had directly accessed and used mental health services in the KSA. As a result, I could deduce that through the attribution theory, when offering an explanation about why this happened, I could give one of two reasons: firstly, external attribution; and secondly, internal attribution. External attribution provides causality to an outside force and the person was not responsible for the event. An external attribution argues that the event was caused by someone or something external; internal attribution, on the other hand, assigns causality to circumstances within the individual. Based on that, the Internal attribution claims that the individual was directly responsible for the occurrence of events (Kelley, 1967).

The first group, who lived complex lives and frequently used the services, had external attribution, and did not reveal the internal attribution to access and use mental health services in the KSA. Therefore, they delayed their treatment for approximately 10 years, unless they were encouraged by other individuals, such as family or friends. Contrastingly, the second group were less well educated, which I think could easily lead them into not providing much thought to the access and use of mental health services in the KSA directly,

and thus, internal attribution that controlled their behaviour and treatment was not delayed. Consequently, my prior assumption regarding interviewing male and female participants was that:

> *''It might be difficult to build effective researcher-participant relationships while interviewing male participants, as some barriers may be created, such as cultural and religious restrictions, when being interviewed by a female researcher (e.g., feeling shy about talking with a female, or not accepting female authority); the interview session time might also become longer or shorter than when conducted with a female respondent''.*

In fact, the opposite happened, as this assumption was my own suspicion regarding male participants. However, the male respondents did not presented barriers and restrictions as I had anticipated, as they were open, flexible, and relaxed. There was one participant, though, who withdrew before he signed the consent form, stating: *"I don't like anybody to know my illness and exposing me to others, I hide my illness to live"*. In my opinion, he tried to express his own feelings toward mental health issues and social reactions toward his illness, as he felt stigmatised. In contrast, the female participants were less talkative, and I had to frequently prompt them to tell their stories during the interview sessions. As a researcher, I might stereotype females as not putting-up verbal barriers, or I might 'imagine' listening to more from them, as this study was inspired by a female person who felt stigmatised and ashamed about her mental issues, and who left me with no details about her story.

During my interview journey I noticed that most of the participants did not mention whether, at the onset of their mental health issues, they had sought help from faith-healers or traditional and herbal treatments before they accessed and used mental health

services, unless I asked them: *"Have you been to seek other treatment before you accessed mental health services?".* I had anticipated that they might be ashamed to mention the traditional measures in front of me, due to my professional experience; as a result, they might not wish to openly share their experiences of faith-healers or traditional help-seeking. They might also expect me to know that the Saudi culture is dominated by religion and culture, as such measures are considered to be basics in their society (Alyahya et al., 2020).

Throughout the interviews, I generally perceived my participants to be from two types: confident or quite/less confident. I think some of them became more confident when they reached the point in their storytelling from the start of the illness to when they started using the service. At this point they became more assured of themselves. Their identity, therefore, changed from an 'illness identity' to a 'service-user identity', and they felt at that point that they were ready to change and allow their voice to be heard by others. On the other hand, the other group were less confident about themselves, which might be due to the sense of instability in accessing and using mental health services in the KSA. Therefore, they might not have acquired a strong service-users' identity, as they had not accessed and used mental health services as frequently.

I have noticed that all my presuppositions have changed following data collection and my reflection work has been completed, which might be due to the little experience I have in narrative research. As I transcribed the stories from the study's participants, it is quite possible that through my choice of words I might have framed certain parts differently, due to my personal outlook on the subject. Even though this would seem to contravene the goal of objectivity that should be maintained, it is arguably inescapable, given that some

participants have different Saudi accents. Therefore, my role to transcribe the data was coupled with additional duties of understanding the meaning for some of the interviews held during data collection. It would be a surprise if my personal scrutiny as I undertook the research was adequate to satisfy all these possibilities of bias and imposition of subjectivity to the study material, therefore the results. I later translated the transcribed interviews into English, which may have also in various ways altered some of the meanings of the narratives.

4.13 Analysis of Data

In his work, Langdridge, focuses on the Greek word, *epoché*, which means to steer away from any presupposition or judgement with regards to that which is being examined (Langdridge, 2007). In this vein, it is important to ensure that the words of the interviewees are heard correctly, without the interviewer making their own judgements into what they perceive is being said. Importantly, *epoché* requires a new perspective to ensure the avoidance of any prejudgments. The analysis undertaken seeks to allow the subjects to explain themselves and their stories, whilst the researcher sets aside their own attitudes (Langdridge, 2007, p.17); therefore, through such an approach, I aimed to be bias-free when it comes to explaining the story communicated through the narrative, ensuring objectivity. More specifically, the researcher separates their own knowledge and experience when it comes to identifying or inferring the benefits or hindrances linked to the narration; this is achieved to ensure the understanding of the individuals' experiences by removing any prejudgement from the results. As a specific example, when completing the analysis, the researcher should not reflect upon their own experiences of other mental health patients describing similar experiences or feelings and deduce her own conclusions, but rather should really listen to what is being said and derive findings from that

only. Hence, sole reliance should be directed towards the participants' statements.

CNA sits within interpretivist and constructionist paradigms. It is argued that these approaches are essential in understanding the meaning of people based on the difference in cultural background, race, and social norms and to help explain social contexts (Saunders et al., 2019). When it comes to data analysis, the researcher seeks to identify subjective meanings from the narrative of each participant and to acknowledge that in that process of analysis, and writing up, the researcher's interpretation of each narrative is unique (Cohen et al., 2018). Narratives are constructed by each participant and interpreted by the researcher of acquiring new knowledge, rather than to prove facts or hypotheses (van der Walt, 2020). As little qualitative research has previously been conducted in the KSA, my interpretation through the analytic process is of most importance in order to create a rationale thesis regarding the phenomenon of accessing mental health services in the KSA.

4.14 Writing up the Analysis

Following the analysis of the data from the audio files and the writing up of the transcriptions, as Langdridge (2007) suggests, it was endeavoured to privilege the voice of the narrator. Quotes from the original transcripts were used to illustrate and underscore findings; each participant's name was changed; places mentioned in transcripts were anonymised; and each transcript was written up in the same format using Langdridge's CNA framework, which involved the identification of narrative themes as adopted by the interviewees, along with highlighting the various cues and identifying markers. The analysis detailed the various themes established as present in the interviewees' narratives, detailing a variety of quotations and statements made by the subjects to support my conclusions as to the

type of narrative adopted by each of the individual participants. Correspondingly, identifying narratives and narrative tone is crucial during this stage and it is done while reading through each participants' transcript. Each transcript was read and re-read to pay attention to the descriptive words the participants used. Moreover, the most common adjectives and other describers that related to key concepts were highlighted, for example: faith healer, stigma, trust, medical, belonging, etc. During that stage, I attempted to discover how their stories narrated to extract the main narrative in each story. Following that I endeavoured to provide these stories with a certain level of sense by examining a narrative tone that was being expressed through the stories with analysis of the actual words and careful listening of the audio recordings.

4.15 Conclusion

This chapter has provided an overview of the methodology that has been implemented in the current study. The first section discussed narrative theory, with the recognition that the approach stems from the individual's own need to derive understanding from their own experiences using storytelling, highlighting change, process, and time. This was all located within an interpretivist paradigm. As with any research method, there was a need to consider the ethics of the study and any implications and/or negative effects that the implementation of the study could have on the research participants.

Following consideration of ethical factors relating to the research, the design of the study was outlined based upon a CNA approach, as presented in the 2007 work by Daniel Langdridge. The process of data analysis adheres to stages of narrative analysis based upon the audio files and transcriptions. The analysis was written up through establishing the narrative themes demonstrated by each of

the participants, with examples of statements and citations provided to support the markers indicating themes. During the process of recruiting participants, interviewing, recording, transcribing, translating, analysing and writing up the study analysis I was constantly aware of Vygotsky's macro-cultural factors to inform each step of the research. For example, mutual trust that was established through careful listening and expressing understanding of the individual's culture and story. In the role of researcher, the individual's 'zone of proximal development' was entered as each story was told that adhered to the qualitative research form, which is rare in the KSA; while narrative research is even rarer. During the interviews, I experienced a sense of privilege and was able to break new ground with this unique approach.

Chapter 5: Findings

5.1 Introduction

Having introduced stage one of Critical Narrative Analysis (CNA) in the methodology chapter, this chapter explains the following three stages and analyses each of the twenty narratives utilising CNA stages 2, 3, and 4. Each analysis adheres to the same format to preserve structure and consistency, as well as to guarantee that one participant's narrative is not privileged more than another.

These CNA stages will be presented in this chapter as follows:

- Firstly, by providing a brief introduction for each participant and an indication of any specific characteristics. This is referred to as presenting a 'Grand or Master Narrative'. According to Frank (1995), when a researcher identifies the Grand Narrative, they are able to gain a better comprehension of how cultural and societal elements may have impacted the participant's experiences and how they are shaped by cultural, social, and historical aspects.

This then moves to:

- Stage 2 - Identifying narratives, narrative tone and rhetorical function for each participant;
- Stage 3 - Identities and identity work;
- Stage 4. Thematic priorities and relationships

A full interview for one participant is also included in Arabic and English (see Appendix E)

5.2 Service Users' Narrative Experiences

5.2.1 Critical Narrative Analysis: Faris

Faris is a male Saudi citizen from Riyadh city. He was an executive secretary prior to experiencing a mental health issue; currently he is working as an ambassador for mental health at a Saudi charity. Faris has an interesting narrative regarding many events, and give the sense of deep meaning. Faris has started to access mental health services after ten years by himself, after long and painful conflicts with incorrect judgments and beliefs from family, culture and society. Indeed, as he considers the community in the KSA to be dominated by religion, he recommends a combined treatment of medical professionals and faith-healers.

In this narrative, Faris uses some metaphors and aphorisms, such as 'I divorced the stigma', amongst others.

Stage 2: Identify Narrative Tone and Rhetoric Function

In Faris's transition-restorative narrative, the extract with a theme at the end of the story expresses a new beginning (Savage et al., 1996). Faris was a logical and chronological storyteller from the beginning:

'I was sick at the age of 12.'

'In 2010, I travelled to...'

'In 2011, along with my family ...'

'In 2013, I headed to …'

'In 2016, it was the turning point.'

There is a significant occurrence of emotive words in these statements:

'I was suffering, feeling abandoned, I was so confused because of my mental illness.'

'I was feeling at risk, I felt that was the alarm just before the crisis happens.'

'I became so unaware of everything.'

'I decided to leave this 'stigma' and defend myself.'

'… That is why I divorced the stigma.'

Faris, in his story, is a protagonist who has no power over the common belief of a society ruled by wrong beliefs:

'…the religion is over the science and that was the main reason behind my cure delay… I was a victim of society culture and lack of knowledge…'

However, when Faris acknowledged that he felt like a victim of prejudice, stigma and discrimination, he started to know that he had to take control:

'I had two choices: either to finalise my life or find a solution to my issue.'

As his consciousness centred on what was going on around him, Faris sought to express his tragic experiences through emotions.

'They used to call me "the dead one who has no life"; my house was really made of glass. I can't hurt anybody when they hurt me—I mean my relatives and family.'

The enormously strong feelings of conflict and regret can be identified in his words. The use of dramatic vocabulary, such as

'blame', 'suicide' and 'death', reveals a tragic tone with a sensitive emotion in his discourse:

'No-one helped for 30 years…'

'I cried so much … I said they are lying to me because they don't really want to help me...'

All the mistrust and suspicious feelings experienced by Faris are mainly due to fighting the stigma, removing the passivity of doing nothing himself, and being either dependent on his family's false help and their wishes, or waiting for an external miracle to save him.

Notably, however, this tragic tone was gradually replaced with positive words, indicating transition:

'After that, I regained my self-trust again by keeping the therapy and the support of the Saudi association and their rehabilitation; I started to learn from the beginning…'

This particular statement highlights the way of Saudi culture and the way in which it seeks to solve problems of mental health.

In the latter part of the story, a new tone of transition and restorative narrative is detected:

'The Chairman was the inspiration reason for me…'

Negative words are replaced with positivity:

'I am looking forward to having a Nobel prize because of my writings, which I am planning to translate into English.'

'Now, I have a goal…'

The function of Faris's story appears to be a transition-restorative narrative from weakness to positivity. Faris used various

rhetorical devices to signpost the role of victim, which gradually changed to a restorative, powerful role:

'They called me "the dead one'' and said my house was "made of glass''.'

Here, Faris used both simile and metaphor to express his feelings of victimisation and weakness when arguing with his family regarding accessing mental health services and no longer seeking unauthorised faith-healers.

Stage 3: Identities and Identity Work

Faris described himself as a victim of societal beliefs and culture; he sees himself as a self-made person, who made up his mind by himself to become a better person. Faris's narrative identity represented the transition from victim to victor, as discovered through the strength of his optimistic emotions, passion and fighting the stigma (Mishler, 1986). He also found himself as a victim of a lack of knowledge:

'I knew then I was a victim of ignorance; I was having a hard time of struggling.'

The strength of cultural and traditional beliefs and ideas overtook him, especially as he was feeling weak. This happened due to Faris's inability to argue with his parents, as they should be respected in Islamic religion, cultural and traditional norms.

Faris separated himself from the illness twice, as he might have either been disoriented from his illness, or he may have unconsciously used separation as a defensive mechanism. To justify himself and present the reasons for this, he said:

'I was the victim of a lack of knowledge of everyone—me, society, even the doctors and faith-healers, and the KSA's society is dominated by religion.'

This may form a spiritual identity and may be due to prejudice, ignorance of true religious provision or lack of skills or knowledge in dealing with people with mental health issues.

Ultimately, Faris portrays himself as a winner over his past, who would overcome even this present situation:

'I didn't recognise I was even a victim until today…'

Faris was seeking a friend to whom he could speak:

'I really needed someone to listen to me.'

From Faris's narrative, it appears that his main barriers to access mental health services are family, cultural and traditional beliefs, lack of knowledge, or people's ignorance. However, Saudi society is dominated by religion, which comes before science and medication. This could indicate that the spiritual identity seems to be significant in the KSA.

Stage 4: Thematic Priorities and Relationships

In this narrative, many correlated themes have revealed the theme of social stigma and how mental health patients cannot be at peace in a society ruled by theological principles and traditional customs. Furthermore, a theme pertaining to the influence of faith-healers alongside the common belief as a first rescue and its importance in terms of manipulating the KSA's cultural domain has also been emphasised. In addition, Faris highlighted the theme pertaining to feeling like there is a lack of support and feeling of belonging, with Faris emphasising the perception that he was being

lied to by those closest to him and that they did not sincerely seek to help him.

The below statements provide specific examples of the themes recognised to have emerged throughout the narration provided by Faris. For instance, in regards the lack of support proffered by Faris's family, the subject made the following comment:

'No one helped you for 30 years...'

The above comment can also be taken to identify a theme concerning a lack of belonging and family support. In addition, this theme was also identifiable in other comments made by Faris, as shown in the following:

'I really needed someone to listen to me.'

'I cried so much … I said they are lying to me because they don't really want to help me...'

In addition, the theme relating to family relationships across Saudi society can also be seen when examining the comments made by Faris as follows:

'They used to call me "the dead one who has no life"; my house was really made of glass. I can't hurt anybody when they hurt me—I mean my relatives and family.'

'I knew I was a victim of ignorance.'

Another theme is the influence of faith-healers in the common belief as a first rescue.

'…my family's trying to heal me with uneducated traditional healers … saying it brings me more demons…'

The narrator seeks to share his pain:

'I really needed someone to listen to me'.

Thus, a lack of belonging and support is another theme discussed in this narrative. This can, as shown by the above statement, stem from a lack of understanding and education in the more traditional use of faith-healers as the first and primary point of call in dealing with such health issues. This presents a further theme in the individual's narration, notably that of the influence of faith-healers.

5.2.2 Critical Narrative Analysis: Bashar

Bashar is a male Saudi citizen from the Western region of the KSA. He accessed mental health services directly after seeking help from faith-healers at the beginning of his illness. His family does not accept or support his illness, but they encouraged him to seek traditional treatment. He considers cultural beliefs and traditional measures to be barriers to the access of mental health services. Throughout his narrative, he expresses his feelings of victimisation and racism; however, he was keen to express these emotions (mainly through facial expressions) and to tell his story, including minor details and situations that occurred, until he accessed mental health services.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

In Bashar's struggled, fragmented and incoherent narrative, which is predominately full of moments of struggle and a feeling of belittling, a lack of self-confidence is strongly detected. Repetitive words and sentences are used when describing the past and present

situation, with rehearsal-telling used to describe his narrative plot (Frank, 1995).

'I have been doing better, little by little. Doing better means it does not happen daily…'

'Quit the treatment. Quit the treatment.'

Bashar's narrative is full of mixed tones, anxiety, and an intense narrative mood full of loquaciousness and garrulous, talkative sentences.

'I was in a shock by my diagnosis, a shock it was, but the work's owner came by me and said to me: did you hear him? you did with your ears, then the work's boss started to love me more and more, he started to be next to me more and more, then and the manager offered me to work for his father…'

In his search for affirmation, an extremely negative, emotionally charged tone, filled with a detailed descriptive style, is seen throughout the narrative:

'…that was the start of my illness. I was so tired, tired and I used to cry, cry. I do not sleep at all, do not sleep at all, used to over-think, over-think, until I had a severe headache, as if someone was beating my head, as if someone is hurting the part of my brain, a very bad pain. I could not speak to anyone, to the point that I could not sleep.'

Repeated words are used, it would seem, as a rehearsal device to re-tell the events of the past to provide the audience with a clear picture of what was going on (Savage et al., 1996).

Bashar developed the sense of restitution narrative:

'I became aware that, without treatment, I could not survive. I became aware and convinced that the treatment is my life, which I appreciate, so I worked, so I persevered on receiving my treatment... At the end of 1430, (2009), I got a job in the civil service … I worked for them, and I worked in this service. Thankfully, I started my first year of administrative communication…'

Long sentences took up over more than half the interview; however, the restoring function (Frank, 1995) returned to Bashar's narrative:

'I stopped the treatment, stopped the treatment, divorced, and then gradually returned to the job.'

'I did not know that this Schizophrenia Association exists … I am currently receiving my treatment here, I am currently receiving my treatment here, thank God, I will be normal thanks to this treatment, this treatment will help me out to be very normal.'

These repetitive, emphatic words reveal a highly strong will, and hint towards a restitution narrative as the core of Bashar's discourse (Frank, 1995).

Stage 3: Identities and Identity Work

The anxiety that Bashar constantly experiences highlights the contrast from his former life as a respected civil servant:

'While I was with the work's owner, my uncle came by and said to the boss, he is your servant.'

From this statement, it is clear that Bashar felt as though he had lost his identity as a professional person, as he is in second place as a servant.

Further:

'…I felt the manager was a kind of racist, so I had a fight with him, and left the work.'

The loss of self-esteem was highlighted in Bashar's experience with his work boss, which took approximately two pages of the whole interview, and concluded with feelings of regret, grief and bitterness:

'He told me on a very crude tone, you come back to work then you get your rights, so I left the work … Then I noticed my picture in all the local newspapers and that I was fired from work, and people started to talk and ask about me. I felt angry and said that when someone ask his rights, you disclose him to newspapers? I had no choice but to file a suit against the boss.'

An emotionally charged tone is apparent at this stage:

'I left the Emirates premises crying … It was a kind of racism…'

There are around two pages concerning Bashar's professional experiences. In the below quote, the situation suggests the work's owner and his father were begging him to work for them:

'…We want to deal with the minister's work, so I said that I am okay with that, but I do not want to leave my work.'

'I will do a part-time job, organise all the work, organise all the work. I had the expertise from my previous job position at the Ministry of Industry … I had the Business Administration expertise, and my wage was 1500R. It was not considered a wage—more like a recompense. I accepted that salary because I was young. I was energetic and sick back then.'

Describing his professional experiences in this alarming manner, and paving the way to elicit two instances of being a victim

of racism, reveals that Bashar is using justification as a defence mechanism in regards to his illness:

'I left work … and went to the hospital. I assume I was not feeling okay, but I was not responsible, and thank God, I was discharged in that case.'

From Bashar's narrative, it appears he constructed a social relational identity that formed the feeling of racism and negativity patterns (Mishler, 1986).

Stage 4: Thematic Priorities and Relationships

There are several interrelated themes in the current narrative. The narrator has been dealing with issues relating to his family, who are perceived as being unsupportive and unaccepting of his illness, and who notably called for traditional assistance. They appeared to be non-supportive, and predominantly influenced by the cultural customs and traditions adopted in the KSA.

'I felt the manager was a kind of racist, so I had a fight with him and left work.'

'I stopped the treatment...'

'While I was with the work's owner, my uncle came by and said to him, he is your servant … I left the premises crying … I felt it was a kind of racism against me.'

Themes related to social class and rank, racism and discrimination are also revealed. Importantly, a theme pertaining to a lack of familial support can also be identified when considering the fact that Bashar's uncle put him forward for work despite suffering from mental illness, and by so doing, and with the statements made, stimulated in Bashar further negative emotions and self-perceptions:

'While I was with the work's owner, my uncle came by and said to the him, "he is your servant".'

5.2.3 Critical Narrative Analysis: Kareem

Kareem is a male Saudi citizen from Riyadh. He is a quiet person whose family encouraged him to access mental health services directly, as they accept his illness and believe mental illnesses to be treated to the same level as any physical disease, and they did not believe in mental health stigma. The family also supported and encouraged him to take his medication, which helped him to accept him situation and his mental health issue. Kareem used a combined treatment of medical and faith-healer treatments, and he believed that most of Saudi society was accepting of mental illnesses and people with mental health issues; this could reflect his family's beliefs. Kareem's narrative was told slowly and reflected his optimistic view and confidence in himself and his family support.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Kareem's quest narrative told of a struggle and in him seeking a remedy (Frank, 2002); looking for a better future by working on his presentation and learning from his past experiences through analysis, illness acceptance, and taking stable steps to become better:

'I discovered my illness a while ago, when I was 15 years-old … I had schizo-affective disorder, changes in my mood. It was not constant. After ten years, when I was twenty years old, it became chronic. I started consulting a doctor, who told me that I had sentimental schizophrenia, a disease like Alzheimer's, diabetes, colds, cough and blood pressure.'

Another captivating element in his narrative can be seen when he discussed scientific treatments, as suggested by his family, before calling out faith-healers and other treatments:

'…my father told me that he noticed that I was not sleeping well—how about we take you to a hospital. There are a couple of competent doctors who can take care of you and treat this insomnia. I felt better and better.'

Kareem's narrative is sincere, honest, and encouraging, and has an emotionally positive tone. He is serious when describing his illness and talking about his feelings versus his ideas:

'…both the Muslim faith-healer and doctors confirmed that I had mental health issue ...'

'I had voices, as if I am being watched and sitting with someone else who was reading my mind.'

'I used to see fantasies and hear voices.'

He is positive, honest, and encouraging as we are progressively discovering the facts, details, reasons, and results. Brief sentences are used—an epitome of confidence and strong desire to feel better, highlighting a positive-restorative tone.

Throughout the story, from presenting a general idea about his mental health issue through to the discovery status, then climax, then adapting, recovery period, dates are given, and succinct and descriptively accurate situations are related with a highly sparse tone and short sentences:

'In 2006, I was at A complex hospital, and in 2005 I was at M Centre, and before that I was at X psychiatrist in 2004…but when I was 28 years old, the disease became chronic.'

'…My family does not say anything. They used to say we all get sick, we all get diseases, whether psychological or physical',

'I am doing great—and better than before. Ten years before I used to feel that I am being watched and followed. Thanks to God and the treatment, I do not care anymore about voices.'

'I advise people to continue receiving their treatments if they have chronic diseases…'

'… now I am learning and have a better understanding about my disease thanks to the hospital.'

Kareem's tone is one of encouragement and optimism, full of hope and willingness, and encouraging the mentally ill to develop insight into their illness and commit to their treatment. His language adopts the tone of one who was rescued to become a rescuer (Frank, 2002).

Stage 3: Identities and Identity Work

Kareem pictured himself as conscious, responsible, and a strong hero with an understanding of his mental health issues (Mishler, 2004):

'At the beginning I was normal, but then it became chronic...'

'I used to hear voices…'

'Things get worse, and the disease became chronic and had to go to the hospital…'

'I received treatment … and felt better after that.'

'…it has a bad influence on my work … but the association promised to help me out in finding the suitable job.'

He also identifies himself as being aware of and familiar with the characteristics of his 'disease'. In these sentences, he mainly identified with his skin colour and uses a simile to emphasise the underlying meaning of fluctuation in committing to treatment:

'*…the fluctuations are like those in the skin colour; if I am not sick my skin colour is normal, if I start hearing voices my skin turns darker … if the voices are no longer heard I turn back into my normal colour…'*

'*…hallucinations are the main cause of insomnia and moody characters…'*

Kareem represents his desire to have a friend that may have indicated a recovery of his social identity (Mishler, 1986):

'I want to have friends, but my disease prevents me.'

Throughout his life story, it is easy to identify Kareem as a patient who spends time looking within himself and understanding his disease, and positively dealing with it. He knew how many hours he could work:

'I can't work more than 8 hours per day, and I want to reduce them.'

'I prefer companies where I can work 5 hours per day.'

Kareem identifies himself as an erudite storyteller with a dialogical identity from the beginning of his narrative, and his performance captivates the audience encouraging identification with his presentation of his family and the support he receives:

'*…it's not the end of the world if no one loves you, or hates you, doesn't give you importance. Live your life as if you are normal. Don't you worry. You are okay.'*

'For me, it is normal if I receive the treatment all through my life; it is good to receive a treatment - it won't harm.'

Finally, analysing his mental health issues and its drawbacks, and his perseverance in having received treatment throughout his life, can be summed up from the last sentence of persistence and determination.

Stage 4: Thematic Priorities and Relationships

This narrative has related themes starting from the influence of faith-healers and their importance in manipulating the KSA's cultural background. They appear to be as equal as the scientific perspective when dealing with medical assistance.

'Both the Muslim faith-healers and doctors confirmed that I had sensational schizophrenia'.

'For me, it is normal if I am receiving treatment all through my life; it is good to receive a treatment - it won't harm.'

This narrative also shows the inter-relational boundaries within Saudi families:

'My family does not say anything, they used to say we all get sick, we all get diseases whether psychological or organic.'

'I advise people to continue receiving their treatment if they have chronic diseases throughout their lives.'

The theme of supportive family has been revealed from Kareem's narrative. This is also made apparent in the following statements made by him:

'…my father told me that he noticed that I was not sleeping well—how about we take you to a hospital. There are a couple of

competent doctors who can take care of you and treat this insomnia. I felt better and better.'

Importantly, themes pertaining to a lack of education and support in regards to mental health were not only seen to be missing from this narrative, but were in fact found to be in opposition. As examples regarding the complete non-presence of any theme pertaining to stigmatisation, the following statement can be reviewed:

'…now I am learning and have a better understanding about my disease thanks to my family support and the hospital.'

Furthermore, in relation to a lack of help and support, the opposite was also found to be the case in Bashar's specific experience, with his employer proving to be accommodating:

'…it has a bad influence on my work … but the association promised to help me out in finding the suitable job.'

Comparatively, however, a lack of relationships has been echoed in the narrative:

'I want to have friends, but my disease prevents me.'

5.2.4 Critical Narrative Analysis: Hameed

Hameed is a male Saudi citizen from Riyadh. He was previously a drug addict with mental health issues. His family encouraged him to seek a faith-healer for help before he travelled abroad to seek a 'magician's treatment'. Subsequently, he received faith-healer treatments for about a year. He delayed accessing mental health services due to his feelings regarding labelling and discrimination. He, though, accessed private mental health services for four years in response to his cousin's recommendation. At that stage, Hameed was satisfied with private services; however, due to medication costs and

a lack of insurance, he stopped taking medicine for a year, which caused him to relapse. Finally, he agreed to statutory mental health services supported by his family after four years of numerous treatments and attempts to access help.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

It is clear from Hameed's chaotic narrative that he rotates between the idea of being a mentally ill person and a drug user:

'…some periods I used to be slightly ill and then I travelled abroad and used to be a drug consumer; and hearing voices increased.'

The narrative picture, of a patient who had schizophrenia and a drug user, all mixed together in one person who seemed helpless, with no mention of any family member's strong presence, except his mother and cousin, said:

'…voices you are hearing are hallucinations, you are mentally ill…'

'My cousin helps me to go to the hospital.'

The people around him showed no support and Hameed felt alone with his decisions in life. This narrative involves digging deeper to understand the past, analyse the present, and find hope for the future, especially as there is no definite or direct description regarding his feelings.

Overall, the indifferent tone to Hameed's narrative revealed dark narrative elements of secrecy, passivity, submission and at times, callous behaviour (Frank, 1995).

Hameed's indifferent tone is depicted in his brief sentences and uncertain vocabulary used throughout his narrative:

'I felt like a woman is over me',

'…maybe 16 or 17 years-old',

'I went back to the magician…then I decided to take the medicines…'

'I am not sure, maybe, I feel it was normal…'

'I am not sure, I think it will go away…'

'…maybe three months after I came back from Morocco…'

'…They said that I have schizophrenia or something like that, I don't know, but I think, in their diagnosis, they said schizophrenia and gave medicines.'

Hameed's secrecy is portrayed initially in his opening discussion about being a drug abuser without emphasising the causes and reasons behind his 'disease', not even mentioning his general knowledge about his difficulties, despite stating the following:

'I am taking advantage of this, although I have sufficient ideas about my disease.'

'I can feel it, and I know everything.'

Not being specific about the details of his mental health issues made Hameed's narrative incoherent and not easy to follow, which further meant I needed to ask many questions of the narrative, which without questioning remained perfunctory and sketchy. In total, more than thirty questions are asked in order to draw out the whole picture. Furthermore, the submissive and callous behaviours and

question/answer discourse suddenly changed into a decisiveness, where Hameed wanted to take control over his life in order to feel better and receive treatment.

The narrative then adopted a restitution tone (Frank,1995) with words and phrases such as, *'I do not know', 'I am not sure', 'Maybe', 'I do not think', 'so' and 'something like that',* being replaced with phrases, such as: *'I am working on receiving the treatment', 'Yes, I am receiving it', 'With the treatment I feel better', 'Yes, I take part of the conferences', 'Yes, there many advantages', and 'Now with the treatment, thank God'.*

Stage 3: Identities and Identity Work

Hameed has not directly identified himself and makes the listener throughout the narrative feel that he is somewhat submissive to fate and destiny, but hints that Hameed is a confined person who does not tell us everything (Mishler, 1986).

In the beginning:

'I feel a woman over me …' then: 'I hear voices…'

and after that:

'I am a drug consumer,'

'I am seeking treatment from magician in M,'

'… actually, I asked for drugs in M.'

'I was trying to get a doctor's help.'

'I am back to the clergymen,'

'…now I decided to go to the mental hospital,'

'Friends want me to consume with them.'

'…after calculating all my expenses, I have decided to regularly receive the treatment.'

Finally, after such desperate outpourings, the narrator started to use more confident statements regarding the enlightened part of his life, almost as if he is avoiding the darker ones. Less uncertain words are used, along with direct answers without twisting concepts, and self-discovery later on in the interview:

'I sometimes try not to avoid it to know what it is and try it…'

'…The problem is that I am sure if it is true or wrong…'

'…but I do not go after danger; I just try voices in an easy way with being risky.' '…Before, I was absentminded. I did not think about anything, but, after receiving the treatment, I became more aware and feel…I feel like had no feeling before.'

Hameed finally identified a healer-seeker identity (Mishler, 1986) in an evasive and self-effacing way through his experimental techniques with language, which are centred on discovering the nature of his problems and the decision to become better.

Stage 4: Thematic Priorities and Relationships

The main theme to emerge is the influence of drugs on Hameed, combined with a lack of knowledge and the seeking of a magician to help as a refuge to deny his mental health issues.

'I am seeking treatment from magician in M.'

'Actually, I asked for drugs in M.'

His family was failing to support Hameed in taking medicine and stopping his drug addiction; they referred him to a faith-healer, as usual. His health deteriorated and he had to return to determination in an effort to feel better and receive treatments. Due to medical expenses, Hameed became overwhelmed with medication costs and drugs.

'I sometimes try not to avoid it to know what it is and try it.'

'The problem is that I am sure if it is true or wrong.'

'But I do not go after danger, I just try voices in an easy way with being risky.'

'Before, I was absentminded. I did not think about anything, but, after receiving the treatment, I became more aware, and I feel… I feel like I had no feeling before.'

However, there was an example provided in the narrative of Hameed that shows some degree of familial support:

'My cousin helps me to go to the hospital.'

Moreover, in regards to treatment, there seems to have been a combination of inclination to opt for more traditional and conventional help and then that of more modern-day practices. This can be seen in the fact that Hameed's family referred him on to a faith-healer, which is common in Saudi culture, with hospitals and drug medication then sought:

'I went back to the magician … then I decided to take the medicines…'

'I am a drug user,'

'I am seeking treatment from magician in M,'

'… actually, I asked for drugs in M.'

'I was trying to get a doctor's help.'

'I am back to the clergymen,'

'…now I decided to go to the mental hospital,'

'… after calculating all my expenses, I have decided to regularly receive the treatment.'

This demonstrates the theme concerning the influence of drugs on him, in addition to a complete understanding of knowledge and the desire to seek out a magician to help as a means to rejecting the presence of any mental health issues.

5.2.5 Critical Narrative Analysis: Mansour

Mansour is a male Saudi citizen from the southern region of the KSA. He is a gentle person with a low level of education, who did not seek any traditional treatment, but rather he has accessed mental health services directly. He is retired and responsible for a large family of 13 people. On the one hand, Mansour has various burdens as a result of his mental health issues, in addition to physical illness and life/family burdens; however, on the other hand, he accepts himself and his mental health issues, and his family accepts his illness as well.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

In Mansour's quest narrative, there is a constant search for solutions to maintain control over his life and to overcome his periodic anxiety (Frank, 2004). Meeting him made me feel anxious as a result of the brief sentences he has used to describe everything and nothing:

'…The disease is over-thinking. It is lack of sleep. Sometimes I do, sometimes I do not. I have spent two months not sleeping.'

'…Maybe 10 years ago …12 years, I think'.

'I spent one day, maybe two days.'

His narrative is one that required me to read and re-read, to go over every sentence, word, intonation to interpret the feeling, despite the fact that it is short. Furthermore, Mansour has jumped to conclusions without giving reasons:

'…They said I have anxiety, which is the reason for the lack of sleep.'

Mansour's narrative has an anxious quest tone interweaving narrative elements of being relaxed whilst at the same time being desperate, including consciousness and unconsciousness, struggle and acceptance:

'I directly went to the hospital, and then I had diabetes and blood pressure... and I continued receiving the treatment.'

'When I sleep, I felt like the one hour is like two hours …'

'I feel like am becoming old.'

He struggled with and accepted his overwhelming life expenses:

'…My rent is 2600 SR—I swear, 2600 SR–but thank God for everything, since we are reasonable enough, which is a grace in itself.'

As Mansour seems to be more concerned about the drawbacks of his illness, expenses, results and implications, as opposed to the treatment itself that is the key major narrative style, which was characterised by anxiety and fear:

'…with God protection',

'…Thank you. You did well. God is with us.'

'…Sometimes in Riyadh, diabetes treatments are available sometimes but sometimes not.'

'…Sometimes there is a medication shortage.'

'…Sometimes I have to take what is provided, which is less than I need.'

His personal life details are more dominant than the disease itself, as identified throughout this narrative. He communicated in regards to the number of children he has, their marital status, the rent, the salary and his financial restraints.

'I have 11 children, 6 of them are married.'

'I have bank credit.'

'I cannot travel.'

'I want to go and get my salary.'

All the anxiety has focused on turning around his personal—and especially his financial—constraints, which comprised a great deal of the narrative—more so than the illness itself—and the reasons behind it, which may affect Mansour's life, and therefore, it might act as a barrier to the access into mental health services.

Stage 3: Identities and Identity Work

Mansour identified himself to be a victim of society, life burdens, and faith and God's will since accepting all that he is going through:

'I do not need anything. I just need money; may God would make it easy for us and hopefully better.'

He reveals a feeling of insecurity, doubt and vacillation:

'…The charity gave me money as I had credits, and with God's willingness, it will be better.'

Discussion of seeking God's help, hope, relief and salvation is present in almost every line and short sentence.

Mansour is portrayed as being a somewhat ominous person; he seemed brooding and anxious, which indicates negative self-identity (Mishler, 1999).

There are no flashbacks or back stories; rather, there are repeated references to his current life with detailed descriptions of it, although notably very brief:

'I sleep only two hours then I wake up.'

'I do not work; I am retired.'

'…after the treatment.'

'…they do not have…'

'I have been told about at the hospital.'

'…they have a treaty between each other.'

'…Thank you very much, but I can't sleep.'

Throughout his brief life story, financial problems and troubles are strongly communicated, even more so than the illness itself, which can be summed up in no more than five lines. He seemed to be seeking to take control over his personal and financial situation more

than over his illness, which is, in one way or another, related to his expenses:

'I buy from the pharmacy, and sometimes I cannot find what I want …'

'Seven pills for 150SR',

'I pay for the lawn, and my salary does not cover the expenses.'

As can be seen from the above statements, reference to illness was very brief, but any reference was more concerned with the issues surrounding purchases, the necessity of such, and how this can be difficult and reinforces Mansour's negative identity of worthlessness.

Stage 4: Thematic Priorities and Relationships

In this narrative, a number of different correlated themes could be seen to reveal themselves, with socio-economic problems-related themes recognised as present. The participant is facing challenging times when it comes to being able to afford treatment costs in a country where medical treatments for retired citizens should be accessible.

'My rent is 2600R—I swear, 2600—but thank God for everything since we are reasonable enough, which is a grace in itself.'

'Sometimes, in Riyadh, diabetes treatments are available, but sometimes they are not.'

'Sometimes, there are medicine shortages.'

'Sometimes, I have to take what is provided, which is less than I need.'

'I do not work; I am retired.'

'I have 11 children, 6 of them are married.'

'I have bank credit.'

'I do not need anything. I just need money, may God make it easy for us, and hopefully better.'

His personal and financial situations affect his illness and the way in which this is managed on a daily basis, as it is related to his income, with expenses the main aspect introduced into the discussion in the current narrative.

'I buy from the pharmacy, and sometimes I cannot find what I want…'

'Seven pills for 150R.'

'I pay for the house, and my salary does not cover the expenses.'

The aforementioned places much emphasis on the financial implications and subsequent problems experienced as a result of Mansour's illness and the worries and obstacles he recognises as a direct result.

5.2.6 Critical Narrative Analysis: Yasir

Yasir is a male Saudi citizen from the southern region of the KSA, who delayed accessing mental health services for a one-year period whilst seeking other traditional treatments. He is retired and responsible for his family and has two sons with mental health disorders. He also carries the burden of his sons' and his own mental health issues, as well as other life and family burdens.

Yasir feels stigmatised by his and his sons' illnesses and has suicidal tendencies; Yasir's narrative reveals a tragic and dramatic sense.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Starting at the beginning of Yasir's story, there is a very dominant and captivating linear chaos narrative (Frank, 1995):

'I was 28 years old. I could not sleep, so I went to a healer, but this did not help me, so I went to the M Hospital. They gave medicines and I felt better. I have financial problems, which are the reason behind being sick, plus my wife wants a separate house from the one we have with my mother (you might have an idea about all the problems that would happen between women), so I was compelled to take a loan to make both my wife and mother feel comfortable. I feel like I'm in a labyrinth.'

Yasir has a strict objective that he wants to deliver through this narrative: to deliver a message of desperation from one point in time. There is no escalation—he is straightforward in communicating his main problem through his narrative:

'My salary is not enough for me.'

'I want to have my own store, and no one to help me out.'

'My wife does not work.'

'I have two children who are sick, too.'

'I do not have a car.'

'I am paying two loans.'

'You know life is becoming harder and harder.'

The main narrative tones, as well as the short, implied story of his financial and social life, are filled with an emotionally charged tone full of unhappiness and concern. Correspondingly, there are disturbed tones and words that illustrate his feelings of desperation:

'I no longer have insurance. It was stopped in the month of May.'

'They said that my salary, 4,000 SR, is enough. I helped my two daughters to get married, but all of it comes to paying a 980 SR bank loan, 1118SR for another bank. I have many loans and heavy charges above my shoulders.'

'I live in Riyadh. I pay 18,000 SR per year.'

Yasir used a whiny, repetitive tone when providing details to deliver the intended meanings (Savage et al., 1996). A change in his manner was detected at the end of the interview, when he starts to describe his illness as pain again, with the use of excuses of his whole life situation and sickness:

'I feel annoyed when I hear voices, I leave home then I come back. I spend some time outside, then I go back home. You know I do not have a car. I have nothing. My wife does not work; I cannot find anyone to help me out with opening a store. Many times, I ask the charity: there is a veggies' store next my house, please help me to get it. You know the rent problems and you know we need a car for merchandise delivery. I cannot find anyone to help me out and stand by me to have this store and have money...God all mighty.'

In a brief and concise tone, Yasir introduces a hint of the possible reason for his illness. Without an introduction, and without even answering a question, he jumped to the conclusion of:

'I think the reason behind my sickness is my parents' divorce when I was young.'

'I was 18 months old. They got a divorce for simple reasons. He left her and 55 years vanished.'

Stage 3: Identities and Identity Work

Indirectly, Yasir portrays himself as a victim of his parents—a battle that started from a young age, which may indicate his family relation identity (Mishler, 2004):

'I was 18 months old. They got a divorce for simple reasons. He left her, and 55 years vanished.'

This closing sentence was the link to understand the entire, untold back story. Back in the introduction, the struggle transferred from the trauma of his parents' divorce to being the victim of his 'wife–mother' relationship—the reason behind his debts and loans:

'I was compelled to have a loan, to make both my wife and my mother feel comfortable. I feel like I'm in a labyrinth.'

Yasir identifies himself as a helpless person, begging for help, but without rescue. He is repeating his actions and fighting to make a better life, but all was in vain, which could also indicate the formation of a poorly developed social relational identity (Mishler, 2004):

'I have many loans…'

'I could not find help.'

'I tried to reach them, but...'

'…because I am jobless, sometimes I walk to them. I do not have a car. Even a cab I can't get.'

Recounting his life story, which is evidently full of key facts and outcomes, Yasir identified as a person who could not control his life; in fact, he has submissive and helpless traits, accepting the results of others' decisions by making them the reasons for his bad financial and social situations.

Stage 4: Thematic Priorities and Relationships

The interrelated themes in the current narrative deal with the narrator's financial and social life, which are full of concern:

'I no longer have insurance. It was stopped in the month of May.'

'They said that my salary, 4,000 SR, is enough. I helped my two daughters to get married, but all of it comes to paying a 980 SR bank loan, 1118SR for another bank. I have many loans and heavy charges above my shoulders.'

'I live in an apartment. I pay 18,000 per year.'

'I was compelled to get a loan to make both my wife and mother feel comfortable. I feel like I'm in a labyrinth.'

'My salary is not enough for me.'

'My wife does not work.'

'I am paying two loans.'

'You know life is becoming harder and harder.'

'I no longer have insurance. It was stopped in the month of May.'

'They said that my salary, 4,000 SR, is enough. I helped my two daughters to get married, but all of it comes to paying a 980 SR bank loan, 1118SR for another bank. I have many loans and heavy charges on my shoulders.'

'I live in Riyadh. I pay 18,000 SR per year.'

'I have many loans…'

Another social theme has revealed the consequences that children might face as a result of their parents' divorce:

'I think the reason behind my sickness is my parents' divorce when I was young.'

The narrator also reveals the everyday life struggle that a Saudi citizen might face. This theme of social instability is depicted through the following sentences:

'I have many loans.'

'I could not find help.'

'I tried to reach them, but…'

'…Because I am jobless, sometimes I walk to them. I do not have a car, even a cab I can't get.'

Furthermore, it may be argued that the theme pertaining to a lack of family support and assistance can be seen in the narration provided by Yasir, as shown in the following comments:

'I want to have my own store, and no one to help me out.'

'My wife does not work.'

In addition, the theme pertaining to the influence of faith-healers is the common belief as a first rescue, and its importance in manipulating Saudi culture can be seen in the following statement made by Yasir:

'I was 28 years old. I could not sleep, I went to a healer, but this did not help me.'

5.2.7 Critical Narrative Analysis: Othman

Othman is a strong, optimistic and obsessive man. He is a Saudi citizen from Al-Kharj village near Riyadh. His family encouraged him to access mental health services with opting to see a faith-healer once a year. He is confident, and strongly believed his illness would be treated. He wants to fight the stigma, as he and his family accept the presence of mental illness. Othman's family consider him to be a 'normal' person; Othman's family believe that the mental issue should be treated the same as any other physical illness, and they supported him.

Othman considered Saudi society as having a high awareness of mental illness and accept mental health issues and mentally ill people in the same way as diabetic and hypertensive individuals. He recommends people with mental health issues to access mental health services as early as possible and to visit a faith-healer occasionally if they wish to do so. Indeed, Othman's narrative has a highly positive tone, along with suspicion, with the source of his obsession in his story potentially produced from his weak belief in the benefits of medication. This belief may be as a result of his own religious and cultural beliefs of using a combined treatment of accessing mental health services, as well as seeking a faith-healer (*Rouqiah*). However, his optimistic narrative overpowered the obsession, or, as would be referred to, there is 'a conflict in determining his identity' (Mishler, 2004).

Stage 2: Identify Narratives, Narrative Tone and Rhetoric Function

In Othman's quest narrative (Frank, 1995), the will and the struggle to identify a solution and accordingly overcome his illness can be highlighted and recognised from the very beginning:

'I was 27 years old when I was diagnosed with schizophrenia, due to drugs, which I try to avoid. It even causes me a mix a feeling full of suspicion, fear, obsession, negative thinking, phobias… The first treatment was beneficial, and then my case relapsed and so I went to all hospitals, which did not help me. Things were good, went well, and till now are a little bit better, as I sometimes have doubts that someone is poisoning my food, or watching me, or going to harm me... so I decided to isolate myself. I do not meet up with anyone. Until now, I sometimes meet some people, but sometimes I do not.'

'No, the treatment did not really help me at all, at all, at all... Until now, my treatment has not helped me... Sometimes it happens to feel better, but now it is not helping.'

This narrative is a quest, picturing someone desperately looking for a solution, and thus, is centred on feeling better with a strong personal readiness to achieve this:

'Doctor, I am self-confident.'

'I know that the disease goes away.'

Throughout the interview, a disapproving tone full of disappointment and distressing short sentences was identified and highlighted:

'I do not feel comfortable with the treatment. I do not feel comfortable at all. I go back to the doctor every day, and he prescribes the same treatment.'

'…When I stop the treatment, I feel happy. I feel people around. I do not feel depressed, but when I get my medicines, I feel depressed...'

'...But, doctor, the treatment did not help.'

'Without treatment, I am way better.'

'Medicines do not help. I have been receiving treatment for four months, but yet until now there are no improvements. Hopefully I will be better soon.'

Argumentation and explanations are presented in this narrative as rhetorical, with the use of solutions versus results in a repetitive style in mind of revealing the deep feelings mixed with a rational state of mind (Savage et al., 1996):

'I go every year... but no results.'

'I have doubts about the treatment. I am doubting everything—and nothing works well. When not feeling well, I can't trust the treatment.'

'... At A and F hospitals ... They are not helping. They want me to do the electroshock treatment, but I have refused. I have doubts and negative thoughts, as I cannot meet anybody ... I am a reclusive person, reclusive person.'

Finally, at the end of the narrative, a wretched and unconfident tone has detected—a tone that confirms all of those used so far:

'The doctor I did not approve is Mr H.'

'I always tell doctors that I do not want medicines. I want to speak out.'

'One doctor is available who prescribes the same medicines.'

'The doctor asks me to visit him when I want.'

'Every time, he switches medicines. Every time it is the same words and deeds. He tells me that I am his brother, and that the best thing about me is that I have a strong personality. I am strong enough and I need to put everything behind my back.'

Stage 3: Identities and Identity Work

Othman has a dialogical or narrated identity as he portrayed himself as a fighter against his mental health issues, his doctors, and the situation he has been experiencing as a whole (vis- a-vis others) (Spencer et al., 2001). Nonetheless, despite his failures, which he considered has been confronted, he continues with his battle:

'I tried many hospitals.'

'Treatments and medicines did not help me to recover.'

'Doctors keep prescribing the same medicines for 30 or 40 patients.'

'I am going to see Mr T a behavioural therapist' (Notably a new doctor).

'I visit the doctor every day.'

'Being sick is a struggle with one's self, a struggle I swear is too much of a struggle, a struggle with one's self.'

Stage 4: Thematic Priorities and Relationships

This narrative has several different associated themes—a theme of psychological distress and mistrust between the patient and the hospital. The narrator does not find that medical interference is helpful, a subject that could potentially be considered important in the Saudi medical system and in regards its cultural background.

'I have doubts about the treatment. I am doubting everything, and nothing works well. Not feeling well. Can't trust the treatment'.

'Without treatment, I am way better'.

'Medicines did not help. I have been receiving treatment for four months, and until now there have been no improvements. Hopefully, however, I will soon be better.'

'I do not feel comfortable with the treatment. I do not feel comfortable at all. I go back to the doctor every day, and he prescribes the same treatment.'

'… When I stop the treatment, I feel happy. I feel people around. I do not feel depressed. When I get my medicines, I feel depressed...'

'... But, Doctor, the treatment did not help.'

This theme has also led to reassembling the general idea of the narrator and the reasons behind his mistrust, with the medical system brought into question:

'...At A and F hospitals they are not helping. They want me to do the electroshock treatment, but I have refused. I have doubts and negative thoughts, ... I am a reclusive person.'

'I always tell doctors that I do not want medicines. I want to speak out'.

'One doctor is available who prescribes the same medicines.'

'The doctor asks me to visit him when I want.'

If the patient does not trust the medical intervention, medication and procedures, this then means there is something missing, which could mean the difference between a help-seeker feeling confident and lacking this much-needed confidence.

5.2.8 Critical Narrative Analysis: Mdawy

Mdawy is a female Saudi citizen from Riyadh. She appears as a woman with a low level of education. She did not seek any traditional treatment and her family encouraged her to access mental health services. She accepts her illness and she does not feel stigmatised. Her family and husband both recognise and accept her illness and they support her. Mdawy's quest narrative is short and optimistic in its content; she expressed positive feelings and attitudes toward her mental health issue and sees a positive future for herself.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

In Mdawy's quest narrative, it became apparent that we are being confronted with a detached and aloof short and guarded narrative, one that is seen to be lacking identity, tone and rhetorical functions (Frank, 1995). The conversations are very brief and straight to the point, with very little expansion and further detail given beyond what the individual clearly considered to be necessary. The narrative was, in essence, a question/answer session, without Mdawy making attempts to divulge anything more than a simple answer to a question, with no recollection or tendency to make reference to the past.

'I suddenly started to be isolated and to over-think.'

'I have been there for 15 days.'

'Yes, extreme depression.'

'No, before giving birth to my child.'

Across the narrative as a whole, there is an easily identifiable flat monotone predominating, with three or four-word answers provided in the form of very brief sentences, with yes and no words, and few intonations. Further, no emotion emerged, nor is there any sense of inner feelings that were otherwise revealed; rather, there is just the feeling of perseverance that Mdawy wants to feel better. No matter what, identifying the value of the medication and intervention is important, whilst acknowledging her own drive to continue, progress and improving:

'The treatment is good. I will never quit, so I won't be sick again.'

It is possible that social pressure to conform to treatment norms and values can be viewed as 'normal' by some individuals, even if there is a risk of stigma associated with seeking treatment for mental health concerns (Gilbert, 1997; Satcher, 2000; Damghanian and Alijanzadeh, 2018). In the case of Mdawy, it appears that her focus is on her own perseverance and desire to feel better, and to adapt with her mental health condition, rather than focus on the potential stigma that might be associated with seeking treatment.

In her story, there are a total of seven 'no' and eight 'yes' responses across a short two-page transcript interview, which contains around 25 questions. This revealed a balanced tone in the narrative—a balance between 'yes' and 'no', what the participant is doing and what she wants to do, and what she is planning in order to achieve her goal of feeling better.

'Yes, after the treatment I felt that I am back to my normal status.'

One last tone was positive, which revealed the acceptance of the help offered at the end of the conversation.

'My husband is sick, too. He is schizophrenic.'

'I will ask him to come if he can for an interview.'

Stage 3: Identities and Identity Work

Mdawy identifies herself as a decisive mother who has to overcome her illness for her children and her future. The narrative has a kind of light, positive tone, with sparse description of her illness and a warm discourse that indicates a positive, but flat identity. Discussion has centred on the journey that Mdawy experienced after going through childbirth and the effects on her emotional wellbeing, with the positive acknowledgement that, although she had felt very negatively about them, she could see the value in her medication and interventions, identified the benefits of their use, and would continue with them due to experiencing improved sleep, as well as generally feeling better.

'After giving birth, I felt worse ... I have two kids ... I would never quit the treatments...'

'Now I feel much better, I sleep well.'

Stage 4: Thematic Priorities and Relationships

A key theme that has developed throughout the interview could be seen to be indicated in the current narrative. Psychological and mental related illnesses are known to suffer from widespread stigmatisation in the KSA. In this regard, patients are recognised as generally not feeling the most comfortable when it comes to sharing

their pain, thoughts and problems, even with medical or professional staff.

In this regard, Mdawy's interview is brief, and the narrator does not seem to feel comfortable with speaking up or making additional comments that would be considered beyond the basics required in order to provide an answer to the question. Accordingly, short sentences and yes/no answers were given in the main, without much tendency to provide additional, more detailed answers.

'Yes, after the treatment I felt back to my normal status.'

'Yes, extreme depression.'

'No, before giving birth to my child.'

'The treatment is good. I will never quit so I won't be sick again.'

'I suddenly started to be isolated and over think.'

As can be seen from the above examples, the answers, comments and statements provided during this narrative are very minimalistic and somewhat restricting when it comes to analysis and theme identification. As has been noted earlier on in this analysis, the interview spanned only two pages, comprising a total of no more than 25 individual answers to questions, which is not a wealth of data or insight into the life of a person experiencing mental illness. Nonetheless, it is considered that, as a result of the stigma associated with mental illness in the KSA, the narrator is perhaps reluctant to disclose more personal accounts of her experiences with mental illness and associated problems for fear of being judged or negatively labelled. This, in and of itself, nonetheless provides the ability to identify stigmatisation and fear surrounding mental health.

5.2.9 Critical Narrative Analysis: Salmah

Salmah is a female Saudi citizen from the southern region of the KSA. She is a highly self-confident person who has worked with a charity for a year in the role of volunteer. Her hobby is designing clothes, and she has a female clothes design booklet published by a Saudi charity. Salmah currently works as an administrator in a primary school. Her family encouraged her to access mental health services directly and did not seek any traditional help. She accepts her illness and does not feel stigmatised. Her family and husband accept her illness and support her. Salmah recommended people with mental health issues to access and use services as early as they can:

'Because I accessed mental health services early, I have never been admitted to hospital.'

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Salmah's interview is a dignified narrative, with her accepting her mental health issues, seeking solutions, improving her situation, and changing her marital status—despite what she had been through:

'I told my sister about it ... She advised me to go to the hospital—an idea that I easily accepted.'

'I used to watch documentaries … It is ok for me … One day I felt that I am not okay. I have ideas in my head that are not normal. I had a feeling that it was not okay.'

This was a contentious and defiant narrative, as well as an inspirational one. The protagonist progressed from the quest for the truth, through to treatments, and went on to actively improve her life whilst fighting to keep healthy.

'Doctors were convinced that I am ready for the treatment, so I did not stay at any hospitals; I am so convinced that I need [some form of] treatment.'

An emotionally positive tone was detected in Salmah's narrative. She made efforts to take me on a tour around her past and into her life, with brief back-stories provided in a perceived effort to give a glimpse of her illness, her situation, both in the past and present, and her beliefs.

'I was not feeling good … I have no problems with psychological treatments, it means I accept it. I had a feeling there was a problem.'

'I used to think that I was married [and that] I had children. I was really convinced I was married. That was the problem that convinced me that something was going wrong.'

'…I did not like the treatment … I was gaining weight—155kg—because of the hormones … I left that centre and went to the M centre, and I have started a new treatment …'

Understating her previous life, Salmah gave details and made statements that encouraged the listener to pay attention, with the narrative provided in such a way that enabled the possibility to follow a straight line of events, where all elements of her story were present. A captivating tone was used to pave the way to know more about her and to achieve the results of her treatment journey:

'I am now feeling better. I got married. I have a baby; she is two years old.'

'Everything is going well psychologically and people are even surprised when I ask for my professional rights … They think that I am totally okay.'

The above statements emphasise her achievements — told through a figure of speech technique.

Stage 3: Identities and Identity Work

Salmah identified herself as a woman with a curious heroine identity (Mishler, 2004) and who discovered her issues by herself 'thanks to wide knowledge'. Salmah challenged herself to work, get married, and have children. She is very proud of herself for fighting the mental health stigma and for being an active and productive member in Saudi society.

'I was not feeling good. I was sure there is something not okay about me.'

'I used to watch documentaries … It is ok for me … One day I felt that I am not okay. I had ideas in my head that are not normal. I had a feeling that it was not okay.'

Salmah was a heroine who is in a constant battle when it came to achieve her dreams, goals and ambitions.

'Now I work at a kindergarten, and I have recently got promoted.'

'Everything happened thanks to God, and of course I cannot deny everybody who has helped me. We cannot deny charity help ... Thank God. Here is the result after ten years of treatment—and I will keep taking my medicines'.

Salmah is a grateful heroine, despite what she has been through.

Stage 4: Thematic Priorities and Relationships

In this narrative, several different linked and interrelated themes could be identified and revealed. The main theme seen to underpin the narrative centred on the Salmah's pain in her life before marriage, and how she feels since then.

'I used to think that I was married, and I had children. I was really convinced that I was married. That was the problem that convinced me that something was going wrong.'

The fact of getting married in Saudi culture remains hugely important for females, whether speaking from a social or psychological perspective. In this specific case, it clearly creates a certain balance for her personal ego—and even in terms of her image in the Saudi society.

'…I did not like the treatment… I was gaining weight—155kg—because of the hormones… I left that centre and went to M centre, and I have started a new treatment…

'I am now feeling better… I got married… I have a baby. She is two years old.'

Saudi society is reserved and conservative, where the woman is not considered to be effective unless she has adopted the role of being a wife, a mother and started a family, where she can prove herself to be responsible. This is, accordingly, extracted from Salma's narrative:

'Everything is going well, psychologically; people are even surprised when I ask for my professional rights… They think I am totally okay'.

5.2.10 Critical Narrative Analysis: Awaad

Awaad is a male Saudi citizen from Riyadh, who comes across as a pessimistic person, who is supported by his wife. He accessed mental health services for the first time after seeking faith-healer treatment for a short period of time. He feels stigmatised and, therefore, he avoids people and a social life and has no job.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Awaad's interview was an interrogative restitution narrative (Frank, 1995) as a storyteller while informing of his illness; he did not refrain from asking questions. He has only recently discovered his illness, which might be the reason behind making the narrative to fluctuate between short answers, questions, and interrogations.

Around ten questions were asked across the duration of the interview:

'Do you have an idea about the treatment?'

'Can I drink coffee?'

'In the evening?'

'Is chamomile good for sleep?'

'Do you think it is better to have two pills before sleeping or at night?'

'Two pills, white with 25mg. Do you think it is good?'

'Is the excessive use of it harmful?'

'Even if I use it a lot?'

'Chamomile?'

The extremely strong feeling of fear and uncertainty predominated Awaad's narrative, with several different instances of providing short answers with a sparse, limited description of his story, whilst simultaneously asking probing questions. It was almost as if he was in a constantly worried state of mind:

'I did not sleep for 27 days.'

'Every time I get new medicines it has side effects.'

'I had new medicines, but it caused other side effects'. 'I do not have any problems; I just cannot sleep'.

'This is my only problem, the doctor prescribed medicines before sleeping, it has muscles pain as side effects, I was no nervous, but I used to sleep even if I drink a whole tank of coffee, I sleep easily.'

Another remarkable tone recognised throughout the course of this narrative is ambiguity and equivocation. Words, such as 'maybe' and 'or', or phrases with uncertainty, such as 'I do not know', were frequently used.

'A week or two.' 'Maybe once or twice.' 'Sometimes it happens, I don't know.'

'Maybe for 20 days or a month....'

This lack of exactitude and precision may reflect a fragile persona coming to terms with life-events.

'I want to sleep; I want to be relaxed and sleep. I do not want to pay a visit to anyone. I want to pray at the Mosque, which is next to my place. I do not go for prayers. I pray at home, or I do not pray at all…'

Stage 3: Identities and Identity Work

Awaad portrayed himself as a petrified victim when it came to the side effects of medicines, whose only desire was to sleep. This may indicate the formation of an illness, medication-orientated identity (Mishler, 2004). In this instance, he is seeking sleep and relaxation time with the help of experts, without wanting to have any concerns or worries about any surprising or undesirable responses to the medication.

'The medicines do not help, every time they switch it, it has side effects ...My muscles, my muscles hurt.'

'Oblivious I am; I just want to sleep. I cannot sleep. I turn right and left, and sometimes I pretend to be closing my eyes and I pretend to be asleep.'

'I do not want to try them again. It causes me muscle pain.'

Awaad also portrays himself as a relief and rescue-seeker. He asked questions related to medicines and tea, as well as herbal and natural remedies.

Stage 4: Thematic Priorities and Relationships

There are several themes that seem to have developed and become identifiable in the current narrative. Beginning with the narrator's words and his bulk of questions, it can be recognised that there is a major lack of information, and assistance and help are missing from his life.

'Do you think is it better to have two pills before sleeping or at night?'

'Is chamomile good for sleep?'

'You mean chamomile tea?'

'Even if I use it a lot?'

If the narrator continues to question simple and everyday life habits that he has to abide by, then this indicates he has been unable to find someone to help him to overcome his feelings of being lost and to provide helpful answers to these questions. The many questions that were asked by the interviewee reveal the patient's constant feeling of worry and anxiety.

'Do you have an idea about the treatment?'

'Can I drink coffee? In the evening?'

'Is the excessive use of medicine harmful?'

'White pills with 25mg. Do you think it is good?'

Another theme was also dealt with in this narrative, which pertains to the patient and his feeling of mistrust, suspicion and ambivalence of medical help.

'The medicines do not help. Every time they switch it, it has side effects... My muscles, my muscles hurt'.

'I do not want to try them again. It causes me muscles pain'.

'So do I have to stand the pain and make it a week?'

'Do you think is it better to have two pills before sleeping or at night?'

5.2.11 Critical Narrative Analysis: Amal

Amal is as a female Saudi citizen from the western region of the KSA, who has a very powerful and strong personality. Amal delayed accessing mental health services for nine years because of seeking

traditional therapy, aromatherapy, and herbal medicine for eight years, and a faith-healer's treatment for one year. After nine years, she decided to access mental health services and told her family of her decision, who accepted her choice. Amal has repeatedly felt stigmatised; however, she tries to fight the stigma. She thinks that Saudi society would benefit from greater awareness towards people with mental health issues and their needs, with society learning how to accept and deal with them. Her family continue to support her and responded well to her decision to access and use services. Amal's family helped her to access and use the services after they realised that, for the past nine years of seeking help, nothing was helping their daughter. Amal has advised mentally ill people to access mental health services immediately—as soon as they feel the need — in order to ensure they prevent their case from worsening. In her experience, she felt that faith-healers and other traditional treatments were not benefitting her, but rather that they have an appeasing or relaxing effect.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Amal's is a theoretical, analytical and rational narrative, which comprises several elements, namely exposition, climax, failure and resolution (Frank, 1995).

'I got sick when I was at the primary school'.

'My mother used to bring me some herbal medicines from the naturalist experts.'

'When I was 19 years old, things got worse ...'

'My parents used to ask my brother and faith-healers to recite verses, I was calm ... I used to have a calendar with many directory

numbers of hospitals, so I said why I do not try one of them, and try to reach them, and I did...'

'There are many good faith-healers, but I do not know, I feel like psychological treatments are better because there are experts, medicines which its results are better than herbal medicines.'

Her entire narrative contained a pragmatic and realistic tone.

She occasionally used interesting metaphors:

'We used to have a housekeeper; this housekeeper was like a magician.'

Gradually opening up about her story, Amal began to provide and incorporate new elements into her narrative as she moved to the climax, clearly intentionally recalling the surprising technique and calculating the timing of the presented element.

At the beginning she said:

'They do not know what I have exactly till now',

Then she expanded by providing details of flashbacks into her childhood life events and life facts, stating the following:

'I totally forgot, after that I went to A Hospital … Yes, I went to A. Yes, I forget to tell you that the doctor's diagnosis revealed that I have schizophrenia … At the beginning it was the doctor, then I was transferred to the A Hospital … so I frequently come here, I have been here since 2008 at the outpatient's clinics.'

Stage 3: Identities and Identity Work

Amal identifies herself as submissive to the commonly prevailing belief that is based on herbal medicines and the faith-healer

techniques for healing people. Such beliefs in that time indicate Amal's traditional relational identity (Mishler, 2004):

'My mother used to bring me some herbal medicines from the naturalist experts.'

'My parents used to ask my brother and clergymen to recite verses, I was calm ...'

'There are many good faith-healers, but I do not know, I feel like psychological treatments are better.'

Amal also portrayed herself as a shy woman who used to refuse things, but who nonetheless was compelled to wear her spectacles:

'I needed spectacles, and I had them, but I used not to wear them, they were ugly, and I used to feel ashamed, when I was the middle school, I tried to have friends, but I could not ... They do want to be friends with me.'

'I used to have some friends, but I always avoid wearing the spectacles, although it was an important part of my life so I can see.'

Amal is a female who fluctuated in her help-seeking behaviour among three forms of treatment, which may reflect on her identity to finally achieve a coping identity.

Stage 4: Thematic Priorities and Relationships

This narrative has several different related themes. Some themes represent a major subject of discussion within the Saudi society, which is the role of faith-healers in the treatment process of mental illnesses and associated ailments:

'My mother used to bring me some herbal medicines from the naturalist experts.'

'My parents used to ask my brother and faith-healers to recite verses, I was calm...I used to have a calendar with many directory numbers of hospitals, so I said why I do not try one of them, and try to reach them, and I did...my family agreed and helped me in that'

'There are many good faith-healers, but I do not know.'

Another interrelated theme can be seen in the identification of the common belief in the existence of magic and sorcery, which can be a source of harm and a cause of mental health issues.

Another related theme can be seen in the common social picture that Saudi society reflects and imposes upon its citizens. Any health issue could be stigmatised, which subsequently leads to people feeling alienated as a result. Many social boundaries could arise, due to different health problem.

'I used to have some friends, but I always avoid wearing my spectacles, although it was an important part of my life to I can see.'

'I needed spectacles, and I had them, but I used not to wear them, they were ugly, and I used to feel ashamed, I was actually shy...when I was the middle school, I tried to have friends, but I could not... They do want to be friends with me'.

5.2.12 Critical Narrative Analysis: Rami

Rami is a male Saudi citizen from the eastern region of the KSA, who has a confident and flexible personality, Rami has worked as a Maths teacher. Rami accessed mental health services after seeking a faith-healer's help for two weeks. He was the subject of his society's discrimination and prejudice whilst looking for a job, as they refused him once they knew that he had mental health issues. Consequently, Rami's view of Saudi society is that they have a negative attitude towards people with mental health issues. He is financially supported

by the Saudi charity, even after they found him a job. Currently, Rami believes in himself, and his family believe in him and support him:

'I believe in myself and accept my mental health issue, this will later reflect on the Saudi society and all the community members'.

Rami indicates that he has challenged stigma by securing work, which appears to have bolstered his self-esteem.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Rami's narrative is an effusive descriptive chaos narrative in terms of feelings, facts and events (Frank, 1995). A linear description of events has presented, with discussion spanning from the past and through to the present results.

'I got sick when I was 19 or 18.'

'I have received a treatment maybe 3 or 4 times, I think 3 times,'

'I got married then I have travelled to the US.'

'I have heard while watching TV, that there is a programme that takes care of patients who are schizophrenic.'

'I have a visit to the association, and they really welcomed me ...'

Rami's narrative declared a positive tone, full of intertwining elements of exposition, failing and resolutions, complete with rationale, emotions and argumentation (Savage et al., 1996). Moreover, a tolerant tone could be identified, as he accepts that the common social beliefs in the KSA create stigma.

'My family, like the commonly followed beliefs in the KSA take patients to faith-healers first; but it did not help, so they have decided to take me to the psychiatrist.'

Rami's own acceptance can be identified when he makes statements, which, therefore, further reflects his own psychological status:

'First my communication skills are not well developed, and I feel that I have a deficiency somewhere …'

'I could not know what kind of cognitive deficiency I suffer from.'

'Sometimes is a positive signal to be sick, maybe because of my sensitivity, or maybe because of intelligence … the disease itself could be a positive indicator, not always a bad sign.'

'I swear, I am being honest, I feel a positive qualitative shift since I joined this association, schizophrenia one, a qualitative shift in my life, before I used to do everything by myself, patiently and in pain, after joining them and their care that provided towards me their understanding, and the way how they embraced my problem and detected my weakness and my strength, I feel like I am very happy, easy with them. I have reached my goals thank to the association.'

Stage 3: Identities and Identity Work

Rami identified himself as a struggling hero—a victim to his cognitive deficiency—whilst at the same time adopting the role of being a positive person who never let it go before reaching his goals (Mishler, 1986). He continuously sought to reach within and look inside himself, and accordingly try to identify his own limits:

'While I was in the US, I have faced many problems in terms of daily life, problems of adaptations until I felt desperate; I decided to go back to the KSA.'

'Thanks to the treatments I have received I started to regain my efforts and my energy.'

'I know that I have a very strong visual memory.'

'The principal used to say to me that we have one of the best Math teachers ever.'

'At the beginning, my problems were related to people who had a bad effect on me, I did not know that I was a reserved person because of their judgement, a very bad one – 100% bad prejudice ... Little by little, I felt like I have to accept myself, and if I do not accept myself people will not accept me. I have to make people accept the psychological problems and behave well ... after a while I felt like they have started to respect me.'

Rami in the last quote portrayed himself as being a self-challenging character.

Stage 4: Thematic Priorities and Relationships

Several themes can be seen to have emerged throughout the course of this narrative. Importantly, as has been recognised previously, the KSA's society imposes the need for a faith-healer as a first port of call before seeking the help of a medical professional.

'My family, like the commonly followed beliefs in the KSA take patients to faith-healer first.'

Another related theme considers the difficulties that Saudi citizens could face when travelling abroad, in a totally different culture, complete with new customs and a new life. Accordingly, the

current narrator's situation worsened as he felt as though he was unable to cope with his new lifestyle and new surroundings.

'While I was in the US, I have faced many problems in terms of daily life, problems of adaptations until I felt desperate o I decided to go back to the KSA.'

Further, another issue, as has been previously discussed, concerns the image and stigma that is related to mental health patients in Saudi society (Alyousef et al., 2020). Saudi society looks upon those people with mental health issues as being handicapped, with mental illness viewed in an extremely negative light, with such an ailment perceived as preventing people from being socially active.

'At the beginning, my problems were related to people who had a bad effect on me; I did not know that I was a reserved person because of their judgement, a very bad one – 100% bad prejudice... Little by little, I felt like I have to accept myself, and if I do not accept myself people will not accept me. I have to make people accept the psychological problems and behave well... after a while I felt like they have started to respect me.'

5.2.13 Critical Narrative Analysis: Bayan

Bayan is a female Saudi citizen from Riyadh, who delayed accessing mental health services for a three-year period; her family encouraged her to access faith and herbal healers instead. From her story, it appears she strongly believes in help from faith-healers and, as a result, was doubtful of the benefits of medication. On a number of occasions, her mental health deteriorated whilst solely depending on the faith-healer's treatment; however, Bayan currently accepts her mental illness according to medical understanding and works hard to establish a socially active identity and is engaged in part-time work.

Stage 2: Identity Narratives, Narrative Tone and Rhetoric Function

Throughout the course of this interview, I experienced listening to a long, brooding chaos narrative (Frank, 1995). In Bayan's narrative the long conversation is full of descriptions and arguments, all of which presented complexity and a need to ensure understanding. The narrative approach adopted by the interviewee is a question/answer narrative, without too much emphasis on the back story. The few past stories that have told had an argumentative function:

'I used to hate my family.'

'I do not bear my home'.

'They accused me of being in love, which was the reason of my problems with my father ... I hated my mother....'

'I am so nervous, so nervous...'

The tragic monotone predominated throughout Bayan's narrative, as can be seen when examining the short answers, brief sentences, yes and no answers, repetitions and intonations.

Furthermore, a number of different instances echoing various tragic feelings are reflected in her chaotic life, filled with anger, hatred and self-rejection, as shown through the use of many adjectives when some dark elements became the subject of conversation, such as:

'I do not like my siblings.'

'I was so nervous.'

This subordinate clause was used more than five times.

'...That caused me problems with my father...'

'I hate my mother; I cannot stand her smell...'

'I used to yell, and go through hysterical periods ... I hate the home ...'

'I was nervous and hated everybody.'

'I was so tired, so tired and I have lost my appetite ...'

'I am tired, I am nervous, I cannot anymore, I can't!'

Bayan also used questions in her search for help and to garner knowledge:

'Do I have to keep having it for my entire life?'

'You mean I pursue my studies?'

'Are there side effects of the medicines I am taking on my baby if I get married?'

'Please call my mother to take me to a doctor to explain to her about the syringe of medicine ...'

The last sentence of her narrative, which encompasses an emotional, pleading and begging tone, asked for help and rescue, which sums up Bayan's entire state of mind. She also reflects her needs to feel a belonging to her family and to access their support in dealing with her situation that requires extra care to live her life as a normal person.

Stage 3: Identities and Identity Work

Bayan identified with turmoil and struggle when it came to her desire to improve her life, and she saw herself as a victim of her family

and society's prevailing customs, which, without question, form the core of social-family-relational identities (Mishler, 2004):

(They would say) 'She might need a husband.'

'She might have been in love.'

'I have been taken to consult some faith-healer.'

'Maybe a spell was cast on her.'

'If you do not find a husband for her, her situation might get worse.'

This led to a new identity for Bayan, which can be seen to be full of self-rejection:

'I never reveal my real age.'

'I am thirty years old now, and no one proposed ... Many came to my family, but they leave. They come and leave ...'

'I am ashamed of my real age. My body does not fit my age... They say I am 20.'

'... because I am thin and sick.'

Bayan has finally fought the stigma through finding a part-time job:

'I recently worked in a chocolate shop for three days a week and happy with that...I am committing to my medical treatment'.

From the last quote Bayan portrays her accepting or balanced identity when she breaks down the barriers that she faced to live her life.

Stage 4: Thematic Priorities and Relationships

In this narrative, there was the identification of several different overlapping themes. Starting from seeking faith-healers' help through to the importance of getting married for females in Saudi society. In addition, creating a social balance was highlighted to finally reveal the stigma where the age of a female, in a society in which the woman is considered a second citizen and not socially related to a husband, is a handicap or unacceptable for some people and families.

As can be observed when reviewing the statements made above, very strong emotions are inherent in the story told by Bayan, with such significant feelings and the thoughts coupled with them leading to greater turmoil with her mental illness. This is not helped by the negative stigma and beliefs adopted by those around her, such as in regard to her possibly feeling that she was in love and needing a husband. Bayan also condemns herself as a result of these factors, holding the view that, because she sees herself as sick and underweight, she has not received a proposal of marriage.

5.2.14 Critical Narrative Analysis: Monerah

Monerah is a Saudi female citizen from the Afief village near to Riyadh. She is a very quiet woman with a strong faith in God and has a burden of debt and house rent that was sometimes financially supported by the Saudi charity. Monerah had been supported by her family and was accepting of her illness and did not feel stigmatised. She sought a faith-healer for three days, who recommended her to complete cauterisation treatment, but she did not like this and was scared by it. Monerah accessed private mental health services two years ago and, due to the costs of medicine and private-sector treatment, accessed statutory services.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

When analysing the information and the interview was completed with Monerah, it was easy to recognise the authentic, straightforward, honest and unreserved manner in her restitution narrative throughout (Frank, 1995). Monerah seemed to be accepting of her mental health issues that she had been experiencing, rather than perceiving herself as a victim, and sought to get better through the application of all possible solutions.

'I received a treatment for 6 months, then they told me to stop, and this got worse, I was sick again.'

'I went to S hospital, they gave me different treatments and have been receiving them for two years; I stopped it, and I was sick again –worse than before.'

'I went to doctors, I had a treatment for two years at T, and then they started reducing the treatment, but I got sick again and worse than before.'

The presence of tragic, gloomy tones can be identified in this narrative, which shows alarming elements of struggle, submissiveness, and self-compliance.

Furthermore, there are various expressions of gratitude and the overall acceptance of her issue on more than seven different occasions:

'Thank God.'

'I am grateful for everything.'

'If God wants...'

'If God allows it.'

'This is welfare from God to whom be ascribed all perfection and majesty.'

Religious scruples are also present in this narrative:

'I have joined some groups of reciting the Holy book, the Quran, all of them they recite it and memorise it.'

'Thanks to God's words, one can feel depressed, God is a refuge that we run to, God to Whom be ascribed all perfection and majesty makes it less intense and makes you feel relaxed.'

'With God's will, My God! Thank God!'

This result in a recourse that the heroine has presented, with the subject seeking to find some peace within herself, and potentially a type of release from her negative thoughts.

Stage 3: Identities and Identity Work

Monerah portrayed herself as a believer and could be seen to adopt a faithful and balanced persona with efforts directed towards doing her best with the resources afforded to her, along with the scientific initiative to get better and keep close to God, who she perceives to own a spiritual identity (Mishler, 2004).

'I am receiving medical help thanks to an expert, with exercises and other things.'

'I was told to try to benefit from the physiotherapy, but taking the medicines can never be stopped ... then I asked can I keep receiving both treatments (the natural and medical one) at the same time.'

'I have joined some groups of reciting the Quran, all of them they recite it and memorise it.'

'With God's will, and thank God for everything, the most important thing, if there are any related issues to the credit, they have to deal with me from now on ... but with God's will, God will make it better and improve things, because I do strongly believe in God to whom be ascribed all perfection and majesty.'

In the last statement, Monerah has identified herself as a hopeful patient with the conscious and determined mind-set to improve her situation and take control of her life with God's help.

Stage 4: Thematic Priorities and Relationships

One of the most dominant themes seen to have developed in the current narrative can be readily identified: this is the theme of faith, along with its influence on the patient's jargon, register and vocabulary.

'Thank God',' I am grateful for everything',' If God wants'

'If God allows it.'

'This is welfare from God to Whom be ascribed all perfection and majesty'.

'I have joined some groups of reciting the Quran, all of them they recite it and memorise it'.

'Thanks to God's words, one can feel depressed, God is a refuge that we run to, God to whom be ascribed all perfection and majesty makes it less intense and make you feel relaxed.'

'With God's will, My God! Thank God!'

'I am receiving medical help thanks to an expert, with exercises and stuff like that.'

Monerah's narrative may be considered to be both a peaceful and quiet one, where the narrator reveals her illness calmly and with great acceptance. The ethical principles she adopts are resourced from her religious beliefs.

5.2.15 Critical Narrative Analysis: Mashayer

Mashayer is a female Saudi citizen from the western region of the KSA (Jeddah), who accessed mental health services directly with the help of her sister after their mother passed away. She also once accessed a faith-healer after accessing mental health services, but she decided to leave it, despite the symptoms still being present. She has a burden of house rent and she does not work, although she has been supported financially, sometimes by a Saudi charity. Mashayer is accepting of her mental health difficulties and does not feel stigmatised, whilst her sister is also supports her in accessing and using mental health services.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

This narrative presents Mashayer, who has a diagnosis of schizophrenia, as an individual who reflects a depressing, sad, gloomy, and discouraging character, as identifiable through the jargon used, as well as the tone and various intonations.

'I was depressed.'

'I had chronic depression.'

'I only think about my mother because I was so close to her.'

'My second diagnosis revealed that I have schizophrenia.'

In the main story, another short story is nested, representing another key identification for the narrative itself, as it has tightly attached to all the causes of her illness.

'Yes, I am married and then a new problem made appearance in my life.'

The narrative is one where there is no apparent compulsion to dig deeper or to self-reflect in an effort to garner further details into, or understanding of, the past or otherwise to analyse the present. Specifically, the death of Mashayer's mother was the cause of the focus of the story, albeit alongside the presence of a few other hidden conflicts.

The overall tragic tone in Mashayer's narrative revealed the various dark elements of struggle, on the one hand; as well as positivity, on the other. Mashayer's struggle throughout the course of dealing with her difficulties could be identified as depicted in her brief sentences and the vocabulary used throughout the course of her narrative:

'After losing my mother, I felt so bad.'

'After the diagnose process, they asked my sister to take a care of me.'

'My sister was of a great help for me.'

'I am schizophrenic.'

Mashayer's positivity could be seen in her narrative regarding her marital problems, as she is constantly seeking to find solutions, recognised alongside her hopes of bringing back her husband. A total of approximately four pages were dedicated to this problem; however, little centred on her mental health issues.

The narrative was full of stories and sub-plots, although it lacked much focus on her illness difficulties, meaning it was, therefore, difficult to decipher and analyse; it was necessary to ask a number of different questions, which may ultimately give the narrative a sketchy quality.

'They refuse all my application ... related to my husband ...'

'Thank you for your help …'

'I want to talk about my high rent expenses...'

A total of more than twenty questions were asked in order to achieve a comprehensive and detailed background picture, as seen in the answers given.

Stage 3: Identities and Identity Work

As can be seen from her narrative, Mashayer portrays herself as being a desperate heroine whose priority is her husband, with her financial situation recognised as forming her family–medicine relational identity (Mishler, 2004). At the end of this narrative, rather than asking for help and for treatment facilities, as with many of the other participants, Mashayer stated the following:

'Thank you for your help. My husband wants to join us ... '

'I have the entire list on a piece of paper. I can't remember them all.'

In addition, from the last quote, Mashayer has also identified herself as a self-rejected character who only remembered all the details regarding her husband's issues, the applications, and people she has tried to reach, rather than concerning her treatment.

Stage 4: Thematic Priorities and Relationships

This narrative has several different related themes that deal with the socio-economic problems that mental health service users might face; particularly a female when her husband is in the picture. The theme of family relationships within Saudi society, coupled with the importance in terms of assisting one another, has also been revealed in this particular narrative. The patient highlighted her sister, who is helping her to overcome her economic problems, as well as her mental health problems.

'After the diagnose process, they asked my sister to take a care of me.'

'My sister was of a great help for me.'

5.2.16 Critical Narrative Analysis: Khalaf

Khalaf is a male Saudi citizen from the village of Al-Namaas near Riyadh. He sought a faith-healer first and then asked his mother to help him access and use mental health services. Khalaf has accepted his illness and does not feel stigmatised. He engaged well in a society and had a job and did not feel ashamed to fight the stigma. He is also supported by his family, who accepted his mental health issue.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

In Khalaf's quest narrative (Frank, 1995) it told a story of struggle when it comes to maintaining control over his life and achieving the rewards and accomplishments for the successes that he considered he deserved. He has accepted his issues and his mental health problems and was ready to feel better and re-join his family.

'I would be grateful if you help me out to transfer to Riyadh and join my family.'

Another captivating element detailed in his story is demonstrated when he started providing details about the symptoms he experienced, his feelings, and the reactions demonstrated by his family.

'I was 15 years old ... I was depressed, I begged my mother to take me to the doctor...'

'My mother took me to the doctor. I am not sure if her decision was right or wrong... They have prescribed for me some medicines related to stress.'

An emotionally positive tone was present throughout Khalaf's narrative, as communicated via the details provided regarding his life in relation to his environment, himself, his father, and the treatment procedure as a whole:

'My father is supervising the whole situation …'

'My father gives me the shots …'

'My father is a soldier in Riyadh …'

Rhetorical elements, including the excessive use of movement verbs, revealed an energetic attitude:

'I passed my high school with good grades.'

'I have joined King Saud University, Education department.'

'I started a new training, with 4 months of practice.'

'I have graduated.'

'I've got a job.'

'I became a new person.'

'I am paying more and more attention to my prayers.'

'It is getting better, ethics and good cooperation.'

Overall, Khalaf has reflected the sense of willingness and desire to overcome his situation and once again become an integral part of his family, with the feeling that otherwise, he could experience loneliness.

Stage 3: Identities and Identity Work

Khalaf puts himself across as being a good example of an individual who had overcome several different problems, but who deserved to see his wishes come true. Khalaf has a positive, energetic heroic identity.

'I want to be transferred to Riyadh next to my family; may I say something, actually I tried hard to join this association (charity), and I have provided reports to Dr S and the SF … my father told me let it go smoothly, do not do anything now … but it is now so hard, as I have been told to wait 3 weeks to provide our report…'

'I confessed to my father that I am doing my best to join the association and move to Riyadh … he told me that they are afraid to take such a decision … so the whole matter was postponed until the next year …'

Khalaf identified with fights and battles associated with the pressing desire to move, but also saw himself portrayed to those decision-makers who might have control over his life, with the view that they might consider him to be a weak and a 'helpless hero':

'My only demand is whether it is possible to help to move to Riyadh; if it is not possible, then I will wait for the next year.'

Stage 4: Thematic Priorities and Relationships

A developing and very important theme was identified and apparent in the current narrative related to the social level and the overall importance of knowledge in facing mental health problems. Khalaf was recognised as belonging to a family where the father seems helpful, comprehensive and supportive; the mother is also acknowledged as adopting a key role in the family, where she was present throughout the course of the interview, contrary to some of the other interviews, where the word 'mother' was rarely dealt with.

'I was 15 years old... I was depressed, I begged my mother to take me to the doctor...'

'My mother took me to the doctor. I am not sure if her decision was right or wrong...they have prescribed for me some medicines related to stress'.

'My father is supervising the whole situation…'

'My father gives me the shots…'

'My father is a soldier in Riyadh…'

'I confessed to my father that I am doing my best to join the association and move to Riyadh… he told me that they are afraid to take such a decision … so the whole matter was postponed to the next year…'

This supportive aspect has created a strong social bound between the patient and his family, which is recognised as being one of the most important key features that allowed us to depict the importance of the family in handling mental issues.

'My only demand is whether it is possible to help to move to Riyadh; if it is not possible, then I will wait for the next year.'

'The only thing I ask for is to know whether the charity's administration really helps me out; I would be very grateful if that happens.'

5.2.17 Critical Narrative Analysis: Nader

Nader is a male Saudi citizen from Riyadh, who holds a diploma in financial and banking business. He has transferred between the departments in different companies due to his mental health issues. Nader has accessed private mental health services for two years following a faith-healer's attempts to help him. Due to being overwhelmed by the cost of medication, he accessed and used statutory services. In regards to his mental health problems, Nader's family supports him, and he has also been supported by the Saudi charity in finding him a job. However, he still felt stigmatised and discriminated against.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Throughout the process of slowly foreshadowing Nader's story, there is the identification and emergence of a gradual descriptive chaos narrative (Frank, 1995), with the interviewee presenting his story with emotion, numbers, and various instances of sparse details about his past and present:

'I've got mental health issue in 2006–2007. Thank God it is stable now.'

'I had a car accident ... because of the voices I was hearing …'

'In 2007, I lost weight and was 55kg...'

'I have lost my appetite …'

'I could not pass in my exams, all my friends did, but me …'

'I had a chronic depression …'

The narrative provided by Nader introduced a somewhat tragic tone, combined with negative feelings, whilst simultaneously experiencing overt emotions, recognised across the few details provided throughout the course of the interview. The beginning of the story was first introduced with a preposition indicating time, as if Nader did not want to talk about that part of his life; he would rather deal with the aftermath. This was made clear through several different statements and comments:

'After travelling, I started to hear voices, looking for any treatments, then started studying; however, I could not graduate, as I started the treatment after that …'

Brief, simple sentences in syntax, but nonetheless complex in meaning, were present throughout the duration of the interview.

'I have lost weight.'

'As previously mentioned, I heard voices.'

'To start a treatment, I had to quit the medicines …'

'Then my father suggested to be transferred to the M hospital.'

'I am 31 years old.'

'I went to many clergymen (faith-healers), more than one, they used to give me stuff that I do not really take …'

The use of adjectives was also recursive throughout this somewhat short narrative. Nader used one or another rhetorical

technique in order to reflect his pain and regret, as well as the negative emotions he was feeling overall:

'Sloth', 'With', 'Uncomfortable', 'Expensive', 'Very bad.'

Another message detected in this narrative was 'regret', although this was spoken in an inverted way:

'I started to see people that I do not know, hear voices that give me orders to do things, I have tried to hurt myself more than once, but thank God, this did not happen … I had a car accident because I have listened to these voices. I was compelled to have the car accident. I know the question, but thank God; as I have previously said, I used to hear voices …'

Stage 3: Identities and Identity Work

Nader identifies himself as being somewhat submissive to the voices he heard; however, because he obeyed them, this subsequently led to an attempt to harm himself. He then made the decision to put himself forward to receive treatment and not to hurt himself anymore.

'I have tried to hurt myself more than once, but thank God, this did not happen.'

Nader also identified himself as a help-seeker owing to the fact he made me feel his will and readiness to seek out, identify and find help in order to feel better.

'They will check my file, if there will be any financial assistance available for me, I always get along with Miss J concerning the financial help, I swear I do not work, I am not employed because of my mental health issue, if they provided me with financial assistance, I would appreciate their reply.'

Stage 4: Thematic Priorities and Relationships

During the course of this narrative, a number of different themes were revealed. Seeking faith-healer support and help, as with most interviews, shows the common belief in Saudi society, where people tend to seek such help and ask for God's mercy more often than they would refer their patient to seek medical help.

'I went to many faith-healers, more than one, they used to give me stuff that I do not really take…'

The cultural shocks and social constraints, as experienced by many Saudi students when travelling abroad for educational purposes, were also identified as a further potentially revealing hint in the current interview—a hint that shows the way in which some students deal with new life situations far away from their hometown and native country.

'After travelling, I started to hear voices, looking for any treatments, then started studying, could not graduate as I started the treatment later on.'

The supportive family and the theme of family assistance were also dealt with in this narrative. The patient gave the impression that he enjoys close bonds and relationships with his family, who have shown him a great deal of help and support.

5.2.18 Critical Narrative Analysis: Bandar

Bandar is a male Saudi citizen from the western region of the KSA. He was an addict who delayed his own access to mental health services for ten years without seeking any other treatment. Bandar's family supported him to access mental health services following ten years of not really being able to help him. Bander's addiction has deteriorated multiple times, due to treatment fluctuations, which led

him to divorce, and his family stopped supporting him. Finally, he accessed the services by himself; this time, he succeeded in his treatment programme, his wife returned to him, and he became more confident. Even though he is still waiting for a job, Bandar now accepts himself and does not feel stigmatised and he is engaging in regular group therapy to avoid relapse.

'When I accept myself, I would finally have accepted by family, community and others.'

This reflects fighting self-stigma. Bandar made various suggestions regarding the treatment programme:

'The current treatment programme has a lack of family awareness and involvement in the treatment. We need to have a governmental programme focusing on family involvement in their relative's case from the beginning until the recovery, rehabilitation and engagement phase.'

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

There was a very dominant and captivating informative argumentative element to Bandar's chaos narrative (Frank, 1995). An overview of the past, his behaviour, thoughts and feelings were all generously described:

'The mental health issue started when as a behavioural unbalanced attitude, I was a very naughty person at school, I love to hurt people, and I love to be with naughty people... I love to do things secretly...'

'At the end, this behaviour grows up with me, at the beginning I love to do weird stuff... I secretly drive cars at a very young age...

I know it is wrong, but I enjoy doing things when I know it is wrong and I am not allowed to do them...'

'No, it is a character; it is because of the drugs.'

'I used not to believe in these rehabilitations programmes…'

The assertive tone was represented in the main aspects of Bandar's narrative, in which different figures of speech, adjectives, definitions, argumentations and description were recalled. Long sentences, detailed narrative, and descriptive passages were used. His narrative did not come easily to him; it was more a trial and struggle to clear things up in his mind and introduce the decision that led him to receive treatment.

'I have a got a divorce, was in a bad situation, I lost control over everything, even my family left me... I had struggled until I joined the treatment, then I decided to join the Programme at the Saudi Centre...'

To make himself clear and accordingly convince the listener of how right he was, as a stable, open-minded person, Bandar used the word 'because' more than 15 times, presenting a justification defensive mechanism.

A positive emotionally charged tone is also detected, as Bandar suggests dealing with this current research in a unique way:

'We have a problem in the KSA I would like to talk about, and it is related to your research, and I find it really important. We do not deal with this matter like in Egypt, for example, which is the communication between the drug user and his family after the rehabilitation phase. Of course, after my programme, and all bad things were erased. Even my lifestyle has changed, it is not like before, when I loved being alone and would do wrong stuff; I have

changed, and they have noticed that I have changed, they do not have any idea about how to deal with me, because the drug user can easily run back to drugs, and here comes the family's awareness role, which is more important than the self-awareness itself.'

and:

'The media has to interfere to raise awareness of how to deal with drug users.'

The result he gives, in addition to the points he emphasised in a direct figurative technique, is crucial in a matter of community awareness through the various media.

Stage 3: Identities and Identity Work

Throughout this informative and highly detailed narrative, Bandar portrayed himself as erudite, reaching three corners of the triangle: me, society and family (Mishler, 1999). He saw himself as an experienced protagonist who, despite his journey, had learnt good lessons to formulate his optimistic hero identity:

'Even when I was consuming drugs, I had positive results that were beneficial, not only negative.'

'It is an individual decision to stop using drugs.'

Bandar also portrayed himself as a blamer and a social worker. He blamed the family for not helping their drug-user relatives, and told of two short stories regarding the suffering that people he knew in the rehabilitation programme were facing:

'The family is putting pressure over them; they do not know how to deal with him and where is the family in this issue?'. 'The family is the cause; they always look at him as a drug consumer…'

Finally, Bandar portrayed himself as a self-educated person and a decision-maker.

'…been to six hospitals, [but] every time, I leave, I was not convinced, right, but at the end when I felt ready and confessed that I am a drug consumer and I need a treatment; thank God, everything went well, but honesty and saying the truth should be there from the beginning.'

Stage 4: Thematic Priorities and Relationships

The main theme developed in the current narrative related to drugs in the KSA, as well as its drawbacks and its results.

'The sickness started when as a behavioural unbalanced attitude, I was a very naughty person at school; I loved to hurt people, and I loved to be with naughty people...I loved to do things secretly...'

'At the end, this behaviour grew up with me, at the beginning I loved to do weird stuff...I secretly drove cars at a very young age...I knew it was wrong, but I enjoyed doing things when I knew it was wrong and I was not allowed to do them...'

'No, it is a not character; it is because of the drugs'

'I used to not believe in these rehabilitation programmes...'

Another theme revealed from this narrative—and it is the narrator who raised the subject—concerns the relationship between the drug abuser and society; how they deal with them, how they behave towards them, and how they marginalise them.

'We have a problem here in the KSA that I would like to talk to you about, and it is related to your research, and I find it really important. We do not deal with this matter like in Egypt, which is the

communication between the drug consumer and his-her family after the rehabilitation phase. Of course, after my programme all the bad things were erased... even my lifestyle has changed; it is not like before, it is like before I loved being alone, and doing wrong stuff. I have changed and they have noticed that I have changed; they do not have any idea about how to deal with us, because the drug consumer can easily run to drugs, and here comes the family's awareness role, which is more important than the self-awareness itself'.

'The family is putting pressure over them'...

'The family does not how to deal with him-her…'

'Where is the family in this issue?'

'The family is the cause...they always look at him as a drug consumer…'

5.2.19 Critical Narrative Analysis: Adam

Adam is a male Saudi citizen from the western region of the KSA, who was an addict who delayed accessing Mental Health Services for an 11-year period without seeking any other treatment. He was encouraged to be an addict by his brother and friends and was admitted to hospital more than six times; his addiction deteriorated whilst he fluctuated in treatment. Adam has been supported and encouraged by his brother to access an addiction therapeutic centre, which helped people to engage in the community. Since that time, Adam has committed to five programmes and has successfully passed them. He is currently accepting himself and does not feel stigmatised and engages well in the community. He worked for a period of two years in the same centre as a volunteer recovery guide. Adam recently joined an online programme called 'The Anonymous Addict

Programme', Which holds online meetings to discuss drug addict issues globally. He is now planning a new job and to get married and have a healthy family.

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Adam's quest narrative, detailing the story of a drug consumer struggling to find peace, whilst also improving his situation (Frank,1995), has provided a strong and detailed portrayal of a long journey of struggle, with the individual at the centre still maintaining hope. This journey lasted a period of ten years, and was complete with different twists and short-term resolutions:

'I thought that consuming drugs is okay.'

'I had many law-suit files against me – I was imprisoned, but now I am out; I have never thought that going to rehab is beneficial, neither going to a clinic. I have always done the same mistakes over and over and every time different results, and I do the same mistakes again and again for ten years. Then I decided to turn the page and go to A Hospital for the first time.'

The captivating tone in this narrative was a mixture of regret and drama (Frank, 1995). There were two parts to the story, notably the before and the after. The first part ('before') included his actions or deeds, thoughts, emotions, and decisions, whereas the 'after' provided the stepping-stone that encourage him to make changes in his life, join a rehabilitation programme, and seek help. The 'before' narration was full of complex sentences and long descriptive passages, comprising at least six subordinates:

'When I was 7 years old, I had around 250gr of Marijuana between my hands. I did not know at that time what it was …'

'I thought that consuming drugs is okay. When I was twenty years old …'

'I thought the government does really pay attention to drugs …'

'After I have started to be a consumer, I knew that it was illegal ...'

'The problem was that I had become an addict …'

'I have used many other drugs …'

'I live to consume; I live to consume …'

'I have lost my job …'

Adam presented his life events and used a number of different instances of flashbacks and back-stories to speak about his history, complete with the presence of a fusion between thoughts and feelings, adopting a chronological rhetorical technique:

'I have lost four job positions. Every time I start a job, I lose it. After nine or ten years, I never thought of starting a rehab programme ...'

'...It means I left the job, I went to jail, went out, went back. I consume drugs, I find a job, I consume drugs again...'

'I used to find the programme very boring, I'd regain my health... I finished a 7-month programme and, after leaving, I went back to drugs within three or four months ...'

Stage 3: Identities and Identity Work

Adam portrays himself as a weak person when it came to dealing with drugs and puts himself across as a person who has tried

many different rehabilitation programmes, but each time felt that it failed to work well for him. However, he also blames the programme.

'I think there is a flaw in the programme I have joined ... this programme gives the opportunity to spend the recovery period outside the centre.'

Adam also identified himself as a solution, adopting an alternative solution-provider relational identity (Mishler, 2004). As can be seen through his tendency to compare all the programmes he has joined, stating what make some more effective than others, and what works well for him more so than others. This alternative solution provided information about the centres' policies, and experts' behaviour, professionalism and ethics.

'... I have appreciated the way how they welcome newcomers, including experts, doctors, psychiatrists...they all had a good experience ... sincerely it makes you want to stay, not boring as if you are in a trip.'

'I have been here for two years ... I was benevolent, then I was recruited, and I will pursue my path, hopefully ... I have even had sessions in coaching in Egypt and Malaysia…'

'I have lost a lot, no benefits till now. I have been jobless for four months, and I am looking for a job and pursuing my programme.'

Stage 4: Thematic Priorities and Relationships

This narrative has presented several different interrelated themes, all of which can be associated with a developing process from facing a problem through to identifying a solution. Drugs, society and users—the trilogy that this narrator emphasises—seeks to sew a strong relationship between its three components.

'I thought that consuming drugs is okay.'

'When I was 7 years old, I had around 250gr of Marijuana between my hands. I did not know at that time what it was …'

'I thought that consuming drugs is okay when I was twenty years old…'

'The government does really pay attention to drugs…'

'After I started to be a consumer, I knew it was illegal ...'

'The problem is that I became an addict…'

'I have used many other drugs…'

'I live to consume; I live to consume…'

Because of this drug issue, Adam ended up in a rehabilitation programme that, in his opinion, both the Ministry of Social Affairs and the Ministry of Health should consider and accordingly seek to tackle, such as by devising and implementing a plan in mind of collaboration with one another and finding a solution.

'I used to find the programme very boring, I regained my health... I finished a 7-month programme, and after leaving, I went back to drugs within 3 or 4 months...'

'I think there is a flaw in the programme I have joined... this programme gives the opportunity to spend the recovery period outside the centre'.

5.2.20 Critical Narrative Analysis: Majed

Majed is a male Saudi citizen from the western region of the KSA, who was an addict (drug user) that had delayed accessing mental health services for a period of eight years, without seeking

any other treatment. He was motivated to access mental health services by a colleague. Majed's story started when he was encouraged to become an addict by his friends at the age of 17; and when his father noted his personality change due to drugs and immediately changed his school. When Majed got a job, he found the environment ideal to return to drug addiction (with money and addicted friends). At that time, he became a heavy addict, until the time at which he was involved in a legal case and was sent to prison. After he was released, he went back to drugs for eight years until he was advised by his job colleague to access mental health services. Majed was subsequently discharged from prison, but he still needed his family's trust and support.

Majed felt stigmatised by both his family and the community. For that reason, he joined an addiction programme, which helped him to engage in the community and taught him how to deal with life's obstacles in a creative manner. Majed gradually became respectful and accepting of himself, as he became more flexible and optimistic. Finally, he attained the position of the head of the addict team group and will now start a new job with his father.

In addition, Majed presented some advice for addicts or mentally sick people:

'People with mental health issues recommended to work on themselves to elevate their self-esteem, then this self could fight the stigma and lead them to engage in the community and be an active member.'

'No decent life with drug usage, it is only a bad way with three choices of the prison, the hospital, or death.'

He also advised family to:

'Give their children trust and frequent support.'

And:

'Involve them in daily work and responsibilities for being independent ones at an early age.'

Stage 2: Identify Narratives, Narrative Tone and Rhetorical Function

Majed's narrative presents a journey that expands across past feelings with the inclusion of current ones, in addition to past thoughts and current ones. He also provides details of his story in a descriptive narrative, as communicated using long passages that move back and forth from the past to the present and back again (Frank, 1995; Savage et al., 1996).

'My journey with drugs started when I was at secondary school… I have tried it and that was the cause that led me to advanced levels of consummation… thanks to it, I experienced the feelings of ecstasy, drug ecstasy'.

Majed's quest narrative revealed a somewhat tragic tone, full of anxiety, fear and timidity (Frank, 1995). The past events in the main story itself were seen to be broken down into three individual phases: the narrator implemented the main elements, including the settings, the characters and the conflict, with the resolution then provided:

'My trip with drugs started when I was at secondary school.'

'I joined the army, which was a fruitful floor to be an addict, as I used to work in a very far location … everybody around me was an addict …'

'It was a second phase of my drug addiction.'

We quickly begin to identify new positive tones in the second half of the story, which comes to light with thanks to help provided by a colleague:

'Why don't we seek help and receive treatment … it is all secrecy … you do not worry about that, they will embrace your problems …'

'That was the good opportunity for me to receive treatment and feel well …'

Stage 3: Identities and Identity Work

From the beginning, Majed communicated himself as being a victim of his illness – victim to balanced identity (Mishler, 1986). When looking behind the words, he was the cause, and the results of his life decisions positioned him as being a victim to his illness. This is a kind of self-projection that was created thanks to the programme he joined:

'I am the victim of my disease.'

'… I started cleaning and healing sessions … I was feeling well, I recognised myself, I had the chance to better know myself that I am able to live, I live my life without drugs; it is an unconditional feeling different than before, and I am psychologically feeling better and feeling better at the continuing care centre.'

Majed identified himself as a timid, victimised person who had been oppressed, but who, inside, had always refused his family principles, rules and ethics:

'I used to be a fearful person, it means I grow up in a very conservative family, who have religious ethics, etc…'

'Drugs used to decrease my fears; I used to feel that I am man enough …'

'When I quit drugs, I used to have a feeling of fear and of course timidity.'

The experience of protagonist in Majed's declarations was shown as:

'I have only words I have to drug addicts; drugs lead whether to jail, or to hospital or to death; there is no fourth choice, there is no dignity when we are under drugs … Many people I know have lost their honour because of drugs.'

Finally, Majed communicated himself as being an experienced protagonist who did not provide choices, but who was tough and straight.

Stage 4: Thematic Priorities and Relationships

The developing theme can be seen to be revealed and identified in this particular narrative, with the theme of drugs in Saudi society. One can easily recognise here the drawbacks of frustration that push Saudi youth to drug issues, despite the hegemony of the religious belief and theological principals.

'My journey with drugs started when I was at the secondary school… I have tried it and that was the cause that led me to advanced levels of consummation… thanks to it, I have experienced the feeling of ecstasy, drug ecstasy.'

Another theme can be identified in this narrative, contrary to other narratives, which is the spread of the drug phenomena across the official and professional field. The narrator is an officer, and it was easier for him to use drugs during office hours.

'I joined the army, which was a fruitful floor to be an addict as I used to work in a very far location… everybody around me was an addict.'

Family support and assistance was seen to be lacking in this narrative, which goes some way to highlighting how even the closest people can stigmatise drug abusers—a feeling that creates a self-stigma and self-rejection.

'Drugs used to decrease my fears; I used to feel that I was man enough.'

'When I quit drugs, I used to have a feeling of fear and of course timidity.'

5.3 Common Themes extracted from Twenty Stories

As can be seen when reviewing and analysing the narratives provided across the twenty participants, there are several key themes identifiable as present in the field of service users' experiences. These are as follows: the influence of faith-healers in the common belief as a first rescue and their importance in manipulating Saudi culture; widespread stigmatisation and socio-economic problems, encompassing financial and social issues and drug use; psychological distress and mistrust or suspicion of medical assistance; the lack of belonging and lack of family assistance, support and help; and family relationships and support (see Table 7 for individual themes and participants' clustering and Table 8 for overarching common themes extracted from the twenty participants).

Table 7: Individual Themes and Participants' Clustering

No.	Participants' Gender	Clusters of Participants	Individual themes
1	Male	Mental health issues	• Mental health stigmatisation in a society ruled by theological principles and traditional customs. • The influence of faith healers in the common belief as a first rescue. • The lack of belonging and support.
2	Male	Mental health issues	• Non-supportive family influenced by the cultural customs, traditional beliefs and stigmatisation. • Themes related to stigma and discrimination.
3	Male	Mental health issues	• The influence of faith healers and their importance in manipulating the KSA cultural background (to be as equal as the scientific point of view when dealing with medical assistance). • The interrelational boundaries within KSA amongst families.
4	Male	Mental health issues	• The lack of knowledge and the seeking of magician to help as a refuge to deny mental health issues. • Family is not supporting in seeking medical help and referred to the faith healers. • Overwhelmed with medication costs and stigmatisation
5	Male	Mental health issues	• Socio-economic problems-related themes. • His personal and financial situations affect his illness.
6	Male	Mental health issues	• The financial and social life theme • The consequences that children might face as a result of their parents' divorce. • The theme of social instability.
7	Male	Mental health issues	• The psychological distress and mistrust between the patient and the health care services/practitioners or treatment.

			• The importance of family support
8	Female	Mental health issues	• Them of the widespread stigmatisation • Theme of reluctant to disclose more personal accounts of experiences with mental illness and associated problems for fear of being judged or negatively labelled.
9	Female	Mental health issues	• getting married in the KSA culture remains hugely important for females from a social /psychological perspective (it clearly creates a certain balance for her personal ego and even in terms of her image in the KSA society). • The KSA society is a conservative society, where the woman is not considered to be effective unless she has adopted the role of being a wife, a mother and family, proving herself responsible.
10	Male	Mental health issues	• Themes of lack of knowledge and missing professional assistance. • Theme of constant feeling stigmatisation. • Theme of feeling of mistrust or suspicion of medical help.
11	Female	Mental health issues	• The role of faith healers in the treatment process of mental illnesses in the KSA and associated ailments. • Theme of the identification of the common belief in the existence of magic and sorcery • Mental health issue stigmatisation in the KSA.
12	Male	Mental health issues	• The importance of faith healer as a first port of call before seeking the help of a medical professional. • The image and stigma related to mental health illness in the KSA preventing people from being socially active.
13	Female	Mental health issues	• Theme of seeking faith healers' help • Theme of the importance of getting married for females in the KSK which creating social balance. • Theme of feeling of stigma

14	Female	Mental health issues	• The theme of faith, along with its influence on the patient's jargon and vocabulary. • The theme of the ethical principles are all resources from the individual's own religious beliefs.
15	Female	Mental health issues	• The theme of socio-economic problems that the mentally health people might face. • The theme of importance of family relationships within the KSA.
16	Male	Mental health issues	• The theme of belonging to a family. • The theme of a strong social bound between the patient and his family.
17	Male	Mental health issues	• Theme of seeking faith healer's support and help. • The theme of close bonds and relationships with family
18	Male	Substance user	• The theme of the relationship between the drug abuser and society • Stigma and Non-supporting family themes.
19	Male	Substance user	• Interrelated themes, all of which can be associated with a developing process from facing a problem through to identifying a solution. • Stigma and lack of family support themes.
20	Male	Substance user	• Theme of drugs in Saudi society and the drawbacks of frustration that push Saudi youth to drug issues, despite the hegemony of the religious belief and theological principals. • Stigma and lack of family support.

Table 8: Common Themes of the Findings

Overarching Common Themes extracted from the twenty participants
1] The influence of faith-healers in the common belief as a first rescue and their importance in manipulating Saudi culture. 2] The widespread stigmatisation and socio-economic problems, encompassing financial and social issues and drug use. 3] The psychological distress and mistrust or suspicion of medical assistance 4] The lack of belonging and lack of family assistance, support and help, and the importance of family relationships and support.

5.4 Analysis

In light of these findings, it is apparent to see the degree to which Saudi Arabian society views individuals with mental health issues. As an example, it was stated by various subjects (Faris, Kareem, Yasir, Othman, Mdawy, Salmah, Awaad, Amal, Rami, Bayan, Monerah, Mashayer, Khalaf, Nader, Bandar, Adam and Majed) that stigmatisation was an issue, with the following statements made to support this perception:

'I decided to leave this 'stigma' and defend myself.' (Faris)

'I knew then I was a victim of ignorance, I was having hard time of struggling.' (Faris)

'When I was the middle school, I tried to have friends, but I could not... They do want to be friends with me.' (Amal)

'… 100% bad prejudice ... Little by little, I felt like I have to accept myself, and if I do not accept myself people will not accept me. I have to make people accept the psychological problems and behave well ... after a while I felt like they had started to respect me.' (Rami)

Conversely, however, some of the subjects felt as though stigmatisation was not a problem for them, as can be seen echoed in the comments below:

'…it has a bad influence on my work … but the association promised to help me out in finding the suitable job.' (Bashar)

'…it has a bad influence on my work … but the association promised to help me out in finding the suitable job.' (Kareem)

It would seem that the stigmatisation associated with mental illnesses and accessing mental health services of such is lessening in

the Saudi context. Even though this cannot be said definitively, it would seem to be a just conclusion to draw owing to the fact that some of the participants in this study do state that they have received support from family and/or friends, without there being any kind of issue, with much acceptance demonstrated by their families. Notably, however, stigmatisation does still remain, as detailed in the statements made by some of them, such as Faris, Amal and Rami (see above), amongst others; and thus, stigmatisation has not been entirely eradicated. This could reflect the emancipatory benefit of the narrative inquiry approach.

Furthermore, Saudi culture is recognised as a culture that is strongly dominated by religion, spirituality and having shown a preference for more traditional faith-healers in seeking help for mental health issues, with such treatments allowing family members to remain 'under the radar', without the community being made aware of any such problems, and thereby 'disgracing the family'.

Particularly, however, this approach to access and use mental health services seems to be changing, with many of the participants highlighting the support they have received from their families in regards to the pursuit of accessing mental health services' treatment and the combination of utilising both a cultural-spiritual model of faith-healers, alongside a medical model. This can be seen in the statements provided by who made some of the following comments:

'…both the Muslim faith-healer and doctors confirmed that I had mental health issues...' (Kareem)

'…my father told me that he noticed that I was not sleeping well—how about we take you to a hospital. There are a couple of competent doctors who can take care of you and treat this insomnia. I felt better and better.' (Kareem)

'My cousin helps me to go to the hospital.' (Hameed)

'I went back to the magician … then I decided to take the medicines…' (Hameed)

'I was 28 years old. I could not sleep – I went to a healer, but this did not help me, so I went to the M Hospital. They gave medicines and I felt better.' (Yasir)

The above examples show that opting for both traditional healers and hospital/doctor-prescribed medication seems to be viewed by the patients as acceptable.

It would appear, in line with the interviews carried out across the participants, that the paralleled use of faith-healers (i.e. a spiritual model, alongside the use of accessing and using mental health services (the medical model) would be advantageous, with some of the individuals emphasising that the non-official spiritual healer did not work, although medication did. It was found amongst the majority of the participants adopting this approach that family support in this management approach was supported. This can be seen in various statements, as shown below:

'My cousin helps me to go to the hospital.' (Kareem)

'…my father told me that he noticed that I was not sleeping well—how about we take you to a hospital. There are a couple of competent doctors who can take care of you and treat this insomnia. I felt better and better.' (Kareem)

5.5 Conclusion

It would seem that the approach of combining contradictory paradigms (faith-healer and the medical model) to help facilitate access to mental health services is accepted in the KSA, especially if

the first port of call is the spiritual/faith-healer. However, an explanatory model is required that may incorporate both paradigms that satisfactorily improves the journey for people experiencing mental distress, whilst also honouring their social, cultural and religious experiences, and ensuring that they receive effective treatment. Faith-healers play a critical role in the treatment of mental health by providing culturally congruent forms of help. Diverse types of religious beings have been discussed in the Islamic texts, including evil eye, spirits, demons, jinn or sheitan (Dein, 2020). Specifically, the jinn spirit has often been associated with mental illness; religious healers are believed to exorcise these malevolent spirits by reciting the Quran. Jinn has been largely evoked in the aetiology of epilepsy and florid madness. Other explanatory models focus on the jinn, evil eye and witchcraft; the evil eye has been associated with personal misfortunes and illnesses (Alsubaie et al., 2020). Further, the multi-dimensional models of understanding mental illness recognise the role of the supernatural, biological, and social factors in the treatment of mental illnesses.

The multi-dimensional model is relevant, as a significant percentage of people initially seek help from faith-healers before they consult mental health practitioners. Over the last decades, health-seeking behaviour has been prevalent and the key reason for this is that faith-healers offer services that are congruent with the beliefs of patients and their families. While faith leaders attribute mental illnesses to external causes, such as jinn, mental health practitioners link the cause to human experiences and internal factors. Hence, religious people are likely to seek the help of faith-healers because they attribute mental illnesses to supernatural explanations. Al Eid et al. (2020) found that many people in the KSA positively associate mental health with spirituality and religious faith. As a result, an individual’s health-seeking behaviour is determined by their coping

mechanisms and the support system provided by cultural and religious practices. It is for this reason that healthcare service providers should take into account people's pluralistic approach to help-seeking and integrate faith-healing into formal mental health services.

In addition, the multi-dimensional model of treating mental illness takes patients' preferences into consideration. Based on the need to provide holistic care, faith-healing should be at the core of the care process. The active involvement of faith-healers demonstrates the role of faith and spirituality in health. According to Hickey et al. (2016), the incorporation of faith-healing practices in contemporary mental health care leads to the effectiveness of services offered to patients.

Healing is a core component of all religious systems. Faith-healers aim to restore wholeness and health, while alleviating human suffering. Therefore, faith-healing, is deeply embedded in religion and embraces all dimensions of life, including social, psychological, physical, and spiritual. Access to mental health care services does not considerably reduce people's dependency on faith-healers. The study's findings also reveal that people simultaneously visit faith-healers, even when mental health services are easily available, which is supported by a recent study by Al-Habeeb et al. (2020). The recognition that faith-healers remain popular, despite the reforms in the advocacy for mental illnesses and the expansion of mental health care to communities, underlies the need to combine the models of care. It is, therefore, important for mental healthcare practitioners to form collaborations with faith healers to promote alternatives for treatment. There is a lack of standard procedures on how such collaborations are able to be achieved.

From the current study, narratives of mental health and religion provide support for the integration of religious practices into mental health care. Greater belief in God correlates with generally high levels of mental well-being. Research has focused on the impact of religion on coping, as 'positive religious coping' has been clearly associated with mental health, while the reverse effect can be observed in negative religious coping (Dein, 2020; Saritoprak and Exline, 2020). Invoking help and confirming faith facilitates control and reduces uncertainty and anxiety, provides meaning in life, and enhances feelings of social support. Additionally, religious practices have been found to restore social and psychic equilibrium. These aspects of faith and spirituality enhance mental well-being.

Combining the two models can also minimise delays in accessing and using mental health services. When faith-healers are accessed in their religious settings (mosques or religious institutions), people are likely to first seek their help before they seek mental health treatment from health care services (Pham et al., 2021). Integrating faith-healing into modern mental health care services settings means that mental health practitioners work collaboratively with faith-healers; therefore, reducing the delays in treatment, which often result in adverse outcomes due to the delayed contact with medical professionals. Having faith-healers in the healthcare system has the potential to improve the timely diagnosis of mental illnesses and to promote the utilisation of mental health services.

Mental health patient satisfaction in healthcare is more likely when the explanatory models of illness are taken into account and elicited. However, the integration of faith-healing in formal mental health services also faces some significant problems that need to be addressed. For example, the holistic combination of the two schools has practical difficulties due to how each is practiced, managed, and

evaluated. The regulations, rules, and standardisation of how faith-healing is practiced, though, are notably lacking. Given that faith-healers are an important resource for mental health care in the KSA, providing services that accommodate religious and cultural beliefs, a standard model is required to guide the incorporation of both paradigms and improve the experience of people with mental health issues, whilst also appreciating and respecting the social, cultural and religious context of the individual.

This study suggests that mental health practitioners could form collaborations with faith-healers to promote alternatives for treatment. However, this collaboration may need to highlight some significant issues related to Saudi women in particular, who might need gender-specific care measures in involving her family members in the holistic care or even in the combination of the two schools, which include how each is practised, managed, and evaluated. Meanwhile, the lack of regulations, rules, and standardisation of how faith-healing might work with health care providers is still unknown in the KSA.

The current study provided voice to six Saudi female participants to share their own experiences in accessing and using mental health services in KSA. However, further narrative research is needed to explore the stories of more Saudi women who face mental health challenges and how they cope with their illnesses while shouldering the responsibility of taking care of their families and meeting their family members' needs. This burden of Saudi women is considered normal in Saudi society, and it is essential to shed more light on it through additional narrative research.

Chapter 6: Discussion

6.1 Introduction

In this chapter I discuss the findings of my study by applying the fifth stage of Langdridge's critical narrative analysis, which he refers to as 'destabilising the narrative'. This involves examining the data in light of critical theory. To achieve this, I will use the lens of Vygotsky's macro-culture psychological theory, which was introduced previously. I am also mindful of the work that Ricoeur and Thompson (1981) undertook, who argued that humans are not only situated physically, but also socially, culturally and politically. As a researcher, at this stage it is crucial to engage with the content of the participants' texts to explore any hidden meanings in an objective way (Ricoeur, 1987; Langdridge, 2007).

Further, at this stage I return to imaginative suspicion (Langdridge, 2007); but rather than turning on myself, as in Stage One, I turn to the narratives. By doing so, I sought to discover the 'below-the-surface' meanings, as well as to make sense of what has been narrated using my 'imaginative suspicion' to interrogate the text. I endeavoured to uncover how the participants' narratives are relevant to my research questions. The complexities of the reliance on faith-healers and the impact of stigma were interrogated as significant barriers that could hinder people from accessing and using mental health services. It became important to understand the depth of these complexities in regards to Vygotsky's theory. I also sought to discover to what extent I had answered my original research questions and what I have discovered in the process, which ultimately added depth to the insights developed through the CNA process.

Ricoeur (1970) appeared to be concerned with the subjectivity of storytelling to strike a balance between the need for objectivity and the desire to stay receptive to what the narrator has to say. His

invention of a hermeneutic of suspicion was one way he claimed that the reader may use art and science: "Hermeneutics appears to be driven by this double motivation: readiness to suspect and willing to listen; vow of rigour and vow of obedience" (Ricoeur, 1970, p.33). Separately, Langdridge (2007) makes it apparent that none of the phases in his paradigm are distinct. In writing this section, I am aware that destabilisation of the narrative will have begun in the preceding chapter.

After grouping related narratives in the previous stage of CNA to extract broad themes, I managed any overlap between individual and collective narratives through emphasising the importance of empowerment in the research process to ensure that the voices of the participants are heard and represented accurately by highlighting the differences and similarities between individual and collective narratives to present the nuances of both. Further, I used the NVivo11 software, which helped to extract the collective narratives from broad themes.

In the Findings Chapter, I identified four common themes that emerged from the data: the influence of faith-healers and their importance in manipulating Saudi culture as a first rescue; widespread stigmatisation and socio-economic problems, including financial and social issues and drug use; mistrust or suspicion of medical assistance; and a lack of belonging and family assistance, support, and help. Each of these common themes contains several nested narratives, which I will explore in the following sections using direct quotes from the research data. My aim will be to retain and enhance the participants' voices in order to prevent letting my own subjective illusions to distort the understanding of their stories.

The identified four nested narratives provide structure for the Discussion Chapter:

- Cultural identity and religion: social attitudes and stigma negatively affect help-seeking behaviour;
- When religious and spiritual beliefs are ignored, mistrust leads to a suspicious dependence on medical assistance;
- Socio-economic problems interfere with access to and use of mental health services; and,
- The lack of a sense of family and social belonging exacerbates mental health difficulties.

6.2 Cultural Identity and Religion: Social Attitudes and Stigma Negatively affect Help-Seeking Behaviour

Vygotsky addressed the relationship between the macro- and the micro- social contexts. Understanding identity calls for a comprehension of culture, society and history that influences how individuals identify themselves. The cultural identity of Saudi participants is strongly influenced by Islamic and Arab/Saudi culture (Abu-Ras, 2014). Arab societies in general are traditional, family-oriented, conservative, and deeply religious (Jelaidan et al., 2018; McCrae et al., 2019).

Not surprisingly, dependence on faith-healers and widespread stigmatisation were common themes in the study. Culture inevitably has a considerable influence on health care delivery (McCrae et al., 2019; Alamri, 2016). The research findings demonstrate that 16 of the participants prefer to seek help primarily from non-medical practitioners, such as faith-healers, who are considered to be life preservers, as a source of care. There are also various overlapping cultural, economic and social issues that could explain help-seeking behaviour from faith-healers. In particular, the prevailing belief system of the Saudi community seems to shape the use of faith-healing among people with mental illnesses. Correspondingly, due to

Islam being a state religion in the KSA, the influence of religion on health-seeking behaviour is profound (McCrae et al., 2019; Alosaimi et al., 2019), and this is confirmed in the current study. Before going to modern medicine, many people seek the help of faith-healers for a variety of psychological problems. It is claimed that faith-healers operate in harmony with a shared world view of Saudi society that includes beliefs in possession, the jinn, evil eye, and magic (Alahmed et al., 2018; Alosaimi et al., 2015). This shows how it is crucial to pay attention to multi-cultural factors (including religious and cultural beliefs) when interacting with Saudis (and most likely other Arabic citizens) who have mental health issues and their families, and subsequently along the journey of treatment.

Faith-healers typically perform religious-based practices, including reading the Holy Quran, to evoke healing, and they follow the provision of the prophet Mohammad with regard to treatment, sickness and health (Jelaidan et al., 2018; Alamri, 2016; Alosaimi et al., 2015). In the current study, citing the Quran was one of the most believed options for the treatment of mental disorders. Given the traditional and religious background of participants, viewing religious practices as a curative adjunct was not surprising (Saged et al., 2018; McCrae et al., 2019). The findings of this study also highlight the significance of faith-healers in their lives as a first rescue or a combined treatment choice. Furthermore, participants recommend establishing collaborative relationships between medical health care organisations and professional faith-healers in recognition of the role of cultural beliefs in the management and evaluation of mental disorders. Therefore, in order to understand the experiences of people with mental health difficulties in the KSA it is imperative to appreciate the significance of the religious/spiritual individual and social identity of its citizens. Two statements from one participant are shown below:

'Thanks to Allah's words, one can feel depressed, Allah is a refugee that we run to, God to Whom be ascribed all perfection and majesty makes it less intense and make you feel relaxed… I have joined some groups of reciting the Holy book, Quran, all of them they recite it and memorise it.' (Monerah)

'Taking the medicines can never be stopped ... then I asked can I keep receiving both treatments the faith-healer and medical one at the same time.' (Monerah)

An example of religious practices to help mental distress is Duaa (talking to Allah-asking), Athkar or awrard (supplications that the prophet Mohamed taught Muslims to say), when they feel sick (Hisnal-Muslim), praying, reading the Quran etc. These kinds of religious behaviours may provide some helpful relief, which could prove beneficial in addressing issues that do not require pharmacological or mental health care interventions. In such instances, faith-healers may prove beneficial (McCrae et al., 2019; Thomas et al., 2015). Despite this, the Islamic religion and the prophet Mohamed encourages people to access treatment wherever it is found (SunanAbiDawud). This view is supported by many recent research studies, which argue that seeking non-medical help can also hinder mental health treatment and recovery in persons requiring medical help (Alosaimi, 2019; Jelaidan et al., 2018). It is for this reason that many participants, who have first consulted a faith-healer for years before seeking mental health services, reported worsened conditions:

'…the religion is over the science and that was the main reason behind my cure delay … I was a victim of society culture and lack of knowledge … etc.' (Faris)

'My family, like the commonly followed beliefs in the KSA, we take patients to faith-healer first.' (Rami)

Accessing mental health services was avoided for various reasons, with the most prominent being the stigma that arose from the association of mental illnesses with an undesirable outcome of behaviours. The findings reveal that cultural beliefs regarding the cause of an illness have been established to formulate peoples' identities (commonly dominated by religion) and they could mainly drive treatment directions. This reflects Vygotsky's theory assumption of identity construction, which mainly relies upon peoples' upbringing. A study of Saudi culture identifies collective decisions and choices that enable understanding why people are reluctant to access statutory services. Furthermore, culture dictates that with any such experience, the faith-healer should be the first interaction.

Religion, jinn and beliefs in magic are, therefore, most likely to influence individuals' help-seeking behaviour (Alosaimi et al., 2015). When community members attribute mental illness to a social cause, they are likely to choose a social route for help, rather than a medical intervention. The findings in this study are consistent with past research findings on this topic. It is possible that this study may help healthcare providers to determine whether faith-healing and other traditional healing practices are non-threatening, harmful, or could be used in combination with health care interventions. Furthermore, faith-healers need to have sufficient knowledge to distinguish between magic, evil eye and psychological disorder symptoms (Al-Habeeb, 2003). However, this would need to be built on recommending a professional and an official faith-healer (official, governmental faith-healers).

In the current study, family, relatives, and friends of patients with mental health issues may hold diverse, multiple, and possibly

contradictory beliefs about mental illnesses. These beliefs can lead to the stigmatisation of persons with a mental health problem. A mental illness is generally considered to be a stigmatising illness that could significantly impact the self-esteem of a patient and, consequently, act as a barrier to accessing treatment- and using mental health services and recovery. The findings highlight the importance of addressing negative perceptions of mental illnesses to reduce delays in accessing appropriate medical treatment. The best time to begin appropriate treatment for mental illnesses is at the identification of the first symptom, and the timing of starting treatment is often linked with the duration of the mental health issues (Abu-Ras, 2014; Hussein, 2014; Alamri, 2016). A robust link has been observed between the outcome of accessing mental health services and the outcome of mental illness problems as an important aspect of mental illness management (Corrigan and Rao, 2012). A delay in treatment may increase the duration of distress experienced by individuals with mental health distress (Anderson et al., 2010) and affected persons may take the trajectory of increased self-harm or harm to others (McCrae et al., 2019). Likewise, with the current study's findings, it also reflects the implementation of Vygotsky's macro-cultural factors theory in practice.

Stigma is a major concern for participants in this study. Persons with different mental disorders are likely to be seen as a burden to the family and they can be rejected by the community (Schomerus and Angermeyer, 2008; Jelaidan et al., 2018; McCrae et al., 2019). The family members of mentally ill persons often conceal the condition from others out of fear of rejection by society and, in the case of mentally ill women, concerns over negative effects on their marital prospects (Alsubaie et al., 2020). Accordingly, Participants were unlikely to consider people with mental illness as close friends (Dardas and Simmons, 2015). Similarly, females with mental illnesses were

less favourably considered as friends. Moreover, female participants in this study believed that they would only recover if they either got married or, and if they were married that they had a good relationship with their husbands who loved them and accepted their mental health issues. For instance:

'She might need a husband, if you do not find a husband for her, her situation might get worse, I am thirty years old now, and no one proposed ... Many came to my family, but they leave. They come and leave; I am ashamed of my real age.' (Bayan)

'I am now feeling better I got married, I have a baby.' (Salmah)

In contrast, males were reported to be leading more successful lives (Alsubaie et al., 2020). Hence, gender plays a significant role in Saudi Arabian culture, where females in marital relations, being dependent on their husbands, always link their well-health, happiness and life satisfaction with their husbands' satisfaction. Within this culture, women's lives are often stressful, as they seek to satisfy their husbands before looking after themselves (Dawood and Modayfer, 2016). The findings on stigma were in concordance with the findings of other studies, such as those that reported discrimination, stigma, and other forms of ill-treatment towards people with mental health issues (Schomerus and Angermeyer, 2008; Alsubaie et al., 2020). Some participants who accessed mental health services also reported a lack of attention from some healthcare providers when they sought medical help. The existence of stigmatisation, even in medical facilities, could signal the need for better training for professionals (Alyousef, 2017; AlSalem et al., 2020).

The findings show that stigma is experienced at two levels: self-stigma and public stigma. Public stigma involves large social groups endorsing stereotypes against the group of persons with mental

illness, while self-stigma is the loss of self-efficacy and self-esteem that occurs when persons internalise the public stigma (Topkaya, 2014; Jelaidan et al., 2018). As a result, individuals with mental illnesses may turn the stigmatising stereotypes and attitudes against themselves (Bathje, 2011). However, public stigma is expressed in the form of discriminatory behaviours and prejudicial attitudes towards persons with mental disorders, with adverse impacts on health care, employment and interpersonal relationships (Vogel et al., 2007; Alyousef, 2017; Jelaidan et al., 2018). At this social level, the stigmatisation and other complex socio-cultural factors have played a significant role in directing the subjects' behaviours in past periods of their lives to seek unprofessional medical treatment or by delaying it. This stigmatisation has had a negative impact on most of the study's participants:

'I knew then I was a victim of ignorance, I was having hard time of struggling.' (Faris)

'… when I was the middle school, I tried to have friends, but I could not ... They do want to be friends with me'. (Amal)

'… 100% bad prejudice ... Little by little, I felt like I have to accept myself, and if I do not accept myself people will not accept me. I have to make people accept the psychological problems and behave well ... after a while I felt like they have started to respect me.' (Rami)

Families, relatives and friends who provide care for people with mental health issues may also endure stigma by association (Alyousef, 2017; Heath et al., 2018); such behaviour and attitudes may impede recovery (Corrigan et al., 2014). Stigma towards mental illness is strong in Saudi Arabia because mental disorders are largely perceived as incurable afflictions. Further, limited awareness and cultural attitudes towards modern interventions hinder people from

seeking mental health treatment (Ae-Ngibise et al., 2010). Robust relationships are considered to be a crucial context of continuing treatment and recovery, and therefore families have to learn to build a strong relationship (rapport) with their relatives with mental illness.

'When I accept myself, I would finally have accepted by family, community and others'. (Bashar)

'I really needed someone to listen to me'. (Faris)

6.3 When Religious and Spiritual Beliefs are Ignored, Mistrust leads to a Suspicious Dependence on Medical Assistance

The theme of mistrust was found in the narratives. Culture impacts upon how health care professionals conceptualise the causes of mental distress, which may lead to variations in choices of intervention (De Hert et al., 2011). In the KSA, the social focus of the causes of mental distress is mainly on religious and supernatural factors, while in western countries, the focus is mainly directed towards psychosocial and biological risk factors. Subsequently, the beliefs about causation might have an impact on the intervention preferred (Shim et al., 2012). Similarly, the cultural reasons dominating society are expressed in the conceptualisation of mental illnesses.

While health care providers may understand the psychosocial and biological factors attributed to mental illnesses, socio-cultural factors may also have a strong influence on some of them and on their practice (Kazdin and Rabbitt, 2013). This reflects the great concern of participants in being able to have professional, effective relationships with health care providers, who, unfortunately, sometimes judge them during treatment according to their own beliefs, rather than helping and assuring them (Alyousef, 2017). From the participants' perspective, trust is mainly associated with better

health outcomes based on a preferred, satisfactory treatment plan without inappropriate judgments. Studies have also found attitudinal barriers to mental health care and mistrust as significant factors associated with a low commitment to medication and regular access to mental health services (Walker et al., 2015; Giallo et al., 2017). Subsequently, the findings show that participants were distrustful of prolonged use of medication, and the high levels of mistrust were associated with unsatisfactory treatment plans that commonly depended solely on the medical model.

'The medication does not help me at all; the doctor gives me the same medications.' (Othman)

'Medications have many side effects.' (Faris)

Regardless of gender and other socio-economic characteristics, individuals who do not trust their medical model (treatment plan, health care providers, dependence on medications) were less likely to use health care services and reported unsatisfactory mental health. The findings highlight the need for more research to ascertain levels of trust before treatment initiation, and to follow patients over a period of time to identify whether trust precedes their pattern of use. The study findings illuminate that lower trust levels among individuals with mental health illnesses were associated with a lower likelihood to seek mental health services and accept mental health medications. Comparatively, most of those individuals were highly likely to visit and trust faith-healers (Alosaimi et al., 2015).

The experience of receiving inadequate care also led to a lack of trust. Furthermore, individuals with serious mental illnesses may express greater distrust and feel more unwell (Majumder et al., 2015). Healthcare providers' attitudes and characteristics also served as a key source of mistrust. A less trusting relationship with

healthcare providers was considered to be a barrier to care (Uebelacker et al., 2016). Participants highlighted the way providers engaged and treated mental health patients as an important factor in determining participants' care-seeking. Studies have found an association between attitudinal barriers to care and mistrust; thus, illustrating that trust is a significant factor in the use of mental healthcare services and interventions (Fischer et al., 2016; Alyousef, 2017). As a result, people with mental health issues in the KSA are likely to seek professional mental health care as a last resort after other modes of interventions have failed. Two specific statements can be seen below:

'I have doubts about the treatment. I am doubting everything, and nothing works well. Not feeling well. Can't trust the treatment.' (Othman)

'The medicines do not help. Every time they switch it, it has side effects ... My muscles, my muscles hurt.' (Awaad)

The findings have important implications for practice. Trust can be created in the healthcare context when patients feel that they are taking part in their caring process; this is often dependent on healthcare professionals' behaviour. Addressing individual characteristics and demands that affect people's trust in the mental healthcare services could also help build trust (Singh et al., 2010). Individual patient demands and treatment preference choices, such as culture, religious beliefs and values have an impact on the perception of care received. Individual characteristics could be addressed when creating a patient-centred approach to care, as they impact the patient's perception of the health care services received, and interactions between providers and patients (Masuda and Latzman, 2011; Price et al., 2014). As such, individual characteristics, needs and treatment preferences should be taken into consideration

when implementing efforts to increase engagement with mental healthcare services (Dixon et al., 2016).

Trust is built with repeated interactions over time and has a strong influence on the health behaviour of patients, health status, and patient satisfaction. The findings of the study also illustrate the need to gain the participants' respect and recognise their treatment preference, which could elevate the level of trust before treatment initiation. This may indicate that the participants are likely to accommodate medical treatment within their cultural framework; they would then be more likely to access and use mental health services.

6.4 Socio-Economic Problems, interfere with Accessing and Using Mental Health Services

Most of the participants did not seek treatment initially, as they did not think that they required help with their condition. They commonly relied upon on their socially-accepted beliefs, and to adhere to socially accepted norms, instead of accessing professional help. Some of the respondents who recognised the need to seek professional mental health services reported socio-economic barriers, such as financial and social issues. The main social barrier among the respondents was the fear of being stigmatised by the community, as well as being known as a mentally ill person ('Nafseia' or 'psycho') among their families and relatives. According to their beliefs, this, in turn, may label them with an unpleasant identity. Respondents wanted to handle the issue on their own, based on the belief that the available healthcare services were ineffective or the belief that the difficulty was not severe, as identified by Henderson et al. (2014) .

Stigma and discrimination were also important social problems, and some of the main barriers stem from discouraging individuals from accessing professional treatment. Indeed, the public holds

various prejudicial attitudes and stereotypes, which culminate in rejection of others (Ciftci, 2013; Jelaidan et al., 2018). Many individuals in Saudi society prefer to distance themselves from people with mental health problems and this stigma surrounding mental illnesses results in driving people away from relationships and statutory services (Abdullah and Brown, 2011; Alyousef, 2020; McCrae et al., 2019).

It has also been observed that the delay in seeking mental health services may create greater risks of suicide (Corrigan et al., 2014; Yilmaz and Okanli, 2015; Bachmann, 2018). Such stigmatisation can be severe, reducing help-seeking behaviour, leading to shame and concealment of symptoms, lower self-esteem and diminishing opportunities for treatment (Henderson and Fortney, 2016; Baba et al., 2017). The findings emphasise the significance of individual characteristics in influencing health-seeking behaviour. It was apparent that the method and time of accessing and using mental health services depended on participants' unique experiences, which mainly formulated the features of treatment and recovery for each participant, based on the meaning of their narrative. In addition, stigma and discrimination created a barrier through different pathways, such as individuals with mental illnesses largely reporting barriers to having their mental health care needs being met, such as being surrounded by people who did not take their symptoms seriously when asking for help (Amri and Bemak, 2013; Abolfotouh et al., 2019), and thus, creating delays in both diagnosis and treatment (Aljabri et al., 2018). For example:

'My friends discriminate and stigmatise the people who have mental illness.' (Rami)

'My family relatives do not consider symptoms of mental illness seriously when a person asks for assistance.' (Faris)

As aforementioned in this chapter the impact of stigma on accessing professional treatment is considered to be a vital barrier. Thus, stigmatisation has a further inward-facing impact on an individual's own willingness to disclose a mental health problem and seeking help, which could lead to over-reliance on low peer support and self-treatment, including judgment and being ostracised from others (Knaak et al., 2017).

As mental ill-health is related to the loss of productivity and absenteeism in the workplace, the barriers of social factors could also be considered in this context (Bubonya et al., 2017). Initial reluctance to seek help may lead to a decline in productivity, which may result in additional stigma and the confirmation of stereotypes by co-workers, resulting in a further unwillingness to seek help and access mental health services (Peters and Brown, 2009; Paterson et al., 2021). Therefore, the key strategies for the reduction of stigma in the health care context should be identified. Specifically, the effectiveness of the key strategy lies in the ability to address the source of stigma (Vigo et al., 2016). However, some participants claimed that they can fight the stigma, but they believe this will only happen when they firstly fight their self-stigmatisation:

'I decided to leave this 'stigma' and defend myself … That is why I divorced the stigma.' (Faris)

'I regained my self-trust again.' (Rami)

'I am self-confident.' (Othman)

Other respondents reported financial barriers, relating to the availability of financial support. The limited budget allocated to mental health service users in the KSA means that many individuals with mental illnesses depend on their own finances to seek medical services and pay for treatment. From the study's findings, it appears

that paying for mental health services in the KSA sometimes occurs when patients live in a village or suburb. The participants, though, also stated that they may pay for mental health services if the medicine is not available via governmental services. The payments for mental health services may lead to indebtedness and poverty based on the high cost of medications, especially among low-income families:

'I have low salary, 11 children, I am paying for medication. Sometimes, there are medicines shortages.' (Mansour)

'I have many loans and do not have medical insurance. The house rent is expensive.' (Yasir)

Additionally, the reliance on out-of-pocket payments is both inequitable and inefficient, and it discourages engagement with mental health services by persons with limited income (Qureshi et al., 2013). This finding is worrying due to the close link between mental ill health and poverty. Financial burdens delay early treatment and lead to untreated mental disorders that increase not only the risk of poor health-related quality of life, but also chronic impairment (Walker et al., 2015). Ultimately, serious economic burdens are considerable contributors to increased healthcare costs and utilisation (Levinson et al., 2010). Indeed, identifying the financial barriers to treatment is essential in designing, developing, and improving access to mental health services (Ifanti et al., 2013).

The barriers identified collectively weigh against diagnosis and treatment. Every barrier may act in isolation, reinforce, or interact with other barriers. The complex relationship between the barriers worsens the problem, and the precipitative effect is unique in different mental health situations. Hence, a more nuanced and greater

understanding of the multiple barriers to treatment is essential in implementing, developing, and designing interventions.

6.5 The lack of a Sense of Family and Social Belonging exacerbates Mental Health Difficulties

Social factors play a critical role in promoting mental health and maintaining health-promoting behaviours. As a result, it is essential to pay attention to social factors, such as the absence of family support and the lack of belonging in determining barriers to access mental health services. Social support is the amount of support that individuals with mental ill/health issues perceive and report. Social support alone is not essential; what is important is the belief in the existence of social support (Jelaidan et al., 2018; McCrae et al., 2019). People who have a strong sense of social support have psychological advantages over people without support, especially when faced with psychological events (Nabi et al., 2013). Participants identified social support as a key component of strong psychological health and solid relationships.

Several participants strongly reported that there is pressure to seek and sustain treatment due to fear of stigmatisation from family and friends. The absence of social support made it challenging to deal with crises due to the impact of stigmatisation. Accordingly, the lack of support is associated with heightened levels of mental health distress. The study suggests that there may be a difference in (self) acceptance associated with educational levels and affluence (Baumeister et al., 2003). However, this does not negate the importance of social support and positive social relations for mental health. Both factors can have a significant impact on mental health, and it is possible that individuals with higher levels of social support and positive social relations may be more likely to have greater (self) acceptance as well (Goodwin et al., 2004). Hence, positive social

communication and a feeling of security and belonging could reduce people's distress. Accordingly, people with higher social support and more positive social relations have better mental health, which induces mental well-being (Chronister et al., 2013).

Participants who express low family support and assistance also reported negative appraisal, failure to adhere to treatment, and engagement in risky behaviours. The lack of active coping mechanisms when dealing with mental health problems aggravates the risk of complicated mental distress, leading them to seek non-professional care and delay in their treatment. The following statements from the participants indicate this:

'No-one helped for 30 years ... I cried so much … I said they are lying to me because they don't really want to help me ... they used to call me "the dead one who has no life"; my house was really made of glass. I can't hurt anybody when they hurt me — I mean my relatives and family.' (Faris)

'My family, like the commonly followed beliefs in the KSA, we take patients to faith-healer first. The current treatment programme has lack of family awareness and involvement in the treatment.' (Rami)

Studies also report that mental health issues could be affected by the quality of social support (Jelaidan et al., 2018; Mahsoon et al., 2020). The social ties that characterise a sense of belonging are protective factors that are essential in the management of mental illnesses issues. When individuals feel that they are not alone, they cope more effectively with hardships (Thoits, 2011):

'My father told me that he noticed that I was not sleeping well —how about we take you to a hospital and have a better

understanding about my disease thanks to my family support and the hospital.' (Kareem)

It is claimed that family function and structure have focused on the effect of support on mental health (McCrae et al., 2019). Therefore, the impact of support from family and friends has a practical significance in mental health care.

6.6 Challenges for Saudi Society

Due to the complex, multifaceted nature of mental health/illness stigma, perception, and factors that impact the access and utilisation of mental health services, the challenges for Saudi society pose equally diverse solutions. In this study, Vygotsky's theory revealed various macro-cultural factors that may affect Saudis' understanding of mental health problems and how to deal with them. Based on that, mental health professionals might be able to deal with people with mental health issues if these cultural factors are taken into account during the treatment process.

One of the challenges that Saudi society is facing in addressing mental health needs is the prevalence of mental health disorders, reportedly reaching rates as high as 48% in some populations (Almutairi, 2015). However, this prevalence does not include all mentally ill people in the KSA (Jelaidan et al., 2018). Despite this alarming prevalence, doubts regarding the legitimacy of mental illnesses still persist in society (Alamri, 2016). One of the challenges for Saudi society is in the area of mental health research, which is critical for the development and improvement of insights into mental health problems. While the KSA has recorded a significant improvement in academic research in general, studies on mental health are still inferior. Abumadini, (2019) reviewed the literature on mental health in Saudi Arabia over the past four decades, comparing the review with research in medicine and surgery. The studies

considered in the review have been published since 1975, with the findings showing that 159,796 research studies undertaken in the KSA were related to non-medical and medical specialties. Among these studies were 52,699 articles related to medical specialities, and 670 were on mental health (Abumadini, 2019). This may reveal that more effort is required to encourage and support mental health research publications in the KSA, which, subsequently, reflects the Saudi government's auspices of people with mental health issues in taking a vital step to minimise stigmatisation in Saudi society.

Without adequate research, Saudi society remains unaware of the prevalence of mental health issues in society and other important factors that would influence how mental health interventions are implemented to deal with mental health issues. In spite of some progress, there is a desperate need for support for mental health research in the KSA (Koenig, 2013; Parentela, 2021). According to Memish et al. (2014), previous research on mental health in the KSA stemmed from two major sources: the first was the Global Burden of Disease (GBD) Initiative; and the second came from small studies based on limited patient samples in the KSA (Memish et al., 2014). The findings of the GBD studies were solely based on an extrapolation of data from epidemiological surveys conducted in other nations (Institute for Health Metrics and Evaluation) (Arthur, 2014). Further, there were no efforts to support the estimates, such as conducting a large-scale epidemiological survey in the KSA. Therefore, the data available represents an approximation of the actual burden of mental health disorders in the KSA. Small studies on psychiatric morbidity in the KSA focuses significantly on specific populations, with small samples (Memish et al., 2014) .

Conducting research to present a more accurate picture of mental health in the KSA is faced with many challenges, including the

lack of funding. Furthermore, the opportunities for professional practitioners, such as nurses, to conduct sponsored research are few and far between. Also, the introduction of complex regulations in areas of grants and ethical approval adds to the barriers to mental health research in the KSA (Mneimneh et al., 2020). According to Abumadini (2019), faculty members view the process of obtaining funds for research to be complex and too long. Administrative duties, teaching overload, and inadequate resources were identified to be additional constraints.

In addition to improving government funding in mental health research, the Saudi society is also facing challenges in the allocation of budget to address mental disorders; Qureshi et al. (2013) presented a systematic review of Saudi's mental health system. The study relied on data from the Assessment for Mental Health Systems by the WHO, based on data from the country's Ministry of Health (MOH) in 2009 and 2010. The average allocation healthcare spending in the KSA, compared with that in other countries worldwide, is 2% allocation for mental health (WHO). Given that the KSA is considered to be a high-income country, it is not at the same level as other high-income countries (Al-Subaie et al., 2020). In high-income countries, on average 6% of total health care spending is allocated to mental disorders (Mental health atlas 2017, WHO, 2018a).

Saudi society is also facing a challenge in the number of mental health practitioners who can address the increase in demand for mental health in Saudi society. The WHO's data provide an in-depth look at the KSA's healthcare system (Mental Health Atlas 2017-member state profile, WHO, 2018a; 2018b). According to the data, the KSA has 19.4 mental health professionals per 100,000 (WHO, 2018b). The global average is 6.6 per 100,000. For high-income countries, the median is 64.3 per 100,000. The proportion of mental health practitioners in the KSA is 7% of other health care providers in

the KSA, while the average in high-income countries and the world is 20%. Thus, the number of mental health professionals is quite low (WHO, 2018b). Specifically, improvements in the knowledge of psychiatry and mental health nursing in the undergraduate and early professional years in the KSA may enhance people's appreciation of the subject and consequently reduce the stigma and other attitudinal barriers (Abumadini, 2019).

This neglect of research and practice development in the KSA has a knock-on effect in wider society. Stigma remains largely unchallenged and there remain obstacles to the access of services. People progress through various stages before seeking mental health treatments. When people experience symptoms, they attempt to evaluate their significance, evaluate whether they can manage them, and finally determine the feasibility of the treatment options before they decide whether to seek treatment (Mojtabai et al., 2011; McCrae et al., 2019). Consideration of the benefits and costs of participating in the treatment is an important factor in determining whether to use the services. The fear of being stigmatised is a significant concern for individuals considering engaging in mental health services in KSA. Many people are hesitant to use mental health services due to the stigma associated with mental health problems, as being labelled as a 'mental patient' may result in negative consequences. Stigma often interacts with other factors to impede access to mental health care (Pattyn et al., 2014). Addressing public stigma is essential in reducing expected and experienced stigma among persons with mental illnesses and facilitates engagement with mental health care and help-seeking. One participant stated:

'I was suffering, feeling abandoned, I was so confused because of my mental illness. After that, I regained my self-trust again by

keeping the therapy and the support of the Saudi association and their rehabilitation; I started to learn from the beginning.' (Faris)

In efforts to address stigma for patients and their families (courtesy stigma) and improving access to care, the WHO recommends integrating mental health with primary healthcare (Al-Subaie et al., 2020). This action also has the potential to improve the overall capacity of the health care system to deal with mental health issues. As a result, mental health training is currently implemented in the KSA and it is available to postgraduates, general practitioners, and primary care doctors in the KSA (Al-Habeeb et al., 2016). Primary care physicians are increasingly providing community health services (Koenig et al., 2014).

According to the Ministry of Health (MOH), there were 2,361 primary health care centres in the KSA (MOH, the KSA, 2018; Al-Atram, 2021). However, only a limited number of mental health services can be accessed at the primary health care centres. For example, general physicians can only treat minor mental disorders through counselling. Continuous training is necessary for mental health professionals in order to offer better quality services to patients seeking mental health services (Al-Habeeb and Qureshi, 2010). Given that primary healthcare is recognised for its essential role in the early identification of mental health conditions and referral (Al-Habeeb et al., 2016), society has the challenge to train more professionals in the field.

From the basis of the current research, I argue that Saudi society also faces challenges due to the lack of successful programmes to address stigma, mental illness understanding and perception when accessing and using mental health services. While the programmes may be related, they may be designed separately, with each programme comprising multiple components targeted to

specific groups, such as young people, the media or the general public. The programmes could also operate at multiple levels, such as in communities, regions, or nationally. Mental health educational and promotional programmes for the public should be designed to enhance awareness of mental health disorders and their potential environmental, genetic and biological causes, as well as the importance of seeking help, with the different treatment regimens available or preferred (involving faith healers), and the preventable consequences (Almutairi, 2015). Such procedures could lead to the early identification and appropriate treatment.

Due to the strong negative attitudes and mental health stigma ingrained in society, programmes need to target mental health problems at an early stage. To address this, it is important to involve religious leaders, 'faith-healers', educationalists, and community leaders in mental health awareness and promotion campaigns. The faith healers and clerics should be used to address mental health issues, as people are bonded with strong religious beliefs (Larson and Larson, 2003; Koenig, 2014). The learning institutions and the clerics could conduct campaigns on improving knowledge and reducing guilt/shame that is associated with accessing mental health services. These campaigns can be used to address mental health issues in both rural and urban areas (Hogan, 2003).

All individuals (faith healers, educational and community leaders) should be educated and trained to recognise the signs and symptoms of mental health disorders and to refer individuals to mental health services or to offer care in collaboration with mental health services (King and DeCicco, 2009; Rosmarin et al., 2013). Ultimately, the goal of mental health educational and promotional programmes should be to enhance awareness of mental health disorders, reduce stigma, and encourage early identification and

accessing mental health treatment. By involving a variety of stakeholders and tailoring treatment approach to local contexts, it could be possible to work to improve mental health outcomes for Saudi citizens.

The collaboration between different ministries in the KSA, such as the MOH, Ministry of Education (MOE), and Ministry of Media (MOM), can help to ensure that mental health promotion and education efforts are integrated and comprehensive (WHO, 2001). This can involve planning training courses and workshops, as well as public awareness campaigns that target people with mental health issues and their families (Alyousef et al., 2020). In Saudi society, where family ties are highly regarded, placing parents and close relatives as the first line of support would be effective when addressing mental health issues. Families need to be informed in regards to the importance of positive and non-stigmatising communication with their relatives with mental health issues (Coverdale and Long, 2015).

In addition, more research is required about screening in the KSA. For example, an annual generalised screening for mental health issues could be incorporated in the KSA, such as those recommended by the United States Preventive Services Task Force, which requires effective professional counselling services to support young people to better cope with behavioural, emotional, and social issues (Grossman et al., 2018). Attention to the awareness of the meaning of mental health, and the capacity for development in mental health is necessary, beginning at universities, where learners can obtain the necessary knowledge and skills to address mental health needs. When prevention programmes, which promote positive mental health, are implemented, society creates a supportive environment to help overcome any stigma and shame linked to mental health problems.

Indeed, the underlying risk factors of mental health highlight the importance of taking essential action and planning appropriate interventions that could lessen the impacts of mental health disorders on society.

Another challenge to Saudi society is to include mental health treatment in their medical insurance cover for people who are unable to afford to access help, as a free governmental mental health service, or for people who prefer to access private services. The promotion would include mental health literacy campaigns that educate the public/community regarding the significance of obtaining treatment for mental illnesses. While there has been an increase in special assistance for divorcees and widows in the KSA, the programmes should not be limited to financial help, but also extend to other forms of assistance (e.g., advocating better utilisation of mental health services in society). Promoting the use of a mental health index (statistics indicating the prevalence of recovered people) would also be essential in encouraging people to seek mental health services in the KSA (Alattar et al., 2021). Moreover, optimising the use of telehealth (telephone or virtual contact) can make a considerable contribution in the reduction of unmet mental health care needs, particularly in remote areas.

Encouraging people to seek mental health services would also be essential in addressing the reported barriers to treatment. In a recent study, Alangari et al. (2020) investigated the barriers to the access of mental health services. The findings show that the most reported barriers were attitudinal factors, such as believing that the condition is not severe enough to warrant seeking help or wanting to handle the problem on their own. Other reported barriers were structural barriers, such as financial constraints and service availability, although attitudinal barriers were the most prevalent.

Additionally, a large proportion of people who used mental health services were categorised as severe cases, demonstrating that many people in Saudi society recognise the demand for treatment when the illness is serious (Alangari et al., 2020). Similarly, the current research findings suggest that the delays in seeking professional treatment are more likely to be related to individual perceptions and cultural beliefs than the availability of mental health services or access. Untreated mental disorders and termination of treatment increases the risk of inadequate health-related quality of life, increasing the risk of chronic impairment, and negatively impacting peoples' lives. They are also linked with serious societal and economic burdens, and eventually a substantial contributor to increased mental health services' care costs and utilisation. Therefore, society has an important challenge to encourage people to seek mental health services and, consequently, address attitudinal barriers.

6.7 What this Study Adds

This study has sought to provide a voice to people's experiences of accessing and using mental health services in the KSA by using a narrative approach to ensure that people's stories may be heard. Whilst there is increasing research focusing on mental health and mental health services in the KSA, there are very few studies that give a voice from the service users' perspectives. The current study makes a significant contribution to the area of mental health by identifying the macro-cultural factors that impact people's mental health experiences, the main barriers experienced in accessing and using mental health services in the KSA, and the effects experienced by those with mental health illness during the process of accessing and using mental health services in the KSA. The findings also form the basis for the recommendations to promote a more positive experience for people with mental health issues.

One of the key factors that impact mental health experience is culture and how it impacts on many aspects of mental health, ranging from how people perceive illness, health, attitudes, and help-seeking behaviour. Culture also influences how mental health is understood and informs acceptable and effective solutions to the problem. This study explores these cultural considerations in Saudi society, such as beliefs and stigma, and how they impact the mental health experience. The exploration is essential as it presents the areas that stakeholders and future researchers may need to address in order to improve mental health attitudes and services in the future.

The study also provides an opportunity to explore factors that could be addressed to meet the requirements of people with mental health care needs effectively and sustainably. Given that culture is heavily influenced by the broader context of social issues and socio-cultural norms, the cultural identity of Saudi Arabian society is heavily influenced by Islamic and Arabian culture. The findings highlight the benefit of being able to have a good understanding of the cultural backgrounds of patients when addressing factors, such as attitude, stigma, beliefs, and accessibility to and utilisation of mental health services. For example, while a health care provider may use their knowledge to diagnose people with mental health issues, most patients and their families may attribute mental health conditions to the evil eye, spiritual possession, and jinn. On the other hand, other patients may accept their medical diagnosis of suffering from mental illness.

The study also adds to the research on the main barriers to the access and utilisation of mental health services in the KSA. There are a number of barriers that could prevent people from seeking help and consequently delay their healthcare intervention including social, psychological and economic. Stigma and discrimination were

identified as significant social problems and were some of the major barriers that deterred individuals from seeking treatment. The prejudicial attitudes and stereotypes carried by the public lead members of society to fear and reject individuals with mental illnesses. Further, stigma can lead to the concealment of symptoms and worsening of difficulties.

Stigma and discrimination were identified as factors that create barriers through diverse pathways, such as discontinuation of treatment, suboptimal therapeutic relationships, and a poorer quality of physical and mental care. Stigma also stems from health care practitioners and contributes to the reluctance to seek mental health services when people with mental health issues feel mistrust in healthcare providers, or they might also feel suspicious of the effectiveness of medication.

In addition, the lack of belonging and absence of family assistance and support was also identified to be a major social barrier. Social support plays a critical role in promoting health and maintaining health-promoting behaviours. The belief in the existence of social support is also essential. The findings demonstrate that persons with high levels of perceived social support have physical and psychological advantages over persons without support. Unfortunately, people with mental health problems are likely to experience low levels of social support. The absence of social support makes it challenging to deal with crises.

Furthermore, financial barriers play an important role in influencing help-seeking behaviour. The lack of money to pay for mental health services makes many people in society become discouraged from accessing and using mental health services or to continue their professional treatment, particularly in the case of low-

income families or those who live in villages or in far-off areas or a distance from the mental health services.

The study also contributes to the effectiveness of mental health services for individuals with mental health illnesses. Despite the importance of cultural and religious influences on Saudi's attitude towards mental health, this must also be viewed from the perspective of effectiveness. A patient's perception of the effectiveness of mental health services is a vital measure in assessing the delivery and quality of mental health services (Weobong et al., 2021). Patients' experiences reflect what happens in mental health care processes. The improvement of the quality of health care delivery is an essential global priority for the purpose of ensuring patient safety, care quality improvement, promotion of public accountability, and improvement of clinical effectiveness. Ensuring patient satisfaction and providing high-quality care is also a challenge that health care organisations face globally (Gishu et al., 2019). Exploring the effectiveness of mental health services from the patients' perspective, therefore, is an essential part of mental health evaluation. Lastly, the study has added to the recommendations necessary to improve the status of mental health services in the KSA. The small workforce and the growing need for mental health treatment calls for the development of a more professional workforce.

It has also been highlighted that the government should develop and implement adequate programmes to address stigma, mental illness understanding and perception, and access to and utilisation of mental health services. The pattern of mental health indicates that the major determinants of the unmet treatment needs are more likely to be related to an individual's perceptions and beliefs, than to the availability of mental health care delivery or access. Thus, a collaboration of Saudi ministries in taking some innovative

measures is initially crucial to reduce the stigma, and then to raise the public awareness towards mental health and encourage people with mental health problems and their families to access health services smoothly and confidently. In addition, such actions could help the Saudi society to help people to accept mental illness as another physical illness, especially as the KSA in the last few years has rapidly changed in many innovative ways.

As one mental health researcher, I endeavoured through this study to initiate some innovative actions and recommendations that could help to reduce the level of stigma and prejudice that people with mental health issues and their families have faced during their treatment and recovery journey.

6.8 The Study's Recommendations

This section proposes some substantive actions and recommendations that could be implemented in Saudi society to enhance mental health care and support the KSA's Visions 2030:

• Knowledge mobilisation: health care providers should indeed mobilise their qualitative knowledge to attract the attention of service users to a pluralistic conception of mental health care.

• Socioeconomic support: Address socioeconomic issues that prevent people from continuing their treatment by providing a mental health patient E-card that they can use to register at the nearest pharmacy to collect their medication or order a home delivery service.

• Attitudes and awareness: Increase Saudi society's awareness of mental illness and how to treat it and reduce public and self-stigmatisation through the use of technology and social media and other audio-visual communication channels or apps. According to the latest statistics, there are only a 3200 Saudi-national mental health

nurses out of 7850mental health nurses in total (Saudi Commission for Health Specialties SCFHS, 2021). The remainder are overseas foreign national mental health nurses. Despite the relatively small number of Saudi-national mental health nurses within the KSA the recommendations of this study have this specific group of nurses in mind, to improve mental health care in the KSA. By addressing the challenges faced by this group, it may be possible to increase their representation in the mental health nursing profession and improve the overall quality of care provided to patients in the KSA and the Saudi-isation policy of the government means that this number will grow significantly over the coming years (Albougami et al., 2020).

• Other recommendations include A] developing cultural competency training for mental health professionals, increasing the number of mental health care providers in the KSA including Saudi mental health nurses. B] providing mental health treatment's financial assistance to all Saudi people with mental health issues. C] involving patients in health care and, D] conducting additional research to investigate the cultural factors that influence mental health experiences and the efficacy of interventions to address these factors.

It is anticipated that if these actions are taken and the recommendations are implemented, there will be a significant qualitative shift in the annals of mental health care in the KSA, supporting the Saudi Vision 2030. These recommendations could contribute to the promotion of a more positive experience for individuals with mental health issues in the KSA, the reduction of barriers to accessing and utilising mental health services, and the enhancement of the quality of mental health services in the country (Sewilam et al., 2015; Aboalfotouh et al., 2019). It is essential, however, to recognise that cultural changes are necessary, and that this is a difficult endeavour (Javadi et al., 2017; Javed et al., 2021).

Consequently, it is essential that the Saudi government collaborates with a variety of stakeholders to work on developing policies and initiate strategies to attain these goals.

6.9 Where do I go from here?

The current study will form an important basis for more research in this area. In the future, I plan to conduct related studies that focus on the meaning of mental health recovery for Saudi citizens. The findings could also act as a framework for the development of an approach to interventions that could improve health care outcomes for mental health service users in the KSA. Given that the field of mental healthcare is of interest to the MOH, the policy implications that stem from the findings and recommendations of this study may have a significant positive effect on the outcomes for mental health service users in the KSA.

6.10 Strength and Limitations of this Study

The narrative approach used in this study has provided more detailed data for the nature of Saudi culture that in many ways impacts upon people's attitudes toward mental health issues. Additionally, this study has the strength of providing a voice to mental health service users in the KSA. However, the depth of the language and the meanings interpreted might be a limitation, due to my lack of skill and experience in narrative inquiry. Despite that, my skills as a researcher in the discovery and analysis have developed during my PhD journey. This study has enabled me to develop the skill of providing people with a voice and to express my own voice as well (interpretation), which will hopefully be judged as a strength of this study. Additionally, other strengths of the current study are driven by the reflexivity used in the current research methodology and analysis, which significantly demonstrate the rigour and trustworthiness of the work that has been conducted.

Another limitation of this study is the recruitment method of the participants, as I used convenience sampling and recruited from just one organisation (a charity) from a single city, although the sample is far from homogenous. In this study, the number of study participants could be perceived as both a strength and a weakness. Twenty participants produced a significant amount of narrative text and a number of reflexive stories of people experiencing mental health issues in the KSA, although positivists may consider this a small number.

Even though it is debatable whether a narrative study will capture the nature of the challenges that people with mental health problems face, the objective here is not to generalise results, because narratives are personal and meaningful in themselves. By being honest about what I know about my influence on the co-creation of these narratives, they are subject to my own interpretation and, in turn, to the interpretation that you provide them as a reader/audience of this thesis.

As previously discussed in the Methodology Chapter, in analysing the interviews, my perspective is that most, if not all, participants had firstly chosen to access faith-healers to deal with their mental health issues. One could say that this would distort the results if the aim was to gain generalisability. Discussing and narrating the experiences of mental health issues in the KSA was not an easy process for both me and participants, as such a topic is sensitive and seldom researched in the KSA. As a result, such a topic may have been a significant barrier to the participation for some people who were concerned that discussing their mental health issues would reveal something they would see as clandestine; either because they may ignore or delay their access to mental health services, or due to the taboo of their disorders from their cultural perspective.

Subsequently, this could be a limitation of the study. However, exploring topics that are socially unacceptable or stigmatised always carries this risk. In these study interviews the participants were remarkably open; this could be because many of them in certain circumstances have grown accustomed to revealing deeply personal information, or it could be because a number of the narrators seemed to place a high value on narrating their stories (Riessman, 2008; Hall and Powell, 2011). Nevertheless, this might count as a strength of the study.

6.11 Conclusion

Through a narrative inquiry methodology, the research study investigates stories of Saudi citizens who use mental health services to address their experiences when they access and use mental health services. Four collective (nested) narratives have arisen from the research findings as follows: firstly, cultural identity and religion - social attitudes and stigma negatively affect help-seeking behaviour; secondly, when religious and spiritual beliefs are ignored, mistrust leads to a suspicious dependence on medical assistance; thirdly, socio-economic problems interfere with the access and use of mental health services; and finally, the lack of a sense of family and social belonging exacerbates mental health difficulties.

Through these collective narratives this chapter provides an opportunity to explore some factors that could be addressed to meet the requirements of people with mental health care issues, both effectively and sustainably. It also highlights how culture and other social factors can play an influential role in help-seeking behaviour. The Discussion Chapter has also identified the key factors that impact people's mental health experiences, the main barriers experienced in accessing and using mental health services in the KSA, and the

effectiveness of mental health illnesses found in the process of accessing and utilising mental health services in the KSA.

Chapter 7: Conclusion

7.1 Introduction

This concluding chapter applies the final stage of Langdridge's critical narrative analysis, known as "a critical synthesis" (Langdridge, 2007, p.140). Through this process, I have attempted to make sense of the findings as applied to the real world of practice having synthesised the participants' personal narratives in the light of the theories and literature. In the KSA, religious and cultural factors, traditional beliefs and medical mental health approaches are all intertwined in the minds of patients and professionals alike and they all play a part in the treatment journey and, ultimately, an innovative, tailored approach emerges as a desirable way forward. Using a narrative methodology, this study aimed to explore people's experiences of mental ill health when accessing and using mental health services in the KSA. Subsequently, the study's findings demonstrate that people are likely to seek the help of faith-healers before they seek the help of professional and more globally 'accepted' health care providers. Accordingly, most people seek formal medical care when their condition has deteriorated, but for many people it is likely that they might never access mental health services and simply learn to live without professional support in the KSA.

Faith-healers in the KSA represent an undeniable source of help and care for people with mental health difficulties. People who often utilise faith-healers believe that they understand the root causes of mental distress and they are well-placed to deal with mental health issues, as such, they turn to faith healers as strong cultural artefacts of social reliance in the KSA (Alahmed et al., 2018).

In addition to religious factors, the study found that there are many cultural, economic and social factors that strongly influence people's help-seeking behaviour. For instance, through non-

negotiable religious beliefs or practices, and families' roles in choosing treatment (i.e., collective decisions - the treatment choice is mostly taken by family members). Furthermore, economic factors that may impact people accessing services in the KSA, such as, financial restraints to buy medication if they choose to access private mental health services when they do not have mental health medical insurance or if they discontinue to take their treatment as they simply mistrust medical treatment.

The prevailing belief system takes a crucial role in shaping the use of faith-healers, as religion continues to play a strong role in the lives of people in the KSA. Faith-healers are perceived to function in harmony with the prevailing consensus of the causes of mental illness of the population; this includes attributing mental distress to demonic possession, the evil eye, and magic, which are also related to formal, socially accepted, religious beliefs. Faith-healers perform religious-based practices, including reading the Holy Quran as a source of healing (Gureje et al., 2020; Mahsoon et al., 2020). Further, faith-healers follow the prophetic teachings of the Prophet Mohammad (PBUH) about their treatment, illness, and health.

To date, there are no studies that focus upon the experiences of people with mental health issues being solely treated by faith-healing in the KSA. Under the strong influence of Islam, supernatural forces, such as jinn, evil eye and witchcraft are culturally accepted and are traditional healing practices undertaken by religious faith-healers, which are mainly faith-based; spiritual practice continues to predominate in the KSA (Koenig et al., 2014; Alamri, 2016; Jelaidan et al., 2018). Hence, little has culturally changed since the introduction of western medical approaches.

Consistent with global inequalities, the findings also show that people with mental health difficulties are more often those who

experience socio-economic problems. Moreover, many people suffering from mental illnesses are heavily impacted both by self-stigma and social stigma. With little confidence in their future, low self-esteem and isolation, the impact is significant on individuals and their families. The current study also reveals that stigma connected to mental illness greatly impacts the well-being of the patient and their family (Dardas and Simmons, 2015; McCrae et al., 2019). Saudis who face stigmatisation are likely to experience a complex mental illness path and are at risk of inadequate quality of life and social isolation (Jelaidan et al., 2018).

The study's findings highlight that the chosen treatment is a crucial determinant of mental health outcomes and prognosis. Stigma linked to mental illnesses considerably compromises people's motivation to adhere to, or seek, biomedical mental health services, as people who experience mental illness symptoms are more likely to be reluctant to seek medical health care (Dardas and Simmons, 2015). The family, relatives and friends play a pivotal role in influencing the behaviour of patients with mental health illnesses and their choice of accessing and using mental health services in the KSA.

Saudi society is a collectivistic society that follows group decisions and these 'group/family decisions' are often to the detriment of the freedoms of the individual. Overall, the major types of stigmas affecting mentally ill people in the KSA have been identified in the current study. The first type of stigma is social or structural stigma, which relates to the discriminatory or negative attitude that other people have regarding mental illnesses. The second type of stigma is self-stigma, which is the negative attitude and internalised shame that affects people with mental illnesses (Corrigan et al., 2012; Stuart, 2016). Nevertheless, mental health stigma not only directly affects people with mental health illness, but also the family members

involved in their care (courtesy stigma). Overall, studying the influence of stigma is essential, as it can be a major barrier to people's access to mental health services, due to its impact on Saudi citizens to be reluctant to seek medical treatment or to adhere to their treatment when they feel stigmatised. Therefore, they could easily start to become isolated in order to try and avoid this.

Another socio-economic factor that affects individuals with mental illnesses in the KSA is the financial barriers reported by several participants. While individuals may recognise that they require medical intervention for their mental health, the lack of funding to tailor the state or private services sometimes makes it challenging to access the required help in the KSA. Correspondingly, most Saudis who suffer from mental health difficulties prefer to access private clinics for various reasons, such as faster appointments and to avoid accidently meeting people who they might know if they were to access state services, even though a lack of mental health insurance makes access to the private sector difficult. Scarcity of financial support among low-income earners presents a significant barrier that the government and other stakeholders, such as the Ministry of Health, Ministry of Human Resources and Social Development, health charities, and health insurance companies can address in their efforts to improve access to mental health services. The challenge for the Saudi Arabian society is to implement freely accessible medical programmes and services for individuals who face financial burdens when accessing mental health services. The programmes could incorporate mental health literacy campaigns and special mental health assistance for all people who need to access and use mental health services.

7.2 How theory has facilitated my Inquiry

Accessing mental health services is a critical step towards reducing the burden of mental illness around the world. However, the stigma of mental illness is one of the most common reasons for not seeking mental health care, leading to negative health consequences and undue suffering for many individuals and their families, as frequently occurs in the KSA. Stigma is embedded in its social context; a phenomenon that is 'acceptable' in one society may be considered unacceptable and open to stigmatisation in other societies; Arabs have a shared set of values, beliefs and traditions that are substantially different from those of Westerners. In most Arab countries, attention to formal mental health resources is scarce due to poor understanding of mental health issues in Arab countries in general and specifically in the KSA, which is exacerbated through widespread stigmatisation of mental ill health and people suffering from mental health difficulties.

The macro-cultural psychological theory of Vygotsky was used during this inquiry, as it recognises that culture is a strong determinant of knowledge acquisition and argues that people learn from attitudes and beliefs modelled by culture. The social world, according to the theory, not only involves the interactions between societal members, but also outside influences, learned behaviour and other prior knowledge from all different areas. Cultural factors play a critical role in people experiencing stigma and Vygotsky's theory highlights the importance and impact of culture on the stigma of mental illness in the KSA. Moreover, culture-specific interventions can be used to reduce stigma by highlighting Vygotsky's macro-cultural factors to gain a deeper understanding of the cultural and societal factors to develop culturally sensitive and effective interventions, and emphasising the implication of the ZPD assumption during this research inquiry. This presents the concept that individuals can learn

and develop through interaction with others, who are more knowledgeable or skilled.

This implication is relevant to the context of reducing stigma in mental health in the KSA, as the ZPD assumption can be used to understand how Saudi individuals learn and grow in their understanding and acceptance of mental health issues. By emphasising the importance of the ZPD assumption in the research inquiry, culture-specific interventions can be developed to support and facilitate this process of growth and learning, thereby reducing stigma in mental health. This educational development is required in both nursing education and in public mental health promotion. In accordance, mental illness stigma, involving discrimination, prejudice and stereotypes, is viewed as a considerable obstacle to the improvement of life for individuals with mental health difficulties in the KSA. Individuals with mental illness may internalise their self-beliefs, which consequently hinders recovery.

Vygotsky's MCP theory is essential in improving the comprehension of culture in Saudi society that affects how people define themselves, as they culturally and socially attach to specific macro-cultural factors. Once people are taught about the concept of stigma surrounding mental health difficulties, through guidance and encouragement, they may be able to help others to understand. The bridge between individual understanding and helping others to understand is the Zone of Proximal Development (ZPD) in a Saudi context. By providing scaffolding and support, Saudi individuals can gain a deeper understanding of mental ill-health, and ultimately reach their full potential to deal with mental distress and its stigma. This process of growth through collaboration and support is crucial in a Saudi context. Obviously, the ZPD concept needs to be embedded in mental health awareness campaigns within the cultural norms of

Saudi life, as most mental health awareness materials and campaigns are Western and nothing like this currently exists in a Saudi context.

Vygotsky's theory is also essential in explaining the relationship between stigma of mental illness and cultural factors in the current study. Through the theory, it has been possible to identify the relevant cultural concepts and values associated with stigmatising beliefs regarding mental illness in the KSA. Throughout the country, people with mental illness are commonly seen as a burden to their families and rejected by the community and family members, and thus, they may conceal their condition from others for fear of rejection. The attitudes and stereotypes influence community members to fear, reject and distance themselves from individuals with mental illnesses in the country. There are no easy answers to these problems, which are deeply engrained in Saudi culture.

7.3 The Original Contribution of the Research

The current research study contributes to the field of mental health nursing in relation to culturally sensitive practice in Islamic countries and especially in the KSA. This study reveals the powerful influence of traditional beliefs and the part that faith-healers might play with individuals and their families experiencing mental distress. Due to various forms of stigmatisation, the study shows that there is widespread mistrust of what is perceived as Western medical approaches. Furthermore, such mistrust is particularly prevalent amongst people from the lower socio-economic classes, preventing many people to access timely help and support due to the cost of treatment. Indeed, most participants received medical help reluctantly, preferring to seek help from non-medical practitioners such as faith-healers. Within the KSA communities, faith-healers represent a considerable source of care for people with mental illnesses (Khalifa et al., 2011).

There are various overlapping cultural, economic, and social issues that could explain the help-seeking behaviour from faith-healers, especially the stigma attached to a mental illness diagnosis. Families of people with mental health distress in the KSA often keep their condition hidden from others for fear of social rejection and negative impacts on marital prospects, especially in the case of women experiencing mental distress. This often stems from gender differences in many families in the KSA that create the expectation that women need to be in a position of being protected by their male relatives (father, brother, husband, son, etc.) Most of the narratives in this study reveal that participants had sought faith-healing before accessing mental health services and/or seeking professional medical help, which was consistent with their beliefs concerning the causes of mental illnesses. Similarly, the cultural reasons dominating society are expressed in the conceptualisation of mental illnesses; while some health care practitioners may understand the psychosocial and biological factors attributed to mental illnesses, social factors also have a strong influence on their practice. Unfortunately, this is reflected in the inadequate care reported in the literature compared to care received in physical health services (Alyousef, 2017). It is often the case that those with a diagnosis of mental health distress also present physical health problems that go untreated (Alyahya et al., 2020).

The methodology employed in the current study is unique in mental health nursing research in the KSA. Whilst a few qualitative studies exist featuring mental health patients in the KSA, this is the first study to use a narrative methodology that presents the opinions and experiences of giving voice to the stories of people diagnosed with enduring mental health issues. Likewise, some researchers and practitioners in other Islamic countries may find some of the findings in the current study directly relevant to their own cultural and social

contexts; although no direct claims of generalisability are made in this study beyond the borders of the KSA.

7.3.1 The Potential of Using a Narrative Approach in Mental Health Nursing Practice

It is not only important but fundamental that mental health nurses garner an in-depth insight into and comprehension of their patients in an effort to understand their social contexts; this enables such professionals to provide sound care (Douglas et al., 2011). However, it is important to acknowledge that many people in need of help and treatment in the KSA fail to ever speak to a medical professional. To better understand people through their own individual stories – notably through the narratives they tell – allows mental health nurses to ascertain contextual details and to identify and establish revealing characteristics, which all define an individual.

Narratives are, in essence, an everyday communicative tool in articulating experiences, with storytelling recognised as adopting a crucial role in almost all cultures. Accordingly, the narrative may be viewed as a culturally consistent and well-aligned approach to understanding experiences (Taylor, 2008). It is possible to consider how mental health nursing services can be improved through gaining a narrative that deeply understand the person in question (Riessman, 2008). This nursing understanding could build up a mutual trust that would enable the Saudi patients (narrators) to feel comfortable to talk freely to construct their narrative events more easily, which in turn would provide nurses with opportunities to deeply absorb the meanings of their experiences. Additionally, such a framework of narration in such robust patient-nurse relationships would reflect Vygotsky's ZPD assumption, which relies on people learning from supportive settings. This would in turn leave people able to learn how

to adjust to their problem and finally achieve the ZPD required development.

When examining narrative in the nursing context, this approach has been at the core of nursing practice for a long time, with a history of narrative recognised in the form of clinical stories when communicating with regards to patients, as well as when relating information between professionals (Diers, 2004; Hall and Powell, 2011). Importantly, patient history is centred, in part, on narrative information, which provides a framework for the findings and the subsequent analysis (Mishler, 1986). Therefore, it may be seen that narrative has been afforded much value and recognition to nursing practice across several domains in many different countries (Hall et al., 1992).

Mental health may be acknowledged as a field of nursing practice that could potentially garner benefit from an even greater understanding and adoption of narrative across groups, as well as throughout times of significant change or shifts in a person's life, such as with changes in relationships, receiving some form of diagnosis, during people's difficult periods. Additionally, narrative in the mental health nursing field could also provide a means to allow patients to link together and combine past events, such as neglect or past ordeals that are commonly recognised as interwoven with the symptoms being displayed by the patient (Klein and Janoff, 1996; Kirkpatrick, 2008). Culturally valuable and relevant information, such as that pertaining to American individuals, for example, may be seen as embedded in the stories communicated by the patients; this facilitates a more culturally sensitive, contextual and holistic knowledge base relating to clients, as well as their surrounding support networks and families (Stevens et al., 2002; Nelson, 2004; Taylor et al., 2008). This

could occur in the KSA in group therapy at inpatient services (hospitalised) or in addict community and rehabilitation centres.

7.4 The Original Contribution to Nursing Practice in the KSA

Nursing plays an important role in the treatment and management of mental health conditions in the KSA. I have been a mental health lecturer for six years and during this time, whilst witnessing much change in practice, it seems that little has changed in terms of public attitudes to mental illness. One of the reasons this research study was initiated was to help bring about some meaningful change to mental health nursing in the KSA, to hopefully be able to impact communities and not just treating people in hospitals, as this was a major underlying issue. Rather than simply doing what has always been done, mental health nursing practice needs to become better informed in regards to people's psychosocial needs in order to help to deal with the perpetual conflict between lay beliefs and professional nursing practice. Nurses have a duty to administer holistic care that includes therapeutic interventions, but nurses also have a responsibility to provide care for people with mental health issues whilst understanding and respecting their cultural beliefs and backgrounds (Sharif et al., 2020). This study has shown the need for mental health nurses in the KSA to become more understanding of the socio-cultural impact of traditional beliefs, and in doing so, help to break down social stigma and provide culturally sensitive care. Mental health nurses in the KSA, though, have progressed via using their advanced knowledge of the assessment, diagnosis and treatment of psychiatric disorders, but little has changed in the acknowledgement of the socio-cultural factors that are rarely addressed. Accordingly, much work needs to be done within communities to begin and sustain conversations regarding religious and cultural beliefs in relation to perceptions of mental distress. Seeking health care services has been commonly avoided for various

reasons, with the most prominent being the stigma that arises from the association of mental illnesses with undesirable outcomes of behaviours. This is the primary reason why families seek the help of faith-healers in the KSA, as shown by the research's participants.

The findings highlight the importance of addressing negative perceptions of mental illnesses in the KSA to reduce delays in accessing and using appropriate medical treatment. The duration of untreated mental illnesses from the identification of the first symptom is often the best time to begin appropriate treatment. As such, nurses need to: use language that shows consideration for the stigma and potential conflicts; assess a patient's mental state whilst acknowledging their religious beliefs; consult with knowledgeable mental health professionals; refer patients to community services without dismissing the role of the faith-healer, as this would create a disconnection with personal beliefs; build a professional relationship with them; establish good communication with the patient; and provide sensitive patient-centred care, which is entirely culturally sensitive.

Accessing mental health treatments and services is critical in order to minimise the national burden of mental illnesses in the KSA. With stigma being one of the most common reasons why individuals do not access and use mental health services in the KSA, not addressing the causes will continue to cause undue suffering and negative consequences for many individuals. Correspondingly, nurses are key players in helping both the individuals with mental health difficulties and their respective families to access and use mental health services. Embracing a holistic approach to care means that nurses and other health care professionals may incorporate cultural perspectives, individual values and beliefs, when developing realistic interventions and treatment plans. As a result, individuals with mental

health difficulties and their families in the KSA could potentially accept mental illnesses and develop collaborative, trusting and respectful relationships with the health care professionals.

Health care professionals can send strong messages to the public to address the stigmatising attitudes and practices that face individuals and families affected by mental illness. In accordance mental health patients may also view mental health professionals, psychologists, psychiatric nurses and psychiatrists as lacking empathy with their personal experiences, not necessarily because they are lacking empathy, but because of the lack of socio-cultural understanding. Therefore, in the development of future services, socio-cultural awareness, including initiatives to tackle stigma, should be at the forefront of prevention and screening programmes in the KSA, as has been shown in many countries around the globe (Al-Sawafi et al., 2020).

7.5 Relevance for Future

There are several key implications from the current study that can be used to shape future research: (i) the implication for research; (ii) the implication for mental health nursing; and (iii) the implication for service development and policy.

7.5.1 The Implications for Research

Through this research journey, it is hoped that future researchers may become inspired to think more critically about the socio-cultural factors in mental health nursing in the KSA and other Arab nations. I would love to think that my efforts have made a small contribution to future research. Nevertheless, much more research is required to be undertaken on the understanding of help-seeking behaviours, and on the exploration of people's hesitancy to access services. Furthermore, Future research in the KSA could focus on

exploring the structural and societal factors that perpetuate stigma associated with mental health issues. Researchers could investigate the mechanisms in place that contribute to the stigmatisation of individuals with mental distress and the impact this has on their experiences and well-being.

7.5.2 The Implications for Mental Health Nursing

In general, over the past two decades, there has been remarkable progress in the KSA when it comes to recognition, as well as treatment of mental health issues. However, there are barriers, including cultural beliefs, which play a significant role in influencing access and use of mental health services for KSA citizens. Specifically, the current research has investigated KSA citizens' mental health issues and experiences when accessing and using mental health services, through narrative inquiry. Some of the key issues that the research investigated were significant factors that impact people's mental health experiences, and the narrative approach brought these experiences to life by showing individuals' perceptions that have been formed through personal experiences. This simultaneously enabled participants to learn new things about themselves by allowing them to share their own stories.

The findings from this study offer a potential framework for mental health nursing in the KSA, based upon the following:

- Cultural identity, stigma and religious beliefs heightens hesitancy to seek help;
- When cultural identity is ignored, there is a mistrust of services and barriers are created;
- Socio-economic problems are strongly related to mental health issues.

These findings could play a crucial role in informing the development of mental health nursing in the KSA; understanding these principles may become a foundation to inform future practice. Often, the focus of care is solely based on diagnosis and treatment. Potentially, a care regime could be developed that takes into account the cultural identity of Saudi citizens. Significantly, the KSA is a Muslim country, which makes the influence of religion on health care profound. Specifically, as previously stated, Saudis commonly believe in the use of faith-healers to treat mental illnesses and trust faith-healers' interventions more than modern medicine. However, when it comes to mental illnesses, faith-healers in the KSA have a different approach, where their diagnoses range from possession to jinn, evil eye and magic. These ways are mentioned in the Muslims Holy book, the Quran, and by the Prophet's hadith (prophet's talks), together with how Muslims' could protect themselves from such symptoms without ignoring medical help when required (AL Habeeb et al., 2020, Obeid et al., 2012).These healers conduct various religious-based interventions to evoke healing for people who suffer from mental health issues, from reading the Holy Quran to other practices (Parentela et al., 2019).

Superstition causes stigmatisation, which exacerbates mental health issues and reluctance to use services, as occurs in the KSA. Nevertheless, faith-healers are known to help in certain cases when it comes to mental health issues, such as counselling, prayers, and advice. One fruitful avenue for future research would be to develop an intervention together with faith healers – to see how they might be able to work together with mainstream services. This has been shown in the current study as mentioned by some participants who choose to seek combined help from both faith healers and medical professionals, as they felt relaxed with the spiritual form, but not comfortable that it was treating the mental illness at its origin. Such

interventions have been proven to work in some cases of mental illness, especially with anxiety, stress, and depression. As such, it is crucial to establish collaborative relationships between health care institutions and faith-healers to come up with sound interventions that might impact the treatment of mental ill health positively.

Another major barrier to accessing mental health services is the impact of socio-economic problems, encompassing financial and social issues. For instance, in the KSA, the gap between the rich and the poor is huge, where there are both extremely wealthy families and very poor communities. In poor communities, people may lack access to services, and stigma and discrimination are among the social issues that prevent Saudis from accessing medical help. In the KSA, mental illness is characterised by certain superstitions that emanate from religious beliefs as well as various traditions. These superstitions are founded on religious and supernatural factors, which also lead to the concept of mistrust and lack of belonging, especially when it comes to the relationship between mental health individuals and medical practitioners (Molloy et al., 2020). In relation to the participants in this study, most of them have a feeling of mistrust in health care providers as patients believe they felt stigmatised by providers who are mainly feel stigmatised from treating people having mental health issues (Alyosef, 2017). Due to the belief that mental illness is associated with the jinn, evil eye, other diagnosis and the violent, dangerous, and unpredictable behaviours of patients, some medical practitioners in Saudi fear treating them. These beliefs regarding the causation of mental health greatly affect the access and use of mental health services in the KSA (Alattar et al., 2021; Alyosef, 2017).

The Ministry of Health (MOH) in the KSA is currently attempting to develop the health system in the country , especially when it comes

to people's awareness of mental health issues (Ministry-of-Health—KSA, 2018).

7.5.3 The Implications for Service Development and for Policy

This research could play a significant role in sharing insights regarding the issues affecting access to mental health services for the people of the KSA. For instance, the Ministry could use the information gathered on the barriers that limit access to mental health services for the people in the country and devise interventions that will not only help to eliminate these barriers, but also educate people. In the KSA mental health initiatives which have been developed recently by the Saudi Mental Health Promotion Centre (SMHPC) have aimed to familiarise citizens in regard to mental health issues and how to stop stigmatisation by attending workshops or by calling the offered call centres if they need. However, this initiative is to focus mainly on the common mental disorders such as depression and anxiety. Despite that, this view has been supported by participants in the current study when they wanted to overcome the stigma and educate society and families to deal with their difficulties. As a result, people dealing with mental health issues might be more able to confidently seek medical help and have access to these services.

The research not only offers vital information and knowledge to the people of the KSA regarding mental health issues, but also to individuals from other nations, especially in surrounding Arabic countries that share the same religious background. This research could be helpful in the development of a framework that will ensure that people experiencing mental health issues are able to receive the care they need despite their beliefs and cultural influences. People in the KSA are guided by their religious and cultural heritage, and this extends to their understandings and beliefs regarding mental illness. Thus, devising a patient-centred approach that focuses on these cultural factors could ensure that nurses are able to help break down

barriers to access and offer more sensitive interventions to their patients in the future. These key messages may be of interest to nurses and healthcare researchers in other Islamic countries beyond the borders of the KSA.

7.6 Knowledge Transfer and Dissemination from the Current Research

The current research seeks to advance the academic knowledge base by constructing people's experiences and the meaning of their narratives. Considering the social and cultural context, the research hopes to have an emancipatory effect in enabling people's voices to be heard by policymakers to achieve the required changes in the KSA. Furthermore, a possible collaboration network might be produced, such as, a co-production with service users through the charity. This has the potential to demonstrate an innovative approach that could inspire service users to undertake a leading role in research; for example, to interview one another and co-produce future research with academics.

Additionally, the current study might help to develop the work of the charity; for example, the charity could create a 'charity of mental health networks' and/or organisational structure of a 'community-based centres' or 'mental health people's cafés' in the KSA. These developments could deal with the various societal obstacles and could help service users to integrate with society by providing peer support, arranging regular meetings at the charity's premises, or inviting them to a mental health awareness symposium for research. The charity could also publish a free and accessible electronic book based on the current research on their website for 'accessing and surviving mental health services', which could be easily read by service users and interested others.

In addition, the current narrative research may have educational implications in the area of the student nursing curriculum by using people's narratives as a framework for teaching. This could be considered as part of a much-need approach to develop the nursing curriculum to include person-centred perspectives. One way to develop the nursing curriculum to include person-centred perspectives is to integrate narrative-based teaching methods into nursing courses (Petty, 2016). This approach could involve incorporating the stories of people with mental health issues into nursing education, either through case studies or personal narratives. By exposing student nurses to the personal experiences of individuals with mental health issues, the curriculum could help to promote empathy, compassion, and person-centred care. Another way to incorporate person-centred perspectives into nursing education is to integrate the concept of "recovery" into the curriculum.

Recovery-oriented care focuses on empowering individuals with mental health issues to take an active role in their own care, which supports the development of skills and strategies to manage symptoms and live a meaningful life (Santana et al., 2018). By incorporating recovery-oriented care into the nursing curriculum, a nursing student could learn how to work collaboratively with individuals suffering from mental health issues to support their recovery goals (Gee et al., 2018). On the level of practice, I could offer training materials to mental health nursing staff at hospitals, clinical symposiums and in the academic sector. Finally, a new potential framework for accessing and using mental health services in the KSA could emerge from the current study.

7.7 Personal Reflection and Way Forward

It has been important to learn how the extent that stigma influences how people view mental illnesses, as well as how it affects

their help-seeking behaviour, or lack of it. Public stigma is expressed in the form of discriminatory behaviour and prejudicial towards persons with mental health difficulties, with unfavourable impacts on health care, employment, and interpersonal relationships. Stigma may also affect treatment provision. Persons who provide care for people with mental illnesses may also feel stigmatised by association. Further, it has been shown that the growth of mental illnesses matches the prevalence of negative attitudes, reasons, and beliefs regarding different conditions or persons with mental health conditions. However, it is also important to note that people have become more aware and concerned about mental illnesses. Social media has been influential in promoting awareness and knowledge in relation to mental illnesses. Due to the nature of the problem, mental illnesses require multiple responses from different stakeholders including health care professionals, health policymakers and governments. Their involvement is crucial in promoting empowerment and emancipation for those affected by mental illnesses. Through their actions, they are able to help educate the public, increase access to treatment options, and develop policies to mitigate public health risks associated with mental illnesses. These actions play a crucial role in breaking down the stigma surrounding mental health and ensuring that those who need help have access to the resources they require.

Creating awareness includes providing a professional academic education in the KSA, which would include facts, not only about mental illness, but also about listening to people having mental health difficulties and give them a voice. This could be encouraged by incorporating narrative inquiry as an innovative and empowering method in Saudi education of nurses, which facilitates developing a robust rapport with patients. With my interactions with nursing students in teaching psychiatric mental health curriculum, it is

possible to encourage them to listen carefully to peoples' stories in the practice field in order to understand their personal experiences with mental illnesses so that the nursing students can subsequently view them as people, rather than their illness. People also need to be treated with dignity and respect, through avoidance of language that puts the mental condition first and the patient second, avoiding saying something inaccurate or stereotypical about mental illnesses, as well as sharing personal experiences on mental health to help encourage others and dispel myths. Doing this can also be helpful in fighting stigma by communicating how those mental illnesses are not shameful or that illnesses should not be hidden.

Other activities that I will engage in and encourage students to follow, is to work to reduce stigma around mental health issues, including being conscious of language, self-education and of others. For instance, talking openly about mental health on public platforms, such as social media, showing compassion to individuals with mental illnesses, and encouraging equality between mental and physical illnesses. There is certainly hope when measured against other countries that in the near future it will be possible to witness the reduction of mental health stigmatisation and view increasing access to mental health services with positive recovery outcomes in the KSA. In addition, understanding the importance of faith-healers in mental health treatment and people's recovery journey is crucial. Hence, considering the future of tailored or collaborative practices (e.g., medical/faith model or spiritual/medical model) should facilitate people to seek professional treatment of accessing and using mental health services in the KSA without feeling stigmatised or stereotyped, and that both models are established in official government policy.

Chapter 8: References

ABDULLAH, A., ROGERSON, S., FAIRWEATHER, N. B., AND & PRIOR, M. 2006. The motivations for change towards e-government adoption: Case studies from Saudi Arabia.

ABDULLAH, T. & BROWN, T. L. 2011. Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review,* 31**,** 934-948.

ABOLFOTOUH, M. A., ALMUTAIRI, A. F., ALMUTAIRI, Z., SALAM, M., ALHASHEM, A., ADLAN, A. A. & MODAYFER, O. 2019. Attitudes toward mental illness, mentally ill persons, and help-seeking among the Saudi public and sociodemographic correlates. *Psychology Research and Behavior Management,* 12**,** 45.

ABU-RAS, W. 2014. Barriers to services for Arab immigrant battered women in a Detroit suburb. Social Work Research and Evaluation, 3(4), 49–66.

ABUMADINI, M., S., 2019. Mental health research in the Kingdom of Saudi Arabia:A review of trend and visibility over four decades. J Family Community Med.;26(3):163-167. doi:10.4103/jfcm.JFCM_215_18.

ACKERMAN, R. H. & MASLIN-OSTROWSKI, P. 2002. The Wounded Leader: How Real Leadership Emerges in Times of Crisis. San Francisco: Jossey-Bass Inc.p120.

AE-NGIBISE, K., COOPER, S., ADIIBOKAH, E., AKPALU, B., LUND, C., DOKU, V. & CONSORTIUM, M. R. P. 2010. 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith-healers in the provision of mental health care in Ghana. *International review of psychiatry,* 22**,** 558-567.

AFIFI, M. 2007. Gender differences in mental health.Singapore Med J;48(5):385-91.

AHMED, A. A. 2016. Integration of mental health service program into primary health care service. *World Family Medicine,* 14**,** 31-37.

AHMED, S. & EZZEDINE, M. 2014. Challenges and opportunities facing American Muslim youth. Journal of Muslim Mental Health, 4, 159-174.

AL-AHMADI, H. & ROLAND, M. 2005. Quality of primary health care in Saudi Arabia: a comprehensive review. International Journal for Quality in Health Care, 17(4), 331-346.

ALAHMADI, H. A. 2010. Assessment of patient safety culture in Saudi Arabian hospitals. Qual Saf Health Care, 19(5).

ALAHMED, S., ANJUM, I. & MASUADI, E. 2018. Perceptions of mental illness etiology and treatment in Saudi Arabian healthcare students: A cross-sectional study. *SAGE open medicine,* 6**,** 2050312118788095.

ALAMRI, Y. 2016. Mental illness in Saudi Arabia: Stigma and acceptability. *International Journal of Social Psychiatry*.

ALANGARI, A. S., KNOX, S. S., KRISTJANSSON, A. L., WEN, S., INNES, K.E.,, BILAL, L., ALHABEEB, A., AL-SUBAIE, A. S. A. & ALTWAIJRI, Y. A. 2020. Barriers to mental health treatment in the Saudi National Mental Health Survey. International journal of environmental research and public health, 17(11), p.3877.

ALATTAR, N., FELTON, A. & STICKLEY, T. 2021. Mental health and stigma in Saudi Arabia: a scoping review. *Mental Health Review Journal*.

AL-ATRAM, A. A. 2021. Improved attitudes of interns versus undergraduate medical students towards patients with mental illness in Saudi Arabia. *Eastern Mediterranean Health Journal*, *27*(4), 361-372.

AL ATRAM, A. R. 2015. Prevalence of Psychiatric Disorders in a Sample of Elderly Residents in Rural and Urban Population of Zulfi Region-Saudi Arabia. *Journal of Psychology & Psychotherapy,* 5**,** 1.

ALBOUGAM, A. S., ALMAZAN, J. U., CRUZ, J. P., ALQUWEZ, N., ALAMRI, M. S., Adolfo, C. A., & Roque, M. Y. (2020). Factors affecting nurses' intention to leave their current jobs in Saudi Arabia. *International Journal of Health Sciences*, *14*(3), 33.

AL EID, N. A., ALQAHTANI, M. M., MARWA, K., ARNOUT, B. A., ALSWAILEM, H. S. & AL TOAIMI, A. A. 2020. Religiosity, psychological resilience, and mental health among breast cancer patients in Kingdom of Saudi arabia. *Breast cancer: basic and clinical research,* 14**,** 1178223420903054.

ALGOSO, M., PETERS, K., RAMJAN, L. & EAST, L. 2016. Exploring undergraduate nursing students' perceptions of working in aged care settings: A review of the literature. *Nurse Education Today,* 36**,** 275-280.

AL-HABEEB, A., HELMI, B. & QURESHI, N. 2016. Mental and Social Health Atlas: An update, Ministry of Health, Saudi Arabia, 2015. *International Neuropsychiatric Disease Journal,* 6**,** 1-20.

AL-HABEEB, A. A. & QURESHI, N. A. 2010. Mental and Social Health Atlas I in Saudi Arabia: 2007–2008. East Mediterr Health J, 16:570–577.

AL-HABEEB, T. A. 2003. A PILOT STUDY OF FAITH-HEALERS' VIEWS ON EVIL EYE, JINN POSSESSION, AND MAGIC IN THE KINGDOM OF SAUDI ARABIA. *Journal of Family & Community Medicine,* 10**,** 31-38.

AL-HABEEB, A., ALTWAIJRI, Y. A., AL-SUBAIE, A. S., BILAL, L., ALMEHARISH, A., SAMPSON, N. A., LIU, H. & KESSLER, R. C. 2020. Twelve-month treatment of mental disorders in the Saudi National Mental Health Survey. *International journal of methods in psychiatric research,* 29**,** e1832.

ALIBRAHIM, O. A., AL-SADAT, N., & ELAWAD, N. A. 2010. Gender and risk of depression in Saudi Arabia, a systematic review and meta-analysis. Journal of Public Health in Africa, 22-25.

ALJABRI, M. K., GADIBALBAN, I. Z., KALBOUSH, A. M., SADEK, H. S., AND & ABED, H. H. 2018. Barriers to special care patients with mental illness receiving oral healthcare: A cross sectional study in the Holy City of Makkah, Saudi Arabia. Saudi Medical Journal, 39(4), 419.

ALKAHTANI, N.S., Sulphey, M.M., Delany, K. and Elneel Adow, A.H., 2021. A conceptual examination about the correlates of psychological capital (PsyCap) among the Saudi Arabian workforce. *Social Sciences*, *10*(4), p.122.

AL-KRENAWI, A. & GRAHAM, J. R. 2016. Culturally sensitive social work practice with Arab clients in mental health settings. Health & Social Work, 25(1).

ALMALKI, M., FITZGERALD, G. & CLARK, M. 2011. Health care system in Saudi Arabia: An overview. East Mediterr Health J, 17:784–93.

ALMOSHAWAH, S. A. 2010. An Evaluation of Psychiatrist View Towards the Mental Health Services in Saudi Arabia. *Journal of Taibah University Medical Sciences,* 5**,** 36-48.

ALMUTAIRI, A. F. 2015. Mental illness in Saudi Arabia: an overview. Psychology Research and Behavior Management, 8, 47-49.

ALOSAIMI, F. D., ALATEEQ, D. A., HUSSAIN, S. I. B., ALHENAKI, R. S., SALAMAH, A. A. B., AND AL MODIHESH, N. A 2019. Public awareness, beliefs, and attitudes toward bipolar disorder in Saudi Arabia. Neuropsychiatric Disease and Treatment, 15, 2809.

ALOSAIMI, F. D., ALSHEHRI, Y., ALFRAIH, I., ALGHAMDI, A., ALDAHASH, S., ALKHUZAYEM, H. & AL-BEESHI, H. 2015. Psychosocial correlates of using faith-healing services in Riyadh, Saudi Arabia: a comparative cross-sectional study. *International Journal of Mental Health Systems,* 9**,** 8.

ALOUD, N. & RATHUR, A. 2009. Factors Affecting Attitudes Toward Seeking and Using Formal Mental Health and Psychological Services Among Arab Muslim Populations. *Journal of Muslim Mental Health,* 4**,** 79-103.

AL-QADHI, W., UR RAHMAN, S., FERWANA, M. S. & ABDULMAJEED, I. A. 2014. Adult depression screening in Saudi primary care: prevalence, instrument and cost. *BMC Psychiatry,* 14**,** 190.

ALRAHILI, N., ALMATHAM, F., BIN HAAMED, H. & GHAZIUDDIN, M. 2016. Attitudes to depression in Saudi Arabia: a preliminary study. *International Journal of Culture and Mental Health,* 9**,** 255-260.

ALSALEM, M., ALAMRI, R. & HEJAZI, S. 2020. Nonpsychiatric Healthcare Professionals' Attitudes Toward Patients with Mental Illnesses in Makkah City, Saudi Arabia: A Cross-Sectional Study. Neuropsychiatric Disease and Treatment, 16, p.341.

Al-SAWAFI, A., Lovell, K., Renwick, L., & Husain, N. 2020. Psychosocial family interventions for relatives of people living with psychotic disorders in the Arab world: systematic review. *BMC psychiatry*, *20*(1), 1-14.

ALSHOWKAN, A., CURTIS, J. & WHITE, Y. 2015. Factors affecting the quality of life for people with schizophrenia in Saudi Arabia: a qualitative study.

ALSHOWKAN, A. A. & KAMEL, N. M. F. 2016. Nursing Student Experiences Of Psychiatric Clinical Practice: A Qualitative Study.

AL-SOLAIM, L. & LOEWENTHAL, K. M. 2011. Religion and obsessive-compulsive disorder (OCD) among young Muslim women in Saudi Arabia. *Mental Health, Religion & Culture,* 14**,** 169-182.

Al-SUBAIE, A. 1989. Psychiatry in Saudi Arabia: Cultural Perspectives. Transcultural Psychiatric Research Review, 26, 245–262.CrossRefGoogle Scholar

AL-SUBAIE, A. S., AL-HABEEB, A., & ALTWAIJRI, Y. A. 2020. Overview of the Saudi National Mental Health Survey. *International Journal of Methods in Psychiatric Research*, *29*(3), e1835.

ALSUBAIE, S., ALMATHAMI, M., ALKHALAF, H., ABOULYAZID, A. & ABUHEGAZY, H. 2020. A Survey on Public Attitudes Toward Mental Illness and Mental Health Services Among Four Cities in Saudi Arabia. *Neuropsychiatric Disease and Treatment,* 16**,** 2467.

AL-SUGHAYR, A. M. & FERWANA, M. S. 2012. Prevalence of mental disorders among high school students in National Guard Housing, Riyadh, Saudi Arabia. *Journal of Family and Community Medicine,* 19**,** 47-51.

ALVESSON, M. & SKöLDBERG, K. 2009. Reflexive methodology: New vistas for qualitative research. Sage.

ALYAHYA, N. M., MUNRO, I. & MOSS, C. 2020. The experience of psychosis and recovery from consumers' perspectives: An integrative literature review. *Journal of Psychiatric and Mental Health Nursing*.

ALYOUSEF, S. 2017. Interventions recommended to combat a stigma of mental health problems to access mental health care services in Saudi Arabia. *Innovative Journal of Medical and Health Science,* 7.

ALYOUSEF, S. M., ALHAMIDI, S. A., ALBLOUSHI, M., & EID, T. A. 2020. Perceptions of media's contribution toward stigmatization of mental health by Saudi Arabian nurses. *Journal of the American Psychiatric Nurses Association*, *26*(6), 568-575.

AL-ZAHRANI, H., AL-QARNI, A. & ABDEL-FATTAH, M. 2013. Pattern of psychiatric illnesses among long-stay patients at a Mental Health Hospital, Taif, Saudi Arabia: A 10-year retrospective study. East Mediterr Health J., 19:37–44.

AMRI, S. & BEMAK, F. 2013. Mental health help-seeking behaviors of Muslim immigrants in the United States: Overcoming social stigma and cultural mistrust. *Journal of Muslim Mental Health,* 7.

ANDERSON, K., FUHRER, R. & MALLA, A. 2010. The pathways to mental health care of first-episode psychosis patients: a systematic review. *Psychological medicine,* 40**,** 1585-1597.

ANDERSSON, L. M., SCHIERENBECK, I., STRUMPHER, J., KRANTZ, G., TOPPER, K. & BACKMAN, G. 2013. Help-seeking behaviour, barriers to care and experiences of care among persons with depression in Eastern Cape, South Africa. *J Affect Disord,* 151.

ANGERMEYER, M. C., & DIETRICH, S. 2006 Public beliefs about and attitudes towards people with mental illness: a review of population studies. Acta Psychiatrica Scandinavica, 113(3), 163-179.

ARABNEWS 2017. Saudi female entrepreneurs increase by 35% in 10 years: Report. Avialiable at: https://www.arabnews.com/node/1200291/saudi-arabia. Accessed 18 Oct 2018.

ARABNEWS 2021. 'An honor and duty:' Meet the female Saudi officers guarding the Prophet's Mosquein Madinah. Available at: https://www.arabnews.com/node/1850621/saudi-arabia. Accessed 20 May 2021.

ARKSEY, H. & O'MALLEY, L. 2005. Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology,* 8**,** 19-32.

ARTHUR, M. 2014. Institute for health metrics and evaluation. *Nursing Standard (2014+),* 28**,** 32.

AUSTIN, E., RAMAKRISHNAN, A. & HOPPER, K. 2014. Embodying recovery: A qualitative study of peer work in a consumer run service setting. Community Mental Health Journal, 50, 879–885.

AVASTHI, A. 2016. Are social theories still relevant in current psychiatric practice? *Indian Journal of Social Psychiatry,* 32**,** 3-9.

BABA, Y., NEMOTO, T., TSUJINO, N., YAMAGUCHI, T., KATAGIRI, N. & MIZUNO, M. 2017. Stigma toward psychosis and its formulation process: prejudice and discrimination against early stages of schizophrenia. *Comprehensive psychiatry,* 73**,** 181-186.

BACHMANN, S. 2018. Epidemiology of suicide and the psychiatric perspective. International Journal of Environmental Research and Public Health, 15(7), p.1425.

BARTHES, R.1977. "Introduction to the structural analysis of narratives", (79-124). In: *Roland Barthes, Image-Music-Text* (trans. Stephen Heath). Collins, Glasgow

BATHJE, G. A. P., J., 2011. The relationships of public and self-stigma to seeking mental health services. Journal of Mental Health Counseling, 33(2), pp.161-176.

BAUMEISTER, R. F., CAMPBELL, J. D., KRUEGER, J. I., & VOHS, K. D. 2003. Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles?. *Psychological science in the public interest*, *4*(1), 1-44.

BECKER, S. M. 2004 . Detection of Somatization and Depression in Primary Care in Saudi Arabia. Social Psychiatry and Psychiatry Epidemiology, 39, 962–966.CrossRefGoogle ScholarPubMed.BERGER, P. & LUCKMA NN, T. 1966. The social construction of knowledge: A treatise in the sociology of knowledge. *Open Road Media: Soho, NY, USA*.

BERRY, J. W., POORTINGA, Y. H., PANDEY, J., SEGALL, M. H. & KAĞıTCıBAŞı, Ç. 1997. *Handbook of Cross-cultural Psychology: Social behavior and applications*, Allyn and Bacon.

BIRBILI, M. 2000. Translating from one language to another. *Social research update*, *31*(1), 1-7.

BIRENBAUM, A. 1992. Courtesy stigma revisited. *Mental Retardation,* 30**,** 265.

BLANCHARD, C. M. 2010. Saudi Arabia: Background and US relations. Darby, US: DIANE Publishing.

BOWERING, G., 2015. Qur'an. In *Islamic Political Thought* (pp. 185-201). Princeton University Press.

BRIL-BARNIV, S., MORAN, G. S., NAAMAN, A., ROE, D. & KARNIELI-MILLER, O. 2017. A Qualitative Study Examining Experiences and Dilemmas in Concealment and Disclosure of People Living With Serious Mental Illness. *Qualitative Health Research,* 27**,** 573-583.

BROOKS, H. L., ROGERS, A., SANDERS, C. & PILGRIM, D. 2015. Perceptions of recovery and prognosis from long-term conditions: The relevance of hope and imagined futures. *Chronic Illness,* 11**,** 3-20.

BRUNER, J. S. 2001. Self-making and World-making,' in Narrative Identity: Studies in Autobiography, Self and Culture, J. Brockmeier & D. Carbaugh, Eds., pp. 25–36, John Benjamins, Philadelphia, Pa, USA. .

BSA 2004. Statement of Ethical Practice for the British Sociological Association. Available from: http://www.britsoc.co.uk/equality/63.htm

BUBER, M. & KAUFMANN, W. 2013. *I and Thou*, eBookit.com.

BUBONYA, M., COBB-CLARK, D.A. AND WOODEN, M., . 2017. Mental health and productivity at work: Does what you do matter?. Labour Economics, 46, pp.150-165.

BUREAU OF LABOR STATISTICS 2017. US. Department of Labor Occupational outlook handbook: Mental health counselors and marriage and family therapists. Available from:http://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-and-marriage-and-family-therapists.html. Accessd April 13, 2017.

BURGE, S., 2020. *The Prophet Muhammad: Islam and the Divine Message*. Bloomsbury Publishing.

BUTCHER, J., MINEKA, S. & HOOLEY, J., ET AL. 2010. Abnormal psychology, first Canadian edition. Toronto, ON: Pearson Education Canada.

CARLISLE, J. 2018. "Mental health law in Saudi Arabia," *BJPsych International*. Cambridge University Press, 15(1), pp. 17–19. doi: 10.1192/bji.2017.10.

CASTELLANOS, M. E. P. 2014. The narrative in qualitative research in health. Ciência & Saúde Coletiva,19(4),pp.1065-1076.http://dx.doi.org/10.1590/141381232014194.12052013

CHATURVEDI, S. 2019. *Mental Health and Illness in Rural World*, Springer.

CHOPERENA, A., OROVIOGOICOECHEA, C., ZARAGOZA SALCEDO, A., OLZA MORENO, I., & JONES, D. 2019. Nursing narratives and reflective practice: a theoretical review. *Journal of advanced nursing*, *75*(8), 1637-1647.

CHOUDHRY, F. R., MANI, V., MING, L. C. & KHAN, T. M. 2016. Beliefs and perception about mental health issues: a meta-synthesis. *Neuropsychiatric disease and treatment,* 12**,** 2807-2818.

CHRONISTER, J., CHOU, C.-C. & LIAO, H.-Y. 2013. THE ROLE OF STIGMA COPING AND SOCIAL SUPPORT IN MEDIATING THE EFFECT OF SOCIETAL STIGMA ON INTERNALIZED STIGMA, MENTAL HEALTH RECOVERY, AND QUALITY OF LIFE AMONG PEOPLE WITH SERIOUS MENTAL ILLNESS. *Journal of Community Psychology,* 41**,** 582-600.

CIFTCI, A., JONES, N. & CORRIGAN, P. W. 2013. Mental health stigma in the Muslim community. Journal of Muslim Mental Health, 7.

CLANDININ, D. J. & CONNELLY, F. M. 2000. Narrative Inquiry: Experience and story in qualitative research, San Francisco: Jossey-Bass.

CLEMENT, S., BROHAN, E., JEFFERY, D., HENDERSON, C., HATCH, S. L. & THORNICROFT, G. 2012. Development and psychometric properties the Barriers to Access to Care Evaluation scale (BACE) related to people with mental ill health. *BMC Psychiatry,* 12.

CLEMENT, S., SCHAUMAN, O., GRAHAM, T., MAGGIONI, F., EVANS-LACKO, S., BEZBORODOVS, N., MORGAN, C., RUSCH, N., BROWN, J. & THORNICROFT, G. 2015. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine,* 45**,** 11-27.

COHEN, M. Z., Kahn, D. L., & Steeves, R. H. 2018. Hermeneutic Phenomenological Research: A Practical Guide for Nurse Researchers. Sage Publications.

CONSIDINE, C., 2021. *People of the Book: Prophet Muḥammad's Encounters with Christians*. Hurst Publishers.

CORRIGAN, P. W. 2016. Lessons learned from unintended consequences about erasing the stigma of mental illness. *World Psychiatry,* 15**,** 67-73.

CORRIGAN, P. W., DRUSS, B. G. & PERLICK, D. A. 2014. The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest,* 15**,** 37-70.

CORRIGAN, P. W. & RAO, D. 2012. On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change. *The Canadian Journal of Psychiatry,* 57**,** 464-469.

COVERDALE, G. E., & LONG, A. F. 2015. Emotional wellbeing and mental health: an exploration into health promotion in young people and families. *Perspectives in public health*, *135*(1), 27-36.

CRESWELL, J. S. 2007. Qualitative Inquiry and Research Design : choosing among five approach, Thousand Oaks, California, SAGE Publication, Inc.

CROSSMAN, J. 2021. *Handbook of Qualitative Research Methodologies in Workplace Contexts*, Edward Elgar Publishing.

CROTTY, J. 2009. Structural causes of the global financial crisis: a critical assessment of the 'new financial architecture'. *Cambridge journal of economics,* 33**,** 563-580.

CROTTY, M. 1998. *The foundations of social research: Meaning and perspective in the research process*, Sage.

CROUCH, M. & MCKENZIE, H. 2006. The logic of small samples in interview-based qualitative research. *Social Science Information,* 45**,** 483-499.

DAHLBERG, H., & DAHLBERG, K. 2020. Open and reflective lifeworld research: A third way. *Qualitative Inquiry*, *26*(5), 458-464.

DAMGHANIAN, M., & ALIJANZADEHl, M.2018. Theory of planned behavior, self-stigma, and perceived barriers explains the behavior of seeking mental health services for people at risk of affective disorders. *Asian Journal of Social Health and Behavior*, *1*(2), 54-54.

DARDAS, L. A. & SIMMONS, L. A. 2015. The stigma of mental illness in Arab families: a concept analysis. *Journal of Psychiatric & Mental Health Nursing,* 22**,** 668-679.

DAWOOD, E. & MODAYFER, O. 2016. Public Attitude towards Mental Illness and Mental Health Services in Riyadh, Saudi Arabia. *Research on humanities and social sciences,* 6**,** 63-75.

DAY, E. 2018. 8 Impactful Quotes from Saudi's Crown Prince Mohammed bin Salman. Available at:https://en.vogue.me/culture/8-impactful-quotes-from-saudis-crown-prince-mohammed-bin-salman/. Accessed on Sep 2018.

DE HERT, M., CORRELL, C. U., BOBES, J., CETKOVICH-BAKMAS, M., COHEN, D., ASAI, I., DETRAUX, J., GAUTAM, S., MöLLER, H.-J. & NDETEI, D. M. 2011. Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World psychiatry,* 10**,** 52.

DEIN, S. 2020. Religious healing and mental health. Taylor & Francis.

DIERS, D. 2004. Speaking of Nursing: Narratives of Practice, Research, Policy, and the Profession, Jones and Bartlett Publishers, Sudbury, Mass, USA.

DIXON, L. B., HOLOSHITZ, Y. & NOSSEL, I. 2016. Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry,* 15**,** 13-20.

DONNER, F.M., 2012. *Muhammad and the Believers: at the Origins of Islam*. Harvard University Press.

DOUGLAS, M. K., PIERCE, J. U., ROSENKOETTER, M., PACQUIAO, D., CALLISTER, L. C., HATTAR-POLLARA, M., LAUDERDALE, J., MILSTEAD, J., NARDI, D. & PURNELL, L. 2011. Standards of Practice for Culturally Competent Nursing Care:2011 Update. *Journal of Transcultural Nursing,* 22**,** 317-333.

DOYLE, L., BRADY, A.-M. & BYRNE, G. 2016. An overview of mixed methods research – revisited. *Journal of Research in Nursing,* 21**,** 623-635.

EL-GILANY, A. H., AMR, M. & IQBAL, R. 2010. Students' attitudes toward psychiatry at Al-hassa Medical College, Saudi Arabia. Academic Psychiatry, 34, 71–74.

El-Shamy, H., 2018. Folklore of the Arab World1. *Humanities*, *7*(3), p.67.

ESTEBAN-GUITART, M. & MOLL, L. C. 2014. Funds of identity: A new concept based on the funds of knowledge approach. *Culture & Psychology,* 20**,** 31-48.

ESTERHUIZEN, P. 2019. *Reflective practice in nursing*. Learning Matters, Sage, London

ETHERINGTON, K. 2013. Narrative approaches to case studies. *(online).*

FATORI, D. & POLANCZYK, G. V. 2020. Gaps Between Knowledge, Services, and Needs. *Mental Health and Illness of Children and Adolescents***,** 75-89.

FISCHER, E. P., MCSWEENEY, J. C., WRIGHT, P., CHENEY, A., CURRAN, G. M., HENDERSON, K. & FORTNEY, J. C. 2016. Overcoming barriers to sustained engagement in mental health care: Perspectives of rural veterans and providers. *The Journal of Rural Health,* 32**,** 429-438.

FLICK, U., VON KARDOFF, E. & STEINKE, I. 2004. A companion to qualitative research. Sage.

FRANK, A. W. 1995. The wounded Storyteller; body illness and ethics. University of Chicago Press, Chicago.

FRANK, A. W. 2002. Why Study People's stories? The dialogical Ethics of Narrative Analysis. International journal of Qualitative Methods 1 (1). 1-20.

FRASER, J. & YASNITSKY, A. 2015. "Deconstructing Vygotsky's Victimization Narrative: A Re-Examination of the "Stalinist Suppression" of Vygotskian Theory"(PDF). History of the Human Sciences. 28 (2): 128–153. doi:10.1177/0952695114560200.

FRESHWATER, D. 2000. Crosscurrents: Against cultural narration in nursing. *Journal of Advanced Nursing,* 32**,** 481-484.

FRID, I., OHLEN, J. & BERGBOM, I. 2000. On the use of narratives in nursing research. Journal of Advanced Nursing 32 (3). pp 695 to 703.

GADAMER, H.-G. 1975. Hermeneutics and social science. *Cultural hermeneutics,* 2**,** 307-316.

GAEBEL, W., RöSSLER, W. & SARTORIUS, N. 2016. *The Stigma of Mental Illness - End of the Story?*

GAEBEL, W., RöSSLER, W. & SARTORIUS, N. 2017. *The stigma of mental illness-end of the story?*, Springer.

GAUVAIN, R., 2012. *Salafi ritual purity: in the presence of God*. Routledge.

GEE, M., BHANBHRO, S., COOK, S., & KILLASPY, H. 2017. Rapid realist review of the evidence: achieving lasting change when mental health rehabilitation staff undertake recovery-oriented training. *Journal of advanced nursing*, *73*(8), 1775-1791.

GENERAL Authority For Statistics, Kingdom of Saudi Arabia. 2020. Available at: Population by Age Groups ,and Gender 0.pdf (stats.gov.sa).

GERGEN, M. 2000. *Feminist reconstructions in psychology: Narrative, gender, and performance*, Sage Publications.

GIALLO, R., DUNNING, M. & GENT, A. 2017. Attitudinal barriers to help-seeking and preferences for mental health support among Australian fathers. *Journal of reproductive and infant psychology,* 35**,** 236-247.

GILBERT, P. 1997. The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British journal of medical psychology*, *70*(2), 113-147.

GISHU, T., WELDETSADIK, AND, A. Y. & TEKLEAB, A. M. 2019. Patients' perception of quality of nursing care; a tertiary center experience from Ethiopia. BMC nursing, 18(1), pp.1-6.

GOFFMAN, E. 1963. *Stigma; notes on the management of spoiled identity,* Englewood Cliffs, N.J., Prentice-Hall.

GOFFMAN, E. 1990. *Stigma : notes on the management of spoiled identity,* London, Penguin books.

GOLBERSTEIN, E., EISENBERG, D. & GOLLUST, S. E. 2008. Perceived stigma and mental health care seeking. *Psychiatric services,* 59**,** 392-399.

GOLDMAN, H. H., FRANK, R. G. & MORRISSEY, J. P. 2020. *The Palgrave handbook of American mental health policy*, Springer.

GOLDSTONE, J. A. 1998. The problem of the" early modern" world. *Journal of the Economic and Social History of the Orient,* 41.

GOODWIN, R., COSTA, P., & ADONU, J. 2004. Social support and its consequences: 'Positive'and 'deficiency'values and their implications for support and self-esteem. *British Journal of Social Psychology*, *43*(3), 465-474.

GREENFIELD, D. 2010. 'When I hear Afrikaans in the classroom and never my language, I get rebellious': linguistic apartheid in South African higher education. *Language and Education,* 24**,** 517-534.

GRIFFITHS, K. M., CARRON-ARTHUR, B., PARSONS, A. & REID, R. 2014. Effectiveness of programs for reducing the stigma associated with mental disorders: A meta-analysis of randomized controlled trials. World Psychiatry, 13, 161–175.

GROSSMAN, D. C., CURRY, S. J., OWENS, D. K., BIBBIN-Domingo, K., CAUGHEY, A. B., DAVIDSON, K. W., ... & US Preventive Services Task Force. 2018. Screening for prostate cancer: US Preventive Services Task Force recommendation statement. *Jama*, *319*(18), 1901-1913.

GUITART, M. E. & RATNER, C. 2011. A Macro Cultural Psychological Theory of Identity. *Journal of Social Distress and the Homeless,* 20**,** 1-22.

GUREJE, O., APPIAH-POKU, J., BELLO, T., KOLA, L., ARAYA, R., CHISHOLM, D., ESAN, O., HARRIS, B., MAKANJUOLA, V. & OTHIENO, C. 2020. Effect of collaborative care between traditional and faith-healers and primary health-care workers on psychosis outcomes in Nigeria and Ghana (COSIMPO): a cluster randomised controlled trial. *The Lancet,* 396**,** 612-622.

HABERMAS, J. 1978. Knowledge and human interests.

HABIBI, N. 2019. Implementing saudi arabia's vision 2030: An interim balance sheet. *Middle East Brief,* 127**,** 1-9.

HALAI, N. 2007. Making use of bilingual interview data: Some experiences from the field. *The qualitative report*, *12*(3), 344.

HALAWANI, S. 2014. INCLUSION OF RELIGION AND SPIRITUALITY IN PSYCHOTHERAPY: A STUDY OF CLIENTS' PERSPECTIVE. *Inpact 2014: International Psychological Applications Conference and Trends***,** 342-344.

HALL & POWELL 2011. Understanding the person through Narrative; Nursing Research and Practice.ArticleID293837.Avaliableat:http://www.hindawi.com/journals/nrp/2011/293837/cta/ . Accessed on 23.05.2017.

HALL, J. M., STEVENS, P. E. & MELEIS, A. I. 1992. 'Developing the Construct of Role Integration: A narrative analysis of women clerical workers' daily lives,' Research in Nursing & Health, vol. 15, no. 6, pp. 447–457. .

HALL, S. 2014. Cultural identity and diaspora. In Diaspora and Visual Culture. *Abingdon-on-Thames, UK: Routledge Publishing*.

HALPERN-MANNERS, A., SCHNABEL, L., HERNANDEZ, E. M., SILBERG, J. L. & EAVES, L. J. 2016. The relationship between education and mental health: new evidence from a discordant twin study. *Social Forces,* 95**,** 107-131.

HAMDAN, A. 2005. Women and education in Saudi Arabia:Challenges and achievements.International Education Journal.vol 6(1).

HAMID, A. & FURNHAM, A. 2013. Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. *Mental Health, Religion & Culture,* 16**,** 741-758.

HANEY, C. 2003. Mental Health Issues in Long-Term Solitary and "Supermax" Confinement. *Crime & Delinquency,* 49**,** 124-156.

HARDY , GARBETT R, T. A. & K, M. 2002. Exploring nursing expertise: nurses talk nursing. Nursing Inquiry. 9 (3), 196-202.

HART, T. E. 2016. How Can Young People, Aged 14-16 Years with Mental Health Problems, Be Better Supported in Mainstream Education?, Department of Neuroscience, Psychology and Behaviour.

HATZENBUEHLER. M. L. 2016. Structural stigma: Research evidence and implications for psychological science. *The American psychologist*, *71*(8), 742–751. https://doi.org/10.1037/amp0000068

HEATH, P. J., BRENNER, R. E., LANNIN, D. G. & VOGEL, D. L. 2018. Self-compassion moderates the relationship of perceived public and anticipated self-stigma of seeking help. *Stigma and Health,* 3**,** 65.

HELKKULA, A. & PIHLSTRöM, M. 2010. Narratives and Metaphors in Service Development, Qualitative Market Research: An International Journal, V13, No. 4, pp. 354-371

HENDERSON, C., NOBLETT, J., PARKE, H., CLEMENT, S., CAFFREY, A., GALE-GRANT, O., SCHULZE, B., DRUSS, B. & THORNICROFT, G. 2014. Mental health-related stigma in health care and mental health-care settings. *Lancet Psychiatry,* 1.

HENDERSON, K. A. & FORTNEY, J. C. 2016. Overcoming barriers to sustained engagement in mental health care: Perspectives of rural veterans and providers. The Journal of Rural Health, 32(4), pp.429-438.

HICKEY, J. E., PRYJMACHUK, S. & WATERMAN, H. 2016. Mental illness research in the Gulf Cooperation Council: a scoping review. *Health Research Policy and Systems,* 14**,** 59.

HISNAL-MUSLIM (124)Chapter: When feeling some pain in the body.Avaliable at:

https://sunnah.com/search?q=%D8%A8%D9%90%D8%B3%D9%92%D9%85%D9%90+%D8%A7%D9%84%D9%84%D9%87%D9%90+%22+%28+%D8%AB%D9%84%D8%A7%D8%AB%D8%A7%D9%8B+%29+%22+%D8%A3%D9%8E%D8%B9%D9%8F%D9%88%D8%B0%D9%8F+%D8%A8%D9%90%D8%B9%D9%90%D8%B2%D9%91%D9%8E%D8%A9%D9%90+%D8%A. Accessed on Sep 2021. 1-6.

HOGAN, M. F. 2003. New Freedom Commission report: The president's New Freedom Commission: recommendations to transform mental health care in America. *Psychiatric Services*, *54*(11), 1467-1474.

HOLLOWAY, I. & FRESHWATER, D. 2007. Narrative research in nursing. Blackwell Publishing. Oxford.

HOLZINGER, A., FLORIS, F., SCHOMERUS, G., CARTA, M. & ANGERMEYER, M. 2012. Gender differences in public beliefs and attitudes about mental disorder in western countries: a systematic review of population studies. *Epidemiology and psychiatric sciences,* 21**,** 73-85.

HSU, L. & ALDEN, L. E. 2008. Cultural influences on willingness to seek treatment for social anxiety in Chinese-and European-heritage students. *Cultural Diversity and Ethnic Minority Psychology,* 14**,** 215.

HURWITZ, B., GREENHALGH, T. & SKULTANS, V. 2004. Narrative research in health and illness. John Wiley & Sons.

HUSSEIN, F. 2014. A study of the role of unorthodox treatments of psychiatric illnesses. Arab Journal of Psychiatry, 2, 170–184. Google Scholar.

HUTCHISON, E. D. 2008. *Dimensions of Human Behavior: Person and Environment*, Sage Publications.

IFANTI, A. A., ARGYRIOU, A. A., KALOFONOU, F. H. A. & KALOFONOS, H. P. 2013. Financial crisis and austerity measures in Greece: Their impact on health promotion policies and public health care. Health Policy, 113(1-2), pp.8-12.

IM, E.-O. & MELEIS, A. I. 2021. *Situation Specific Theories: Development, Utilization, and Evaluation in Nursing*, Springer.

IM, H., FERGUSON, A. & HUNTER, M. 2017. Cultural translation of refugee trauma: Cultural idioms of distress among Somali refugees in displacement. *Transcultural psychiatry,* 54**,** 626-652.

ISLAM, F. & CAMPBELL, R. A. 2014. "Satan Has Afflicted Me!" Jinn-Possession and Mental Illness in the Qur'an. *Journal of Religion and Health,* 53**,** 229-243.

ITAI, I. 2008. Self actualisation: For individualistic cultures only? *International Journal on Humanistic Ideology,* 1**,** 113-139.

JAVADI, D., FELDHAUS, I., MANCUSO, A., & GHAFFAR, A. 2017. Applying systems thinking to task shifting for mental health using lay providers: a review of the evidence. *Global Mental Health*, *4*, e14.

JAVED, A., LEE, C., ZAKARIA, H., BUENAVENTUR, R. D., Cetkovich-Bakmas, M., Duailibi, K., ... & Azeem, M. W. 2021. Reducing the stigma of mental health disorders with a focus on low-and middle-income countries. *Asian journal of psychiatry*, *58*, 102601.

JBI 2015. Guidance for conducting systematic scoping reviews. Joanna Briggs Institute, International journal of evidence-based healthcare, 13, 141-146.

JELAIDAN, M., ALKHAIR, L., THANI, T. & SUSI A, S. R. 2018. General Background and Attitude of the Saudi Population towards Mental Illness. *J Psychol Clin Psychiatry 9(1): 00510. DOI: 10.15406/jpcpy.2018.09.00510*.

JOHNSON, P. & DUBERLEY, J. 2003. Reflexivity in management research. Journal of management studies, 40(5), 1279-1303.

JOSSELSON, R. 2004. The hermeneutics of faith and the hermeneutics of suspicion. *Narrative inquiry*, *14*(1), 1-28.

JOYCE, M. 2015. Using narrative in nursing research. *Nursing Standard,* 29**,** 36-41.

KATZ, N. & MCNULTY, K. 1994. Reflective listening. University of Syracuse.

KAYED, R. N. & HASSAN, M. K. 2010. Islamic entrepreneurship: A case study of Saudi Arabia. *Journal of developmental entrepreneurship,* 15**,** 379-413.

KAZDIN, A. E. & RABBITT, S. M. 2013. Novel models for delivering mental health services and reducing the burdens of mental illness. Clin Psychol Sci, 1:2170–2191.

KEANE, N. & LAWN, C. 2015. *The Blackwell Companion to Hermeneutics*, Wiley.

KELLEY, H. H. 1967. Attribution theory in social psychology. Nebraska Symposium on Motivation, 15, 192-238.

KHALIDI, T., 2009. *Images of Muhammad: Narratives of the Prophet in Islam across the Centuries*. Harmony.

KHALIFA, N., HARDIE, T., LATIF, S., JAMIL, I., & Walker, D. M. 2011. Beliefs about Jinn, black magic and the evil eye among Muslims: age, gender and first language influences. *International Journal of Culture and Mental Health*, *4*,1, 68-77.

KING, D. B., & DeCicco, T. L. 2009. A viable approach to mental health care: The role of spiritual and religious factors in treating depression. Journal of Religion and Health, 48(3), 281-293.

KIRKPATRICK, H. 2008. A Narrative Framework for Understanding Experiences of People with Severe Mental Illnesses,' Archives of Psychiatric Nursing, vol. 22, no. 2, pp. 61–68. .

KLEIN, I. & JANOFF, R. 1996. Trauma History and Personal Narratives: Some clues to coping among survivors of child abuse,' Child Abuse and Neglect, vol. 20, no. 1, pp. 45–54. .

KLEINMAN, A. 1980. *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*, University of California Press.

KLERES, J. 2010 Emotions and Narrative Analysis: A Methodological Approach, Journal of the Theory of Social Behaviour, V41, No. 2, pp. 182-202. .

KNAAK, S., MODGILL, G. & PATTEN, S. B. 2014. Key ingredients of anti-stigma programs for health care providers: a data synthesis of evaluative studies. *The Canadian Journal of Psychiatry,* 59**,** 19-26.

KNAAK, S., SZETO, A. C., KASSAM, A., HAMER, A., MODGILL, G. & PATTEN, S. 2017. Understanding stigma: A pooled analysis of a national program aimed at health care providers to reduce stigma towards patients with a mental illness. *Journal of Mental Health and Addiction Nursing,* 1**,** e19-e29.

KOENIG, H. G. 2009. Research on religion, spirituality, and mental health: a review. *Canadian journal of psychiatry. Revue canadienne de psychiatrie,* 54**,** 283-291.

KOENIG, H. G. 2013. *Is religion good for your health?: The effects of religion on physical and mental health*, Routledge.

KOENIG, H. G., AL ZABEN, F., SEHLO, M. G., KHALIFA, D. A. & AL AHWAL, M. S. 2013. Current State of Psychiatry in Saudi Arabia. *The International Journal of Psychiatry in Medicine,* 46**,** 223-242.

KOENIG, H. G., AL ZABEN, F., SEHLO, M. G., KHALIFA, D. A., AL AHWAL, M. S., QURESHI, N. A. & AL-HABEEB, A. A. 2014. Mental health care in Saudi Arabia: Past, present and future. Open Journal of Psychiatry, 4, 113-130.

KOENIG, H. G. 2014. Religion, spirituality, and health: A review and update. Advances in Mind-Body Medicine, 28(2), 10-18.

KOUCHI, A. N., NEZHAD, M. Z. & KIANI, P. 2018. A study of the relationship between the growth in the number of Hajj pilgrims and economic growth in Saudi Arabia. *Journal of Hospitality and Tourism Management,* 36**,** 103-107.

KOZULIN, A. 1986. "Vygotsky in Context" in Vygotsky L. "Thought and Language", MIT Press. pp. xi – lvii.

LANGDRIDGE, D. 2007. *Phenomenological Psychology: Theory, Research and Method*, Pearson Education.

LANGDRIDGE, D. & BUTT, T. 2004. A hermeneutic phenomenological investigation of the construction of sadomasochistic identities. *Sexualities,* 7**,** 31-53.

LARSON, D. B., & LARSON, S. S. 2003. The forgotten factor in physical and mental health: What does the research show?. Religion and Health: Is There an Association?, 7-44.

LAUBER, C. & RöSSLER, W. 2007. Stigma towards people with mental illness in developing countries in Asia. International Review of Psychiatry, 157-178.

LAVERS, A., 1995. *Roland Barthes*. na. Available at : Structuralism_reading_1.pdf

LEBOW, R. N. 2016. Max Weber (1864–1920). *The Return of the Theorists.* Springer.

LENFESTY, K., REICHLING, K., & & SCHULTZ, T. n. d. Narrative Research Design, Colorado State University *Avialiable at :http://edrm600narrativedesign.weebly.com/ethics.html*.

LEONTIEV, A. N. 2005. Study of the Environment in the Pedological Works of L.S. Vygotsky: A Critical Study, Journal of Russian & East European Psychology, 43:4, 8-28, DOI: 10.1080/10610405.2005.11059254.

LEONTIEV, A. N., & & LURIA, A. R. 1976. Iz istorii stanovleniya psikhologicheskikh vzglyadov L.S. Vygotskogo [From the history of the development of psychological views of L.S. Vygotsky]. Voprosy psikhologii, (6), 84–93.

LEVINSON, D., LAKOMA, M. D., PETUKHOVA, M., SCHOENBAUM, M., ZASLAVSKY, A. M., ANGERMEYER, M., BORGES, G., BRUFFAERTS, R., DE GIROLAMO, G., DE GRAAF, R. A. & GUREJE, O. 2010. Associations of serious mental illness with earnings: Results from the WHO World Mental Health surveys. The British Journal of Psychiatry, 197(2), pp.114-121.

LIM, A., HOEK, H. W., GHANE, S., DEEN, M. & BLOM, J. D. 2018. The attribution of mental health problems to Jinn: An explorative study in a transcultural psychiatric outpatient clinic. *Frontiers in Psychiatry,* 9**,** 89.

LIVESEY, C. 2004. Culture and identity:, Sociological pathways. [online].<Available at: http://www.sociology.org.uk/pathway2.htm. [Accessed September 2018].

LIVINGSTON, J. D. & BOYD, J. E. 2010. "Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis," Social Science & Medicine, Elsevier, vol. 71(12), pages 2150-2161, December.

LONG, D. E. 2005. Culture and customs of Saudi Arabia. US: University Park, Penn State Press.

LUCHKOV, V. V., & PEVZNER, M.S 1981. Znachenie teorii L.S. Vygotskogo dlya psikhologii i defektologii [Contribution of L.S. Vygotsky's theory to psychology and defectology]. Vestnik Moskovskogo universiteta. Seriya 14. Psikhologiya, (4), 60–70.

LURIA, A. R. 1935. Professor L.S. Vygotsky (1896-1934). Journal of Genetic Psychology, pp. 224–226.

MACLEOD , J., YANG, H. H., ZHU, S., & LI, Y. 2018. Understanding students' preferences toward the smart classroom learning environment: Development and validation of an instrument. *Computers & Education*, *122*, 80-91

MAHSOON, A., SHARIF, L., BANAKHAR, M., ALASMEE, N., ALMOWALLAD, E., JABALI, R., & & ASSUR, S. 2020. Parental support, beliefs about mental illness, and mental help-seeking among young adults in Saudi Arabia. International Journal of Environmental Research and Public Health, 17(15), 5615.

MAJUMDER, P., O'REILLY, M., KARIM, K. & VOSTANIS, P. 2015. 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International journal of social psychiatry,* 61**,** 129-136.

MAK, W. W. & CHEUNG, R. Y. 2012. Psychological distress and subjective burden of caregivers of people with mental illness: The role of affiliate stigma and face concern. *Community Mental Health Journal,* 48**,** 270-274.

MALTERUD, K. 2001. "Qualitative research: Standards, challenges and guidelines." The Lancet. 358: pp. 483-488.

MASUDA, A. & LATZMAN, R. D. 2011. Examining associations among factor-analytically derived components of mental health stigma, distress, and psychological flexibility. *Personality and Individual Differences,* 51**,** 435-438.

MATHEWS, R. R., HALL, W.D., VOS, T., PATTON, G.C., DEGENHARDT, L 2011. What are the major drivers of prevalent disability burden in young Australians? Medical Journal of Australia 194, 232–235.

MCCRAE, N., SHARIF, L. & NORMAN, I. 2019. Media portrayals of mental disorder in Saudi Arabia: a review of popular newspapers. *Transcultural Psychiatry,* 56**,** 428-442.

MEMISH, Z. A., JABER, S., MOKDAD, A. H., ALMAZROA, M. A., MURRAY, C. J., AL RABEEAH, A. A. & COLLABORATORS, S. B. O. D. 2014. Peer reviewed: Burden of disease, injuries, and risk factors in the Kingdom of Saudi Arabia, 1990–2010. *Preventing chronic disease,* 11.

MERRIAM, S. B. 2002. Qualitative research in practice: Examples for discussion and analysis. Jossey-Bass Inc Pub.

MHCL 2014. Mental Health Care Law.Minestry of health portal.Kingdom Of S audi Arabia. Avaliable at http://www.moh.gov.sa/en/Ministry/Rules/Documents/Menatl-Health-Care-Law.pdf

MIEHLS, D. & MOFFATT, K. 2000. Constructing social work identity based on the reflexive self. *British Journal of Social Work,* 30**,** 339-348.

MINAS, H. & COHEN, A., . 2013. Why focus on mental health systems? Int J Ment Health Syst, 1:1.

MINISTRY-OF-HEALTH—KSA 2018. Annual Statistical Book—2017. Retrieved from https://www.moh.gov.sa/en/Ministry/Statistics/book/Documents/ANNUAL-STATISTICAL-BOOK-1438H.pdf.

MISHLER, E. G. 1986. Research Interviewing; Context and Narrative. Harvard University Press. Cambridge, MA.

MISHLER, E. G. 2004. *Storylines*, Harvard University Press.

MITCHELL, M. C. & EGUDO, M. 2003. A review of narrative methodology.DTIC Document,EdinburghSouthAustralia.(online)http://www.webpages.uidaho.edu/css506/506%20readings/review%20of%20narritive%20methodology%20australian%20gov.pdf

MNEIMNEH, Z. N., HEERINGA, S. G., LIN, Y. C., ALTWAIJRI, Y. A. & NISHIMURA, R. 2020. The Saudi National Mental Health Survey: Sample design and weight development. *International Journal of Methods in Psychiatric Research,* 29**,** e1829.

MOADDEL, M. 2016. The Saudi public speaks: Religion, gender, and politics. . *International Journal of Middle East Studies,* 38.

MOJTABAI, R., OLFSON, M., SAMPSON, N. A., JIN, R., DRUSS, B., WANG, P. S., WELLS, K. B., PINCUS, H. A. A. & KESSLER, R. C. 2011. Barriers to mental health treatment: results from the National Comorbidity Survey Replication (NCS-R). Psychological medicine, 41(8), p.1751.

MOLLOY, L., BECKETT, P., CHIDARIKIRE, S., MERRICK, T. T., GUHA, M. & PATTON, D. 2020. Culture, the stigma of mental illness, and young people. *Journal of Psychosocial Nursing and Mental Health Services,* 58**,** 15-18.

MORAN, G. S., RUSSINOVA, Z., GIDUGU, V., YIM, J. Y. & SPRAGUE, C. 2011. Benefits and mechanisms of recovery among peer providers with psychiatric illnesses. Qualitative Health Research, 30, 1–16.

NABI, R. L., PRESTIN, A. A. & SO, J. 2013. Facebook friends with (health) benefits? Exploring social network site use and perceptions of social support, stress, and well-being. Cyberpsychology, Behavior, and Social Networking, 16(10), pp.721-727.

NELSON, K. 2004. Construction of the Cultural Self in Early Narratives,' in Narrative Analysis: Studying the Development of Individuals in Society.

NIBLOCK, T. 2004. Saudi Arabia: Power, legitimacy and survival, *Abingdon-on-Thames,UK:Routledge Publishing*

NTINDA, KAYI. 2020. Narrative Research. 10.1007/978-981-10-2779-6_79-1.

NOLAN, J. A., WHETTEN, K. & KOENIG, H. G. 2011. RELIGIOUS, SPIRITUAL, AND TRADITIONAL BELIEFS AND PRACTICES AND THE ETHICS OF MENTAL HEALTH RESEARCH IN LESS WEALTHY COUNTRIES*. *International journal of psychiatry in medicine,* 42**,** 267-277.

NORMAN, I. & RYRIE, I. 2013. *The art and science of mental health nursing: Principles and practice: A textbook of principles and practice*, McGraw-Hill Education (UK).

OBEID, T., ABULABAN, A., AL-GHATANI, F., AL-MALKI, A. R. & AL-GHAMDI, A. 2012. Possession by 'Jinn' as a cause of epilepsy (Saraa): A study from Saudi Arabia. *Seizure,* 21**,** 245-249.

OKASHA, A. & KARAM, E. 1998. Mental health services and research in the Arab world. Acta Psychiatrica Sscandinavica, 98(5).

OKKELS, N., KRISTIANSEN, C. B. & MUNK-JøRGENSEN, P. 2017. *Mental health and illness in the city*, Springer.

OUDA, O. K. 2016. Treated wastewater use in Saudi Arabia: challenges and initiatives. *International Journal of Water Resources Development,* 32**,** 799-809.

PAGE MJ, MOHER D, BOSSUYT PM, et al. PRISMA 2020 explanation and elaboration: updated guidance and exemplars for reporting systematic reviews. Bmj. 2021;372:n160.

PARENTELA, G. M. 2021. Mental Health Research Studies in Saudi Arabia for the Years 2009-2019; A Systematic Scoping Review. *Archives of Psychiatric Nursing*.

PARENTELA, G., ALHARBI, H., ALAHMADI, A., ALBURKANI, H. & ALJUMAYI, I. 2019. Socio-demography and psychosis symptom severity among male schizophrenia–Diagnosed patients of MOH Mental Health Facilities, Kingdom of Saudi Arabia; a correlational study. *Archives of psychiatric nursing,* 33**,** 110-115.

PARGAMENT, K. I. & LOMAX, J. W. 2013. Understanding and addressing religion among people with mental illness. *World Psychiatry,* 12**,** 26-32.

PATERSON, H., TODOROVA, G. K., NOBLE, K., SCHICKHOFF, S. & POLLICK, F. E. 2021. Evaluation of Headtorch WORKS as a workplace intervention for improved support and understanding of co-workers with poor mental health and well-being. *European Journal of Work and Organizational Psychology***,** 1-12.

PATTON, M. Q. 1990. *Qualitative evaluation and research methods*, SAGE Publications, inc.

PATTYN, E., VERHAEGHE, M., SERCU, C. A. & BRACKE, P. 2014. Public stigma and self-stigma: Differential association with attitudes toward formal and informal help seeking. Psychiatric Services, 65(2), pp.232-238.

PESCOSOLIDO, B. A., MEDINA, T. R., MARTIN, J. K. & LONG, J. S. 2013. The "Backbone" of Stigma: Identifying the Global Core of Public Prejudice Associated With Mental Illness. *American Journal of Public Health,* 103**,** 853-860.

PETERS, H. & BROWN, T. C. 2009. Mental illness at work: An assessment of co-worker reactions. *Canadian Journal of Administrative Sciences/Revue Canadienne des Sciences de l'Administration,* 26**,** 38-53.

PETTY, J. 2016. Learning from narrative to understand the person-centred experience in neonatal nursing: A literature review. *Journal of Neonatal Nursing*, *22*(6), 297-308.

PHAM, T. V., KOIRALA, R., WAINBERG, M. L. & KOHRT, B. A. 2021. Reassessing the mental health treatment gap: what happens if we include the impact of traditional healing on mental illness? *Community Mental Health Journal,* 57**,** 777-791.

POLANCZYK, G.V., SALUM, G.A., SUGAYA, L.S., CAYE, A. and ROHDE, L.A., 2015. Annual research review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. *Journal of child psychology and psychiatry*, *56*(3), pp.345-365.

POLKINGHORNE, D. E. 1988. Narrative Knowing and Human Sciences, State University of New York Press, Albany,USA.

POLKINGHORNE, D. E. 2007. Validity Issues in Narrative Research, Qualitative Inquiry, V13, No. 4, pp. 471-486.

PRICE, M., YUEN, E. K., GOETTER, E. M., HERBERT, J. D., FORMAN, E. M., ACIERNO, R. A. & RUGGIERO, K. J. 2014. mHealth: a mechanism to deliver more accessible, more effective mental health care. Clinical Psychology & Psychotherapy, 21(5), pp.427-436.

QUMAR, M. M. 2020. *Education System in Saudi Arabia: Of Change and Reforms*. Springer Nature.

QURESHI, N. A., AL-HABEEB, A. A. & KOENIG, H. G. 2013. Mental health system in Saudi Arabia: an overview. *Neuropsychiatric Disease and Treatment,* 9**,** 1121-1135.

RASSOOL, P. D. G. H. 2018. *Evil Eye, Jinn Possession, and Mental Health Issues: An Islamic Perspective*.

RATNER, C. 1991. Vygotsky's sociohistorical psychology and its contemporary applications.

RATNER, C. 2000. A Cultural-psychological analysis of emotions. Culture and Psychology,6, 5-39.

RATNER, C. 2011a. *Macro Cultural Psychology: A Political Philosophy of Mind*, Oxford University Press.

RATNER, C. 2011b. Macro Cultural Psychology. In Jaan Valsiner (Ed.), Oxford Handbook of Culture and Psychology. New York: Oxford University Press.

RATNER, C. 2011c. Cultural Psychology. In Robert Rieber (Ed.), Encyclopedia of the history of psychological theories. New York: Springer.

RATNER, C. 2011d. Macro cultural psychology, the psychology of oppression, and cultural-psychological enrichment. In P. Portes & S. Salas (Eds.), Vygotsky in 21st century: Advances in cultural historical theory and praxis with non-dominant communities. New York: Peter Lang.

RATNER, C. 2013. Macro Cultural Psychology: Its Development, Concerns, Politics, and Direction.In M. Gelfand, C. Chiu, Y. Hong (Eds.), Advances in Culture and Psychology .vol. 3, chap. 6. N.Y.: Oxford University Press.

RATNER, C. 2014. Macro Cultural Psychology. *In:* TEO, T. (ed.) *Encyclopedia of Critical Psychology.* New York, NY: Springer New York.

RATNER, C. 2019. Macro Cultural Psychological Science Generates Insights for Cultural Emancipation and Psychological Emancipation. *Neoliberal Psychology.* Springer.

RATNER, C. 2019. *Psychology's Contribution to Socio-Cultural, Political, and Individual Emancipation*, Springer Nature.

RATNER, C. & EL-BADWI, E.-S. 2011. A Cultural Psychological Theory of Mental Illness, Supported by Research in Saudi Arabia. *Journal of Social Distress and the Homeless,* 20**,** 217-274.

RAZA, K. 2016. Islamic Contemporary Alternative Treatments with regards to Mental Health: a cross-cultural qualitative study.

REAVLEY, N. & JORM, A. 2012. Public recognition of mental disorders and beliefs about treatment: Changes in Australia over 16 years. Br J Psychiatry, 200:419–425.

RICOEUR, P.1970. Freud and philosophy: An essay on interpretation. Yale University Press.

RICOEUR, P. 1987. The Teleological and Deontological Structures of Action: Aristotle and/or Kant? *Royal Institute of Philosophy Lecture Series,* 21**,** 99-111.

RICOEUR, P. 2010. *Time and narrative*, University of Chicago Press.

RICOEUR, P. & THOMPSON, J. B. 1981. *Hermeneutics and the human sciences: Essays on language, action and interpretation*, Cambridge university press.

RIESSMAN, C. K. 1993. Narrative analysis, Vol. 30. Qualitative Research Methods Series. Sage, London.

RIESSMAN, C. K. 2008. Narrative methods for the human sciences, Sage.

RINALDO, R., 2021. Spirituality and Islam. *Situating Spirituality: Context, Practice, and Power*, p.297.

RITCHIE, J. & LEWIS, J. 1993. Qualitative Research Practice London: Sage. Silverman, D.Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction. Sage: London.

RITCHIE, J., LEWIS, J., NICHOLLS, C. M. & ORMSTON, R. 2013. Qualitative research practice: A guide for social science students and researchers. Sage.

RMHCL 2016. Regulations of the Mental Health Care System.General Administration of Mental and Social Health.Minestry of health. Avaliable at: http://www.moh.gov.sa/en/Ministry/Rules/Documents/Executive-Regulation-of-Menatl-Health-Care-Law.pdf.

ROSSMAN, G. & RALLIS, M. 2003. *Learning in the field: An introduction to qualitative research*, Sage.

ROSMARIN, D. H., PIRUTINSKY, S., COHEN, A. B., & GALLER, Y. 2013. Integrating religious clients into psychotherapy: A review and preliminary meta-analysis. Journal of Clinical Psychology, 69(9), 886-897.

RUBIN, I. L., MERRICK, J., GREYDANUS, D. E. & PATEL, D. R., . 2016. Health care for people with intellectual and developmental disabilities across the lifespan, Springer.

RUSCH, N., ANGERMEYER, M. C. & CORRIGAN, P. W. 2005. Mental illness stigma: concepts, consequences, and initiatives to reduce stigma. European psychiatry, 20(8), 529-539.

RUSSELL, G. M. & KELLY, N. H. 2002.Research as interacting dialogic processes: Implications for reflexivity. Forum Qualitative Sozialforschung/Forum: Qualitative Social Research.

SAGED, A. A. G., YUSOFF, M. Y. Z. M., LATIF, F. A., HILMI, S. M., AL-RAHMI, W. M., AL-SAMMAN, A., ALIAS, N. & ZEKI, A. M. 2018. Impact of Quran in treatment of the psychological disorder and spiritual illness. *Journal of religion and health***,** 1-14.

SALEM, J. 2017. 4. Ramadan, Eid al-fitr, and eid al-Adha: fasting and feasting. *The Practice of Islam in America.* New York University Press.

SANDELOWSKI, M. 1991. Telling stories: Narrative approaches in qualitative research. Journal of Nursing Scholarship, 23(3), pp.161-166.

SANDELOWSKI, M. 1995. Whatever happened to Qualitative description? Research in Nursing & Health, 23: 179–183.

SANDEN, R. L., BOS, A. E., STUTTERHEIM, S. E., PRYOR, J. B. & KOK, G. 2015. Stigma by association among family members of people with a mental illness: A qualitative analysis. *Journal of Community & Applied Social Psychology,* 25**,** 400-417.

SANTANA, M. J., MANALILI, K., JOLLEY, R. J., ZELINSKY, S., QUAN, H., & LU, M. 2018. How to practice person-centred care: A conceptual framework. *Health Expectations*, *21*(2), 429-440.

SAUNDERS, B., SIM, J., KINGSTONE, T., BAKER, S., Waterfield, J., Bartlam, B., ... & Jinks, C. 2019. Saturation in qualitative research: exploring its conceptualization and operationalization. Quality & Quantity, 53(4), 1893-1907.

SARBIN, T. R. 1986. Narrative Psychology: The Storied Nature of Human Conduct, Praeger, New York, USA.

SARITOPRAK, S. N., & EXLINE, J. J. 2020. Religious coping among Muslims with mental and medical health concerns. In *Working with Muslim clients in the helping professions* (pp. 201-220). IGI Global.

SAUDI COMISSION FOR HEALTH SPECIALITIES, 2021. treaveid from: Saudi Commission for Health Specialties (scfhs.org.sa)

SAUDI MENTAL HEALTH PROMOTION CENTRE (SMHPC). (n.d.). About SMHPC. Retrieved March 13, 2022, from https://www.smhpc.gov.sa/en/about-smhpc

SATCHER, D. 2000. Mental health: A report of the Surgeon General--Executive summary. *Professional Psychology: Research and Practice*, *31*(1), 5.

SAVAGE, MURRAY J, HATCH SL, HOTOPF M, EVANS-LACKO S & JSL., B. 1996. Exploring professional help-seeking for mental disorders. Qual Health Res. 2015;26:1–12.

SCHIERENBECK, I., JOHANSSON, P., ANDERSSON, L. & ROOYEN, D. 2013. Barriers to accessing and receiving mental health care in Eastern Cape, South Africa. *Health Human Rights,* 15.

SCHNYDER, N., PANCZAK, R., GROTH, N. & SCHULTZE-LUTTER, F. 2017. Association between mental health-related stigma and active help-seeking: systematic review and meta-analysis. *The British journal of psychiatry : the journal of mental science*.

SCHOMERUS, G. & ANGERMEYER, M. C. 2008. Stigma and its impact on help-seeking for mental disorders: What do we know? *Epidemiol Psichiatr Soc,* 17.

SCOTLAND, J. 2012. Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching,* 5**,** 9.

SEIDMAN, S. 1991. The end of sociological theory: The postmodern hope. *Sociological theory,* 9**,** 131-146.

SEWILAM, A. M., WATSON, A. M., KASSEM, A. M., CLIFTON, S., MCDONALD, M. C., LIPSKI, R., DESHPANDE, S., MANSOUR, H. & NIMGAONKAR, V. L. 2015. Suggested avenues to reduce the stigma of mental illness in the Middle East. *International Journal of Social Psychiatry,* 61**,** 111-120.

SHABANI, K., KHATIB, M. & EBADI, S. 2010. Vygotsky's zone of proximal development: Instructional implications and teachers' professional development. *English language teaching,* 3**,** 237-248.

SHAHROUR, T. M. & REHMANI, R. S. 2009. Testing psychiatric stigma in a general hospital in Saudi Arabia. *Saudi medical journal,* 30**,** 1336-1339.

SHARIF, L., BASRI, S., ALSAHAFI, F., Altaylouni, M., Albugumi, S., Banakhar, M., ... & Wright, R. J. 2020. An Exploration of Family Caregiver Experiences of Burden and Coping While Caring for People with Mental Disorders in Saudi Arabia—A Qualitative Study. *International journal of environmental research and public health*, *17*(17), 6405.

SHIM, R. S., KOPLAN, C. & LANGHEIM, F. J. E. A. 2012. Health care reform and integrated care: A golden opportunity for preventive psychiatry. Psychiatr Serv, 63:1231–1233.

SILVEY, R. 2004. c. *Singapore Journal of Tropical*

SINGH, S. P., PAUL, M., FORD, T., KRAMER, T., WEAVER, T., MCLAREN, S., HOVISH, K., ISLAM, Z., BELLING, R. & WHITE, S. 2010. Process, outcome and experience of transition from child to adult mental healthcare: Multiperspective study. The British Journal of Psychiatry, 197(4), pp.305-312.

SIRGADO, A. P. 2000. The social and cultural in Vygotsky's work. *Educação & Sociedade,* 21**,** 45-78.

SMITH, J. A. 2011. Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review,* 5**,** 9-27.

SMYTH, M. & WILLIAMSON 2004. W.Researchers and their 'Subjects': Ethics, Power, Knowledge and Consent. Policy Press: Bristol.

SPENCER, S. J., FEIN, S. & LOMORE, C. D. 2001. Maintaining one's self-image vis-à-vis others: The role of self-affirmation in the social evaluation of the self. *Motivation and Emotion,* 25**,** 41-65.

SRA 2003. Ethical Guidelines.Available at: http://www.the-sra.org.uk/ethicals.htm

STACEY, G., FELTON, A., MORGAN, A., STICKLEY, T., WILLIS, M., DIAMOND, B. & DUMENYA, J. 2016. A critical narrative analysis of shared decision-making in acute inpatient mental health care. Journal of Interprofessional Care, 30(1), 35-41. http://dx.doi.org/10.3109/13561820.2015.1064878

STAIGER, T., WALDMANN, T., RUSCH, N. & KRUMM, S. 2017. Barriers and facilitators of help-seeking among unemployed persons with mental health problems: a qualitative study. *BMC health services research,* 17**,** 39.

STEVENS, P. E., HALL, J. M. & MELEIS, A. I. 2002. Narratives as a Basis for Culturally Relevant Holistic Care: Ethnicity and everyday experiences of women clerical workers,' Holistic Nursing Practice, vol. 6, no. 3, pp. 49–58. .

STUART, H. 2016. Reducing the stigma of mental illness. *Global Mental Health,* 3.

STUBER, J. P., ROCHA, A., CHRISTIAN, A. & LINK, B. G. 2014. Conceptions of mental illness: Attitudes of mental health professionals and the general public. *Psychiatric Services,* 65**,** 490-497.

SUNANABIDAWUD 29 Medicine (Kitab Al-Tibb).chapter 1. *https://sunnah.com/abudawud/29*.

TANHAN, A. & YOUNG, J. S. 2021. Muslims and mental health services: A concept map and a theoretical framework. *Journal of Religion and Health***,** 1-41.

TAYLOR, J. 2008. *The construction of identities through narratives of occupations.* PhD, University of Salford.

TAYLOR, J. Y., MACKIN, M. A. L. & OLDENBURG, A. M. 2008. Engaging Racial Autoethnography as a Teaching Tool for Womanist Inquiry,' Advances in Nursing Science, vol. 31, no. 4, pp. 342–355. .

TAYLOR, S. E. & BROWN, J. D. 1988. Illusion and well-being: A social psychological perspective on mental health. Psychological Bulletin, 103(2), 193-210.

TEO, T. 2014. Encyclopedia of Critical Psychology, 4 Volume set.

THOITS, P. A. 2011. Mechanisms Linking Social Ties and Support to Physical and Mental Health. *Journal of Health and Social Behavior,* 52**,** 145-161.

THOMAS, J., AL-QARNI, N. & FURBER, S. W. 2015. Conceptualising mental health in the United Arab Emirates: The perspective of traditional healers. *Mental Health, Religion & Culture,* 18**,** 134-145.

THOMPSON, M. C. 2017. 'Saudi vision 2030': A viable response to youth aspirations and concerns? *Asian Affairs,* 48**,** 205-221.

THORNICROFT, G., MEHTA, N., CLEMENT, S., EVANS-LACKO, S., DOHERTY, M., ROSE, D., KOSCHORKE, M., SHIDHAYE, R., O'REILLY, C. & HENDERSON, C. 2016. Evidence for

effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet,* 387**,** 1123-1132.

TIMOTHY, D.J., 2020. 18 Religious Tourism and Pilgrimage. In *Cultural Heritage and Tourism* (pp. 417-441). Channel View Publications.

TOPAL, A. Economic reforms and women's empowerment in Saudi Arabia. Women's Studies International Forum, 2019. Elsevier, 102253.

TOPKAYA, N. 2014. Gender, Self-Stigma, and Public Stigma in Predicting Attitudes toward Psychological Help-Seeking. Educational Sciences: Theory and Practice, 14(2), pp.480-487.

TURNER, H. R. 2010. Science in medieval Islam: Aan illustrated introduction. Austin, US: University of Texas Press.

UEBELACKER, L. A., BAILEY, G., HERMAN, D., ANDERSON, B. & STEIN, M. 2016. Patients' beliefs about medications are associated with stated preference for methadone, buprenorphine, naltrexone, or no medication-assisted therapy following inpatient opioid detoxification. *Journal of substance abuse treatment,* 66**,** 48-53.

VAN DER WALT, J. L. 2020. Listening to the voices of South African women living with HIV: A narrative inquiry into their experiences of seeking healthcare. Curationis, 43(1), e1-e8.

VAN LAER, T., DE RUYTER, K., VISCONTI, L. M. & WETZELS, M. 2014. The extended transportation-imagery model: A meta-analysis of the antecedents and consequences of consumers' narrative transportation. *Journal of Consumer research,* 40**,** 797-817.

VAN MANEN, M. 1990. Researching Lived Experience: Human Science for an Action Sensitive Pedagogy.Albany, NY;SUNYpress.

VANALEESIN, S., SUTTHARANGSEE, W. & HATTHAKIT, U. 2010. Cultural aspects of care for Muslim schizophrenic patients: An ethnonursing study. Songklanagarind Medical Journal, 25, 361-370.

VIGO, D., THORNICROFT, G. A. & ATUN, R. 2016. Estimating the true global burden of mental illness. The Lancet Psychiatry, 3(2), pp.171-178.

VOGEL, D. L., WADE, N. G. & HACKLER, A. H. 2007. Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *J Couns Psychol,* 54.

VON KARDORFF, E., SOLTANINEJAD, A., KAMALI, M. & ESLAMI SHAHRBABAKI, M. 2016. Family caregiver burden in mental illnesses: The case of affective disorders and schizophrenia - a qualitative exploratory study. *Nordic journal of psychiatry,* 70**,** 248-254.

VYGOTSKY, L. 1986. *Thought and Language - Revised Edition*, The MIT Press.

VYGOTSKY, L. S. 1978. Mind in society: The development of higher psychological processes. Cambridge, MA: Harvard University Press.

VYGOTSKY, L. S. 1998. The collected works of L. S. Vygotsky (vol. 5). New York: Plenum.

VYGOTSKY, L. S., RIEBER, R. W., VAN DER VEER, R., WOLLOCK, J. & CARTON, A. S. 1997. *The Collected Works of L. S. Vygotsky: Problems of the Theory and History of Psychology*, Plenum.

WAHASS, S. & KENT, G. 1997. A Comparison of Public Attitudes in Britain and Saudi Arabia Towards Auditory Hallucinations. *International Journal of Social Psychiatry,* 43**,** 175-183.

WAHL, O. & AROESTY-COHEN, E. 2010. Attitudes of mental health professionals about mental illness: a review of the recent literature. *Journal of Community Psychology,* 38**,** 49-62.

WALKER, E. R., CUMMINGS, J. R., HOCKENBERRY, J. M. & DRUSS, B. G. 2015. Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatric Services,* 66**,** 578-584.

WALLER, V., FARQUHARSON, K. & DEMPSEY, D. 2015. *Qualitative Social Research: Contemporary Methods for the Digital Age*, SAGE Publications.

WATZLAWICK, P. 1984. The Invented Reality: How Do We Know What We Believe We Know? Contribusion to Constructivism, New York, Norton.

WERTSCH, J. V. & TULVISTE, P. 1992. L. S. Vygotsky and contemporary developmental psychology. Developmental Psychology, 28(4), 548-557.

WESSELMANN, E. D., DAY, M., GRAZIANO, W. G. & DOHERTY, E. F. 2015. Religious beliefs about mental illness influence social support preferences. *Journal of Prevention and Intervention in the Community,* 43**,** 165-174.

WEOBONG, B., SAKYI, L., & LUND, C. 2021. Towards Implementation of Context-specific Integrated District Mental Health Care Plans: A Situation Analysis of Mental Health Services in Five Districts in Ghana.

WHITE, R. G., JAIN, S., ORR, D. M. & READ, U. M. 2017. *The Palgrave handbook of sociocultural perspectives on global mental health*, Springer.

WILLIAMS, D. R., YU, Y., JACKSON, J. S. & ANDERSON, N. B. 1997. Racial Differences in Physical and Mental Health:Socio-economic Status, Stress and Discrimination. *Journal of Health Psychology,* 2**,** 335-351.

WIRTH, J. H. & BODENHAUSEN, G. V. 2009. The role of gender in mental-illness stigma: A national experiment. Psychological Science, 20, 169-173.

WOLGEMUTH, J. R. & DONOHUE, R. 2006. Toward an inquiry of discomfort: Guiding transformation in“emancipatory” narrative research.Qualitative Inquiry,Vol12.5.pp1024-1034.

WORLD HEALTH ORGANIZATION. 2001. *World health report 2001: mental health* (No. EM/RC48/INF. DOC. 1).

WORLD HEALTH ORGANIZATION. 2009. Mental Health Policy and Service Guidance Package: Mental Health Legislation and Human Rights Geneva: WHO; 2009. Available from: http://www.who.int/mental_health/resources/en/Legislation.pdf Accessed February 2017.

WORLD HEALTH ORGANIZATION. 2018a. Mental health atlas 2017. Geneva, Switzerland: World Health Organization.Retrieved from https://apps.who.int/iris/bitstream/handle/10665/272735/9789241514019-eng.pdf?ua=1.

WORLD HEALTH ORGANIZATION .2018b. Mental health atlas 2017 member state profile: Saudi Arabia. Retrieved from https://www.who.int/mental_health/evidence/atlas/profiles-2017/SAU.pdf?ua=1.

WORLD HEALTH ORGANIZATION, &, W. O. O. N. C. & ACADEMIC ASSOCIATIONS OF GENERAL PRACTITIONERS/FAMILY PHYSICIANS. 2008. Integrating mental health into primary care: a global perspective. World Health Organization.

YAMANI, M. 2004. Cradle of Islam: The Hijaz and the quest for an Arabian identity. London: IB Tauris Publisher.

YANG, L. H., KLEINMAN, A., LINK, B. G., PHELAN, J. C., LEE, S. & & GOOD, B. 2007. Culture and stigma: Adding moral experience to stigma theory. Social Science & Medicine, 64, 1524-1535. .

YAP, M. B. H., REAVLEY, N. J. & JORM, A. F. 2013. Associations between stigma and help-seeking intentions and beliefs: Findings from an Australian national survey of young people. *Psychiatry Research,* 210**,** 1154-1160.

YILMAZ, E. & OKANLI, A. 2015. The Effect of Internalized Stigma on the Adherence to Treatment in Patients With Schizophrenia. *Archives of Psychiatric Nursing,* 29**,** 297-301.

Chapter 9: Appendices:

Appendix A: Charting tables for the included studies

SOURCE NO 1	Al-Qadhi *et al.* (2014)		TITLE: Adult depression screening in Saudi primary care: prevalence, instrument and cost COUNTRY: *Saudi Arabi			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Cross-sectional study design QN	To estimate the point prevalence of screened depression in primary health care setting and exploring the risk factor associated with screening such as cost factor for screening	No	Patients between 18-65 years attending three large primary care centres in Saudi Arabia were selected for the study.	Survey with participants by distributing the questionnaires. Data was collected using the validated interview questionnaire for analysis. Personal data regarding age, income, past medical history, area of residence and social habits was also collected during the survey	The point prevalence of screened depression is high in primary care visitors in Saudi Arabia. A significant association of depression was found in female genders and education level of participants and screening for depression in primary care setting is cost saving	Limitation: Volunteer bias seen in the study as only those who agreed to participate were included in the survey. The analysis of cost estimate is also not strong as it is based on assumptions due to lack of data related to cost in the country. Thoughts: There is a need to increase awareness regarding the early detection of depression symptoms so that patients to avoid progression of the disease to severe form and save cost.

SOURCE NO 2	Al-Sughayr and Ferwana (2012)		TITLE: Prevalence of mental disorders among high school students in National Guard Housing, Riyadh, Saudi Arabia. COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Cross –sectional study QN	-To investigate the prevalence of mental health disorders among high grade students -To explore some socio-demographic data related to the first research question	No	354 students were included in the study and were selected randomly from four different high schools- two females and two male high schools Riyadh and Iskan. The students were of grade 12.	Mental health issues in adolescents were linked with experiences of social, psychological and biological transitions. The General Health Questionnaire (GHQ) was used that was self-administered screening instrument. The design was so done as to facilitate detection of current psychiatric disorders that are diagnosable.	The prevalence of mental health illness was found to be 48%. Around 80% of the cases were either moderate or mild. Females had more severe mental disorders than men. Students who performed well had lower rate of disorders.	Limitation: -small sample size that may have led to failure to address the research question adequately -use of GHQ-28 as there were chances of over-estimation of prevalence of the disorders. Thoughts: More extensive research is needed to highlight clearer association between social variables and psychiatric disorders

SOURCE NO 3	Al Atram (2015)		TITLE: Prevalence of Psychiatric Disorders in a Sample of Elderly Residents in Rural and Urban Population of Zulfi Region-Saudi Arabia. COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Population based cross-sectional study QN	To evaluate the prevalence of psychiatric disorder among elderly in Saudi Arabia and to compare the difference between urban and rural areas.	No	rural & urban study was 550&392 persons from 65 years and more, Elderly patients without any severe mental illness were taken for the study. People with any form of mental retardation that might have an impact on the communication process was excluded from the study.	Cross-sectional interview was done with participants. Structured clinical interview for DSM-IV was done. Systematic random sampling method was used to collect data and	The result revealed that the prevalence of mental disorder was more in urban population compared to rural population. The most prevalent symptoms of psychiatric disorder in urban area included dysthymia and in rural areas, depressed mood	Limitation: The finding is not consistent with earlier studies and there was significant difference in the distribution of mental disorder in urban and rural setting. Thoughts: It is suggested that increased number of camps should be held for elderly as they cannot seek help on their own. The future research in this area should be done more comprehensively by taking larger sample size and latest scales for measuring depression.

SOURCE NO 4	Sewilam *et al.* (2015)		TITLE: Suggested avenues to reduce the stigma of mental illness in the Middle East			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
A literature review was conducted using the PUBMED database and all-important studies	The literature review was mainly conducted to find the different types of stigmas that is present in domains of mental illness in the middle east. This would ultimately help in formulating interventions for mental illness which would be effective and sustainable	No	The paper is based on the secondary data obtained from various primary sources present in pub med and therefore specific participants are not present in the particular paper.	Inclusion criteria were fixed which helped in the acceptance of paper that matched with the inclusion criteria. The other articles were discarded. Data collection was mainly done in a tabulated form by distinctively analysing the results of each paper and relating it with the topic of concern. From the results and discussion part of every paper reviewed, conclusions were made about whether stigma played a role in interventions for mental illness.	Stigmatisation was found to be high mainly in cases where the mental illness was culturally prescribed like that of alcohol abuse. It is however low in case of other disorders like depression and psychosis. In fact, many of them are also found to go to traditional healers in place of medical practitioners as they believed it would help them to avoid stigmatisation. Culture and society mainly believe mental illness in mainly due to unbalanced lifestyle concerning diet, patterns of sleep, patterns of activities, remembrance to God and so on.	Educate families to help their patients to overcome shame and thereby seek treatment, increase communication between medical practitioners and traditional healers. One should also include religious leaders and educate young people, use social media.

SOURCE NO 5	Almutairi (2015)		TITLE: Mental illness in Saudi Arabia: An Overview COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Review report on mental illness in Saudi Arabia	To determine the status of mental illness in Saudi Arabia	No	Report on information about mental illness among the Saudi population.	review report defines the estimate of mental illness in the world population and lack of estimate regarding the prevalence in Saudi Arabia.	There is lack of evidence regarding the accurate estimate of mental illness in Saudi population	Limitation: In the review of literature for the report, the sample size was very small which may lack generalizability. Thoughts: There is a need to implement public education programs to manage the increased prevalence of mental illness in the community. Government and private agencies also need to take urgent actions regarding the implementation of initiatives to manage the burden of mental illness.

SOURCE NO 6	Alrahili *et al.* (2016)		TITLE: Attitudes to depression in Saudi Arabia: a preliminary study. COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
A random controlled trial <u>QN</u>	The main aim was to study the perceptions about the causes of the occurrence of depression in different regions in Middle East The study also wanted to portray the importance of incorporating cultural and religious strategies as interventions for depression	No framework was identified.	A random sampling was conducted taking. a total of 137individuals Out of them 80 were male and 57 were female.	The participants were asked to respond to a questionnaire so that their perceptions can be understood through the availability of their options namely yes, no or do not know. This helped the researchers to gather statistical information about the perceptions they believe or reject by making a statistical analysis of the three options of no, yes or do not know against the fixed set of questions, which were fixed. This helped to understand the inclination of each individual to a particular perception and gain an idea from it.	About 87% believed it to be a mental illness and 75% believed it be associating with praying and beliefs in God. Again approximately 58% believed it be associated with black magic and 83.94% believed it to be healed by medical interventions. Again 45% believed that antidepressants for this treatment might cause addiction. It was proved that although certain portion believed it occurred die to supernatural factors, but many believed that it was a disease that can be healed by treatment.	The findings recommended the importance of including cultural and religious strategies to help superstitious people treat depression

SOURCE NO 7	Alshowkan *et al.* (2015)		TITLE: Factors affecting the quality of life for people with schizophrenia in Saudi Arabia: a qualitative study. COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Qualitative study	To review the findings of qualitative study investigating the quality of life (QoL) for participants with schizophrenia	(Thematic analysis)	159 Saudi Arabian citizens with Schizophrenia between the age of 18-65 years and meeting the DSM-IV criteria for diagnosis of schizophrenia.	Face to face interview with participants regarding their view of QoL and facilitating and challenging factors to QoL Data obtained from interview with participants was collected by recording on a digital voice recorder.	The results revealed shame of schizophrenia as the barrier that affects the QoL and religion acting facilitating factor in QoL.	Limitation: As the participants were mainly from outpatient clinic, the study finding cannot be generalized for the people admitted in psychiatric hospitals and the people with severe psychotic symptoms. Thoughts: There is a need to integrate mental health and religious treatment to support people with mental illness and maximize their quality of life. As shame affects the life of these patients, strategies should be planned to destigmatize this effect.

SOURCE NO 8	Jelaidan *et al*. (2018)		TITLE: General Background and Attitude of the Saudi Population towards Mental Illness COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
cross sectional study QN	To evaluate the general population's history and attitude toward mental illnesses in Saudi Arabia.	No	There were 5850 people in the study who were 18 or older. This research has drawn participants from all 13 Saudi Arabian districts. .	For one month, data was collected via a self-administered anonymous electronically disseminated questionnaire. The data was then analysed using SAS (Statistical Analysis System). Crude relationships were determined using the Pearson Chi-square test. A statistically significant difference was defined as a P value of less than 0.05.	To reduce the stigma associated with psychiatric patients, greater education is required. The Saudi population's history with mental illnesses, on the other hand, is deemed fair.	Because many patients do not seek medical care from psychiatrists due to the stigma associated with mental illness, there are no specific figures on the number of psychiatric patients in Saudi Arabia. Further exploratory research may be required to give the Saudi people the opportunity to share their views on mental illness.

SOURCE NO 9	Abolfotouh et al., 2019		TITLE: Attitudes toward mental illness, mentally ill persons, and help-seeking among the Saudi public and sociodemographic correlates COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
cross-sectional survey QN	To determine the Saudi public's knowledge, perceptions, and attitudes concerning mental illness, as well as attitudes toward obtaining mental health treatment, and to uncover sociodemographic correlates of correct knowledge and favourable views.	No	on 650 Saudi citizens aged 18 and up who visited the annual culture and heritage event in Jenadriyah, Saudi Arabia, in February 2016.	The Attitudes to Mental Illness Questionnaire, which has previously been validated, was utilised. A measure collected from the World Mental Health Composite International Diagnostic Interview part II was used to examine attitudes toward professional help-seeking.	Most Saudis said they didn't understand the nature of mental illness and had stigmatising attitudes toward persons with mental illnesses when it came to treatment, work, marriage, and recovery, as well as seeking professional help. Correct knowledge and favourable opinions were predicted by sociodemographic variables, whereas negative attitudes toward mentally ill people were most likely caused by Saudi culture.	Because the data is cross-sectional, a strict causal interpretation of the findings is impossible.

SOURCE NO 10	Bril-Barniv *et al.* (2017)		TITLE: A Qualitative Study Examining Experiences and Dilemmas in Concealment and Disclosure of People Living with Serious Mental Illness. COUNTRY: Israel			
Study design (methodology)	Aim	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Qualitative research	To get a thorough understanding of the dilemma regarding whether to conceal or disclose one's experience and diagnoses with mental health disturbances through exploration of whether people can identify themselves along the continuum and are readily accept the practices, experiences and reasoning.	Phenomenological framework	29 individuals with mental illness of whom 16 had major depression or bipolar disorder and 13 has schizophrenia	Semi-structured interview with open-ended questions Analysis of individuals' decision-making process, experiences and views of gains and costs regarding disclosures and concealment of mental illness.	Participants employed negative and positive concealment or disclosure practices. Positive practise encompassed community integration and personal recovery. Negative practices took place in uncontrollable situations. Influencing factors encompassed accumulated experiences.	Limitation: narrow focus of diagnoses, potential self-selection bias study did not focus on the accurate information disclosed. Thoughts: Future studies must examine concealment and disclosure among individuals with wider range of diagnoses

SOURCE NO 11	Sanden *et al. (*2015)		TITLE: Stigma by association among family members of people with a mental illness: A qualitative analysis COUNTRY: USA			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main findings	Limitation and recommendation
Qualitative research	The main aim was to study whether stigmatisation is also faced by family members who live in association with mentally ill people	No	23 immediate family members of mentally ill patients were interviewed	Interview questions were set which mainly contained three important protocols. These were the participant's stigma by association perceptions regarding community views of mental illness of family members, about how their experiences affected lives and wellbeing also, their perceptions about familial relationships, gender and coincidence in SBA experiences Semi-structured interviews answers were analysed to find their perceptions and important points were wrote down, transcripts were analysed, and important points were noted.	Family members living in association with mentally ill patients reported of stigmatisation experiences. Parents and spouses reported of higher-level stigmatisation than siblings and children. It was seen the females were more blamed because of occurrence of mental ill health in family than males.	Education and emotional support are required for altering the condition of family members of mentally ill patient. Moreover in-service training should be provided to mental health professionals so that they can develop relevant social skills which will help them to recognize familial relationships and roles along with concern, fear and problems of family members.

SOURCE NO 12	Dawood & Modayfer (2016)		TITLE: Public Attitude towards Mental Illness and Mental Health Services in Riyadh, Saudi Arabia COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
cross sectional research design QN	To find out how the general Saudi public feels about mental illness and those who have mental illnesses, as well as how they feel about mental health resources accessible in Saudi Arabia.	No	3464 Saudi adults were recruited from various public settings in Riyadh, Saudi Arabia.	Data was obtained using a survey questionnaire composed of sociodemographic data sheet, questions involving personal experience with persons with mental disorders, Attitudes towards mental Illness Scale (Shokeer, 2002) and attitude towards the mental health services questionnaire.	• A family member with mental illness was diagnosed in more than a third of the individuals (36.9%). • Nearly two-thirds of people (62.2%), excluding family members, knew someone who had been diagnosed with mental illness. • 36.5 percent of participants believed that they could talk to anyone who has a mental illness and that they can go on a picnic with them. • 43.5 percent say they are not fearful of interacting with people who have mental diseases, and 41.4 percent say they will not refuse to sit with someone who has a mental condition. • More than three-quarters of those polled believed that the Saudi government should spend more money on mental health hospitals and community mental health services.	Limited empirical evidence, However the study concludes that the positive attitudes towards mental illness in KSA might be the waited future outcome runs among Saudi society population

SOURCE NO 13	Von Kardorff *et al.* (2016)		TITLE: Family caregiver burden in mental illnesses: The case of affective disorders and schizophrenia - a qualitative exploratory study COUNTRY: Iran			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Qualitative research	To determine the condition and extent of burden on the caregivers of patients suffering from schizophrenia	No	The chosen participants are 45 caregivers of patients suffering from schizophrenia and other related disorders chosen from Shahid Beheshti Psychiatric Hospital	A qualitative study was conducted by semi-structured interviews with 45 caregivers of patients with schizophrenia and affective disorders the qualitative analysis has been undertaken	The prevailing burden on the caregivers are due to incertitude, unawareness, emotional burden, blame, financial burden, stigma, physical burden, troublesome patients, restricted and disruptive routine, dissatisfaction and ineffective government support	Limitation: -Need more optimal data collection Caregivers of outpatient was not included. Ineffective social and cultural networking -Small sample size. Thoughts: This study optimally determines the condition of carers and measures for rectification.

SOURCE NO 14	Al-Habeeb (2003)		TITLE: A pilot study of faith-healers' views on evil eye, jinn possession, and magic in the Kingdom of Saudi Arabia COUNTRY: * Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Qualitative research	To analyse the manner in which treatments are given b faith-healers practicing in Al-Qassim region of Saudi Arabia	No	45 male faith-healers were selected from Al-Qassim, the most conservative province of Saudi Arabia. No female faith-healers found in the area.	A self-administered Semi-structured open-ended questionnaire was distributed by social worker to participants. The questionnaire was related to sociodemographic detail and questions on evil eye, jinn possession and magic.	The study revealed that faith-healers mostly provide therapies related to religious concepts to alleviate suffering of the people with mental illness.	Limitation: The exploratory design of the study has limitations as it lacks detailed analysis and advanced statistical analysis may have given accurate results. Thoughts: It is recommended that future research should focus on diagnostic methods used by faith-healers to identify spiritual and mental disorder in patients.

SOURCE NO 15	Alosaimi *et al.* (2015)		TITLE: Psychosocial correlates of using faith-healing services in Riyadh, Saudi Arabia COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Comparative cross-sectional study QN	To compare the prevalence of psychiatric disorder in patients who use or do not use faith-healer service and analyse independent factors of participants who chose to visit faith-healer service.	No	cross-sectional study compared those who use FHs (n = 383) with a control group of those who do not use them (i.e., shopping mall visitors, n = 424) The study was conducted in shopping malls and faith-healing setting with participants consisting of faith-health seekers as well as regular shoppers	Questionnaire related to baseline factor as well as past medical history and history of seeking help from healing service was collected. Participants readily available in shopping malls and faith-healing setting was selected for the comparative study	It revealed past psychiatric history and current psychotic symptoms as risk factors for using faith-healing services. Large number of faith-healing seekers had depression and other form of psychiatric disorder.	Limitation: As cautious sampling approach was used in this study, they may not representative of all patients in the country. Secondly, general shoppers mat not reflect the whole population group with psychiatric disorder. Thoughts: It is recommended to increase access to mental health care system particularly for those group of people who use faith-healer service

SOURCE NO 16	Al-Soalimi & Loewanthal (2011)		TITLE: Religion and obsessive-compulsive disorder (OCD) among young Muslim women in Saudi Arabia. COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Qualitative research	To analyse the role of religion in OCD experience among female Saudi Arabians and to understand its effect on functioning of an individual.	Yes (Thematic analysis)	15 Female Muslim Saudi Arabian participants between the age group of 14 and 30 years were taken. Inclusion criteria was onset of OCT before the age of 21 years and confirmation through medical records and verbal reports.	Semi-structured interview with participants regarding demographic detail and questions on presenting problems, religious symptoms, religious coping and role of religion in maintaining presenting conditions	It gave insight into the experience and perception of illness in religious society of Saudi Arabia Religion plays an important role in determining the acceptability of treatments and treatment providers.	Limitation: Lack of generalizability of the findings due to small sample size and selection bias Thoughts: As male participants have not been considered for this study, including them in future study might have an impact of sufferings of participants.

SOURCE NO 17	Halawani (2014)		TITLE: Inclusion of Religion and Spirituality in Psychotherapy: A Study of Clients' Perspective COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Quantitative study	-To explore the attitude and perceptions of clients regarding inclusion of spirituality and religion in psychotherapy -To analyse the correlation between perception of individuals and level of religiousness	No	96 Muslim clients receiving or previously received psychotherapy. **96 Muslims** Client snowball and convenient sampling approach to gather data used in two ways as the survey was spread throughout different social media tools and asked from whoever has visited psychotherapy to complete it. Further, the researcher asked different psychologists, psychological clinics and hospitals to distribute surveys for clients of psychotherapy.	Assessment of perception of individuals Instruments used were Attitudes towards Spirituality in Therapy Survey (CAST) and Psychological Measure of Islamic religiousness (PMIR)	-High preference towards inclusion of spirituality and religion in psychotherapy -positive and statistically significant correlation between religious dimension of CAST and PMIR	Limitation: -sampling nor perfect

SOURCE NO 18	McCrae et al. (2019)		TITLE: Media portrayals of mental disorder in Saudi Arabia: a review of popular newspapers review COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Review of common mental health Saudi newspapers	To examined portrayals of mental disorder in Saudi Arabian news papers	No	No	Using a pre-determined framework, articles were classified for descriptive and thematic analysis. Four of the most popular newspapers provided a cross-sectional sample of relevant articles.	• The three most common themes were advocacy, activities, and worries. • By enhancing public knowledge, the pieces have a good impact. • Various reports on the topic of treatment and recovery advised about the possibility of removing barriers to seeking help. • A quarter of the pieces dealt with the subject of blame. • Several commentaries or reports on spiritual possession were published, which may have perpetuated stigmatising beliefs. • There were a variety of cultural perspectives on display, including the prevalent belief of the 'evil eye.'	The review authors recommended that there is a crucial demand for mental health experts, patients, and family caregivers to collaborate to develop recommendations for more accurate mental disorder reporting by Saudi media.

SOURCE NO 19	Obeid *et al.* (2012)		TITLE: Possession by 'Jinn' as a cause of epilepsy COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Survey QN	This study was mainly conducted to understand whether the belief of Jinn affecting people resulting in epilepsy is still present or not	NO	398 participants were included which consisted of university educated schoolteachers and undergraduate students. There were 198 women and 200 men.	The main questions, which were, included mainly shed light on the perceptions of their familiarity with epilepsy, sources of different knowledge, depth of knowledge about different factors and others. Data collection was based on the questionnaires that were responded by the participants. An SPSS was conducted in order to get a statistical data about the various percentages of positive or negative replies for each answer.	172 members accounting for 42% believed that epilepsy is a psychiatric disease. 62 schoolteachers (40.3%) and also 123 students (50.4%) believed that it is mainly due to demonic possession. Although majority believed that medical treatments are necessary, yet many believed that help from traditional healers and faith-healers are important. It is very much astonishing to see such beliefs in people even with higher levels of education.	Urgent need of public education campaigns in all levels of education

SOURCE NO 20	Pargament and Lomax (2013)		TITLE: Understanding and addressing religion among people with mental illness Country: USA			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Literature review of recent advances in the domain of psychiatry and religion	reviews recent advances in the domain of psychiatry and religion that highlight the double-edged capacity of religion to enhance or damage health and well-being, particularly among psychiatric patients	No	No	Religious problems are understood as a by-product of mental ill health (secondary), a source of psychiatric illness (primary), or both (complex)	Psychiatric diagnosis and assessment should incorporate an understanding of the practices, beliefs, and values that define the world of the mentally ill patient. The study also found that the effectiveness of spiritually integrated treatments encourages patients to draw more fully on their religious resources.	Recommendations to advance future research and practice, including the need for additional psychiatric studies of people from diverse cultures and religious traditions.

SOURCE NO 21	Raza (2016)		TITLE: Islamic Contemporary Alternative Treatments with regards to Mental Health Country: Pakistan, Saudi Arabia and other Muslim countries			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Qualitative study	This study was mainly conducted to see if religious components had a positive effect in treating stress	Thematic analysis was conducted for theme identification in the transcripts	6 Muslim women from various backgrounds were selected between the ages eighteen to forty-five.	Data was collected by semi structured interviews that lasted for 30 to 40 minutes. Voice recording was collected, transcripts prepared, important notes were made. The Muslim women were asked about their perception of their religious beliefs. They were also asked whether being more inclined to religion helped them in overcoming mental stresses	The finding included that the Muslim women mainly believed that inclination to religious beliefs like offering prayers, maintaining lifestyles according to Quran helped them to cope with mental health issues in a better way than others. They felt shameful in reaching to mental health practitioners and documented that it would have been better if they had combined CBT technology with religious components	It included Muslim women only from university student background who are strong believer of religious components. Therefore, it did not cover Muslim women from different backgrounds and also those who are not strict believers of religion.

SOURCE NO 22	Alamri (2016)		TITLE: Mental illness in Saudi Arabia: Stigma and acceptability. COUNTRY: New Zealand			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Review	To administer Arabic Hospital Anxiety and Depression Scale (HADS) to patients in tertiary neurology clinic to determine the level of future assessment needed in patients.	No	the study based on one study result, that recruited a 237 patients and family members from outpatient tertiary clinic were selected for the analysis based on	HADS scale administered to all patients. A survey was done with the participants and there was no differentiation based on sex, age, education level and marital status.	The study revealed that majority of them did not wanted support from mental health service as it is just for mad people and very few reported previous interactions with mental disorder patients.	Limitation: Factors of upbringing and prior contact with mental illness might play a role in acceptability of mental illness, however this factor was not considered in the study. Hence, competitive answer is missing. Thoughts: There is a need for further research addressing the challenges faced by non-health care workers. Increased number of educational campaigns is also needed to change people's attitude towards mental illness.

SOURCE NO 23	Ahmed (2016)		TITLE: Integration of mental health service program into primary health care service. COUNTRY: *UAE, Dubai			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Report Review detailing integration of service	To present detailed report on the issue of mental health in primary care and analyse the experience of countries in integrating the service in primary health service.	No	estimate of number of adults suffering from mental disorder in different countries of the world was given	The study established the rational and action plan for integration of mental health service in primary care. Data regarding interview with patients was collected from primary health care setting in four countries	The report revealed lack of adequate mental health staffs in low developed countries and showed ways to integrate the service.	Limitation: The limitation was seen in the manner of coordination with staffs to integrate care. Thoughts: There is a need to follow the structure of integrating mental health service into primary health care to address the weakness in this area.

SOURCE NO 24	Almoshawah (2010)		TITLE: An Evaluation of Psychiatrist View Towards the Mental Health Services in Saudi Arabia. COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Quantitative Descriptive study	To evaluate the current challenges faced by mental health services in SA in terms of awareness, effectiveness, roles,referrals and personal characteristics in psychiatrist in Saudi Arabia	No	158 Psychiatrist working in mental hospitals in Saudi Arabia between the ages of 26 to 45 years and having a post graduate degree.	The quantitative data was collected in four stages. It included data preparation, data description, analysis of difference and similarities and interpretation of the data. Questionnaire for the study was designed which included detail on demographic data and view on mental health services through the use of Likert scale.	The results revealed that 90% of them are aware of their goals in providing care, however many different views were seen for response to role and responsibilities, clinical outcome and personal developments. They regarded their referral system as flexible.	Limitation: No significant limitation seen in research design. Thoughts: Due to the difference in view related to the role and responsibilities in mental health service, it is recommended to provide more training to mental health professional in the country.

SOURCE NO 25	Alshowkan & Kamel, (2016)		TITLE: Nursing student experienced of psychiatric clinical practice COUNTRY: * Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Qualitative study	To analyse the experience of nurse who were part of psychiatric clinical practice in the University of Saudi Arabia	Thematic analysis	20 third-year female nursing students who completed the Psychiatric and Mental Health Nursing course agreed to participate and were divided into 4 focuses groups.	The focused group discussion was done by means of specific interview questionnaire. The man focus of questionnaire was related to nursing student's belief about mental illness, challenges and feelings at the time of interacting with patients with mental illness during psychiatric clinical practice	The thematic analysis of interview data with participants revealed the theme of initial fear and anxiety in nursing student. It also revealed facilitation of role due to helping role of clinical supervisor.	Limitation: Certain confounding variable was seen in the study. Thoughts: Linking theory with practice in different scenarios can help nurses to simulate psychiatric learning in actual setting.

SOURCE NO 26	Koenig *et al.* (2013)		TITLE: CURRENT STATE OF PSYCHIATRY IN SAUDI ARABIA COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Secondary data analysis- Review	To provide a 30-years update on advancements in mental healthcare in the kingdom of Saudi Arabia.	No	No	Data was collected from wide spectrum of sources that included the 2007 Saudi Arabian Mental and Social Health Atlas The researchers described the functioning of the mental health system in the country and the requirement for health care. The researchers also emphasised on the requirement for training and education in the domain of psychiatry within the country. Whether cultural and religious factors play a role in psychiatry practice as also explored.	Mental healthcare has witnessed developments in Saudi Arabia in the recent past. All barriers of religious, political, religious and cultural aspects have been overcome in the past to take forward mental health care in the country. However, there are some sectors that need improvement. The concerned authorities need to pay special attention to eliminate the confounding barriers. The development of psychiatry in the country acts as a model for many other countries in the Middle East as well as across the globe.	Limitation: No limitations Thoughts: Further progress in mental healthcare in KSA would only be possible if religious and cultural values and beliefs are given attention.

SOURCE NO 27	(Koenig *et al.*, 2014)		TITLE: Mental Health Care in Saudi Arabia: Past, Present and Future COUNTRY: *Saudi Arabia			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Secondary data analysis-Review	To explore and analyse the past, present and future state of mental health care in the Kingdom of Saudi Arabia (KSA)	No	No	Data was collected from rick pool of articles published previously and dating back to the year as old as 1992. The status of mental healthcare in KSA was explored with reference to wide range of literature. The goal was to develop a blueprint for the advancements of the state-of-the-art mental health serving as the model for other countries.	A remarkable and splendid progress has taken place in Saudi Arabia in the past 60 years regarding treatment and diagnosis of mental health disorders. The past two decades have seen magnificent developments in this regard. However, much more is to be done for extending adequate care to the whole population.	Limitation: No Thoughts: Further research is needed that can highlight the implications for impact of religion, culture and family on mental health care. Systematic research would identify the means of developing novice methods of diagnosis and treatment of mental health illness.

SOURCE NO 28	Staiger *et al.* (2017)		TITLE: Barriers and facilitators of help-seeking among unemployed persons with mental health problems: a qualitative study. COUNTRY: Germany			
Study design (methodology)	Aim or purpose	Theory or framework	Participants	Data collection method	Main finding	Limitation and recommendation
Qualitative study	To determine prevailing barriers and facilitators of provision of help and undertaking of service of the unemployed people suffering from mental conditions	No	Participants were 15 unemployed people suffering from different mental condition.	semi-structured individual interviews were conducted Qualitative analysis has been undertaken with the help of survey for the determination of sample and interview for the data collection	These patients suffered barriers and facilitators on the basis of literacy, stigma, healthcare condition, discrimination. Furthermore, awareness and effective training is required to prevent such barriers	Limitation: The samples were not selected on the basis of questionnaire while self-determined analysis. No heterogeneity was maintained as the sample takes was Germans only. Small sample size. Thoughts: This study provides a detailed analysis on the prevailing barriers and facilitators and requires further analysis keeping limitations in mind.

Appendix B: Study tables, boxes, and figures

Table 1: Scoping review framework steps (Arksey & O'Malley, 2005)

Stage No	**Stages of conducting scoping review**
1	Identifying the research question
2	Identifying relevant studies
3	Study selection
4	Charting the data
5	Collating, summarising, and reporting results
6	Consultation (optional)

Table 2 : Elements of the inclusion criteria (Algoso et al., 2016)

Population	Mental health/ill patient/public people
Concept	Experiences of stigma and seeking help from mental health services
Context	Mental health services in KSA

Table 3: Search keywords

Keywords
Mental illness; mental health; mentally ill people; people with mental illness; mental illness stigma; accessing mental health services; barriers to accessing mental health treatment; mental disorders; coping behaviour; mental health discrimination; social acceptance; community attitudes; help-seeking behaviour; faith-healing; major depression; mental illness in Saudi Arabia; traditions in Islam or religious beliefs; social interaction; religiosity, culture or Muslims, spirituality

Table 4: Literature inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Paper focused on related key terms. • Paper published in English. • Papers published in peer-reviewed journal. • Articles 2002 or later (literature reviews, qualitative and quantitative research) • Relevant title or abstract	• Paper not in English • Papers not relevant to research topic • Articles older than 2002 • Non-peer reviewed, discussion pieces, commentaries and editorials

Table 5: Main themes

	Themes extrapolated from included studies
1.	Prevalence of mental illness in the Saudi Arabian community
2.	Mental health/illness stigma
3.	Attitudes towards and perceptions of mental illness and mentally ill people
4.	Understanding of mental illness among Saudi people, Arab Muslims and cultural and religious influences
	Availability and accessibility of mental health services in the KSA

Table 6: Participant eligibility criteria

Inclusion criteria
People with mental health problems
• An adult, either with or previously diagnosed with any type of mental health problem, with the capacity to provide consent. • Is accessible (living in Riyadh city, where the charity is located). • No specific age or gender. • Only service users who had not been in hospital for the previous six months to avoid interviewing anyone who may possibly be mentally or emotionally fragile.
Exclusion criteria
• The study excluded any participant who was deemed not to have the capacity to give their consent. • Any person who had had a hospital admission (for mental health difficulties) within the previous six months.

Table 7: Individual Themes and Participants' Clustering

No	Participants' Gender	Clusters of Participants	Individual themes
1	Male	Mental health issues	• Mental health stigmatisation in a society ruled by theological principles and traditional customs. • The influence of faith healers in the common belief as a first rescue. • The lack of belonging and support.
2	Male	Mental health issues	• Non-supportive family influenced by the cultural customs, traditional beliefs and stigmatisation. • Themes related to stigma and discrimination.
3	Male	Mental health issues	• The influence of faith healers and their importance in manipulating the KSA cultural background (to be as equal as the scientific point of view when dealing with medical assistance). • The interrelational boundaries within KSA amongst families.
4	Male	Mental health issues	• The lack of knowledge and the seeking of magician to help as a refuge to deny mental health issues. • Family is not supporting in seeking medical help and referred to the faith healers. • Overwhelmed with medication costs and stigmatisation
5	Male	Mental health issues	• Socio-economic problems-related themes. • His personal and financial situations affect his illness.
6	Male	Mental health issues	• The financial and social life theme • The consequences that children might face as a result of their parents' divorce. • The theme of social instability.
7	Male	Mental health issues	• The psychological distress and mistrust between the patient and the health care services/practitioners or treatment. • The importance of family support
8	Female	Mental health issues	• Them of the widespread stigmatisation

			• Theme of reluctant to disclose more personal accounts of experiences with mental illness and associated problems for fear of being judged or negatively labelled.
9	Female	Mental health issues	• getting married in the KSA culture remains hugely important for females from a social /psychological perspective (it clearly creates a certain balance for her personal ego and even in terms of her image in the KSA society). • The KSA society is a conservative society, where the woman is not considered to be effective unless she has adopted the role of being a wife, a mother and family, proving herself responsible.
10	Male	Mental health issues	• Themes of lack of knowledge and missing professional assistance. • Theme of constant feeling stigmatisation. • Theme of feeling of mistrust or suspicion of medical help.
11	Female	Mental health issues	• The role of faith healers in the treatment process of mental illnesses in the KSA and associated ailments. • Theme of the identification of the common belief in the existence of magic and sorcery • Mental health issue stigmatisation in the KSA.
12	Male	Mental health issues	• The importance of faith healer as a first port of call before seeking the help of a medical professional. • The image and stigma related to mental health illness in the KSA preventing people from being socially active.
13	Female	Mental health issues	• Theme of seeking faith healers' help • Theme of the importance of getting married for females in the KSK which creating social balance. • Theme of feeling of stigma
14	Female	Mental health issues	• The theme of faith, along with its influence on the patient's jargon and vocabulary. • The theme of the ethical principles are all resources from the individual's own religious beliefs.
15	Female	Mental health issues	• The theme of socio-economic problems that the mentally health people might face. • The theme of importance of family relationships within the KSA.
16	Male	Mental health issues	• The theme of belonging to a family. • The theme of a strong social bound between the patient and his family.
17	Male	Mental health issues	• Theme of seeking faith healer's support and help.

			• The theme of close bonds and relationships with family
18	Male	Substance user	• The theme of the relationship between the drug abuser and society • Stigma and Non-supporting family themes.
19	Male	Substance user	• Interrelated themes, all of which can be associated with a developing process from facing a problem through to identifying a solution. • Stigma and lack of family support themes.
20	Male	Substance user	• Theme of drugs in Saudi society and the drawbacks of frustration that push Saudi youth to drug issues, despite the hegemony of the religious belief and theological principals. • Stigma and lack of family support.

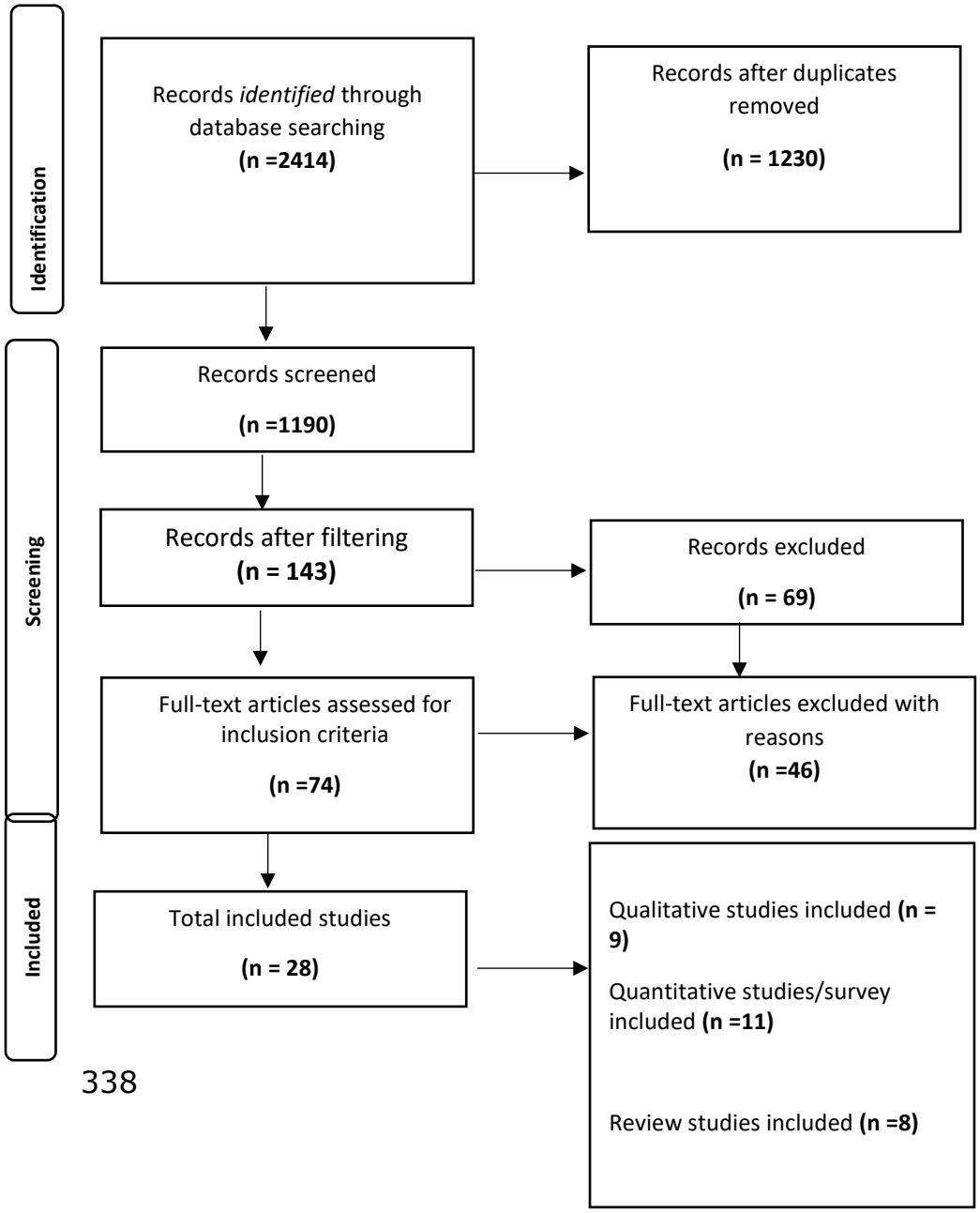
Table 8: Common Themes of the Findings

Overarching Common Themes extracted from the twenty participants
1] The influence of faith-healers in the common belief as a first rescue and their importance in manipulating Saudi culture. 2] The widespread stigmatisation and socio-economic problems, encompassing financial and social issues and drug use. 3] The psychological distress and mistrust or suspicion of medical assistance 4] The lack of belonging and lack of family assistance, support and help, and the importance of family relationships and support.

Box 1: Recruitment and Interview process

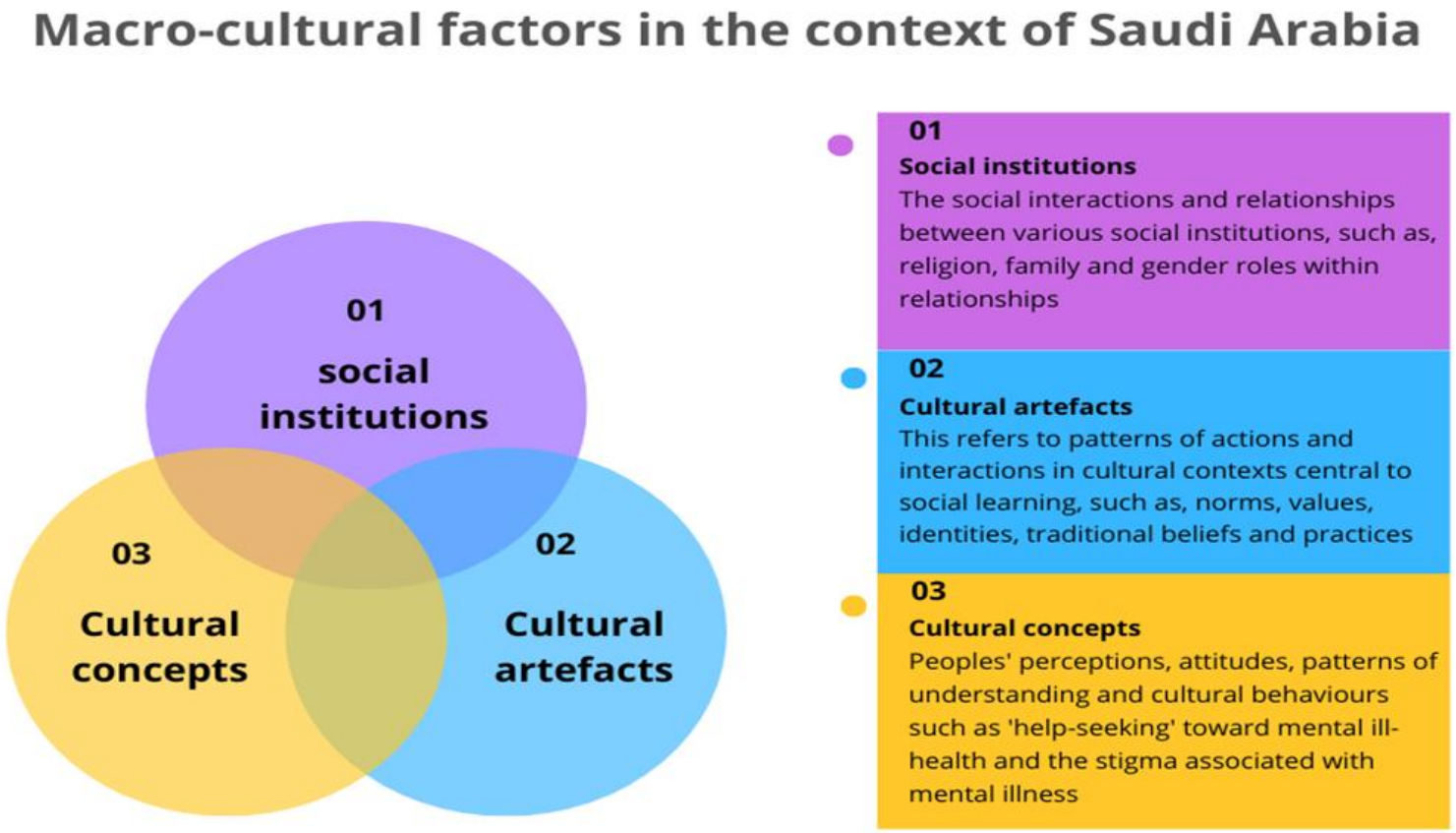
- The participants were contacted by SSCA's professional person or the researcher herself through a phone call to provide the research information aim and obtain their permission.
- The participants who agreed to share in the study were given a preferred appointment time to visit the SSCA location (the charity).
- On the day of interview, the researcher established rapport with the participant to create a comfortable environment and put the participant at ease. I welcomed the participants and offered them a seat and welcoming drink (Arabic coffee with dates, water or juice).
- At this meeting, agreement to attend a one-to-one interview was obtained after reading and discussing the information sheet.
- At the beginning of the interview, the participants were given time to read the information sheet again and ask for clarification if required.
- The researcher then informed the interviewee of the importance of confidentiality and stressed the anonymity of names and data and assured that no feedback would be given to the care team, in or outside the charity premises for other purpose than the research.
- The participants were then asked to sign the consent form after a clear explanation regarding their right to withdraw from the study or stop the interview at any time during the research.
- The participants were then given a brief introduction to the study and asked to narrate their experiences of their diagnosis as a 'mentally ill' patient, as well as how they used mental health services and anything that might facilitate or act as a barrier to their access to mental health services treatment during their journey of mental health difficulties.
- The researcher conducted the interview in a conversational manner, to allow the participants to speak freely and without interruption. However, sometimes I used prompts to encourage them to share more information or to clarify a point.
- At the end of the interview, the researcher thanked the participants for their time and contribution to the research.

Figure 2: PRISMA flowchart of literature identification process (Page *et al.,* 2021).



338

Figure 2: Macro-Cultural Factors in the Context of the KSA



Appendix C: Ethical approval letters

C.1. Ethical approval letter (University of Nottingham)



ity of
nam
LAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottinrjham NC72UH

24th July 2017

Nada AL-Attar
PhD Student, School of Health Sciences
c/o Dr Theodore Stickley
Associate Professor and Academic Lead for Public Engagement
School of Health Sciences,
University of Nottingham
Institute of Mental Health Building
Jubilee Campus Triumph Road, Innovation Park
Nottingham, NG7 2TU

Dear Nada

Ethics Reference No: 56-1707 — please always quote	
Study Title: An Exploration of the Apparent Reluctance of People to Access Mental Health Services in the Kingdom of Saudi Arabia	
Short Title: Accessing Mental Health Services in KSA	
Chief Investigator/Supervisor: Dr Theodore Stickley, Associate Professor of Mental Health and Academic Lead for Public Engagement, Dr Anne Felton, Associate Professor of Mental Health, Nursing- Mental Health Branch.	
Lead Investigators/student: Nada AL-Attar, PhD Student, School of Health Sciences	
Type of Study: Overseas: Saudia Arabia, PhD Student Project Qualitative,	
Proposed Start Date: 01/09/2017	Proposed End Date: 31/08/2019 24mths
hlo of Subjects: 20	School: Health Sciences

Thank you for submitting the above application which has been considered by the Committee at its meeting on 18 July 2017and the following documents were received:

- FMHS REC Application form and supporting documents version 01: 03.07.17
- Official Letter of support from the Saudi Schizophrenia Charity Association Date:21/08/1438 H corresponds to Date:17/05/2017G

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A Favourable opinion is given on the understanding that all appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved.

A favourable opinion is given on the understanding that the conditions set out below are followed:

.1 You should follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).
.2 You must notify the Chair of any serious or unexpected event.
.3 An End of Project Progress Report is completed and returned when the study has finished (please request a form).

Yours sincerely



Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

C.2. Saudi Charity Society for Schizophrenics patients' agreement letter



المملكة العربية السعودية
الجمعية السعودية الخيرية لمرضى الفصام
مسجلة في وزارة الشؤون الإجتماعية برقم ٥٧١

الجمعية السعودية الخيرية لمرضى الفصام
SAUDI SCHIZOPHRENIA CHARITY ASSOCIATION

الصادر: ١١٣٧
التاريخ: ١٤٣٨/٠٨/٢١هـ
المرفقات:

إفادة

الموضوع: التعاون مع الباحثة ندى العطار

بناء على إفادة الملحقية الثقافية للمملكة العربية السعودية في لندن برقم ملف (KSU1457) وتاريخ ٢٠١٧/٠٤/٠٦م بشأن /ندى محمد محمد سلطان العطار (سجل مدني رقم ١٠٢٩٠٣٠٥٥٦) المبتعثة من قبل جامعة الملك سعود لدراسة الدكتوراه بجامعة Nottingham في مجال التمريض اعتبارا من تاريخ ٢٤-٠٩-٢٠١٥م الموافق ١١-١٢-١٤٣٦هـ حتى تاريخ ٣٠-٠٩-٢٠١٩م الموافق ٠١-٠٢-١٤٤١هـ

وبناء على طلب الباحثة /ندى العطار؛ حسب الإفادة لتعاون الجمعية في رسالتها.

نفيدكم بأنه لا مانع لدى الجمعية من التعاون معها في رسالتها حسب النظام والإمكانيات المتاحة، ويهمنا جدا دعم الباحثين والتعاون معهم لخدمة مرضى الفصام والوصول إلى نتائج بحثية تعود عليهم بالنفع، كما أنه هدف أساسي من أهداف الجمعية.

وقد أعطيت هذه الإفادة بناء على طلبها لتقديمها إلى من يهمه الأمر دون أدني مسؤولية على الجمعية.

رئيس مجلس الإدارة

سميرة بنت عبدالله الفيصل الفرحان آل سعود

المملكة العربية السعودية
الجمعية السعودية الخيرية لمرضى الفصام
مسجلة في وزارة الشؤون الإجتماعية برقم ٥٧١

P.O.Box, 8582 صندوق بريد Postcode, 11413 الرمز البريدي Unified number, 920008874 الرقم الموحد
www.ssca.cog.sa Fax, 0112818887 – 0114807776 الفاكس TEL, 0114821112 – 0112812221 الهاتف
IBAN, SA8080000368608017000007 Account, 368608017000007 حساب الجمعية في مصرف الراجحي

Appendix D: Study information sheet and Consent form

D.1. Information sheet (English)

University
of Nottingham
School of
Health Sciences
Institute
of Mental Health
Triumph Road
Innovation Park
Nottingham
NG7 2TU

Accessing Mental Health Services in KSA

PARTICIPANT INFORMATION SHEET
(2017)

You are invited to take part in the above research study. Before you decide whether to take part 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 carully and discuss it with others if you wish.

Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not.

What is the purpose of the study?

The aim of the research is to explore the experiences of people with mental ill-health and their experiences of accessing and using mental health services in the Kingdom of Saudi Arabia

Why have I been asked to take part in the study?

You have been asked to take part in the study because you have identified that you meet the criteria for participation. That is, you either,

Saudi survivors from schizophrenia who are:

- An adult, either having or having been diagnosed with any type of mental health problem with the capacity to give consent.
- Is accessible (living in Riyadh city, where the charity setting is located).
- No specific age or gender.
- Only service users who have not been in hospital for the previous six-months.

Do I have to take part?

No. Involvement in the research is entirely voluntary, and it is up to you to decide whether or not to take part. If you do decide to take part, you will be given a copy of this information sheet for your reference. You will be asked to give your written consent at the start of the study and will be given a copy of this to keep. However, you are still free to withdraw at any time and without giving any reasons.

What does the study involve?

I would like to interview you in Saudi Charity Society for Schizophrenics patients. Interviews may last between 30-60 minutes, although their length will depend on how much you want to say. The audio of the interview will be recorded and later transcribed. Your anonymity, and anyone else mentioned, will be preserved in any written publication produced as a result of the study.

What do I have to do?

You can choose whether you wish to be interviewed.

What are the possible benefits of taking part?

The study will not have any bearing on your normal activities, current accessing to mental health services. Although it will not benefit you directly, the results of the study will help to further develop our understanding of the accessing to mental health services in kSA. You will be asked to tell your story of your experiences in accessing mental health services and the researcher uses phrases such as: “What is your story?”. I hope that taking part in the research will prove to be an interesting experience.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. Names and other personal information will be removed from the research data and records. With your permission, I will make an audio recording of the interviews

so that I can obtain an accurate record of what was said. If you do not want us to record specific parts of your contribution, I will make detailed notes at that time instead.

Directly quoted extracts from the interviews will only be used if you have given your written permission. Names and other personal information will be removed from these so that it will not be possible to identify people who took part in the study or people referred to during interview. All your personal information, such as name and contact details, will be stored in a locked filing cabinet to which only the researchers have access, and will be destroyed at the end of the study. Non-identifiable data will be retained in a secure, password-protected archive within the University of Nottingham for 7 years after publication.

Where will the research take place?

Research interviews will take place in a private meeting room at the Saudi Charity Society for Schizophrenics patients.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time, and without giving any reason. If you do this, you can decide if you are willing for me to use the information and contribution you have already made to the project, or if you want this to be excluded from the study.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak with the researcher (Nada AL-Attar, contact details below) who will do their best to answer your questions.

Who can I complain to?

In case you have a complaint on your treatment by the researcher or anything to do with the study, you can initially approach the researcher (Nada AL-Attar), or their supervisor (Theo Stickley, contact details below). If this achieves no satisfactory outcome, you should then contact the Administrator, Faculty of Medicine and Health Sciences Research Ethics Committee, c/o School of Medicine Education Centre, B Floor Medical School, QMC Campus, Nottingham University Hospitals, NG7 2UH. Email: louise.sabir@nottingham.ac.uk.

What will happen to the results of the research study?

The results of the study will be made available through journal publications, conference presentations and at public events. Individual participants will not be identified in any publication resulting from the study. If you would like a summary of the results at the end of the study, please indicate this on the consent form.

Who is organising and funding the research?

The study is being carried out by Nada AL-Attar, a PhD student from the University of Nottingham. Nada AL-Attar is full-funding the research from Saudi cultural Bureau, Saudi Ministry of higher education and King Saud University.

Who has reviewed the study?

This study has been reviewed and approved by the University of Nottingham Medical School Ethics Committee.

Contacts for further information

If you have any questions or concerns about taking part in the research, or would like to discuss this further, please contact:

Researcher:	Supervisor:
Nada AL-Attar School of Health Sciences Faculty of Medicine & Health Sciences University of Nottingham QMC office B33 Nottingham NG7 2RD Tel: 07538830038 Email: ntxnma@nottingham.ac.uk	Dr Theodore Stickley School of Health Sciences Faculty of Medicine & Health Sciences University of Nottingham Institute of Mental Health Building Triumph Road Innovation Park Nottingham NG7 2TU Tel: 0115 7484305 Email: theo.stickley@nottingham.ac.uk

Thank you for your interest.

D.2. Information sheet (Arabic version)

جامعة نوتنجهام

كلية علوم الصحة

معهد الصحة العقلية

طريق تريمف

حديقة إنوفيشن

نوتنجهام

عنوان البحث

اللجوء إلى خدمات الصحة النفسية في المملكة العربية السعودية

نموذج معلومات المشاركة

لقد تم دعوتك للمشاركة في الدراسة البحثية المذكورة بالأعلى. وقبل اتخاذ القرار بالمشاركة فإنه من المهم بالنسبة لك أن تكون على علم بسبب إجراء الدراسة وما ستتضمنه تلك الدراسة. من فضلك خذ وقتك في قراءة المعلومات التالية بعناية ثم ناقش الأمر مع الأخرين في حالة رغبتك ذلك.

يرجى السؤال إذا ما وجدت شيئًا غير واضح بالنسبة لك أو في حالة أنك تريد المزيد من المعلومات. خذ وقتك كاملًا في التقرير عن إذا ما كنت تريد المشاركة في الدراسة أم لا.

ما هو هدف الدراسة؟

إن هدف ذلك البحث هو استكشاف خبرات الناس الذين يعانون من مشاكل في الصحة النفسية بالإضافة إلى تجاربهم في اللجوء إلى واستخدام خدمات الصحة النفسية في المملكة العربية السعودية.

لماذا تم الطلب مني بالمشاركة في الدراسة؟

لقد تم طلبك للمشاركة في الدراسة بسبب أنك مطابق لمعايير المشاركة. فلابد أن تكون من احد الفئات التاية: سعودي بالغ، سواء أنه تم تشخيصه بأنه لديه أو انه قد كان لديه أي نوع من مشاكل الصحة النفسية وله المقدرة على التوقيع بالموافقة على البحث.

- اي شخص يسكن في مدينة الرياض او ضواحيها ويرتاد الجمعية الخيرية.
- لا يشترط سن معين او جنس معين.
- ان تكون أحد مستخدمي الرعاية الصحية الذي لم يسبق لهم الدخول إلى المستشفى في الستة أشهر الأخيرة.

هل أنا مجبر على المشاركة؟

لا، عن المشاركة في البحث هي أمر طوعي بالكامل وهذا الأمر يرجع لك القرار فيه سواء بالمشاركة أو عدم المشاركة. في حالة موافقتك على المشاركة، فسيتم إعطائك نسخة من ملف المعلومات هذا ليكون مرجع لديك. سيتم كذلك مطالبتك بالموافقة الكتابية في بداية الدراسة، وسيتم كذلك إعطائك نسخة من تلك الموافقة الكتابية للاحتفاظ بها. على الرغم من ذلك، فسيكون لك الحرية أن تقوم بالانسحاب من الدراسة في أي وقت من دون إبداء أي أسباب.

ما الذي يوجد في الدراسة؟

سأقوم بإجراء مقابلة معك في الجمعية السعودية الخيرية لمرضى الفصام. قد تستمر المقابلات بين 30 – 60 دقيقة سيعتمد طول مدة المقابلة على الكم الذي تريد الإدلاء به. سيتم تسجيل المقابلة صوتية ثم تفريغ ذلك الصوت بعد ذلك. إن إخفاء هويتك وإخفاء هوية أي شخص أخر مذكور في المقابلة سوف يتم الحفاظ عليه بشكل سري للغاية.

ما الذي يجب على فعله؟

يمكنك الاختيار إذا ما كنت تريد أو لا تريد إجراء المقابلة.

ما هي المنافع المحتملة من المشاركة؟

لن يكون لتلك الدراسة أي تأثير على الأنشطة العادية الخاصة بك، او دخولك الحالي على خدمات الصحة النفسية. على الرغم من ذلك، فإن المشاركة لن تفيدك بشكل مباشر حيث أن نتائج تلك الدراسة ستساعد في تطوير الفهم الخاص بنا فيما يتعلق بالدخول إلى خدمات الصحة العقلية في المملكة العربية السعودية. سيتم الطلب منك أن تقوم بالإخبار بقصة تجاربك في الدخول إلى خدمات الصحة العقلية وسيقوم الباحث باستخدام جمل مثل: "ما هي قصتك؟" أنا أتمنى ان تكون المشاركة في البحث حقيقة تجربة ممتعة.

هل سيتم الحفاظ على سرية مشاركتي في الدراسة؟

نعم، ستكون جميع المعلومات الخاصة بمشاركتك في تلك الدراسة سرية. سيتم إزالة الأسماء والمعلومات الأخرى من بيانات البحث وسجلاته. من خلال الحصول على إذن منك، سأقوم بتسجيل صوتي للمقابلات حتى يمكنني الحصول على تسجيل دقيق يشمل ما قلته. في حالة أنك لا تريد تسجيل أجزاء محددة من مشاركتك، سأقوم بكتابة ملاحظات مفصلة عن تلك الجزئية بدلًا من التسجيل.

سيتم استخدام المستخلصات التي تم قولها بشكل مباشر في المقابلات فقط في حالة أنك قمت بإعطائنا موافقتك هنا .... اوافق ( ) لا اوافق ( )

سيتم إزالة الأسماء والمعلومات الشخصية الأخرى من تلك الدراسة حتى لا يكون من المتاح التعرف على الأشخاص الذين قاموا بالمشاركة في تلك الدراسة أو الأشخاص الذين قد تمت الإشارة إليهم في أثناي المقابلة. سيتم حفظ جميع المعلومات الشخصية الخاصة بك مثل الأسماء وأرقام التواصل في خزانة مغلقة لحفظ الوثائق حيث سيكون لدى الباحث فقط إمكانية الدخول إلى تلك الخزانة. كما سيتم الاحتفاظ بالبيانات التي لم يتم التعرف عليها في أرشيف آمن محمي بكلمة مرور على كمبيوتر الباحث.

إين سيتم إجراء البحث؟

سيتم إجراء المقابلات الخاصة بالدراسة في مقر الجمعية السعودية الخيرية لمرضى الفصام.

ما الذي سيحدث في حالة أنني لم أرد الاستمرار بالمشاركة في الدراسة؟

يمكنك الانسحاب من الدراسة في أي وقت، ومن دون إبداء أي سبب. في حالة أنك قمت بعمل ذلك، يمكن إذا ان تقرر إذا ما كنت تريدني أن أقوم باستخدام المعلومات والمشاركات التي قمت بالفعل بعملها معي في البحث، او أنك تريد ان يتم استبعاد تلك الأشياء من الدراسة.

ما الذي سيحدث في حالة وجود مشكلة؟

في حالة أنه قد كان لديك أي قلق حول مجال تلك الدراسة، فإنه يجب عليك طلب التحدث إلى الباحثة (ندى العطار، بيانات التواصل موجودة بالأسفل) والتي ستقوم ببذل قصارى جهدها للإجابة على أسئلتك.

من الذي يمكنني الشكوى إليه؟

في حالة أنه كان لديك شكوى حول معاملة الباحثة معك او أي شكوى أخرى تتعلق بالدراسة، يمكنك بصورة أولية التواصل مع الباحثة (ندى العطار) او المشرف الخاص بها (د/ ثويدور ستيكلي، حيث توجد بيانات التواصل معه بالأسفل). في حالة عدم جدوى تلك الأمور، يمكنك في تلك الحالة التواصل مع المدير، كلية الطب والعلوم الصحية – لجنة أخلاقيات البحث، عناية/ مركز تعليم كلية الطب، الطابق ب بكلية الطب، حرم كلية الملكة ماري، مستشفيات جامعة نوتنجهام، إن جي 7 2 يو إتش، البريد الالكتروني: **louise.sabir@nottingham.ac.uk.**

ما الذي سيحدث لنتائج الدراسة البحثية؟

سيتم إتاحة نتائج تلك الدراسة لنشرات الجرائد العلمية وعروض المؤتمرات في أي أحداث عامة لن يتم الإشارة إلى أي من المشاركين في أي من المنشورات المنبثقة من تلك الدراسة. في حالة رغبتك في الحصول على ملخص بالنتائج في نهاية الدراسة، يرجى الإشارة إلى ذلك الأمر في نموذج الموافقة.

من الذي يقوم بتنظيم وتمويل البحث؟

إن تلك الدراسة بتم القيام بها بواسطة ندى العطار، طالبة درجة الدكتوراه في جامعة نوتنجهام. تحصل ندى العطار على تمويل كامل لذلك البحث من الملحقية الثقافية السعودية، وزارة التعليم العالي السعودية وجامعة الملك سعود.

من قام بمراجعة الدراسة؟

لقد تمت مراجعة والموافقة على تلك الدراسة بواسطة جامعة نوتنجهام – كلية الطب – لجنة الأخلاقيات.

أرقام التواصل للمزيد من المعلومات

في حالة أنه كان لديك أي أسئلة أو مخاوف حول المشاركة في ذلك البحث، أو أنك تريد مناقشة أكثر لذلك البحث، يرجى التواصل مع:

الباحثة:	المشرف:
ندى العطار	د/ ثويدور ستيكلي
كلية العلوم الصحية	كلية العلوم الصحية
كلية الطب والعلوم الصحية	كلية الطب والعلوم الصحية
جامعة نوتنجهام	جامعة نوتنجهام
كلية الملكة ماري مكتب بي 33	مبني معهد الصحة العقلية
نوتنجهام	طريق تريمف
إن جي 7 2 أر دي	حديثة إينوفيشن
هاتف: 07538830038	نوتنجهام
البريد الإلكتروني:	إن جي 7 2 تي يو
ntxnma@nottingham.ac.uk	هاتف: 01157484305
	البريد الالكتروني:
	theo.stickley@nottingham.ac.uk

شكرا لتعاونكم واهتمامكم

D.3. Consent form (English)

University of Nottingham, School of Health Sciences



Participant identifier: _____

INTERVIEW CONSENT FORM
(1st September 2017)

Accessing Mental Health Services in KSA

Researcher: Nada AL-Attar. Supervisor: Theo Stickley.

		Please initial
	After reading the information sheet provided, please read each of these statements, initial each one as appropriate, and sign and date the form.	
1	I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to ask questions and have understood the information given. I understand that I can ask for further instructions or explanations at any time.	☐
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without having to give a reason.	☐
3	I agree to the audio recording of interviews in which I take part for the purposes of the research. I understand that I may ask for the recorder to be stopped at any time.	☐
4	I understand that the recordings will be transcribed and looked at by authorised individuals from the University of Nottingham. I give permission for these individuals to have access to these records and to collect, store, analyse and	☐

publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.

5 I agree to the use of extracts from the interviews being used in publications resulting from the research. I understand that all personal details will be removed and that I, and anyone else mentioned in the interviews, will not be identified in any published work or other output of the research. ☐

6 I understand that the anonymised research data will be archived on a secure, password-protected server at the University of Nottingham for 7 years after publication and then destroyed. ☐

7 I voluntarily agree to take part in this study. ☐

8 I would/would not* like to be informed of the results from this study. ☐

(*Please delete as appropriate)

Name of respondent	Date	Signature
Name of researcher taking consent	Date	Signature

D.4. Consent form (Arabic version)

جامعة نوتنجهام – كلية علوم الصحة

التعريف الخاص بالمشارك: .....

نموذج الموافقة على المقابلة

لبحث بعنوان: اللجوءإلى خدمات الصحة النفسية في المملكة العربية السعودية

الباحث: ندى العطار المشرف: د/ ثويدور ستيكلي

بعد قراءة ملف المعلومات المقدم، يرجى قراءة كل من تلك البنود مع الموافقة على كل منها ثم التوقيع وكتابة التاريخ في النموذج.

1- **أقر أنني قد قمت بقراءة وفهم ملف المعلومات وللدراسة المذكورة بالأعلى. لقد اتيحت لي الفرصة لطرح الأسئلة وعليه فقد قمت بفهم جميع المعلومات المبينة. أنا على علم بأنني يمكنني طلب تعليمات إضافية أو توضيحات في أي وقت.**

2- **أنا اتفهم بأن مشاركتي هي تطوعية وأنه لدي الخيار في الانسحاب في أي وقت من دون إبداء أي أسباب.**

3- **أنا أوافق على التسجيل الصوتي للمقابلات التي أشارك فيها لغرض البحث. وأنا على علم بأنه يمكنني طلب إيقاف التسجيل في أي وقت.**

4- **أنا على وعي بأن التسجيلات سيتم كتابتها نصًا وسيتم الاطلاع عليها بواسطة أشخاص متخصصين من جامعة نوتنجهام. وأنا اسمح لهؤلاء الأشخاص بجمع وتخزين وتحليل ونشر المعلومات التي تم الحصول عليها من خلال مشاركتي في الدراسة دون ذكر لاسمي. أنا كذلك على وعي بأن البيانات الشخصية الخاصة ستظل سرية.**

5- **أنا أوافق على استخدام مستخلصات المقابلات في المواد المنشورة الناتجة عن البحث. وكذلك فإني على وعي بأن جميع البيانات الشخصية سيتم إزالتها وأنني أنا وأي شخص أخر مذكور في المقابلات لن يتم تعريفنا في أي عمل منشور أو أي مخرجات أخرى للبحث.**

6- **أنا على وعي بأن البيانات البحثية مجهولة المصدر سيتم أرشفتها من خلال خادم أمن محمي بكلمة سر في جامعة نوتنجهام لمدة سبع سنوات بعد النشر ثم سيتم إتلافها.**

7- **أنا أوافق طوعًا على المشاركة في تلك الدراسة.**

8- **أنا أود/ لا أود أن يتم إرسال نتائج تلك الدراسة إلى.**

(*يرجي التأشير بعدم الموافقة في حالة رغبة ذلك)

اسم المشارك	التاريخ	التوقيع
اسم الباحث الذي حصل على الموافقة	**التاريخ**	**التوقيع**

Appendix E: Example of participants transcript

E.1 Transcript in participants' language (Arabic transcript)

ممكن تحكيني لنا عن تجربتك مع المرض وكيف اكتشفت المرض ومتى اكتشفته وكيف بدأت علاج وكيف تعافيت أو تشافيت من المرض؟

دكتورة أنا اكتشفت المرض من زمان أكثر من 15 سنة كان عمري يوم كنت ادرس في أولى ابتدائي كان المرض عندي فصام الوجدان كان تفكير وجداني تقلبات مزاج تيجي وتروح ما كانت مزمنة بعد عشر سنوات يوم جاء عمري 20 كدة تحولت إلى مزمنة وتعالجت عند طبيب نفسي وروحتله قال لي بيك مرض الفصام الوجداني مرض مثل الزهيمر والسكر والزكام والكحة والضغط

طيب كيف عرفت أن هذا مرض؟ الأهل عندك حسوا أو لاحظوا إن فيه تغيرات عليك وقالوا على طول يخدوك للطبيب النفسي؟

البداية أول ما صابني قبل ما يكون مزمن يعني دائم, كنت طبيعي بس يوم صرت مزمن المرحلة المزمنة, قال أبوي أشوفك ما تنام مانت مرتاح مانت على بعضك قال نوديك مستشفى أ فيه دكاترة ممتازين يعالجونك منه هذا جاني الأرق الحمد لله من العلاج تعافيت وتقلبات المزاج برده تعافيت

يعني ما مثلا الوالد أو الوالدة توجهوا مثلا على شيوخ يقرون وكدة؟

صحيح من المستشفى ومن الشيوخ روحت للشيوخ يقرون

لكن مو مثلا بس بدأنا شيوخ وبعدين ما لقينا فائدة روحنا المستشفى؟ ولا كل الاثنين سوى؟

كل الاثنين سوى قالوا الشيوخ ما فيك إلا مرض يمكن يكون مرض نفسي وشخص الدكتور إنه مرض الفصام الوجداني

كانت تيجيك هلاوس؟

تجيني أصوات كأني مراقب كأني بجلس مع إنسان كل ما يقرأ أفكاري يعطيني أفكاره مثل كدة

بس كدة يعني؟

إي

لكن ما تسمع ناس تكلمك بأذنك تشوف ناس

أشوف خيالات ما عندي بس اسمع الأصوات

تسمع أصوات تؤمرك بأشياء أحيانا

تؤمرني بس تسببلي تقلبات مزاج نرفزة تخليني متضايق زعلان دائما إنت فايز خليك منهزم إلى متى إنت فايز ومرتاح خليك منهزم تابعني انهزم وأنا ما نصدقه طبعا ما فيه أحد يحب أحد بالمرض بالعكس ما أحد يحب الثاني إلا في العافية

وبعدين لما بدأت العلاج سنة كم هذا؟

عام 2006 في مجمع أ قبل مجمع أ 2005 وقبل م مستوصف عام 2004 والأصوات هذي أحسها كانت مو مزمنة تروح وتيجي من عام 1418 وأنا أحس فيها تروح وتيجي بس يوم ما صار عمري عام 28

خلاص تحولت إلى مزمنة وأحسست إني واحتجت إني أكمل العلاج بس إلي ما يصبر على العلاج 13 14 سنة فاتت بعدها حسيت بالعافية المزاج والأصوات ما عاد لها أهمية سواء راحت أو ما راحت ما لها أهمية

ما تضايقك يعني؟

ما تضايقني يعني اشكر مجمع الفصام على العلاجات الممتازة علاج زبركسا وإبرة هوليدول ا في البداية كانوا يعطوني أنبولتين ثم حطوها أنبولة واحدة كل إسبوعين وقبل تنومت ثلاث مرات بمجمع الأ مجموع التنويم ثلاث شهور أو ما يقارب ثلاث مرات الحمد لله ما أحس إلا بالعافية

يعني حسيت لجوءك للعلاج كان سلس بسرعة يعني مثلا ما كان فيه أحد يقول لك من العائلة لا إنت مو مريض ما تروح تتعالج يعني عندك الأهل كانوا متقبلين أنك إنت مريض وعادي؟

الأهل ما يقولون أي شيء يقولون كلنا نمرض وكلنا تجينا أمراض عضوية أو نفسية يعني لا تخاف متقبلين؟

متقبلين بس يقولون أهم شيء تداوم على العلاج مثل ما يقول لك الدكتور من شان تقاومولا تفكر مين يحبك ويكرهك مايهم لا تعطيهم اهمية وحياتك اهم شي عيشها زيك زي الطبيعين لاتقلق انت طبيعي ومافيك شي

هذا المرض ما أثر على دراستك على حياتك؟

أثر علي في الدوام بس ما أقدر اتحمل الدوام كامل ثمان ساعات مثلا أداوم ست خمس ساعات في اليوم معقولة لإني الساعة سبعة صباحا أداوم هذا إلي يتقبلوا ولحد الآن ما لقيت وظيفة تناسب بس جمعية الفصام إن شاء الله تدورلي وتحصل لي الوظيفة المناسبة لمرضي

إنت معاك شهادة جامعية؟

شهادة ثانوية وادرس تعليم عن بعد بالجامعة

إيش التخصص؟

أصول الدين المرض مثل التقلبات في لون البشر إذا صحيت من المرض ألقى لوني طبيعي أبيض إذا جات الأصوات هذي ينقلب لوني أسمر التقلبات في اللون أحس كدة تقلبات حتى ألاحظ وجهي بالمراية يتغير إذا ارتحت من الأصوات هذي أو الهلاوس يرجع اللون طبيعي المرض ممكن يكون له تأثير لإني سألت الدكتور قال طبعا له تأثير

إيش تحس مثلا واجهتك أي صعوبات إنك تاخد علاجك ولا مثلا تستمر في العلاج أو توقف العلاج فيه أي صعوبات؟

أنا بالنسبة لي عادي لو استمر عليه مدى الحياة الشيء الروتيني كويس العلاج ما ضر

كيف لجأت للجمعية هنا وبدأت تتعاون معاهم؟

أنا سمعت عن الجمعية في مستشفى الأ الدكتور بيكلم مريض مثلي إن فيه جمعية فصام يقول له ادخلها ومن ذا الكلام دخلت على الإنترنت وسجلت

عام كم؟

العام قبل سنة 2016 اتوقع وصار الوضع هنا الحمد لله

عشان التأهيل؟

إي

طيب إيش استفدت؟ تحس إنك بعد مرحلة التأهيل قدرت تندمج أكثر في المجتمع حسيت إنك إنت أفضل الآن؟

الآن ممتاز والله أحسن من أول قبل عشر سنوات كانت الحالة يعني دائما أحس أني مراقب وملحوق وكل شيء لكن بفضل الله ثم العلاج صرت طبيعي ما عاد اهتم بالأصوات والتخيلات شيء طبيعي

تقدر تتجاهلها بكل سهولة طبعا مع العلاج طبعا والتأهيل كان له دور؟

له دور كثير ما قصرت سمو الأميرة

كيف؟

الجمعية ممتازة شرحوا لنا المرض العضوي والنفسي وكل شيء عن الفصام والانفصام

صرت تفهم أكثر عن مرضك؟

إي صرت أفهم معي المستشفى برده يعلموني ويفهموني يعني شيء طيب

إيش تحس لو مرضى الفصام كلهم عرفوا مشاكلهم وتكون سهلة عليهم؟

مشاكلهم سهلة مريض الفصام يحب الراحة بالذات الفصام الوجداني

كيف يحب الراحة؟

يعني إذا كان يشتغل فترات طويلة 8 ساعات 7 ساعات تيجيه مثل الضيقة ما يرتاح ينقلب مزاجه فصام وجداني متقلب المزاج

طيب إيش تنصحهم؟

أنصحهم بالاستمرار على العلاج إذا كان مزمن طبعا مدى الحياة وإذا كان بسيط يحتاج سنة بالمستشفى لكن المزمن مدى الحياة إنه يزين مزاجك والنوم يبعد الأرق وينظملك النوم ويعطيك راحة راحة نفسية وعضوية

كيف تحس تقبل المجتمع لمريض الفصام؟ هل متقبلينه؟

فيه بعض الناس الناس يختلفون عن بعضهم فيه ناس يتقبلون ويقولون شيء طبيعي وكلنا نعاني من أمراض عضوية وبعضهم يقولوا لا مرض الفصام مرض يكون الإنسان مجنون

طيب كثير ولا قليل إش في رأيك؟

قليل إلي يقولون إنه مجنون يقولون مجنون مريض الفصام واخدين فكرة سيئة مرض الفصام مرض الأذكياء اتوقع هذي الهلاوس والأصوات تعطي الإنسان ذكاء عمره أكبر من عمره تخليه يفهم إلى حوله

كيف؟

لما تتابعين هذي الأصوات هي تتحكم به تتحكم بمريض الفصام تتحكم تقول إنت لو مثلا تسوي لحاله تعطيك ذكاء إحنا ممنوع عندنا بالسعودية إنك تشتغل شيء بدون ممارسة أو تصلح أي شيء كل شيء السعودية استهلاكية بس تعلمك تفكر بمكينة السيارة تعلمك كيف تصلح

إنت تحب تفكك أشياء وتصلحها؟

أنا ما أفكر ما أصدقها ولا هي تقدر تقول تابعني طبعا مثل إلي تحركك لا إرادي تصلح وتزين ذكاء

طيب لو إنت مثلا مريض فصام وما يتعالج جالس في بيته ويسمع هذي الهلاوس بس ما يستجيب لها هل يعتبر هذا علاج؟

برده هذا علاج إلى ما يستجيب لها طبيعي جدا

يعني ممكن يستغنى عن الدواء؟

ممكن يستغنى لو عنده إرادة قوية

إذا كانت مثلا عنده إرادة قوية ممكن يستغنى عن الدواء ويطنش الهلاوس ويتعافى؟

هو الهلاوس تسبب ممكن أرق وممكن تقلبات مزاج وممكن يصدق الناس يقرأون أفكاره إذا كان هو يتجنبها نهائي وواثق من نفسه مية بالمية هذا على حسب رغبته يتعالج وإن كان يحس بمعاناة أنا عشان بيصير أرق عندي تقلبات في المزاج شوي قلت ابغا اتعالج لما بكون جالس مع زوجتي كدة ابغي استأنس ابغا أسولف معي يقلب مزاجي آخذ السيارة وأروح مكان ثاني هذا طبعا في بداية المرض لكن الآن مع العلاج الحمد لله طبيعي

كنت تحس أول في بداية المرض إنه مثلا ما تبغا تتكلم مع أحد تبغا تنعزل تبغا تنطوي؟

لا احب اندمج وأحب كل يوم اكسب صديق بس الفصام إلي معي يمنعني من بعض الأصدقاء إلي ما أثق فيهم أو أشك فيهم أو أخاف منهم مثل إلي يخليني أصرف نفسي ما ارتاح إلا مع إلي أثق فيه وبالذات إذا كان العمر قريب لي وأنا قريب له

تحس إن الفصام ممكن يصنفلك الناس ناس شر وناس خير

إي لازم إلي أثق فيه هذا يثق فيه معي إذا ما وثقت ما وثق مثلا ناس يجلسون يخذون مخدرات لا قدر الله ما أجلس معهم وأخاف منهم أخاف منهم يمسكوني يسببونلي سجن ولا شيء لا قدر الله يعني الأفضل إني أجلس مع ناس واثق منهم

هذا مع المرض طيب بعد المرض هل هذي الهلاوس طلعت حقيقية؟ يعني مثلا بعد العلاج مثلا الناس هادول الي كانت الهلاوس تقول لك لا تجلس معهم صح هم ما هم كويسين؟ شر؟

مرض الفصام مرض مثل إلي يقرأ مخ الإنسان هو أصلا أساس تفكير الإنسان يفكر ما يجول في مخه وأفكاره ثم يقرر هو يقرر معي المرض

يستخدمها ممكن ضده ضد المريض؟

إي أنا أسمي مرض الفصام مثل المنبه يذكرك بحاجات ناسيها يذكرك بالماضي وش كانت حياتك أول في بداية المرض وشلون وكيف يعني مثلا أنا عندي موعد مع صديقي بالليل بعد العشاء أنا نسيت هو يذكرني روح موعدك مع فلان

حتى بعد العلاج؟

حتى بعد العلاج

إيش يقولك؟ يقول لك فيه موعد؟

يقول لي عندك موعد ونسيته حاول ما تنسى يعني الفصام بالذات الفصام المزمن بالعلاج ممتازة يعني يعتبر نفسه طبيب سواء عقلي أو وجداني

الآن مع العلاج تحس إن عادي حياتك طبيعية تقدر تدرس تكمل تقدر تتوظف؟

طبيعية الحمد لله

لو الحين عرضت عليك وظيفة، حتى لو أكثر من ثمان ساعات بتوافق؟ لو مثلا وفرتلك الجمعية كدة تقدر؟

أكثر من ثماني ساعات؟

إي أنا أسألك فرضا

إذا كان المرض متقبلها وياي عادي شيء طبيعي لإني كنت توظفت وظيفة حارس أمن الصراحة تقبلتها وارتحت نفسيا وداومت فيها أربع شهور

كنت تتعالج؟

وأنا اتعالج ثمان ساعات مدة الدوام بس ابغي أحول من بدون تأمينات إلى تأمينات رافضين فقلت بدور غيرها

ليش؟

عشان يصيرلي تقاعد بس هم ما عندهم تأمينات وفيه بعض الوظائف أخشها ما ارتاح فيها، حتى لو أداوم ساعة ساعتين أحس بالضيقة

إيش الوظائف إلي تحس إنها ممكن تنتج فيها؟

مثل الشركات شركات شغلها اتوظف دوامي من خمس لست ساعات

هو الأفضل إنك إنت تداوم ساعات قليلة بالتدرج مع العلاج طبعا مع العلاج والتأهيل والدورات وكدة صحيح

كيف لاحظت تأثير الدورات والتأهيل على الأسرة مثلا؟ أهلك يحضروا معاك الدورات؟

لا ما يحضرون معي أهلي يقولون روح واستفد وأهم شيء لا تفكر بالعلاج فكر إن ما فيك شيء لا تفكر إنك مريض خلاص انتهت الدنيا ما إذا أحد يحبك أو يكرهونك أو أي من هالقبيل لا تهتم لا تصدق يعني عش حياتك كأنك طبيعي مثل السليمين ما فيك أي شيء لا تخاف من أي شيء

هذا الصحيح. إن شاء الله تلاقي وظيفة هل تحب تضيف شي او تسالني اي سؤال او مساعدة؟

لا شكرا اتمنى إني فدتكم بقصتي

اكيد شكرا لك

E.2 Example of translated transcript to English

can you please tell me about your experience with the disease, how did you discover it, when and, how did you begin treatment, accessing mental health services and how did you feel you adapt or recover from the illness?

I had discovered my illness a while ago, when I was 15 years-old … I had sentimental schizophrenia, changes in my mood, it was not constant, after ten years, when I was 20 years-old, it became chronic, I started consulting a doctor who told me that I had sentimental schizophrenia, a disease similar to Alzheimer's, diabetes, colds, cough and blood pressure.

Ok how did you know that this is a disease? Do you or your family noticed that there are changes on you and they said along you need a psychiatrist?

The first thing I had before I was chronically mean permanent, I was normal but the day I became chronic…, chronic stage then, my father told me that he noticed that I was not sleeping well - how about we take you to a hospital, there is a couple of competent doctors who can take care of you and treat this insomnia, I felt better and felt better.

I mean, for example, your parent went with you to the faith-healer first to approve that you have an illness not jinn or magic?

It is true I went to faith-healer and to the hospital, and both the Muslim clergymen (sheikh or faith-healer) and doctors confirmed that I had mental health issue, schizophrenia.

Have you had any sort of hallucinations?

I had voices, as if I am being watched and sitting with someone else who was reading my mind. I used to see fantasies and hear voices.

Have you been commanded by these voices?

True it is telling some things to me to just cause my mood swings and made me jerks…it says to me, "You are not worthy to anyone no one loved you when you are well."

And I do not believe those commands and do not follow them, of course, because no one loves the disease, on the contrary, no one likes the other except in wellness.

And then, when did you start your treatment?

In 2006, I was at A complex, and in 2005 I was at M Centre, and before that I was at x psychiatrist in 2004 … but when I was 28 years old the disease became a chronic one.

Do you mean that hallucinations no longer bother you?

True it does not bother me and thanks to the A complex for the excellent treatments. The treatment of Z and H were initially given two ampoules and then became one every two weeks and before that I was admit three times to the A complex for almost three months or nearly three times… Thank God I feel only good and well.

Do you mean that your accessing the mental health services was easy and accepted by your parents and family?

Yes thanks god it was so easy to me …..my family does not say anything, they used to say we all get sick, we all get diseases whether psychological or organic.

So, they accept your illness?

Yah they always say'' the most important thing is to continue on the treatment, follow the doctor instructions to resist the illness and do not think about the people thoughts and telling ''it is not the end of the world if no one loves you, or hates you, don you give an importance, live your life as if you are normal don you worry, you are okay''

Can you tell me please more about how the illness is influenced your life, or job?

Of course, it has a bad influence on my work … but the Saudi association promised to help me out in finding the suitable job.

What is your qualification, Kareem?

I have a high school certificate and currently studying on distance learning a bachelor's degree in the religion basics…I need also to say that the fluctuations are like those in the skin color, if I am not sick my skin color is normal, if I start hearing voices my skin turn darker … if the voices are no longer heard I turn back into my normal color.

I see, so do you think that you had faced any difficulties to access the treatment or in continuing your medications?

For me it is normal if I will be receiving the treatment all along my life, it is good to receive a treatment it won't harm.

Great, could you tell me please more about when did you start to access the Saudi society and when did you start to cooperate with them in your case?

I have been in my regular check-up and heard the doctor when he advised one person as my case to visit the association 'the charity'' if he need any help of mental health rehabilitation-engagement courses. Then i visited their website and register with them…this was in 2016…and until now I am continuing to attend their helpful courses.

Ok, how do you feel now? Tell me more about the difference between before and after community engagement and rehabilitation courses?

I am doing great, and better than before, before ten years I used to feel that I am being watched and followed and thanks to God and the treatment I do not care anymore about voices…. now I am learning and have a better understanding about my disease thanks to the charity and the A hospital as well.

What do you think if the people with mental health issues knows more about their illness, is that could help them to deal with their illness in easy way and live a normal life?

Their problems are easy if we talked about schizophrenic patient, they mainly love comfort especially the schizoaffective schizophrenia

How did they like comfort? Clarify that to me please.

Means… if they work for long periods 8 or 7 hours, they feel like they strangulate…I mean they did not feel relaxed as they are moody people.

Do you have any advice for them?

I advise people to continue receiving their treatments if they have chronic diseases throughout their lives and they will feel better in their fluctuated mood.

Ok thanks Kareem… how do you see the acceptance of Saudi society to the people with mental health issues? Did they accept this group?

People is different some of them accept mental ill people and see them like any one of them they might got sick physically or psychologically and others see people with mental health issues as an insane ''majnoon'' and their thought is wrong as they are not.

Ok what do you think what is the majority?

I think …the majority think that the mental ill people are as any normal people who might got any physical or organic disease in any period of their life.

Do you think the people with mental health issues needs to have a strong will to fight such stigma and their illness?

That is true they should have the willingness to accept their illness and let other to accept them… hallucinations are the main cause of insomnia and moody characters although, they should be confident about themselves to overcome the disease symptoms to live a normal life.

Well, Kareem how do you feel now about having a friend? Do you feel isolated or you have friends?

I want to have friends, but my disease prevents me as I am not easily trust people… I name the schizophrenia the illness of genius one....it is like the alarm in my mind it is remember me with my important appointment…and alert me from the dangerous people or places.

Ahaa, is this remain until now? I mean even after you have started the treatment.

It is true, but it does not bother me as before the treatment.

Now you are on medication and regular follow up, how about if the charity finds you a job of 8 hours? Can you accept that?

In fact, I was worked for 8 hours under treatment as a security man but after a while of four months I could not tolerate that.

So, I can't work more than 8 hours per day and I want to reduce them, and I want a work from which I can benefit of a retirement program…I prefer companies where I can work 5 hours per day.

Alright Kareem hopes the charity would find you a job soon. Would you like to say anything more to me or ask me anything to help?

No thank you…I hope I told you the useful story.

Of course, do not wary and thanks for your cooperation.