# THE STANDARD OF CARE IN MARITAL AND FAMILY THERAPEUTIC INTERVENTIONS IN SAUDI ARABIA: A MODIFIED DELPHI STUDY ON THE CURRENT STATUS AND NEEDS

By

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ABSTRACT

THE STANDARD OF CARE IN MARITAL AND FAMILY THERAPEUTIC INTERVENTIONS IN SAUDI ARABIA: A MODIFIED DELPHI STUDY ON THE CURRENT STATUS AND NEEDS

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There is a recognized need for identifying barriers and solutions to the currently provided marital and family therapeutic practices in the mental and social health care in the Kingdom of Saudi Arabia (KSA). This multiphase mixed method dissertation research is set to portray a systematic current account of the marital and family therapeutic practices, regarding barriers, needs, and identified solutions. Also, to explore the preparedness of the professionals delivering interventions for individual and relationally based concerns, based on their training and supervision. Further, this study set out to gain a better understanding of the sociocultural challenges for seeking help and obtaining effective help.

The first phase of the data collection was carried out by two online surveys. The first survey had 221 mental health professionals (MHPs) who gave an account of their perceptions of the meaning of marriage and family therapy (MFT), the current status of the mental health care system in KSA, satisfaction with services provided, and the significance of some of the mental health concerns. The second survey had 147 psychotherapists/MFTs participants who gave an account of their current training, supervision, personal proficiency, and their main theoretical orientations. Finally, a third study included two rounds of the modified Delphi method administered with a panel of experts from various mental health fields in KSA.

Findings from the first phase provided guidance on MHPs perceptions surrounding the meaning of "marriage and family therapy," and identified its relevance as a modality of care. Results showed that 91% of the MHPs are not satisfied with the current services available to treat relational concerns. The second survey provided inputs on the ongoing training and supervision and identified the most familiar form of training as individual case consultation supervision. In the Delphi study, panelists reached consensus around barriers related to professionals, availability of services and facilities, and collaborative care and support. Some sociocultural challenges were identified throughout the two phases. Clinical and training considerations for the future of MFTs training in KSA, general training, and professional preparedness, logistical recommendations, and future directions are discussed.

I dedicate this work to my grandfathers, Mohammed Gassas and Mohammed Osta, who are missed and are no longer with us. To my grandmothers, Hyatt Abdulkader and Beshara Al-Ahmadi. To my parents, Fouad Gassas and Elham Osta. To my siblings, Rezan and Ahmed.

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TABLE OF CONTENTS

## LIST OF TABLES

## LIST OF FIGURES

# CHAPTER 1: INTRODUCTION

Marriage and family therapeutic interventions are needed worldwide, including the Kingdom of Saudi Arabia (KSA). Due to the rapid social changes in KSA, the country is experiencing concerns related to substance abuse, domestic violence, child abuse and neglect, partner relational problems, parent-child relational problems, and other mental health concerns (Albrithen, 2006; Al-Eissa & Almuneef, 2010; Almuneef & Al-Eissa, 2010; AlMadani, Bamousa, Alsaif, Kharoshah, & Alsowayigh, 2012; Aziz, 2013; Karthikeyan, Mohanty, & Fouzi, 2006; National Family Safety Registry, 2010). Many of these reported concerns exist in the context of relational difficulties, factors that require intervening with more than one person to affect change. Moreover, mental, neurological, and substance-use disorders also touch the client's families and communities, and it is acknowledged as a global mental health challenge (Collins, Patel, Joestl, March, Insel, Daar, Scientific Advisory Board, & the Executive Committee of the Grand Challenges on Global Mental Health, 2011).

The mental health field in KSA is still developing; moreover, the field of marriage and family therapy (MFT) is still in its infancy and as a result, there is a lack of literature allowing an accurate assessment of the present status of MFT in KSA. Besides the reported presenting family relational concerns mentioned above, the media has been the frontrunner in bringing attention to the current state of affairs related to the practice of marital and family counseling/therapy. The media noted that the current status of marital and family counseling/therapy practice is somewhat chaotic, and lacks regulation. Furthermore, practitioners have limited qualifications and credentials which lower the confidence in those who seek out MFTs for help (Al-Moflah, 2008; Al-Sadhan, 2012; Althamena, 2014).

## Statement of the Problem

Despite the availability of family therapy and family counseling centers and clinics in KSA, there is only one accredited institution that offers a family counseling diploma in Al-Imam Muhammad Ibn Saud Islamic University. Although the practice exists, there is no consensus about MFT practice or empirical data indicating the essence of what is the standard of care for *marital and family therapeutic interventions* in KSA. Furthermore, there is no detailed consensus on identifiable challenges that professionals face in acquiring the needed clinical skills and competencies to meet the needs of the clients, including couples and families in the unique cultural context of KSA.

Many of the generic mental health professionals are the gateway to marriage and family therapeutic referral services, especially in the healthcare sectors; yet there is little empirical data on mental health professionals' perceptions, beliefs, and attitudes of MFT in KSA. There are many possible reasons contributing to the currently confused status of MFT in KSA: (a) unclear understanding of what is MFT by insiders (mental health professionals) and what are the standard practices involved in carrying out therapeutic interventions to children, couples, and families; (b) lack of clarity in specification of clinical skill requirements for the practice of MFT; (c) existence of context-specific challenges to the growth of professionals working with children, couples, and families in KSA, and (d) challenges related to the specific context of culture and society in KSA.

### Barriers Related to Providers and their Qualifications

Ambiguous understanding of the profession of MFT by other mental health professionals leads to speculation that professionals might advocate the services under misconceptions of what

the practice offers. There is limited literature on clinical practices and interventions by MFTs in KSA, neither are there any descriptions of the outcomes of the treatment. One would speculate that this ambiguity about therapeutic services provided to couples and families, as well as the arbitrary practices by some practitioners in the field will only foster the already existing barriers. These obstacles are discussed in other sections of this dissertation.

The issue of the unclear specification for clinical skills requirements is parallel to specifications related to practicing as a psychologist or social worker in KSA. In the case of credentialing, according to Al-Habeeb and Qureshi (2010), the majority of psychologists and social workers in KSA do not hold postgraduate degrees and lack appropriate clinical skills training. Moreover, previous studies have recommended the need to develop further training for school counselors and other mental health providers. (Alghamdi & Riddick, 2011; Al-Bahadel, 2004; Al-Moshawah, 2005). It is not a simple proposition to enhance this training; the needs of the training must be empirically explored and strategically identified to overcome cultural and resource barriers to the training of practitioners working with couples and families in KSA.

Without adequate trained providers, creating a uniform standard of care will be challenging. The lower standard of care contributes to lower levels of accountability for mental health professionals in KSA that may increase resistance and mistrust in the mental health services provided. These issues are further complicated due to the unclear qualifications of mental health practitioners which lead to unknown consequences and malpractices. Because of this, the public does not know what to make of the mental health profession in general and MFT practice specifically. There are unclear descriptions for the public and other mental health professionals of what the practice of MFT encompasses; there is confusion about the conditions

and circumstances dictate the need for help seeking from a provider. The above-described challenges at the current time reflect insufficient training and inadequate field training for psychotherapists and *marital* and *family therapy* practitioners in KSA.

**Barriers Related to the Context of the Country, Society, and Culture**

Some of the context specific barriers affecting MFT practice in KSA include the lack of clear policies and guidelines, inadequate resources, a high ratio of clients to providers, lack of cooperation from other counseling and support staff, and issues of confidentiality and privacy (S. Al-Gahmdi, 1999; N. Al-Gahmdi, 2010). There are additional barriers when it comes to family/ marital counseling. According to (Al-Shahrani, 2003; Koenig et al., 2014) dealing with family problems is considered a very sensitive topic in the Saudi context; sometimes religious scholars even take the role of dealing with family related concerns (Al-Ghadyan, 2001). Therefore, the identity of professionals providing services for children and relational concerns faces challenges concerning who delivers the needed services and how mental health professionals are distinguished from alternative faith healers. Another challenge is that few previous studies address how psychotherapists in KSA tacitly work with special concerns that might exist in a collectivist and paternalistic society, such as males' guardianship over women, gender power differentials, gender roles, divorce and child custody, parenting styles, and sexuality.

Furthermore, one of the other challenges is that cultural concerns exist regardless of the model or the intervention being taught or delivered; this is especially challenging when considering that Saudi psychotherapists usually implement Western therapy approaches in a cultural context that is not always therapy-or western-friendly. Implementing Western therapy

creates a twofold challenge: first with psychotherapists themselves accepting Western family therapy theories, and the second is clients/families themselves accepting help seeking from outsiders, which is considered to be a foreign notion by Saudi citizens. In addition, previous studies have explored the feasibility of establishing family counseling and women counseling in KSA (Al-Bahadel, 2004; Al-Mosharraf, 1990) concluding that these approaches need to adapt to an Islamic framework while their study discussed the feasibility of the practice of MFT. Few previous studies have tackled the issues of how to incorporate societal and cultural challenges such as gender inequality, child and domestic abuse, and the stigma of help-seeking in the realm of training practitioners themselves and the delivery of services.

## Significance of the Study

Through this study, I will contribute to the mental health field in KSA, by adding to the scholarly research a current understanding of marital and family therapeutic practice in KSA. A previous study on KSA explored the school counselor role (Al-Ghamdi, 2010), yet no previous studies have examined the perceptions that other mental health professionals have about their understanding of MFT and the therapeutic interventions delivered to children, couples, and families. The aim of this study was to reach a consensus from mental health professionals on the current professional standard of practice in the delivery of relational therapeutic interventions and the barriers against the practice. This knowledge will be substantial for understanding the cultural and societal challenges to the marriage and family therapy profession that are significant to the Saudi context to identify possible solutions.

This study identified possible solutions to improving the practice of implementing effective marital and family therapeutic practice in KSA, by exploring how those who identify

themselves as MFTs practice and other mental health professionals perceive the practice. A deeper understanding was also identified relating to what the MFT field is composed of in KSA. As a result, training will improve by having a better understanding of priorities required to graduate informed mental health professionals who are competent in the realm of marital and family therapeutic interventions, which will help in recruiting better advocates of the services that MFTs offer. Furthermore, improving the practice is feasible when the knowledge about the barriers to interventions and training becomes available. The findings will be helpful in adapting and improving interventions to clients and families dealing with specific family health concerns such as domestic violence, child abuse, divorce, empowerment of women, children, and elders.

The findings of this study may help improve policy and decision making by understanding expert consensus on these issues. The consensus of the experts will help in setting a current standard of what the practice of marital and family therapeutic intervention entails as well as standards for training in KSA that will contribute to regulating the current chaotic practice of training and interventions that have been provided by unqualified practitioners.

**Reasons for Undertaking the Study**

Based on the current needs to improve mental health services in KSA, and as a Saudi MFT doctoral researcher, I acknowledge the importance of establishing more rigorous training for the future generation of MFTs in KSA. In addition, as a Saudi therapist who has been receiving my education and training in the United States, and who has experienced clinical practice in both worlds, I seek to investigate areas that will benefit and improve the practitioners serving children, couples, and families in KSA.

As an MFT, I am interested in implementing effective training of mental health professionals, specifically for those working with children and families. Defining the training requirements and competencies in working with relational concerns in KSA will clarify and support any request to recognize the field of MFT in the future as a profession that will be recognized in the country, as well as by major accreditation bodies such as the Saudi Commission for Health Specialties (SCHS).

## Purpose of Proposed Study

The intent of this modified Delphi multiphase mixed method study is to understand the current status of couple, marital, and family therapeutic practice in KSA. There were two phases; the first phase consisted of two online surveys. The first survey was directed toward mental health professionals (MHPs) and inquired about their current perceptions and competencies about the practice of marriage and family therapy in KSA; the second survey was directed towards psychotherapists/MFTs and explored their perceptions about the present state of training and supervision satisfactions and personal proficiencies. The two surveys were followed by two rounds of a Delphi study that sought out experts' opinions and consensus about the current status of the professional standard of practice, context specific barriers to training and practice, and recommended solutions.

The objectives of this study are as follows: (a) to identify assumptions of what mental health professionals understand about marital and family therapeutic practice in KSA; (b) to gauge practitioners own competencies about delivering interventions for relational concerns; (c) to assess and identify the needs for professional standards and training requirements; (d) to

identify societal/cultural context-specific challenges to practicing with couples and families; and (e) to identify solutions to improve the practice.

**Theoretical Framework**

The Saudi psychotherapist goes through a process of negotiating the uncertainty of implementing theoretical knowledge that is considered imported from the West; these interventions are delivered in a context where few resources and research exists demonstrating its effectiveness in an Arabic and Islamic society. The development and growth of the practice of therapeutic interventions for marital and family concerns in KSA are not exempt from negotiating the multiple interactions and different influencing factors. Urie Bronfenbrenner's ecology of human development theory and the cultural adaptation framework guided the rationale for this study (figure 1.1), illustrates the conceptualization further.

The ecology of human development perspective revolves around going beyond direct observation into uncovering multiple interactions in various setting, with different aspects of the human's environment (Bronfenbrenner, 1977). This study draws from the successive levels of structure for the ecology of human development theory to delineate marital and family therapeutic practice in KSA. It is useful in conceptualizing the current understanding of the practice and to considering the different interactions with the education that practitioners get expose to in training sites, work sites, and other contextual factors that are drawn from the societal, cultural, and regulations of the professional's standard of practice.

Bronfenbrenner (1977) describes four successive structures contained within each other; they are as follows: microsystem, mesosystem, exosystem, and macrosystem. Also, the last added level to the ecology of human development theory is chronosystem (Bronfenbrenner,

1986). Moreover, the framework of cultural adaptation (Bernal, Bonilla, Bellido, 1995; Bernal & Saez-Santiago, 2006) is an essential lens to consider in that this framework aims to establish culturally sensitive interventions with ethnic populations. My goal is to utilize this framework to understand the processes of adaptation that needs to occur for relational therapeutic interventions to be implemented with an adequate professional standard of practice in a non-Western context. The eight elements are as follows: language, persons, metaphors, content, concepts, goals, methods, and context (Bernal, Bonilla, Bellido, 1995; Bernal & Saez-Santiago, 2006).

The cultural adaptation framework by Bernal, Bonilla, and Bellido (1995) and Bernal and Saez-Santiago (2006) investigation to delineate more about how psychotherapists in non-Western countries, such as in KSA, handle the practice of marital and family therapeutic interventions, and what specific elements need particular adaptation. Many areas require further exploration regarding what specific barriers exists that prevent implementing therapeutic interventions to couples and families in a non-Western setting. Given the fact that professionals are exposed to imported knowledge, models and interactions that were developed in an entirely different societal context, and are delivering what they have learned in a context that may be hostile to the approach and a culture that mistrusts therapy.

**Ecological Paradigms and Cultural Adaptation Elements**

The ecological paradigms are useful to conceptualize the relationship of Practitioners and the Marital and Family Therapeutic Interventions (PPMFTI) with other influencing factors. For this study, at the core of the ecological development paradigms exist the practitioners and the PPMFTI, and their developmental process is demonstrated as follows: at the microsystem level, the practitioners' own understanding of the practice informed by their own beliefs and

experiences of the practice; at the mesosystem level, direct influence on the practitioners interactions with different systems; at the exosystem level; indirect influence on the practice due to interactional influences not necessarily linked to the practitioners; at the level of macrosystem, their development interaction with the existence of embedded influential factors that are found in the environment; and at the chronosystem level, is the existence of the development that are yet to be achieved depending on the transitions that will be taking place in the future. In all of the coming further elaboration of the different levels and paradigms of the ecology of human development theory, the developing person represents what this study refers to as the PPMFTI.

The first level of the ecology of human development theory is the microsystem. Microsystem relates to the immediate setting that the developing person's interact with (Bronfenbrenner, 1977). Two elements of a cultural adaptation are that the person and goals are present in close interaction with the practice of marital and family therapeutic intervention. The person element refers to the dimension of client-therapist relationship (Bernal, Bonilla, & Bellido, 1995; Bernal & Saez-Santiago, 2006). In this study, the person (practitioner) elements and client (the practice of marital and family therapeutic intervention) indicating the role of ethnic, racial, and cultural similarities and differences between the therapist and the client. The role of the practitioners delivering marital and family therapeutic interventions is essential to explore, regarding what the expectation of an Arab and a Muslim psychotherapist. Previous studies indicated that Arab clients/families expect the role of the therapist to be one of a teacher and take an authoritarian role (Abu Baker, 2003; Al-Krenawi & Graham, 2000; West, 1987).

Moreover, the element of goals refers to an agreement between therapists and clients on the goals of treatment (Bernal, Bonilla, & Bellido, 1995; Bernal & Saez-Santiago, 2006). There

are many assumptions of Western marital and family therapeutic interventions that do not fit well with a Saudi context. Client goals in Saudi may directly conflict with a Western approach, especially when considering issues with strong values attached including sexuality, child and adolescent behavior, and gender roles and norms. How practitioners maneuver these different goals, are sometimes central to the assumptions of the model of Western approaches, and in Arabic and an Islamic strict society need further exploration.

The second level of the ecology of human development theory is the mesosystem. Mesosystem refers to the interactions of different situations or settings that the developing person is surrounded with (Bronfenbrenner, 1977). The third level is Exosystem, which refers to formal and informal interactions with settings that influence the developing person (Bronfenbrenner, 1977). The fourth level is Macrosystem; it refers to "blueprints" and patterns that encamp knowledge of cultural, societal, ideological beliefs, economic situation, and legal system and other manifestations (Bronfenbrenner, 1977). In those three described parameters of the ecology of human development theory, two elements of the cultural adaptation are present, which are the methods and context.

The element of methods refers to therapeutic procedures implemented to help clients to reach goals of treatment (Bernal, Bonilla, & Bellido, 1995; Bernal & Saez-Santiago, 2006). The element of the method also applies to the practice of marital and family therapeutic intervention as well, how the training of delivering the relational intervention is provided. One example occurs with gender segregation, how are practitioner trained to fulfill interventions to couples and families when different gender interactions are restricted in educational and work settings at times. Another example would occur with self-of-the-therapist work, which requires practitioners

to explore their family-of-origins and personal lives. Self-of-the-therapist work needs to happen in a culturally appropriate way, given that practitioner comes from a culture that values keeping the personal matter private.

The element of context refers to client's changing context, such as acculturation stress, migration history, and country of origin, economic, political, and social context (Bernal, Bonilla, & Bellido, 1995; Bernal & Saez-Santiago, 2006). It is essential to consider the context of the practice of marital and family therapeutic intervention, in which considering access to power dynamic in the couple's relationship, gender equality, gender roles, and family members hierarchy in the relationship.

The last level is the chronosystem, which refers to the passage of time and cumulative effects on the developing person, and it includes the developmental transitions (Bronfenbrenner, 1986). This parameter fits very well with these study goals of generating solutions for the barriers, those solutions will be generated through a step-by-step plan indicating the needed developments which will have articulated sequence and transition of growth that need to take place for the practice of marital and family therapeutic interventions to be at its optimal effectiveness in KSA.

The remaining elements are language, metaphors, content, and concepts, which revolve throughout the different levels of the ecological human development theory. Language is explained regarding treatment delivery to the target population (Bernal & Saez-Santiago, 2006). Also, it is essential for treatment delivery to be established using culturally syntonic language (Bernal, Bonilla, & Bellido, 1995). Arabic is the spoken language in KSA. Therefore; education,

training, and future development need to make resources more available in Arabic and the translations' of resources to be more syntonic to the culture.

The metaphors element is the category that refers to shared concepts and symbols (Bernal, Bonilla, Bellido, 1995; Bernal & Saez-Santiago, 2006). Dwairy (1997) discusses that non-Western clients bring forth imaginative experiences that need not be treated as pathology since clients describe their concerns in physical and metaphoric manner. Viewing metaphoric language as a way to understand descriptions of the concern may require closer attention in training Arabs and Saudi psychotherapists.

Moreover, since the Arabic language is very rich in metaphors, practitioners in training will benefit from exploring the use of religious and cultural sayings. Symbols that are full of constructive messages about parenting and marital relationships. Moreover, practitioner's training need to be attentive to cultural and societal deconstructive metaphors that encourage abuse and devalue women as well as the idea of equalities in the marital relationships.

The content element refers to knowing about cultural values, customs, and traditions of the ethnic and minority in the population; as well as to incorporate it into assessment and treatment planning (Bernal, Bonilla, & Bellido, 1995; Bernal & Saez-Santiago, 2006). When clients and therapists share the same background, the content dimension of understanding cultural values and tradition concerning the content is less important (Bernal, Bonilla, & Bellido, 1995). As an Islamic country, KSA draws its principals from the teachings of the Quran (holy book) and the Shari'ah (Islamic law) (Office of the Royal Embassy of Saudi Arabia, 2013). Despite the fact that almost all practitioners are familiar with the basic Islamic teachings in KSA, specific attention might necessitate adaptation to working with different degrees of religiosity,

varying practice of adherence to traditional and, societal customs which requires attention in the training of practitioner dealing with relational cases.

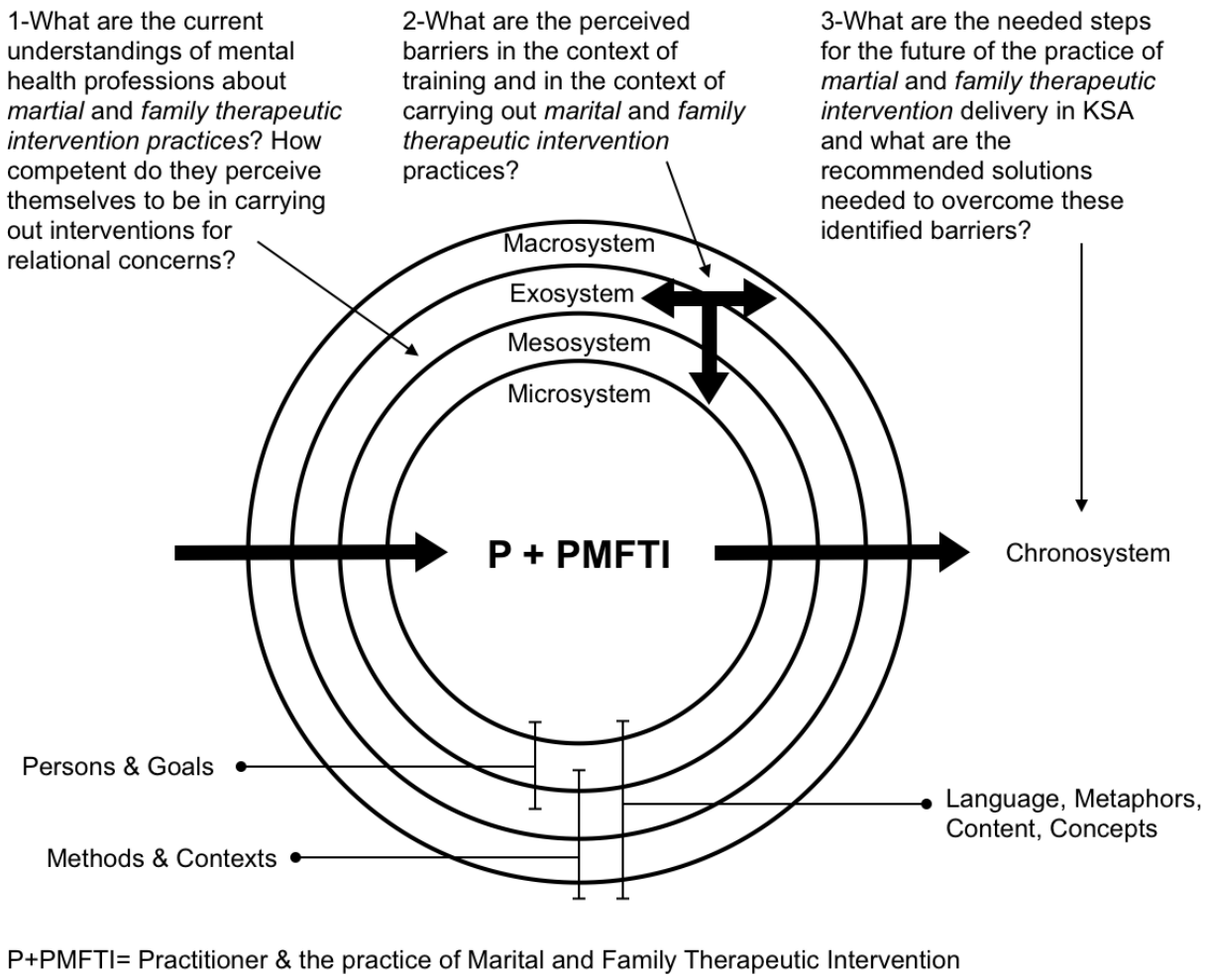


**Figure 1.1:** Combined Theoretical Conceptual Map

In viewing the content of training in a non-Western context, it will be helpful to understand the recommendation of adequate training regarding what specific content needs consideration in the training of Saudi practitioners working with couples and families; plus, the usual standard training curriculum. For example, how to prepare practitioners to work with client hesitation in sharing personal information with a stranger, how to work around specific cultural

customs regarding the presence of male guardianship of women (muhrum), and how to address culturally sensitive issues such as gender segregation.

The concept element refers to the way of conceptualizing and communicating concerns with clients (Bernal, Bonilla, & Bellido, 1995; Bernal & Saez-Santiago, 2006). According to Bernal and Saez-Santiago (2006), congruency between culture and concept is essential in that the theoretical models are attuned to the client's culture in understanding and communicating the problem to foster treatment efficacy. Congruency to the culture is of particular importance in KSA as the Saudi society is conservative and patriarchal, which stands in stark contrast to many Western societies, where concerns about gender including equality, resources, power, roles, and responsibilities are taught overtly in training programs. In Saudi society, this issue should be approached with more caution and sensitivity towards traditional cultural views.

Regarding training, one can speculate that if the Western model is delivered to trainees without addressing how applicable concepts fit with Islamic principles and cultural norms, problems will then inevitably occur, and these problems may end up sabotaging the training in its entirety. For example, Daneshpour (2012) draws attention to how equality in gendered relationships from an Islamic perspective, is viewed, as although men and women are equal in Islam, each have different roles and responsibilities which are to be treated as complementary to one another and not based on superiority or inferiority.

The ecology of human development theory and the cultural adaptation elements offers a framework that will help to illustrate the current practices, different factors contributing to hindering the development of the practice of marital and family therapeutic interventions. Further, the combination of those two frameworks will be a great asset in clarifying the needed

adaptation regarding transferring professional cross-cultural standards of practice and training of practitioners working with couples and families from a Western context to a non-Western context.

## Research Questions

The main research questions guiding this study are illustrated in figure 1.2, the questions are as follows:

1-What are the current understandings of mental health professionals about *marital* and *family therapeutic intervention practices*? How competent do they perceive themselves to be in carrying out interventions for relational concerns?

2-What are the perceived barriers in the context of training and in the context of carrying out *marital* and *family therapeutic intervention* practices?

3-What are the needed steps for the future of the practice of *marital* and *family therapeutic intervention* delivery in KSA and what are the recommended solutions needed to overcome these identified barriers?

## Definition of Terms as Used in the Study

In the context of this study, the following terms are defined as follows:

**Mental Health Professionals:** refers to professionals from many disciplines involved in the delivery of mental health services. They include psychotherapists, clinical psychologists, marital and family therapists, counselors, and clinical or medical social workers. Also, medical doctors such as psychiatrists and family medicine physicians who deal with mental health concerns, are also among the mental health professionals in this study.

**Family Therapy:** refers to the psychotherapeutic approach of treatment that focuses on the system as a whole and how events and patterns are connected. It aims to bring change to the whole system or part of it to make shifts and shift problematic patterns.

**Marriage Therapy:** refers to an approach to treatment that targets the couple as a system. Its various theories range from exploring the family of origin and implementing different strategies that aim to help couples reach understanding and healthier pattern of interaction.

**Marital and Family Therapist:** refers to professionals who have obtained degrees and training in MFT. They practice with the notion of interconnectivity of the parts of the systems, by influencing at least one part of the system that will affect the other parts.

**Marital and Family Therapeutic Intervention Practices:** refers to techniques and strategies that acquired from couple and family therapy concepts, theories, and modules that are utilized to bring change to the system of the family. In the context of this study, the initial use refers to those who are carrying interventions delivered to children, couples, and families that practiced by those who have the academic and training qualifications, as well as practitioners with minimum or no qualifications. The term is meant to be used with less description to elicit participants' perception and beliefs about the topic.

**Counseling vs. Therapy:** counseling in Arabic means (*Irshaad*), which means advising and guidance. Therapy (*Alaij*) refers to actions or strategies that are taken to produce healing.

A range of individuals from paraprofessionals to professionals can practice counseling. On the other hand, therapy refers to actions that are carried out by professionals who undergo excessive training and deliver interventions out of an informed best practice and evidenced-based treatment bring more healing and change.

## Summary and Overview of the Dissertation

The increase attention given to the existence of relational concerns in KSA demands that professionals who are practicing marital and family therapeutic intervention to have a clearly articulated vision of the standards of professional practice and training. It is essential to understand the current perception of what is known about the practice and the competencies involved at present in delivering marital and family therapeutic interventions.

Experts' opinion are critical in reaching consensus on what the current and ideal professional standard, current training status, context barriers to training and delivery of interventions, and identifiable feasible solutions; the previous studies have addressed the existence of this problem. The current study articulated ways of overcoming barriers and identifying solutions for reforming the standard of professional practice to training and interventions that meet the needs of couples and families. This exploratory investigation is critical since it takes into account the cultural and societal context specific barriers, and seek experts to identify how to maneuver those obstacles that come from insiders.

## Dissertation Organization

The remaining chapters are organized as follows: chapter two covers the first manuscript titled: "Marriage and Family Therapy in Saudi Arabia: An Online Survey of Professionals': Perceptions and their training and practice." Chapter three covers the second manuscript titled: "Awareness and Preparedness of Mental Health Professionals in Saudi Arabia: Marital and Family Interventions." Furthermore, phase two of the study is covered in chapter four, which is the third manuscript titled: "Professionals Training and Services in Mental and Social Health in

Saudi Arabia: A Modified Delphi Study." The dissertation concludes with the conclusions, implications, and future work.

| Research Question | Ecology of Human Development Theory | Linkage to Concepts of Cultural Adaptation | Research Goals |
|---|---|---|---|
| 1- What are the current understandings of mental health professionals about *marital* and *family therapeutic intervention practices*? How competent do they perceive themselves to be in carrying out interventions for relational concerns? | Microsystem<br>Mesosystem | Persons & Goals<br>Methods & Context<br>Language, Metaphors, Content, & Concepts | - Uncover current thinking of MHPs about their beliefs, attitudes, and perceptions of the practice of marital and family therapeutic interventions.<br>- Aims to gain insights about MHPs own evaluation of their training, satisfaction, and competency delivering relational interventions.<br>- Gauge MHPs own evaluation of barriers to building therapeutic relationship. |
| 2- What are the perceived barriers in the context of training and in the context of carrying out *marital* and *family therapeutic intervention* practices? | Exosystem<br>Macrosystem | | - Intent to pull together experts collective wisdom to identify contextual barriers such as cultural, societal, and beliefs system.<br>- Target to identify linkages between current therapeutic relational intervention practices to legal system, training and educational institutions, professional standard of practice, licensure system that might contributes to the barriers. |
| 3- What are the needed steps for the future of the practice of *marital* and *family therapeutic intervention* delivery in KSA and what are the recommended solutions needed to overcome these barriers? | Chronosystem | | - Aims to generate experts' feedback on some of the needed initiatives to foster the future development of effective marital and family therapeutic practice. Moreover, the goal of this question is to determine what solutions needed to improve interventions to specific family health concerns and to improve policy and decision making in regard to mental health standard of professional practice in providing care for couples and families. |

**Figure 1.2:** Research Questions, Goals, and Linkage to Concepts of Ecology of Human Development Theory & Cultural Adaptation

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## CHAPTER 2: MANUSCRIPT I

### Marriage and Family Therapy in Saudi Arabia: An Online Survey of Mental Health Professionals' Perceptions of their Own Training and Practice


## ABSTRACT

This research focuses on the emerging profession of Marriage and Family Therapy (MFT) in the context of Saudi Arabia. There is a lack of literature on MFT and the training of psychotherapists and family interventionists in this country. Data gathering was conducted via two online surveys, with 221 mental health professionals in the first survey, and 147 in the second. The findings of the first survey generated themes describing mental health professionals understandings of MFT and identifying their views of the core concerns that MFTs handle. Results show that while 49% agreed that there are inherent global conflicts between the mental health practices between the East and the West and that there is great deal of misconceptions in MFT practice. The second survey provides insight into the current training, supervision, psychotherapists and MFTs perceptions on their personal proficiency, and common used theoretical orientations of MFTs in Saudi Arabia. A number of recommendations are provided that will improve the skills and competencies of mental health providers in Saudi Arabia.

## Introduction

Little is known about the practice of delivering mental health care specifically to couples and families in the Kingdom of Saudi Arabia (KSA). Due to well-documented marital and family difficulties in the country (Afifi, Al-Muhaideb, Hadish, Ismail, & Al-Qeamy, 2011; Al-Eissa & AlMuneef, 2010; Bohlaiga, et al., 2014; Edoseri, Tufts, Zhang, & Fish, 2014; Fageeh, 2014; NFSP, 2013; Tashkandi & Rasheed, 2009), it is important to incorporate the Marriage and Family Therapy (MFT) profession into mainstream mental health care in KSA. There have been several studies/publications in varying countries related to MFTs working with Muslims or Arab populations including those living in Western countries. These Muslim majority countries include Iran (Moghadam, Knudson-Martin, & Mahoney, 2009; Khodayarifard & McClenon, 2011), Pakistan (Naeem, Waheed, Gobbi, Ayub, & Kingdon, 2011), and Turkey (Ozerdem, Oguz, Miklowitz, & Cimilli, 2009). While these studies may inform implementing MFT in a predominantly Muslim society, there are many differences between varying Muslim countries, such as languages spoken, variety and types of expressions of culture and customs, and other historical and political differences that shape the experience of Muslims and Arabs across the globe. In this study, I specifically describe the state of MFT in KSA.

KSA was unified and established in 1932, and it is located in Southwest Asia (MOFA, 2015). The official religion of the country is Islam (The Saudi Embassy, 2015). Moreover, KSA has 13 provinces (MOFA, 2015), and each of these provinces represents a slightly different cultural context, such as different dialects and cultural customs. KSA population is 29.196 million; slightly more than thirty percent of the population are less than 15 years old (WHO, 2013).

The increase in oil prices that took place in the mid-1970s leads to a significant growth in the country's economy (MOFA, 2015). This sudden and rapid economic growth along with globalization have had a substantial impact on the Saudi families as a whole including strains in marital relationships (Al-Khateeb, 1998; Pharaon, 2004). MFT as a profession does not exist in KSA at this time, yet it is needed and as a result, it is delivered in some format to families and couples. However, because of the lack of existence of a formal profession, MFT is unregulated and practiced with few guidelines and little monitoring.

**Specific Needs for Marital and Family Interventions in KSA**

Mental health concerns for adults and children, addiction, domestic violence, and other chronic conditions come with relational components that affect the lives of individuals, couples, and families. Those mentioned concerns and others place a toll on Saudi families when those challenges exist in a context lacking proper resources to ameliorate these concerns. The good news is that MFT have been shown to be effective in intervening with many of these problems (Sprenkle, 2012).

**Adult Mental Health Concerns.** A number of mental health concerns exist within a family context. For example, family difficulties are listed as one of the reasons that drive individuals to use more substances, and this overall has implications for family relations (Koenig et al., 2013; Albrithen, 2006; Bassiony, 2013). Clients with chronic drug addiction; as well as, those with chronic psychiatric disorders stay longer than expected in treatment when families refuse to take them home (Al-Habeeb & Qureshi, 2010; Al-Zahrni, Al-Qurni, & Abdel-Fattah, 2013). Furthermore, clients with chronic illness who do not receive proper interventions can cause strain on the entire family system. This works both ways; for example, children who are

terrorized by their parents manifest as children with chronic illness (Elarousy & Al-Jadaani, 2013).

Other mental health conditions are associated with gender and the role of women in families. For example, a mental health condition that females in families encounter is Postpartum depression (PPD), which has been associated in many cases with family and marital problems (Alasoom & Koura, 2014; Al-Modayfer, Alatiq, Khair, & Abdelkawi, 2015). At times, PPD and domestic violence (DV) coexist. Findings on females who screened positive for PPD reported that 11% experienced family violence compared to 5% in those who screened negative for PDD (Al-Modayfer et al., 2015).

Intimate partner violence is also a big problem for women in many countries. The World Health Organization (WHO, 2013) estimates that in the region of the Eastern Mediterranean, intimate partner violence toward females is about 37%. In a cross-sectional survey study in the city of Jeddah with 2301 participants, findings indicate that there is 34% lifetime prevalence of DV (Fageeh, 2014).

There is an overlap in studies examining DV, child abuse and neglect, and family relationships. Elarousy and Al-Jadaani (2012) studied 60 children aged 12-18 years old. When these children were asked if father hits mother in front of them; participants answered (21.7% usually, 8.3% sometimes, and 11.7% rarely). When they were asked if the father yells at the mother in front of them they responded (10% usually, 6.7% sometimes, and 6.7% rarely). Although it is surprising that physical attack reports are higher than screaming, these numbers indicate that DV and marital conflicts are witnessed by a sizable number of children and adolescents in this study, which likely impacts their mental health.

**Child and Adolescent Mental Health.** Reviews of the literature about children and adolescent mental health concerns and family-related stressors in KSA indicates that prevalence rates of mental health concerns of children and adolescents are slightly above 15% (Mahfouz et al., 2009; Al-Gelban, 2009). Anxiety disorder is a commonly reported child mental health disorder (Desouky, Abdellatif, & Salah, 2015; Al-Gelban, 2009; Al-Gelban, Al-Amri, & Al-Mostafa, 2009; Mahfouz et al., 2009; Al-Gelban, 2007), while depression is also common (Al-Haidar, 2003 ). Another diagnosis commonly given to children is related to intellectual disability which constitutes 30% of all diagnoses (Al-Habeeb, Qureshi, & Al-Maliki, 2012). Desouky et al., (2015) discuss the high prevalence of the mental health diagnoses among female adolescents which are hypothesized to exist due to parents' expectations along with parenting practices in a conservative community such as KSA. Additionally, the high prevalence of child and adolescent mental health concerns might have to do with the stress that is placed on the Saudi families due to the societal and cultural transformation (Al-Gelban, et al., 2009; Al-Gelban, 2007).

Concerning risk factors for child and adolescent mental health in KSA, some research has identified dysfunctional families, family conflict, and divorce and separation as possible stressors and risk factors (Al-Haidar, 2003; Al-Habeeb, Qureshi, & Al-Maliki, 2012). Family disruptions are associated with more behavioral and emotional health difficulties in children, not dissimilar to other cultures. Moreover, other potential stressors faced include multiple marriages, financial problems, residential problems, parenting, and academic concerns (Al-Habeeb, Qureshi, & Al-Maliki, 2012). Other stressors on children include birth order, school type, father education, and mother occupation (Mahfouz et al., 2009). In addition, some have reported that large family size as a possible stressor (Jenahi, Khalil, & Bella, 2012; Al-Habeeb, Qureshi, & Al-Maliki, 2012), in

that families in KSA can be quite large ranging from 5.5 to 8.4 members (Salam, 2013). These topics all warrant more study given that Abdel-Fattah et al., (2004) found no significant association between child stress and number of siblings or birth order, nor parental education level, and father occupation. The same study indicated that children with a working mother are at higher risk for emotional and behavior disturbance symptoms (Abdel-Fattah et al., 2004). Despite whether it is family size, mother's occupation, or parental education these studies indicate cases where familial issues are causing difficulties for children living in KSA and where appropriate marital and family therapeutic interventions will help with these issues. Those factors are reflecting the changes in the structure of the Saudi Arabian families and couple and marital life that needs attention in delivering mental health care.

Since the 1990s there are reports and discussions of child abuse and neglect cases across different regions of the country, and the prevalence of reported abuse started to emerge in more recent studies (Elkerdany, Al-Eid, Buhaliqa, & Al-Momani, 1999; Al-Eissa, 1991; Al-Eissa, 1998; Al Ayed, Qureshi, Jarallah, & Al Saad, 1998; AlMadani, Bamousa, Alsaif, Kharoshah, & Alsowayigh, 2012; Al-Eissa & Almuneef, 2010; Karthikeyan, Mohanty, & Fouzi, 2006; National Family Safety Registry, 2010). These findings indicate that parents are to blame for child maltreatment in 48.9% of the reported cases (Al-Eissa & Almuneef, 2010). In light of these unfortunate realities and since children and youth constitute a high percentage of the population in the country, interventions for parents and parent-child relations are needed including effective MFT evidence-based practices. At this point, due to the lack of regulation of MFT and due to the absence of a distinct MFT profession, not enough is known about these practices and whether families are getting good quality care.

**Professionals' Education, Training, and Satisfaction**

Twenty-five years ago, Al-Mosharraf (1990) recommended in her dissertation study, about the need to establish parental education and family counseling majors in Saudi universities and to implement those services in the community. Twelve years ago, another dissertation study explored the feasibility of introducing family therapy in KSA (Al-Bahadel, 2004). Nevertheless, until the present day, there is only one diploma certificate degree in family counseling at Al-Imam Muhammad Ibn Saud Islamic University, along with a few accredited workshops to train marital and family therapy interventionists.

Regarding modality of care prescribed or recommended in previous studies and reviews, there are few mentions of family therapy for children and adults (Alasoom & Koura, 2014; Al-Habeeb, Qureshi, & Al-Maliki, 2012). There is almost no mention of couple therapy, and even when a suggestion of family therapy arises, its implementation is unclear as to what exactly is being referred to, since MFT practice and the MFT profession is not entirely understood and established in KSA.

The literature on MFTs in KSA is also scattered. The few places in the literature that discusses training and coursework in Saudi universities related to psychotherapy are for the most, focused on counseling, psychology, and social work (review Koenig et al., 2013 for details). While a number of studies have discussed the need to increase and develop more focused clinical training in universities (Al-Bahadel, 2004; Almoshawah, 2005; Al-Habeeb & Qureshi, 2010; Al-Shahrani, 2003; Bin Hussein, 2003; Koenig et al., 2013), there are few studies that explain or explore what supervision or training modalities trainees undergo to develop clinical skills in any mental health discipline. In one study that focused on satisfaction with training and supervision,

Albrithen and Yalli (2013) reported on social workers in the Western region of KSA about their views on the professional training that they received at work; 54.8% agreed that they are expected to perform complex therapy tasks, yet their inadequate training hinders their role performance. Similarly, Al-Shahrani (2003) indicates that social workers are dissatisfied with their training curriculum found in universities in KSA. In another study of 100 mental health counselors in hospitals in KSA, individuals indicated that they were overall satisfied with their personal perceived effectiveness in delivering psychotherapy treatment, yet the study reported that clients want more time during sessions and more staff available for them (AlMoshawah, 2005).

**Purpose of this Study**

From the above review, it is evident that there are many difficulties with mental health services in KSA. While there are widespread mental health and family health needs, as in any society, the training, delivery, and organization of mental health services needs more development and refinement to ensure individuals, couples, and families are receiving effective services. In particular, this study focuses on MFT in KSA and the need to launch the MFT as a profession in KSA and to organize the standards for how these interventions are delivered and by whom.

The aims of this current study are as follow: (a) explore the views and assumptions of mental health professionals in KSA related to what MFT entails in terms of what it offer and what hinders its practice; (b) to learn more about the supervision, training, personal proficiency, and theoretical orientations of current psychotherapists in KSA, and how this training is related to their current practice of MFT.

## Method

Two online-based surveys delivered by Qualtrics software were used for data collection. The first survey targeted general mental health professionals in KSA (defined as any individual working in the mental health field). One of the advantages of asking the mental health professionals is that it targets a larger sample that captures the varied perceptions of the status of the mental health as well as professional understanding of MFT.

The second survey directed specifically to psychotherapists and MFTs who implement interventions in the form of psychotherapy working with children, individuals, couples, and families in KSA. A survey methodology was determined to be the best approach to finding out more about the beliefs and practices of mental health professionals who identify as MFTs in KSA. Additionally, a survey of practicing psychotherapists and MFT interventionists is utilized to capture the present status of training and practice. This type of methodology has been previously used in conducting similar research (e.g., Nelson and Allred, 2005). The first survey was distributed six weeks before the initiation of the second. The surveys administration time lasted 9 and 15 weeks respectively. The second survey encountered technical difficulties; therefore, it was maintained online for a longer duration of time and participants were asked to use computers instead of mobile devices. The Institutional Review Board of Michigan State University approved this research.

### Participants

The first survey had 315 and the second 226 respondents, who began the survey and 221 and 147 participants who completed the surveys (see Table 2.1). Two participant responses were excluded from each survey due to participants failing to meet the inclusion criteria of being a

mental health professional in Saudi.

**Procedures**

The survey questions were derived from literature and the researcher's personal observations and experience in clinical work and training in both the USA and KSA. Each survey took 12-15 minutes to complete. Moreover, the surveys were available in two languages. To ensure the surveys had content validity regarding the clarity of the content and what each item aimed to assess, four graduate students reviewed each survey. Half of the reviewers were bilingual in English and Arabic and were also asked to evaluate the accuracy of the translation. Changes to the surveys were made based on the communicated feedback.

Participants were recruited for both surveys through KSA social media, such as Twitter, LinkedIn, and Facebook. In addition, some email invitations were sent to recruit professionals who are less active on social media. Flyers were designed to attract potential participants. The advertisements on social media acted as word of mouth and created ripple effects as to the number of respondents interacting with the surveys. As recommended by Dillman, Smyth, and Christian (2014), some strategies were utilized to increase the response rates such as revealing the number of respondents on a weekly basis. Additionally, study flyers were placed in hashtags that might attract known potential participants, tweets to accounts of main mental health events and key professionals utilized as a recruitment strategy. Incentives in the form of $10 electronic gift cards were provided and were sent to each participant upon confirmation of their participation completion.

In addition to gathering demographic characteristic, participants were asked dichotomous, Likert scale, and closed-ended questions in both surveys. The first survey utilized

open-ended questions to explored mental health professionals understandings of marriage and family therapy, concerns or diagnoses that require intervention. Moreover, a dichotomous question was used to determine to what extent mental health professionals believe that there are inherent conflicts between the Western practice of marital and family therapeutic interventions/or psychotherapy and the Saudi culture and customs, and followed by open-ended questions to identify those inherent conflicts.

The second survey explored the views of both psychotherapists and MFT interventionists. The inquiry asked several questions including, a dichotomous question about training in KSA versus abroad, a checklist of the types of supervision received, and Likert scale questions about the degree of satisfaction with the clinical training experienced before working independently with clients, another Likert scale questions about the participants personal proficiency working with each populations (individuals, children, couples, families), and what theoretical orientation they delivered with good proficiency. Furthermore, the second survey used closed-ended questions to explore the present needs for training of psychotherapists and MFTs in KSA to deliver interventions with proficiency to children, couples, and families in KSA.

**Data Analysis**

SPSS version 23 was used to obtain descriptive statistics on demographic characteristic and Likert scale questions. Thematic qualitative text analysis of the qualitative data was conducted using MAXQDA 12; which is a qualitative coding system software. Thematic qualitative text analysis is one of the basic methods of qualitative text analysis (Kuckartz, 2014). Qualitative responses for each of the open-ended questions were read and highlighted similar statements with color codes and initial coding and memos. Next, those initial codings were

retrieved and reviewed, and that lead to the development of the main thematic categories and their subcategories. Moreover, passages were reread line-by-line in addition to utilizing the color codes activation feature, and the word search was used on the data browser to review further codes and make modifications when needed.

Questions that had short answers were analyzed using word-based techniques. Kuckartz (2014) describes that qualitative content analysis offers an interpretive kind of analysis on which is based on human understanding, classifications, and interpretations. Responses to guiding theories were grouped based on pre-determined classifications. Word count was used utilizing the MAXQDA options of retrieving word frequency.

## Results

### Participant Demographics

**Survey I demographics.** Two hundred and twenty-one mental health profession completed part or all of the questions on the first survey. The participants reported belonging to one of the following age group: 22% for (36-40) years old, 21% for (31-35) years old, and 19% for (25-30) years old. The gender division among the participants is 55% female respondents and 45% male respondents. Regarding the current work setting 38% identified working in a medical setting. The larger majority of the participants reported holding bachelor's degree represented by 42%. Almost more than half of the participants have psychology background as reflecting by 32.5% identified themselves as psychologists and 21.5% identified themselves as clinical psychologists. Only 6.5% identified themselves as MFT.

**Survey II demographics.** One hundred and forty-seven psychotherapists and MFTs responded to all or some of the questions regarding the present situation of training and

supervision in KSA. Twenty-eight percent of the respondents reported belonging to (31-35) age range group, and it is the largest age group in this survey. There are slightly more male participants 53% compared to 47% female participants. There is a relatively equal division of reported degree level: 44% (N = 46) reported holding a bachelor's degree and 43% (n = 45) reported holding a master's degree.

Moreover, similar to the first survey, participants reported at times more than one professional job title; therefore, current work settings were not asked for survey two since similar to survey one participants will be working in more than one setting. The largest segment reported their professional job title as mental health counselors by 26% and clinical psychologists by 25%, in addition those who identified as others indicated that they are assistant psychologists. Moreover, only 5% identified themselves as MFT (see Table 2.1 for more details about the frequency and demographic for both surveys). About one-fifth of trainees received their training outside of KSA while the rest received their training in KSA. Moreover, participants were asked if they offer any online psychotherapy. The findings indicated that the majority, 83% do not offer any on-line services and only 17% reported that they do provide on-line psychotherapeutic services.

**Findings from Survey I: Mental Health Professionals Survey**

The results of the first survey responses from the mental health professionals fill in the gap in these three areas: meaning of "marriage and family therapy," concerns or diagnoses requiring marital and family therapeutic interventions, and conflicts around the practice of marital and family interventions in KSA.

Table 2.1

*Frequency and Percentages for Participant Demographics*

| | **First Survey *n* (221)** | | **Second Survey n (147)** | |
|---|---|---|---|---|
| | *n* | % | *n* | % |
| **Age Group** | | | | |
| 21-24 | 25 | 12 | 7 | 6 |
| 25-30 | 39 | 19 | 28 | 24 |
| 31-35 | 45 | 21 | 32 | 28 |
| 36-40 | 47 | 22 | 20 | 17 |
| 41-45 | 25 | 12 | 13 | 11 |
| 46-50 | 11 | 5 | 8 | 7 |
| 51-55 | 11 | 5 | 5 | 4 |
| 56-60 | 6 | 3 | 2 | 2 |
| <61 | 1 | .5 | - -[a] | - - |
| **Gender** | | | | |
| Male | 91 | 45 | 56 | 53 |
| Female | 112 | 55 | 50 | 47 |
| **Current Work Setting** | | | | |
| Academic Institution | 37 | 18 | NA | NA |
| Medical Setting | 83 | 38 | NA | NA |
| Private Practice | 17 | 8 | NA | NA |
| Private Nonprofit Agency | 7 | 3 | NA | NA |
| State or Community Agency | 50 | 23 | NA | NA |
| School Setting | 16 | 7 | NA | NA |
| Others | 11 | 5 | NA | NA |
| **Degree Level** | | | | |
| Ph.D/PsyD or equivalent | 44 | 23 | 13 | 13 |
| Master's degree | 57 | 30 | 45 | 43 |
| Medical degree | 8 | 4 | NA | NA |
| Bachelor's degree | 79 | 42 | 46 | 44 |
| Diploma | 2 | 1 | NA | NA |

Table 2.1 (Cont'd)

| **Professional Job Title or Specialization** | | | | |
|---|---|---|---|---|
| Marriage & Family Therapist | 13 | 6.5 | 6 | 5 |
| Clinical Psychologist | 43 | 21.5 | 29 | 25 |
| Medical Social Worker | 8 | 4 | 10 | 9 |
| Clinical Social Worker | NA | NA | 5 | 4 |
| Mental Health Counselor | 9 | 4.5 | 30 | 26 |
| Psychiatrist | 33 | 16.5 | 5 | 4 |
| Psychologist | 65 | 32.5 | NA | NA |
| School Counselor | 7 | 3.5 | NA | NA |
| Family Medicine Physician | 1 | .5 | NA | NA |
| Social Worker | 10 | 5 | 13 | 11 |
| Others | 11 | 5.5 | 18 | 16 |

*Note.* NA = Not applicable. Some of the categories will add up to more than 100% due to working in more than one setting, or holding more than one job title/specialization.
[a] No participants found for over 60 years old.

**Meaning of "marriage and family therapy."** One hundred and ten statements generated by participants who answered the open-ended question to describe their perceptions of the meaning of "marriage and family therapy." There are five emerging themes related to this inquiry: *Conceptualization* of what is MFT*, concerns* that necessitate the therapeutic interventions*, goals and aims* of the therapy*, procedures of MFT,* and *significance and importance*. Those themes illustrate the perception of MFT by mental health professionals in KSA (see Table 2.2-2.6 for excerpts illustrating the five themes).

***Conceptualization.*** This theme references to ideas, information, or bits of knowledge of how MFT is understood and what theories explain it, as well as the core emphases and references made about how it is viewed. The conceptualizations included references that were made regarding understanding MFT as associated with *theories and models*, and what it *focuses on*, and the use of *counseling* as a synonym term attached to MFT in the participants' descriptions in this study.

Overall, *theories and models* have the largest description associated with the conceptualization theme where participants describe models and assumptions responding to what MFT means as a practice and what theories constitute its makeup. Moreover, from the descriptions of how participants in this study conceptualize MFT, there is an appearance of a focus on the dynamic of the family relationship as a holistic and systemic approach. Moreover, there is an emphasis on patterns of how family members related to one another. Further, the use of the word "counseling" as a cross-referenced to MFT is documented as a synonym, with only one exception, where one participant was indicating that it is higher than counseling. It is important to note that the word "counseling" means guidance and giving advice that might have

cultural specific implications (see Table 2.2).

***Concerns.*** Several concerns were raised related to MFT practice especially related to two sub-themes: *marital* and *family relational concerns*. The marital relation concerns reported by the participants: marital discord, marital challenges, marital burden, marital agreement, marital compatibility, marital understanding, and marital differences in personality and communication. There are many references to couple incompatibility and disagreement throughout the responses that discussed concerns that necessitate MFT. Besides partner relationship difficulties, family relation concerns are described as follows: family relation, challenges, stressors, disputes, disturbance, method of communication, and defects in communication. Also, it refers to problems among the members, and difficulties concerning other family members experiencing psychological concern. When participants described concerns, those concerns are often connected with how the concerns addressed through goals and aims of MFT. (see Table 2.3 for excerpts of the second theme).

***Goals and aims of MFT in KSA.*** This theme has the highest description of how MFT is understood by participants. Participants described their views of the *objectives* of MFT and described these *objectives* as the actions that therapists need to do, and/or processes that clients/ families/couples need to enter into in order to restore, improve, raise awareness, gain the ability, teach, guide, acquire, and rebuild. Another goal of MFT and the one most endorsed was the answers that refers to providing *solutions* and helping families to overcome life challenges. Moreover, several participants considered *solving* as reforming and correcting. Participants also viewed MFT as focused on achieving specific types of *results*. They saw MFT as a process that

Table 2.2

*First Theme:Conceptualization for the Meaning of MFT*

| **Excerpt for Conceptualization for the Meaning of MFT: Theories/Models, Focus & Counseling** |
|---|
| **Theories/Models** |
| • Family systems interventions with couples and families |
| • A form of psychotherapy, which means treating marital and family problems using specific scientific theories and specific techniques |
| • Helping people from and within a system context |
| • Enforcement of intellectual and behavioral therapeutic approaches for the treatment of family members or couples by practitioner who received training and mastered it, and is qualified in family or marital therapy |
| • Psychological therapy that deals with the problems of the family and the couple |
| • It is possible for the therapist under this path of psychotherapy follow the psychological therapeutic approaches such as analytical or cognitive or cognitive-behavioral or other known theoretical frameworks |
| • Thoughts and behavior modification |
| **Focus** |
| • …understand the internal relations, or relations and problems between any family member with the other family members |
| • The dismantling of unhealthy patterns of interaction between family members |
| • Trying to distinguish faulty patterns in the dynamics of relationships in particular household and to try to modify it to become more effective |
| • Treatment of family members in a holistic manner to help them overcome the crises and problems |
| • Treatment of the dynamics of the family as a whole among its members |
| • … deal with the case in the field of family as a system and not as an individual, as the case in psychotherapy |
| • Develop a clear picture about marital life and its problems and clarify solutions to the particular situation |

Table 2.2 (Cont'd)

| **Counseling** |
| --- |
| • Is higher than just counseling |
| • Counseling treatment sessions |
| • Family Counseling |
| • counseling advises |
| • Provide counseling |
| • Treatment through best practices in counseling |
| • … within a framework of a psychological counseling or a social one |

Table 2.3

*Second theme of the Meaning of MFT*

| **Excerpt for Concerns: Marital Relation & Family Relational Concerns** |
|---|
| **Marital Relation** |
| • Solving problems among the couple and trying to understand the dynamics of the relationship and its psychological complications |
| • …marital compatibility or understanding, and the ability to express positive feelings |
| • Mean any case that have problematic maladjustment in their relationships functions and methods of communication and relating on the level of couples and how their differences are reflected on the children, in addition; to the differences in their personalities as partners and their ways of communication and understanding |
| • Solving marital discord |
| • Rehabilitation of both sides of each circumstances and challenges they may face during their marriage and also rehabilitation for wife for life circumstances and marital burdens that she faces in her married life as well as the rehabilitation of the husband to bear the burdens in life and management of his marriage and especially financial matters |
| **Family Relational Concerns** |
| • Addressing individual's psychological dysfunction through rebuild the whole family dynamic and help each and everyone knows how to relate to one another without over demanding or over controlling. It's a clinic where the family might get to know each other truly for the first time. It's a clinic of team work that may include a child, teen, adult, and elder |
| • …problems that hinder healthy family relationships |
| • Treatment of family disputes to ensure happiness and health of the family members, whether to stay together or to separate |
| • Treatment for troubled family relationships that began because of defects in communication |

is a vehicle to reach healthy and positive relationships, help with coping and adaptation, and achieve family stability (see Table 2.4).

Also, MFT importance is demonstrated by some of the participants indications that it necessitates more consideration, that it is nonetheless limited in the society, and that it is a delicate specialization and in demands for a legal procedure to be in place upon all intruders. In the participants descriptions about their understanding of MFT they indicated its significance and importance. Participants descriptions of the meaning of MFT demonstrated its importance by plainly stating that it is important, and some participants included terms or descriptions that signal the necessaries of the MFT and further described its benefits such as economic gain and for the society productivity. Also described MFT as a practice that had the potential to provide additional indirect benefits such as its prevention benefits for a more secure generation (see Table 2.5 for excerpts of the fourth theme).

***Procedures of MFT practice.*** Descriptions of the understanding of MFT also described its procedures. Participants viewed the *process* as crucial, and some described who *gets involved* in the therapy. Finally, participants discussed the *training and skills* required to do an effective family intervention. They were concerned that many unqualified individuals were engaged in this practice and that this was of concern in that MFT practice involves non-professionals (see Table 2.6 for excerpts of the fifth theme).

**Concerns or diagnoses requiring marital and family therapeutic interventions.** The second area regarding MFT, participants were asked: “In your opinion, what concerns or diagnoses require marital and family therapeutic interventions?” One hundred and four

Table 2.4

*Third Themes of the Meaning of MFT*

| **Excerpt for Goals & Aims of MFT in KSA: Objectives, Solving/Solution/Overcoming, & Results** |
|---|
| **Objectives** |
| • The ability to help spouses and family in solving their problems in ways that are professional and specialized which help them acquire special skills to adapt and modify the difficulties that they face |
| • Treatment of family members in a holistic manner to help them overcome the crises and problems and build adaptive communication skills and handling one another in a healthy manner .. etc |
| **Solving/Solution/Overcoming** |
| • Family therapy helps to provide solutions for communication, resolving disputes, and form positive relationship between the family members through a directed method /Marital, aims to form a positive relationship between the couple and deals with all matters relating to the couple own medical, mental, social health, and other within a framework of a psychological counseling or a social one |
| • Reform between the two individuals for the sake of preserving the marital relationship and address the problems that hinder family members relationship |
| **Results** |
| • Marital and family therapy is a therapeutic intervention that targeted family members to help them to understand each other and improve their ability to show their feelings and their needs properly and improve their communication with one another in order to make a positive change in the relationship and among them |
| • Family reaching stability and better understanding of the problem and it open new horizons for them to find solutions that suit them to reach their desired goal |

Table 2.5

*Fourth Themes of the Meaning of MFT*

| **Excerpt for significance & Importance: Importance & Indirect Benefits** |
|---|
| **Importance** |
| • Family therapy is evident by its name that it focuses on the family as the unit of treatment and not the individual patient. Meaning that the therapist or the counselor deals with the family as a whole. The main conceptualization upon which this type of treatment operate is that it is more logical and more economic successful that we deal with all individuals involved in the nuclear family… |
| • Very, very important and currently an essential pursuit, and it is important to find specialists that are scientifically qualified individuals and to take strict legal action to stop all intruders on this sensitive specialization. |
| • A realm of psychotherapy, which has became necessary in the Arab societies and specially in Saudi Arabia for its importance. |
| **Indirect Benefits** |
| • A therapeutic line to directly keep the family cohesion, and indirectly maintain the integrity and effectiveness of the community |
| • Contributing to the prevention of future generations and create a generation that have a more secure psychological health |
| • Formation of family that are harmonious and productive in the society |

Table 2.6

*Fifth Themes of the Meaning of MFT*

| **Excerpt for Procedures of MFT: Process, Who is involved, & Practice Specification & Requisite** |
|---|
| **Process** |
| • The cooperation of among all, the psychologist and the client and his/her family in identifying the problem and in establishing a suitable treatment plan<br>• And the task of the counselor or therapist is to work to change the troubled family relations among the family members in such a way so that trouble or targeted behaviors for treatment can disappears |
| **Who is involved** |
| • More than one individual participate in the therapeutic relationship according to a list of problems and treatment goals<br>• Help the couple or family members in a problem by brining one or more family member with another member within the system. |
| **Practice specification & Requisite** |
| • Enforcement of intellectual and behavioral therapeutic approaches for the treatment of family members or couples by practitioner who received training and mastered it, and is qualified in family or marital therapy<br>• Bad and staffed by non-specialists |

participants responded to this open-ended question. There are four main themes of responses: *marital relationship, family relational problems, children and adolescents concerns, and culture-related family difficulties***.**

***Marital relationship.*** Many respondents viewed the marital relationship as an important area of intervention for MFTs. They raised concerns related to couples communication including disagreement, ineffective communication, and silence, and other identified areas of general concern including problems of neglect, second marriages issues, suspicion/jealousy, and most commonly mentioned, issues related to couples' incompatibility (mismatched family upbringing and educational backgrounds). In addition to these marital concerns, many respondents described difficulties related to divorce in KSA bringing up the issue of emotional or silent divorce in addition to keeping the wife in the marriage despite her wanting to get a divorce. This type of practice occurs when a male party abandons his wife but does not grant her a formal divorce despite her requests for divorce. This leaves her in a state of stuckness and in many cases she is powerless to alter this situation. Another concern raised by participants were related to sexual issues in the marital relationship including marital infidelity, betrayal, and sexual concerns. One participant noted that because of gender roles, some women live in marriages where they are not satisfied sexually or emotionally.

***Family relational problems.*** Respondents viewed MFTs as well suited to treat family relational difficulties including family disputes and disagreements among family members, helping to heal cut-offs, and communication difficulties. In addition, some participants viewed MFTs as important in treating mental illness or addiction specifically related to family functioning. These were viewed as "psychological problems of the family members that are

caused by the interaction of family, or can benefit one of the family as a supportive treatment …as well as the psychological conditions which are suffered by a family member that affect the rest of its members" (direct quote from one participant). In addition, some respondents brought up the issue of domestic violence as occurring in some relationships in KSA. These concerns include both violence within the marital relationship as well as violence from parents directed to children. MFTs were seen as essential in preventing/intervening in this violence as well as helping victims overcome the aftermath of the violence.

***General children and adolescents concerns.*** MFTs were also seen as well suited to treat general problems of childhood including issues of child abuse and neglect, parent-child relationship difficulties, and parenting concerns. Participants also viewed MFTs as well suited to help children deal with stressful life events including family problems and life-threatening physical illnesses.

***Culture-related family difficulties.*** Some respondents brought up the issue of culture and cultural clashes that bring about difficult family problems. For examples, some respondents discussed cases where family members did not or refused to conform to Saudi customs and traditions and that this was an area where MFTs could be effective. Suggestions were raised that MFTs could help the individual to conform or that the MFT could help the family as a whole be more flexible in dealing with the family member. In addition to the above-mentioned specific items that came up regularly in responses, some participants also raised other general issues where MFTs could be effective. These issues included self-esteem, stress, work-related problems, loss, and anger management. In addition, one participant raised homosexuality as a concern, as individuals negotiated this reality in the Saudi culture.

**Conflicts around the practice of marital and family in Saudi Arabia.** One of the questions on the survey was related to practicing marital and family therapy, as largely Westernized forms of treatment, in Saudi Arabia. Out of the total surveyed, 140 responded to the question about the inherent conflict between the Western practice of marital and family therapeutic interventions, or psychotherapy and the culture and customs of Saudi society. Results show that 49% agreed that there are tensions between the two while 51% disagreed that there are inherent conflicts. Those who agreed that there were conflicts were asked to expound upon this by responding to an open-ended question. Of the 49%, who agreed there was a conflict, 54% provided more details about their views of conflicts around the practice of marital and family therapeutic interventions in the Saudi society.

***Eastern/Western differences.*** Participants provided views on the inherent conflicts between the East and the West as well as on the need for adaptations in the process and practice of therapies developed in the West. *Conflicts* refer to statements regarding differences or difficulties in implementing the practice of marital and family therapy interventions in KSA. Some participants viewed Westernized approaches as completely incongruent with Saudi Arabian culture. These individuals believe that there are simply too many clashes between the customs and traditions amongst Arab peoples and foreigners/Non-Arab. These participants viewed misconceptions about families between Western and Eastern societies and how these created conflicts. For example, one participant raised the concern that family structures differed completely with Western families characterized as open systems, but Saudi families as closed systems with structures very different from families in the West.

Other participants described the need for *adaptation*. This idea refers to the adaptation of

Westernized concepts and interventions in a way that would help them to fit better with Saudi culture. Suggestions were to adapt the Western interventions in a way that they would fit with the Arabic conservative Muslim society. Others suggested adaptations that took Eastern societal contexts into account. Other participants also mentioned *societal/cultural* issues including the societal and cultural barriers, such as awareness, acceptance, and cultural and custom; commonly discussed societal and cultural level of concerns are referencing to gender issues. In terms of awareness, participants did not believe that Saudi culture was aware enough of mental health concerns and how to receive help from them in such a way that individuals would benefit from interventions. Stigma was highlighted as a real challenge for individuals visiting mental health clinics secretly, or staying away even though there is a great need. Participants highlighted that individuals view mental health conditions as belonging to individuals who are disturbed or abnormal, fearful, and withdrawn.

Moreover, participants indicated that customs, traditions, and the culture act as barriers to effective work. Gender power differences in relationships were often raised as of concern. These included gender role differences in Western compared to Eastern cultures, and male/female differences when it comes to attending and disclosing in therapy. These concerns included cultural gender concepts getting in the way of the structure of treatments and male dominance and control which could affect therapy and place the therapist in an awkward situation.

Another major concern raised was related to the profession of MFT. Concerns related to this were related to resources, confidentiality, and privacy issues. Participants discussed the lack of available resources in terms of the lack of available centers and practitioners. Others raised concerns about issues of privacy, secrecy, and the fear of being exposed by a breach of their

confidentiality. Participants describe a real fear of the lack of the therapist commitment to the confidentiality of information. In terms of the professionals themselves, participants discussed in terms of professionals there is the lack of adequate qualifications and credentials that specify who is a competent and qualified to practice. Participants discussed the existence of intruders, non-professionals who deliver interventions. These include individuals who call themselves family consultants, individuals who are academically not qualified, not trained, and do not have standards of professional ethics. They are wrongly practicing which leads to distorting the reputations of others who are professional and hold to ethical standards. Additionally, the general public, unfortunately, confuses unqualified consultants and family therapists since they cannot distinguish between them.

**Findings from Survey II: Psychotherapists and MFTs**

Survey II explored responses to questions about family therapy practice from those qualifying psychotherapists and MFTs in KSA. Since, one of the aims of this study is to determine the present status of training, supervision, and competencies of current psychotherapists and MFTs it was imperative to ask them separately to identify some characteristics of psychotherapists and MFT. Therefore, this second survey targeted precisely this group. The bulk of the responses fell into three categories: training and supervision of qualifying individuals to practice, future training needs, and theories guiding practice.

**Training and supervision.** Three questions explored this area asking participants to identify their clinical training and supervision. Participants were asked if they are satisfied with the clinical training that you received prior to working independently with your clients (individuals, children, couples, families). The survey defines working independently as

delivering psychotherapeutic interventions without live or direct monitoring during the session. Clients indicated as any or all of the listed population: individuals, children, couples, and families. Of the training received, satisfaction varied with 41% reporting satisfaction with the training, 44% saying that they were somewhat satisfied, and 15% dissatisfied.

**Proficiency as a result of training and supervision.** Participants were asked to rate their personal proficiency as a result of the training and the supervision they received for delivering interventions for each population (individuals, children, couples, families), on a 5-item Likert scale which ranged from "excellent" to "not applicable." The rating of "good" received the highest rating in delivering interventions in the following order: (63%) for Individual, (50%) for families, (48%) for couples, and (45%) for children. "Poor" was reported by (3%) for services provided for each of the population of children and families, and (1%) for couples, and none indicated ratings of "poor" for services provided to individuals. Along the same line, children followed by couples scored the highest on "fair" and "poor" regarding participants proficiency of practice to these population. Additionally, (7%) of participants responded with "not applicable" in regard to their training and supervision to work with children and couples.

Regarding gender differences, more female participants responded with "not applicable" regarding their satisfaction with the training and supervision they received working with different populations as follow: individuals by (3%), children by (10%), couples by (13%), and families by (7%). On the other hand, male participants responded with "not applicable" for working with children by (5%) and couples by (3%). On the other hand, (33%) of females participants indicated ratings of "excellent" about training and supervision received for working with children compared to (18%) of male participants. Along the same line, males reported

(28%) as “fair,” and (5%) as “poor” compared to females who reported (10%) as fair, and none reported poor.

On the other hand, regarding working with couples, male participants reported slightly more ratings of “excellent” and “good” (28% and 51%), and none reported “poor.” On the other hand, female participants reported (20%) “excellent,” (43%) “good,” (13%) “not applicable," and (3%) indicated “poor.” Regarding working with families, male participants reported (38%) as “excellent,” (41%) as “good," and (18%) as “fair,” and (3%) as poor. Female participants reported (21%) as “excellent,” (62%) as “good," and (7%) as “fair,” and (3%) as “poor,” and (7%) as “not applicable.” This illustrates that there are some gender differences regarding satisfaction in clinical training and supervision that are delivered to children, couples, and families (see Table 2.4 for more details).

Moreover, 72 participants checked on the survey all applicable forms of supervision that they experienced before independently working with their clients. The following are the items in the order from most to least experienced as a type of supervision by therapists in KSA: 24% individual case consultation supervision, 20% shadowing, 15% group case consultation supervision, 11% direct live supervision via audio and equally 11% classroom role-playing, 9% videotape supervision, 6% two-way mirrors or television monitors, and 5% indicated others. The written specifications for those who checked the other category are as follows: received their supervision through the internet, workshops, readings in English, and three elaborated briefly about their shadowing experience. As can be seen from these findings, individuals are receiving a range of training experiences.

Table 2.7

*Personal Ratings of Proficiency as a Result of Training and Supervision*

| % of Personal Ratings of Proficiency | | Population | | | |
|---|---|---|---|---|---|
| | | **Individual** | **Children** | **Couples** | **Families** |
| **Excellent** | | | | | |
| | % Overall | 28 | 25 | 25 | 31 |
| | % Male | 30 | 18 | 28 | 38 |
| | % Female | 26 | 33 | 20 | 21 |
| **Good** | | | | | |
| | % Overall | 63 | 45 | 48 | 50 |
| | % Male | 57 | 44 | 51 | 41 |
| | % Female | 71 | 47 | 43 | 62 |
| **Fair** | | | | | |
| | % Overall | 8 | 20 | 19 | 13 |
| | % Male | 14 | 28 | 18 | 18 |
| | % Female | 0 | 10 | 20 | 7 |
| **Poor** | | | | | |
| | % Overall | 0 | 3 | 1 | 3 |
| | % Male | 0 | 5 | 0 | 3 |
| | % Female | 0 | 0 | 3 | 3 |
| **Not Applicable** | | | | | |
| | % Overall | 1 | 7 | 7 | 3 |
| | % Male | 0 | 5 | 3 | 0 |
| | % Female | 3 | 10 | 13 | 7 |

**Training needs.** Participants were asked to reflect on their training and on the best training practices and needs that will foster proficiency in psychotherapeutic interventions for children, couples, and families in Saudi Arabia. Participant responses fell into two categories. First, several commented on the *needs* related to improving training, while some also discussed their views on the *current status* of training.

In terms of *needs*, participants mentioned six areas that ideally should be developed to improve the training experience in KSA: *Field/practical experience; duration of training; supervision; the specialists and supervisors and trainers themselves; workshops;* and *establishing centers/programs.* These responses all reflect on the need to increase and intensify the depth of training experiences that students receive. Suggestions for this were plentiful including better internship experiences, more hands on training (e.g. role plays), subjecting trainees to their own personal therapy. Besides, participants viewed the length of training as inadequate. Participants stated the need for a longer and an increase in the *duration of training*, some specified full year, to acquiring over thousand hours, and ongoing training. In addition, participants called for more in the field training, and a complete intensification of the curriculum.

Participants also highlighted the need for improvements in supervision and training. The most discussed sub-themes in terms of frequency of the segments are *supervision* and followed by the need for a *qualified specialists, supervisors, and trainers*. Participants discussed the need for direct supervision and follow-up with supervisors. Moreover, participants want supervision that is adequate, and which is delivered by experts who are qualified and certified (credentialed) and who bring experience and seniority to the process.

In addition, participants recommended that there is a need for more *workshops*, which are

intensive and specific. Participants viewed the opportunities for in-depth training as lacking. They also see a need to establish more training centers with a focus on quality training and scholarship.

The second theme, which emerged is participants' discussion of the *current status* and the way ahead for therapist training. These respondents viewed therapists in KSA as lacking experience and efficiency. They viewed training as a whole to be sub-standard and believed that there is an urgent need for improved training. About half of participants reported providing supervision. Though, training in these two areas is lacking.

**Theories guiding practice.** Participants were asked to list their main theoretical orientation that they deliver with excellent to good proficiency. Respondents endorsed three theoretical categories, and an additional observations category. The first category is *couple and family theories.* Overall, only 4 participants out of 54 responded with answers that indicate models, theories, or names related to MFTs. Bowen and Structural theories were each mentioned twice; Strategic, Systematic, and a family therapy pioneer Virginia Satir, each was mentioned once.

The second category is *theories other than MFT*. Participants endorsed non MFT theories as follows: CBT (30), Behavioral (13), Psychoanalytic (8), Cognitive (7), Humanistic (5), Ellis/ REBT (4), Reality/Choice Theory (3), Intrapersonal (2), Roles Theories (2), and others. The other included theories or names that were only mentioned once such as Commitment and Acceptance Theory, logotherapy, Pavlov's Theory, Thorndike, Personalities Theories, Social Pattern Theories, and the Theory of Role-playing.

The third category constitutes the *population* that therapists work with using a particular

form of therapy. Four responders answered the questions indicating what theory they use and its applicability to a particular population, including Behavioral therapy for children, Play Therapy for children, train parents on parenting skills, and Emotional Theory for couples.

Furthermore, some additional observations are worth pointing out in the results. The other observations are findings from respondents who did not name theories or mentioned the use of methods as connected to a particular population. The following were observed: four participants just wrote only numbers indicating how many theories they use instead of naming the methods. Others, provided a description or the modality of therapy that they use without the mention of the model or theory such as follows: family counseling, group therapy, crisis intervention, indirect counseling, short-term. Also, some of the descriptions are not very clear for example, play therapy for children might be referring to the use of "play therapy" theories in working with children, or it means interacting with a child using play and activity. Another example is parenting, one participant wrote, “General parenting principals from the general culture.” Also, some of the participants wrote about being eclectic and integrative which indicates that the therapist does not prescribe to a specific theory. For instance, one of the participants wrote, “It does not depend on a specific theory; you may choose some of the theories depending on what the case needs. For children, of course, behavioral.”

## Discussion

The aim of the research is first, to capture the extent of what mental health professionals understand about MFT in KSA, and what they know about MFTs role in the management of mental health difficulties. The emerging themes from this study portray a picture of perceptions about MFT as understood by mental health professionals in KSA. The second goal was to

explore psychotherapists and MFTs current training and supervision.

The demographic characteristic of this study illustrates that participants in both surveys came from several mental health background such as: MFT, psychology, psychiatry, social work, and counseling. MFT, as demonstrated by this study findings, represent a small portion of respondents with only 6.5% in the first survey, and 5% in the second survey identifying as MFTs. Additionally, bachelor's degree is illustrated to be the larger segment of professionals and practitioners in both surveys. These findings are not surprising in light of the findings of previous research that indicate most mental health professionals in KSA holds undergraduate degrees (Al-Habeeb & Qureshi, 2011).

Robust and realistic expectations of MFT are clearly articulated in the responses about professionals understanding of MFT, as evident by participants discussing the significance and importance of the field. Along the same lines of their knowledge of the particular procedures of MFT processes, including: who receives treatment, and the profession prerequisites. Similarly, there was overlap in the description of the meaning of MFT and mental health concerns related to couple and family relational difficulties. Both inquiries informed the descriptions of the different types of marital and family relational concerns and both are realistically representing concerns that are typically within the lines of the MFT profession modalities of care (AAMFT, 2015).

Moreover, touching on the conceptualization theme, findings on the theories and the models in the participants' descriptions of their understandings of MFT are connected to a particular classification of models or interventions such as CBT, or behavioral modification. These are somewhat concerning since it limited the profession to just a theory or intervention.

Despite this, there were some respondents who mentioned that MFT focuses on the whole and holistic system. Similarly, findings from the second survey revealed that psychotherapists identify their prime theoretical orientation as CBT, Behavioral, Psychoanalytic, and Cognitive therapy. Whereas few MFT theories are named in this current study as the main theoretical orientation by therapists in KSA, only a small number appear to base their work on family systems approaches. This is not surprising since previous KSA studies mentioned supportive counseling, supportive psychotherapy, CBT, behavioral therapy, and psychoeducation as the recommended psychotherapeutic interventions for children and adolescents mental health concerns (Al-Haidar, 2003; Mahfouz et al., 2009; Al-Gelban, 2009). While many therapists are practicing MFT, few are trained in MFT approaches, and many approaches are dated and not the most current ways of working with couples and families.

Additionally, the terms "counseling" and MFT are used interchangeably in professionals' references to MFT. It is worth mentioning that the term used in the Arabic version of the survey is the word "Alaaj," which refers to therapy, treatment, and cure. It is important to note that counseling is "Irshaad" in Arabic, which means to advise, guide, consult, and to give direction. Accordingly, anyone can be a counselor from a religious leader to another family member. Therefore, the use of the word "counseling" in this study about the meaning of MFT may reflect a less than accurate view of the practices and interventions by assuming that MFT is a form of counseling. Despite that, some of the descriptions of MFT meanings mentioned specification prerequisites for providing therapy indicates that some professionals in KSA do believe that MFT requires qualified specialists. According to AAMFT (2015), MFTs are well-experienced professionals who undergo at least 24 months of clinical training. Along similar lines, the need

for qualified practitioners was raised by psychotherapists identifying future training needs in the second survey.

Similarly, the highest description of meaning attached to the understandings of MFT are articulated clearly by the professionals who wrote using keywords that reflect objectives of providing MFT interventions. While, at times the goals and aims are described using words such as to reform and correct, which convey beyond being merely directive in therapy. Being directive in therapy has been recommended at times when working with Arab clients (West, 1987). However, the tone of the use of correcting and reforming may signal a disturbing value-judgement within the provider.

Additionally, response to what mental health difficulties that requires therapeutic interventions generated culturally related concerns, such as gender roles and "not confirming to custom and tradition" that was described as a matter that necessitates therapeutic intervention. Moreover, listing homosexuality as an issue that requires marital and family therapeutic interventions is a huge misconception about MFT.

The idea that there is an inherent conflict in delivering MFT in KSA due to East-West differences is a problematized notion to begin with and has been taking an undeserved magnitude as demonstrated in the findings of this study. Results of this study indicate that 49% of the participants agree that there are inherent conflicts between the Western theories and the practice of marital and family therapeutic interventions in the Saudi society. Themes about the Eastern/ Western inherent conflict demonstrated that there are at times misconceptions about Western societies. The current study findings indicate that only 54% of those who responded agreed that there is an inherent conflict and these individuals provided further clarification by answering the

open-ended questions. Those who discussed the inherent conflict also mentioned the possibility of adapting interventions to make them more suited to Saudi culture. These results support Al-Mosharraf (1990) recommendation about family counseling and parent education in KSA that it should be informed by Islamic principles. Furthermore, different sociocultural issues were raised by participants who provided answers about the East/West inherent conflicts differences. Participants mentioned that stigma, awareness, acceptance, and cultural and custom as some of the challenge, where individuals and families may seek mental health clinics secretly or do not ask for help altogether even though they need it.

The majority of the psychotherapists and MFTs in this study are educated exclusively in KSA, only 19% received trainings outside of KSA. Moreover, the majority of the participants provide face-to-face interventions. Further, the study findings on participants training satisfactions concerning indicated that 41% are satisfaction, while more than half of the participants reported moderately to unsatisfied with their training with 44% of the participants reporting somewhat satisfied, and 15% are dissatisfied.

Moreover, the current study assessed psychotherapists and MFTs preparedness through participants perceptions about their proficiency based on the training and supervision they received for providing services to individual, children, couples, and families. The results indicated that many professionals reported “good” in the following order: Individual, families, couples, and children. The previous study by Almoshawah (2005) conducted on 100 mental health counselors in hospitals in KSA indicates that they are satisfied with their effectiveness in treatment, yet the patients in the study show that they see the need for more practitioners to be available to them and to have more time allocated to them during sessions. Therefore, more

research is needed to assess psychotherapists/MFTs sense of proficiency and actual treatment outcomes.

Other previous studies that explored dissatisfaction is an example of research conducted by Al-Bahadel (2004) found that counselors criticize the concentration on theoretical focus in their education. In a more current study by Albrithen and Yalli (2013) concerning social workers in the Western region of KSA about their views on the professional training that they received at work, 54.8% agreed that while they are expected to perform tasks, they view their training as inadequate and a hindrance to their role performance.

Moreover, the current results indicate that interventions to children, couples, and families are an area that needs attention since 7% of the participants said it is “not applicable” when asked about their training and supervision for those populations. In addition, there are some gender differences when it comes to satisfaction with the training and supervision received for working with children; more females indicated “excellent” ratings and none reported “poor” compare to males who indicated lower ratings. Moreover, slightly more male participants had higher ratings when it came to working with couples. Little is known about ways of handling gender segregation when male trainees are present in clinics that are attended by mothers and children versus if they were attending couple session. Gender power imbalance, consent of guardianship for women, and transportation restriction such as driving ban on women have been discussed in the previous literature for its adverse factors (Pharaon, 2004; Mobaraki & Söderfeldt, 2010). The implications of such unbalance in power need further exploration on how it plays out in the clients-providers building rapport, therapeutic relationship, and alliance.

Furthermore, improving supervision is the most mentioned necessity to foster proficiency

in psychotherapeutic interventions for children, couples, and families in KSA. Moreover, case consultation and shadowing are the most mentioned received types of supervision by the therapists in this study. According to Stewart (2002), case consultation cannot be used in place of live video or audio supervision since it does not adequately represent the benefits from experiencing direct clinical work.

**Limitations.** Although the study revealed and uncovered some preliminary findings of MFT in KSA, there are still some limitations. One of the study limitations is that the study data collection was conducted online; therefore, there is a possibility that some mental health professionals and psychotherapists who are not active on social media were left out. Second, although screening questions were set in place, it is hard to escape the chances that there are no error in the representation of the sample. Third, some participants may have got confused since the first survey and the second survey were conducted simultaneously at one point and shared similar advertisement layout of the flyer. Fourth, some technical difficulties were experienced while answering the survey using Mobile devices, and this may have lead to drop out.

**Future Direction and Implications.** One of the strengths of this study is that it represents a comprehensive view of how MFT is understood, what concerns it help with, and sheds a light of the Eastern/Western differences by diverse mental health professionals in KSA. Another key finding is that it provided insights into psychotherapists and MFTs in KSA and their trainings, supervisions, satisfactions, and needs. The findings from this study make several contributions to the literature of MFT when it comes to KSA.

First, findings from this study can provide a guide for the construction of establishing training curriculums that focus on the growth of the therapist providing therapeutic interventions

to children, couples and families. Since the findings indicated concerns that exist within the partner-relations, family-relations, and parent-child relations that demonstrates power differential among the couples and the family members, attention need to be payed for those contextual issues in the assessment and administrating therapeutic interventions. Moreover, future research needs to identify ways that psychotherapy and marital and family interventions can be enhanced to meet the demands of children, couples, and families.

Second, knowing the misconceptions about the profession may help educators and trainers in spending some time to explore therapist's fear and hesitation of learning different models of interventions and the use of common factors in their practice. Special attention needs to be given to the common factors of working of the therapist delivering the interventions and on the therapeutic relationship, some of the findings indication that MFT is understood as confirming or correcting; therefore, trainees in mental health professionals and MFTs needs to become more aware of the importance of working with individuals who are different and staying away from the notion of conforming or correcting others.

Third, incorporating self-of-the-therapist training will be essential, given that mental health professionals in KSA are living in a patriarchal, religious, and conservative society; therefore, monitoring self-of-the-therapist issues is significant to becoming competent in providing care for others and the competency of those they help (Timm & Blow, 1999). This especially important that trainees and supervisees become more aware if they had ever experienced domestic violence or abuse, how does that play out for them in sessions, and how they can be more aware.

Fourth, assessing trainees' satisfaction and professional growth are critical. Fifth,

supervision needs to be strengthened by providing opportunities for implementing different types of supervision that trainees can go through to improve their practice and foster proficiency and competency in the quality of care that they provide.

According to the findings of this present study, there is considerably more work that will need to be done to determine the specific entails in tailoring psychotherapy and MFT to be culturally sensitive and culturally adapted interventions. In addition, there are logistical and training needs that need to be further explored and addressed to advance mental health and family health care in KSA. A call for future studies should focus on examining outcomes of the currently credentialed programs and their trainees' efficacy and outcome. Therefore, this will lead to establishing a platform to strengthen what works and find ways to foster trainees competencies. Also, there is a demand for bringing more cultural awareness to encounter stigma and for delivering more awareness and acceptance of treatment on a societal and community level.

# APPENDICES

Appendix A1

Study One Consent Form

Dear Mental Health Professionals,

You are invited to participate in this multiphase research study on the standard of care in the practice of mental health and marital and family therapeutic interventions. We would like to seek your kind assistance in completing a short survey (12-15 minutes), about your perceptions of the current status of mental health and marital and family therapeutic interventions in Saudi Arabia. Mental health professionals include those who are counselors, marriage and family therapists, psychologists, psychiatrists, psychotherapists, nurse practitioners, social workers, family medicine physicians, and others.

If you are interested to learn more about this study and participate, please read the consent form and take the survey on the following link:

https://hdfs.az1.qualtrics.com/SE/?SID=SV_cAb1fnFMtpK66a1&Q_Language=AR

Also, Please feel free to share this email and information with others professionals in mental health who might be interested in participating. Your efforts are highly valued.

We thank you in advance.

Sincerely,

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Doctoral candidates
Michigan State University
gassasre@msu.edu

Adrian Blow, Ph.D.
Professor
Michigan State University
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Appendix A2

Study One Consent Form (Arabic)

عزيزي المختص في إحدى مجالات الصحة النفسية،

أنت مدعو(ة) للمشاركة في هذه الدراسة البحثية المتعددة المراحل عن مستوى رعاية الصحة النفسية والتدخلات العلاجية للأزواج والأسر. نود مساعدتكم الكريمة لنا بالإجابة عن هذا الاستبيان القصير مدته (12-15 دقيقة). الاستبيان يتضمن الاستفسار عن تصورك الخاص للوضع الراهن لمجال الصحة النفسية والتدخلات العلاجية للأزواج والأسر في المملكة العربية السعودية. هذه الدراسة تشمل مختلف المختصين في مختلف مجالات الصحة النفسية المتعددة من معالجين نفسين ومرشدين و معالجين للأزواج و الاسر ومختصين في مجال علم النفس الإكلينيكي وعلم الإجتماع الإكلينيكي وأطباء علم النفس وطب الأسرة و الممرضين في مجال الصحة النفسية وغيرها.

إذا كنت ترغب(ين) في معرفة المزيد عن هذه الدراسة والمشاركة، يرجى قراءة استمارة الموافقة، في رابط الاستبيان الإلكتروني.

https://hdfs.az1.qualtrics.com/SE/?SID=SV_cAb1fnFMtpK66a1&Q_Language=AR

أرجو إرسال هذه الرسالة والمعلومات الي المختصين في مجالات الصحة النفسية الذين سوف يفيدونا بمشاركتهم. نقدر مشاركتك ووقتك. لطرح أسئلتكم و استفساراتكم يمكنكم التواصل معانا علي البريد الإلكترونيgassasre@msu.edu أو blowa@msu.edu.

مع خالص التقدير،


أ.رهام قصاص
طالبة دكتورة
جامعة ولاية متشجن

د.إدريان بلو
بروفسور
جامعة ولاية متشجن

Appendix B1

Study One: Mental Health Professionals Survey

Q1 Are you currently a mental health practitioner in Saudi Arabia?

- ❍ No
- ❍ Yes

Q2 Please indicate the appropriate age group that represents you?

- ❍ Less than 21
- ❍ 21-24
- ❍ 25-30
- ❍ 31-35
- ❍ 36-40
- ❍ 41-45
- ❍ 46-50
- ❍ 51-55
- ❍ 56-60
- ❍ 61 or above

Q3 What is your gender?

- ❍ Male
- ❍ Female

Q4 Please indicate your current work's setting?

- ❑ Academic Institution
- ❑ Hospital
- ❑ Private Practice
- ❑ Private nonprofit agency
- ❑ State or community agency
- ❑ School setting
- ❑ Other, please specify _____

Q5 Please indicate your highest academic qualifications?

- ❍ MD
- ❍ PhD/ PsyD or equivalent
- ❍ Master's degree
- ❍ Bachelor's degree
- ❍ Diploma
- ❍ Undergraduate student

Q6 Please indicate below your professional job title and specialty?

- ❑ Mental Health Counselor
- ❑ Mental Health Nurse Practitioner
- ❑ Nurse Psychotherapists
- ❑ Clinical Social Worker
- ❑ Psychiatrist
- ❑ Marriage and Family Therapist
- ❑ Clinical psychologist
- ❑ Social Worker
- ❑ Medical Social Worker
- ❑ Other, please specify _____

Q7 How would you rate the current status of the mental health services in Saudi, on the following areas?

| | Very Dissatisfied | Dissatisfied | Neutral | Satisfied | Very Satisfied |
|---|---|---|---|---|---|
| Practitioners' qualification | | | | | |
| Professional Collaboration | | | | | |
| Referral system | | | | | |
| Resources for clients/ families | | | | | |
| Resources for professional | | | | | |
| Malpractice regulations | | | | | |
| Client's Confidentiality | | | | | |
| Faith healers' Knowledge about MH | | | | | |

Q8 In your opinion, "marriage and family therapy" mean(s)

Q9 In your opinion, what concerns or diagnoses that requires marital and family therapeutic interventions?

Q10 Some scholar says there are inherent conflict with the western practice of marital and family therapeutic interventions/or psychotherapy and the cultural and customs of the society, do you agree that there are some conflicts?

❍ Disagree
❍ Agree

Q11 If you answered "agree", Please explain in your opinion what are some of the reservations around the practice of marital and family therapeutic interventions in Saudi?

Q12 List some of the strength in the Saudi family, that is an assets for the mental health?

Q13 Are you satisfied with the current mental health services available to children, couples, and families?

- ❍ No
- ❍ Yes

Q14 Have you referred any of your clients/families for marital and family therapeutic interventions before?

- ❍ Yes
- ❍ No

Q15 To what extend do you agree or disagree that the following topics are presenting mental health concerns in KSA? (Online each statement is pulled to one of the three categories)

| Agree | Disagree | Neither Agree nor Disagree |
|---|---|---|
| _____ Parenting | _____ Parenting | _____ Parenting |
| _____ Partner Relational Problem | _____ Partner Relational Problem | _____ Partner Relational Problem |
| _____ Child abuse and neglect | _____ Child abuse and neglect | _____ Child abuse and neglect |
| _____ Financial difficulties | _____ Financial difficulties | _____ Financial difficulties |
| _____ Sexual difficulties | _____ Sexual difficulties | _____ Sexual difficulties |
| _____ Gender inequality | _____ Gender inequality | _____ Gender inequality |
| _____ Physical abuse of child | _____ Physical abuse of child | _____ Physical abuse of child |
| _____ Physical abuse of adult | _____ Physical abuse of adult | _____ Physical abuse of adult |
| _____ Sexual abuse of adult | _____ Sexual abuse of adult | _____ Sexual abuse of adult |
| _____ Sexual abuse of child | _____ Sexual abuse of child | _____ Sexual abuse of child |
| _____ Marital affairs | _____ Marital affairs | _____ Marital affairs |
| _____ Substance Abuse | _____ Substance Abuse | _____ Substance Abuse |
| _____ Work related problems | _____ Work related problems | _____ Work related problems |
| _____ Discrimination | _____ Discrimination | _____ Discrimination |

| | | |
|---|---|---|
| _____ Abuse of male guardians | _____ Abuse of male guardians | _____ Abuse of male guardians |
| _____ Elder abuse | _____ Elder abuse | _____ Elder abuse |
| _____ Young adult radicalization | _____ Young adult radicalization | _____ Young adult radicalization |
| _____ Bullying | _____ Bullying | _____ Bullying |
| _____ Incest | _____ Incest | _____ Incest |
| _____ Dependency on domestic workers for childcare | _____ Dependency on domestic workers for childcare | _____ Dependency on domestic workers for childcare |
| _____ Multiple spouses | _____ Multiple spouses | _____ Multiple spouses |

Appendix B2

Study One: Mental Health Professionals Survey (Arabic)

Q1 هل أنت حالياً ممارس في مجال يتعلق بالصحة النفسية في المملكة العربية السعودية؟

- لا
- نعم

Q2 يرجى الإشارة إلى الفئة العمرية التي تنتمي اليها؟

- أقل من 21
- 21-24
- 25-30
- 31-35
- 36-40
- 41-45
- 46-50
- 51-55
- 56-60
- 61 وما فوق ذلك

Q3 جنسك؟

- ذكر
- أنثى

Q4 يرجى الإشارة إلى مقر عملك الحالي؟

- مؤسسة أكاديمية
- قطاع طبي
- عيادة خاصة
- مؤسسة خاصة غير ربحية
- مؤسسة حكومية او إجتماعية
- منشأة مدرسية
- أخرى، يرجى تحديدها _____

Q5 يرجى الإشارة إلي أخر مؤهل أكاديمي حصلت عليه؟

- دكتوراه
- ماجستير
- بكالوريس في الطب والجراحة
- بكالوريوس
- دبلوم
- طالب جامعي
- ثانوي

Q6 يرجى الإشارة الي المسمى الوظيفي و تخصصك؟

- معالج أسري و زواجي
- أخصائي نفسي إكلينيكي
- أخصائي إجتماعي طبي
- مرشد نفسي
- طبيب نفسي
- أخصائي نفسي
- ممرض معالج نفسي
- مرشد مدرسي
- طبيب طب أسرة
- أخصائي إجتماعي
- ممرض مختص في الصحة النفسية
- أخرى، يرجي تحديدها _____

Q7 كيف تقيم الوضع الحالي للصحة النفسية في السعودية، في المجالات التالية؟

| | ضعيف | مقبول | جيد | ممتاز |
|---|---|---|---|---|
| التدريب الإكلينيكي للمتخصين | | | | |
| التأهيل العلمي للمتخصين | | | | |
| التعاون المهني بين المختصين | | | | |
| نظام إحالة الحالات | | | | |
| الموارد المتوفرة للافراد والأسر | | | | |
| الموارد المتوفرة للمختصين | | | | |
| اليات المحاسبة للمارسة الخاطئة | | | | |
| سرية العميل في العلاج | | | | |
| معرفة المعالجين بالرقية الشرعية بالصحة النفسية | | | | |

Q8 في رأيك "العلاج الأسري والزواجي" يعني؟

Q9 في رأيك، ما هي الشكاوي أو الحالات التي تتطلب تدخلات العلاج الزواجي أو الأسري؟

Q10 بعض العلماء أو الممارسين يقولون إن هنالك تضارب بين ممارسة التدخل العلاجي الأسري والزواجي /أو العلاج النفسي، وبين ثقافة المجتمع الغربي وثقافة المجتمع الشرقي، هل توافق على ذلك؟

- لا أوافق
- أوافق

Q11 إذا كانت إجابتك "أوافق"، يرجى توضيح رأيك في ما هي بعض تضارب المفاهيم حول كيفية أوطريقة ممارسة التدخل العلاجي الزواجي والأسري في السعودية؟

Q12 عدد بعض نقاط القوة في الأسرة السعودية، والتي تعتبرها ذات ميزه ومنفعة للمحافظة على الصحة النفسية؟

Q13 هل أنت راضٍ عن الخدمات الحالية للصحة النفسية المتوفرة للأطفال، والأزواج، والأسر؟

- لا
- نعم

Q14 هل قمت من قبل بتحويل اي من الحالات التي تتابعها الي عيادة أخرى بهدف الحاجة للتدخل العلاجي الأسري أو الزواجي؟

- نعم
- لا

Q15 إلى أي مدى أنت تتفق أوتختلف في أن المواضيع التالية تعتبر شكاوي مهمة في مجال الصحية النفسية في المملكة العربية السعودية؟

| لا أوافق ولا أعارض | أعارض | أوافق |
|---|---|---|
| _____ الأمور التربوية | _____ الأمور التربوية | _____ الأمور التربوية |
| _____ المشكلات المتعلقة بالعلاقة الزوجية | _____ المشكلات المتعلقة بالعلاقة الزوجية | _____ المشكلات المتعلقة بالعلاقة الزوجية |
| _____ اساءة معاملة الطفل واهماله | _____ اساءة معاملة الطفل واهماله | _____ اساءة معاملة الطفل واهماله |
| _____ الصعوبات المالية | _____ الصعوبات المالية | _____ الصعوبات المالية |
| _____ الإضطرابات الجنسية | _____ الإضطرابات الجنسية | _____ الإضطرابات الجنسية |
| _____ عدم المساواة بين الجنسين | _____ عدم المساواة بين الجنسين | _____ عدم المساواة بين الجنسين |
| _____ الإيذاء الجسدي للطفل | _____ الإيذاء الجسدي للطفل | _____ الإيذاء الجسدي للطفل |
| _____ الإيذاء الجسدي للكبار | _____ الإيذاء الجسدي للكبار | _____ الإيذاء الجسدي للكبار |
| _____ الاعتداء الجنسي على الكبار | _____ الاعتداء الجنسي على الكبار | _____ الاعتداء الجنسي على الكبار |
| _____ الاعتداء الجنسي على الأطفال | _____ الاعتداء الجنسي على الأطفال | _____ الاعتداء الجنسي على الأطفال |
| _____ الخيانة الزوجية | _____ الخيانة الزوجية | _____ الخيانة الزوجية |
| _____ إساءة استعمال المواد المخدرة | _____ إساءة استعمال المواد المخدرة | _____ إساءة استعمال المواد المخدرة |
| _____ مشاكل ذات صلة بالعمل | _____ مشاكل ذات صلة بالعمل | _____ مشاكل ذات صلة بالعمل |
| _____ العنصرية | _____ العنصرية | _____ العنصرية |
| _____ الإساءة من الأوصياء الذكور | _____ الإساءة من الأوصياء الذكور | _____ الإساءة من الأوصياء الذكور |
| _____ إساءة معاملة المسنين | _____ إساءة معاملة المسنين | _____ إساءة معاملة المسنين |
| _____ التطرف الإرهابي للشباب | _____ التطرف الإرهابي للشباب | _____ التطرف الإرهابي للشباب |
| _____ العنف بين الأطفال | _____ العنف بين الأطفال | _____ العنف بين الأطفال |
| _____ زنا المحارم | _____ زنا المحارم | _____ زنا المحارم |
| _____ الاعتماد على عاملات المنازل لرعاية الأطفال | _____ الاعتماد على عاملات المنازل لرعاية الأطفال | _____ الاعتماد على عاملات المنازل لرعاية الأطفال |
| _____ تعدد الزوجات | _____ تعدد الزوجات | _____ تعدد الزوجات |

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## CHAPTER 3: MANUSCRIPT II

### Awareness and Preparedness of Mental Health Professionals in Saudi Arabia: Marital and Family Interventions


## ABSTRACT

This paper describes the findings from a larger multiphase mixed-method study about the emerging profession of Marriage and Family Therapy in Saudi Arabia. The study data was collected via online-based surveys, including 221 participants. The aims were to explore perceptions of current mental health professionals of aspects of mental health domains, services provided, and the importance of presenting relational contextual concerns that individuals, children, couples, and families experience, and identify strengths in Saudi Arabian families. The findings indicate "client's confidentiality" as a continued area of controversy within the Saudi mental health field with respondents showing the most lack of consensus in their views of its importance. Moreover, 91% of the participants expressed dissatisfaction with the current services available to address relational concerns. In addition, suggestions, implications, and future direction are discussed.

## Introduction

Globally, mental disorders make up 7.4% of the total health burden according to the 2010 study on the global burden of diseases (Whiteford, Degenhardt, Rehm, Baxter, Ferrari, Erskine, & Burstein, 2013). This finding signifies that there is a need for a well prepared mental health professionals (MHPs) worldwide. The Kingdom of Saudi Arabia (KSA), is one of the developing countries that currently has evolving mental health services; there is a current focus on the quality of care delivered by mental health professionals in KSA. Recent publications on mental health in KSA, indicate that there are needs for further research to be conducted on mental health practices in the country (Al-Habeeb & Qureshi, 2010; Koenig, Al Zaben, Sehlo, Khalifa, Al Ahwal,2013; Koenig, Al Zaben, Sehlo, Khalifa, Al Ahwal, Qureshi, & Al-Habeeb, 2014; Qureshi, Al-Habeeb, & Koenig, 2013). Previous research on mental health in KSA has focused on the prevalence of the mental health and services provided, primarily in hospitals (Qureshi, Al-Habeeb, & Koenig, 2013). However, advancement and improvement of the quality of care must take into consideration the consumers of mental health services including all clients as well as children, couples, and families, whether the professionals are prepared to meet the demands of these diverse populations.

### Mental Health in Saudi Arabia

Preceding the 1950s in KSA, individuals with mental health concerns and who were regarded as dangerous, were locked in public buildings (Al-Habeeb & Qureshi, 2010). The first psychiatric hospital was founded in 1952 in the city of Taif, followed by the second hospital in 1960, in Medinah city (Al-Habeeb & Qureshi, 2010; Qureshi, Al-Habeeb, & Koenig, 2013; Koenig et al., 2013; Koenig et al., 2014). Meanwhile, the first mental and social health atlas in

KSA describes that the General Administration of Mental Health and Social Services (GAMHSS) in the Saudi ministry of health took the task of collecting information and generating a unified manual for psychiatric hospital services (Al-Habeeb & Qureshi, 2010). One of the tasks of the GAMHSS national strategic plan illustrated the urgency to advance the field of mental health in KSA, by focusing on the advancements of professionals, services, and new specialties (Al-Habeeb & Qureshi, 2010). However, it is unclear how much actual advancement has occurred in areas related to marital and family interventions.

**Significant Recognitions and Legislation.** Koenig et al., (2014) reviewed the past 60 years of mental health care in KSA; they cited a previous study by Dubovsky which indicated that partner abuse and child maltreatment were not addressed until the early 1980s since it was not deemed as a crime. Therefore, no reported interventions were established for it (Koenig et al., 2014). Child abuse and neglect was first recognized in KSA as a criminal problem in 2000 (Al-Eissa & Almuneef, 2010). In 2004, KSA implemented the first national move toward protecting children's rights and implementing prevention measures for child maltreatment (Al-Eissa & Almuneef, 2010). The National Family Safety Program (NSFP) established in 2005 by a royal decree established a national registry for child maltreatment, to determine prevalence and patterns (NFSP, 2014). Recently, the Saudi Council of Ministers (Majlis al-Wazuara), has established a child protection system on November 17, 2014 (Saudi Press Agency, 2014), but the impact of this system on actual abuse prevention still is unknown.

The Saudi Mental Health Act was established in 2012 (Koenig et al., 2014), the legislative body of the consultative council known as Shura Council made recommendations for Saudi Mental Health Act three years ago. The ‘Saudi Council,’ of Ministers approved the Mental

Health System Act on July 7, 2014, and was passed by a royal decree (National Committee for the Promotion of Mental Health, 2014; Okaz Newspaper, 2014). The aims of the mental health system Act are as follows:

(1). Organize and promote mental health care needs of mental health patients;

(2). Protect the rights of individuals with mental illness, and save their dignity, and their families and the society; and

(3). Establish a mechanism for handling and implementing therapeutic practice in mental health facilities.

Moreover, another significant advancement that came to be approximately at the same time is the passing of the Abuse System Policy by a royal decree on September 20th, 2013 and the Executive Regulation for the Abuse System Policy (Bureau of Experts at the Council of Ministers, 2013; MOSA, 2013; 2014). The policy defines what constitutes abusive acts and neglect, as well as providing some steps to ensure the supportive and preventive measure against abuse including mandated reporting by professionals and the identification of needed services and programs (Bureau of Experts at the Council of Ministers, 2013; MOSA, 2013; 2014).

The ministry of justice has initiated social services in courts, as well as family counseling and mediation services which are delivered by paraprofessionals as a modality of intervention for divorce cases and family disputes ( Aldehaiman, Aloud, & Aldakhil, 2015; Aloud, Albakran, & Alfaiem, 2013). Recently, every divorce and child custody case presented to the court included an assessment conducted by a social worker and psychologist along with a recommendation as to what the best for the family (Aloud, 2015). Additionally, new regulations for divorced women and their children has been established by the Ministry of Justice, which aims to empower

women to gain their rights after divorce (Aldehaiman, Aloud, & Aldakhil, 2015). Since those regulations have been recently implemented, no studies exist that explore and discuss the implications of the utilization of those new policies and legislations by mental health professionals as they provide services to individuals, children, couples, and families.

**Professionals.** The WHO mental health system reports on KSA indicate that mental health professionals are estimated to be 22 per 100,000 population, which the report breaks down to three psychiatrists, 13 nurses, two psychologists, three social workers, and one other mental health professionals (may include assisting staff, occupational therapists, health assistants, medical physicians, medical assistants, professional and paraprofessional counselors) (Qureshi, Al-Habeeb, & Koenig, 2013). The review indicates that 80% of psychiatrists work in public health facilities, and about 60% of the psychosocial staff are: psychologists, social workers, and occupational therapists who work in government agencies. In addition, only 15% of elementary and secondary schools have school counselors.

According to Al-Habbeb and Qureshi (2010), WHO has emphasized that globally the Primary Health Care (PHC) centers need to integrate mental health services (Al-Habbeb & Qureshi, 2010). Nevertheless, the current status of services is described as limited; only 20% of PHC providers in KSA use assessment and have a clear treatment plan for mental health, while only 20% make referrals to a mental health professional (Qureshi, Al-Habeeb, & Koenig, 2013).

**The Need for Programs and Interventions.** There are numbers of articles and studies on mental health in KSA. These literature indicate the existence of high prevalence of child abuse and maltreatment which result in urgent demands in addressing these needs and prioritizing of interventions. In one study on the readiness of KSA to implement evidence-based

child maltreatment prevention programs, findings suggested that there is only a moderate/fair degree of readiness (Almuneef, Qayad, Noor, Al-Eissa, AlBuhairan, Inam, & Mikton, 2013). Both key informant and experts who participated in the study indicated low readiness scores (<5 out of 10) on institutional links and resources, materials, and human/technical resources (Almuneef et al., 2013). Human resources here refer to professionals; therefore, this finding signals a lack of training for professionals. Regarding applying an evidence-based intervention for child abuse and neglect prevention, the researchers state that there are needs for prevention programs that are appropriate for the Saudi cultural context (Almuneef & Al-Eissa, 2010). Moreover, Koenig et al., (2013) indicate that there also not much information on whether services for children and adolescents exist that are meeting the current needs of the country (Koenig et al., 2013). Mahfouz et al., (2009) also indicate that there is a need to establish a national program in KSA to integrate adolescent mental health programs into the health and educational sectors.

The following studies identified specific needs for interventions for women's mental health, substance abuse, domestic violence, and community centers. Hamdan (2009) reviewed previous studies on women's mental health in the Arab region and concluded that there is an urgent need to close the gap when it comes to service for women's mental health needs and provided services. She recommended implementing mental health services to women through providing integrated services and emphasizing the importance of enhancing professionals training. Albrithen (2006) advocates for the needs of psychotherapists and interventions programs to deal with the social, psychological, and health concerns that exist concerning alcoholism and substance abuse in the Saudi society. According to the findings of the first Saudi

health and social Atlas, the report indicates that KSA has inadequate community mental health care services and that one of the priorities is to develop community mental health care centers since that will reduce the number of hospitalized chronic mental illness clients (Al-Habeeb & Qureshi, 2010).

**Gender Inequality.** The previous literature demonstrates that the culture influences different members of the family, especially women. Meanwhile, Mobaraki and Söderfeldt (2010) highlight that the understanding of the Islamic law in KSA and how the existing social norms have contributed to the negative influences on women's well-being and public health. Fageeh (2014) argues that there is a need to bring more awareness to the public concerning norms and to address the concerns of domestic violence in KSA.

Mobaraki and Söderfeldt (2010) reviewed the existence of gender inequity due to the power imbalance between males and females. The power imbalance illustrates influential adverse factors on Saudi women on their educational attainment, choice of career, transportation restrictions placed on women, consents of guardianship, male polygamy, issues around the age of marriage, and high fertility rates (Mobaraki & Söderfeldt, 2010; Pharaon, 2004). Fageeh (2014) also explains that women in Saudi society are restricted to living with a male relative if they are either single or divorced; this way of life often limits her options of housing and other resource options if she walked out on an abusive partner. The Ministry of Justice has started to implement some regulations to counter those adverse factors (Aldehaiman, Aloud, & Aldakhil, 2015; Aloud, Albakran, & Alfaiem, 2013), yet still continuous efforts are needed. Alternatively in an Islamic society, marital relationship concerns and gender equality continue to be a difficult issue.

Furthermore, Daneshpour (2012) discusses equality in relationships and how men and women could have different roles and responsibilities that are complementary and not superior to one another. She suggests that issues of inequality need to be explored in psychotherapy and MFT and that finding an Islamic culturally adapted intervention is possible. There are currently no studies in KSA that investigate the handling of oppression toward women and others in the practice of delivering marital and family therapeutic interventions. In addition, professionals are part of the society and do not live in isolation of being culturally accepting, and may even unintentionally support imbalances in power, privilege, and oppression that play into the experience of humans and contributes to mental health concerns.

Mental disorders co-exist with relational concerns that often necessitate an equipped professionals in MFT to treat both issues. MFT as a profession is almost nonexistent in KSA at this time, yet some qualified and unqualified practitioners do practice it. As a result, in this study, I set out to learn more about MFT practice in the KSA to gauge the perceptions of current MHPs toward MFT practice and their views on what needs to be done to inform the current preparedness and awareness of mental health concerns existing in a relational context.

## Method

### Participants

This study is part of a larger multiphase mixed-method study. A survey was administered online using Qualtrics software. The initial sample size, was (n=315) participants for the survey that targeted mental health professionals (MHPs). Furthermore, the survey had (n= 221) participants, with 45% males and 55% females.

**Procedures**

Survey invitations and recruitment for the online-based survey were disseminated via social media, specifically through Twitter, LinkedIn, and Facebook; these social media platforms are common methods of recruitment in KSA. Additionally, to ensure recruitment of less active professionals, emails were also sent as invitations via LinkedIn. The survey started with demographic information questions, Likert-type scale, and closed-ended questions. The survey addressed the following items:

a. A MHPs perception of the current status of mental health in KSA. Participants were asked to rate nine domains that addressed professionals training and qualification; as well as, other considerations that contributed to the currently provided services. Rating is based on four Likert-type of scale as follow: poor, satisfactory, good, and excellent.

b. MHPs satisfaction with mental health services available to children, couples, and families in KSA: for assessing the satisfaction with the current status, MHPs completed a global satisfaction question. Moreover, MPHs were asked if they have made referrals to individuals with expertise in marital and family therapeutic interventions.

c. MHPs perception about relevant presenting mental health concerns in KSA: for participants responded to a 21-items list of presenting concerns and responses on a three-point Likert-type scale, which are as follow: agree, disagree, and neither agree or disagree.

d. MHPs perception of strengths in Saudi Arabian families: an open-ended question to assess perceptions of what MHPs identified as strengths for mental health in Saudi families.

**Data Analysis**

Survey data were analyzed with SPSS version 23 to obtain descriptive statistic results and cross-tabulations to assess gender differences. The open-ended survey questions responses were translated and entered into MAXQDA 12 for coding and analyzing. The thematic qualitative text analysis utilized for this study is one of the best known basic methods of qualitative text analysis (Kuckartz, 2014). The vast majority of the responses generated words and short phrases that described family strengths. First, a list of the most repeated keywords in the data was created and translated into Arabic, while at the same time, another corresponding English translation was established to unify the translations. Next, statements were read and highlighted for initial coding. Furthermore, initial codings were retrieved and examined in order to identify the main thematic categories, and a word-based strategy was utilized to analyze using a keyword based search to review the codes further and do further modifications to distinguish the overlapping data.

## Results

This section describes the demographic characteristics of both surveys. The results of the first survey, reflects perceptions of mental health professionals on awareness and preparedness in the following areas: current status about nine domains that relates to mental health in KSA, professional satisfaction and referral, awareness of important presenting mental health concerns in KSA, and identified views on strength of Saudi Arabian families as assets for mental health.

**Participants Characteristics**

In terms of gender, there was 45% male participants and slightly more female participants represented by 55%. The majority of participants had almost equal age representation across groups as follow: (25-30) 19%, (31-35) 21%, and (36-40) 22%. The survey had 42% (n=79) holding a bachelor's degree and 30% (n=57) had a master's degree.

The work settings for the participants in this study was as follows: medical institution 38% (n=83), state and community agency 23% (n=50), academic institution 18% (n=37), private practice 8% (n=17), school setting 7% (n=16), private nonprofit agency 3% (n=7), and other 5% (n=11). The percentages add up to more than 100% since some participants indicated more than one work settings.

More than half the participants identified as psychologists (32.5%) or clinical psychologist (21.5%); the number of participants who identify as MFT specifically, there were (n=13) 6.5% (See Table 3.1 for more details on the demographics information for Saudi MHPs Survey).

**Current Status of the Mental Health in Saudi**

Participants were asked: "how would you rate the current status of the mental health in Saudi, in the following areas?" 1) clinical training, 2) academic qualifications, 3) professional collaboration, 4) referral systems, 5) resources for clients/families, 6) resources for professionals, 7) malpractice regulations, 8) client's confidentiality, and 9) faith healer's knowledge about mental health. Ratings were given in response to a four point Likert scale ranging from "poor" to "excellent."

Table 3.1

*Demographics Information for Saudi MHPs Survey*

| | ***n (221)*** | **%** |
|---|---|---|
| **Age Group** | | |
| 21-24 | 25 | 12 |
| 25-30 | 39 | 19 |
| 31-35 | 45 | 21 |
| 36-40 | 47 | 22 |
| 41-45 | 25 | 12 |
| 46-50 | 11 | 5 |
| 51-55 | 11 | 5 |
| 56-60 | 6 | 3 |
| <61 | 1 | .5 |
| **Degree Level** | | |
| Ph.D/PsyD or equivalent | 44 | 23 |
| Master's degree | 57 | 30 |
| Medical degree | 8 | 4 |
| Bachelor's degree | 79 | 42 |
| Diploma | 2 | 1 |
| **Professional Job Title or Specialization** | | |
| Marriage & Family Therapist | 13 | 6.5 |
| Clinical Psychologist | 43 | 21.5 |
| Medical Social Worker | 8 | 4 |
| Clinical Social Worker | NA | NA |
| Mental Health Counselor | 9 | 4.5 |
| Psychiatrist | 33 | 16.5 |
| Psychologist | 65 | 32.5 |
| School Counselor | 7 | 3.5 |
| Family Medicine Physician | 1 | .5 |
| Social Worker | 10 | 5 |
| Others | 11 | 5.5 |

Table 3.1 (Cont'd)

*Note.* NA = Not applicable. Some of the categories will add up to more than 100% due to holding more than one job title/specialization.

[a] No participants found for over 60 years old.

Overall, participants endorsed ratings of “poor” and “satisfactory” far more frequently than they rated with “good” and “excellent”. Moreover, there are some large visible gaps among the ratings of “satisfactory” and “good”. Thus, to illustrate this significantly noticeable gap, the percentage differences between the “good” and “satisfactory” scales were calculated, and it resulted in 29% gap differences for “resources for professionals” and 23% for “professional clinical training.”

The highest ratings on each of the scales were demonstrated on the domains as follows: “poor” endorsed by (71%) for malpractice regulations, “satisfactory” endorsed by (43%) for professional collaboration, “good” endorsed by (37%) for professional academic qualification, and “excellent” is endorsed by (20%) in the client’s confidentiality item. Furthermore, the other ratings for client’s confidentiality were divided as follows: “poor” (16%), and both “satisfactory” and “good,” each indicated by (32%) respectively. Client's confidentiality was the domain that participants were equally more distributed and are divided up more on their perception of the current status of mental health. (See Table 3.2 for more details on the nine domains.)

**Professional Satisfaction and Referral**

A total of (n=123) participants answered closed-ended yes or no questions. Participants were asked to respond to the following two questions: Are you satisfied with the current mental health services available to children, couples, and families? And have you referred any of your clients/families for marital and family therapeutic interventions before? Ninety-one percent of the MHPs indicated “No”, and that they are not satisfied with the current mental health services available to children, couples, and families. Meanwhile, 69% of the MHPs participants indicated “Yes”, which they have made referrals for their clients recommending seeking marital and family

therapeutic interventions. These results indicate a high rate of need (referral) but an extremely limited pool of individuals considered competent to conduct the treatment.

**Important Presenting Mental Health Concerns in KSA**

Participants were presented with a 21-items list and asked to answer a three Likert-type scales (agree, disagree, or neither agree or disagree) to each of these question. The highest "agreement" rating items came in response to partner relational problems with (97%); followed by child abuse and neglect (93%); child sexual abuse (89%); sexual difficulties (86%); child physical abuse (85%); parenting and substance abuse each had (84%) of agreement; and marital affairs (81%).

The highest items that had "disagreement" ratings came as follows: elder abuse (40%); discrimination and adult physical abuse each (39%); gender inequality (38%); adult physical abuse (35%); and financial difficulties and young adult radicalization (29%). It is important to mention that, participants were almost equally agreeing and some were disagreeing that elder abuse is an important mental health concern in KSA, with (42%) and (40%) in the respective order. Moreover, discrimination had higher "disagreement" compared to "agreement" indicated by (38%) of the participants, and (23%) responded with "neither agree or disagree."

Furthermore, some of the 21-items were not answered; few participants did respond to the questions as "neither agree or disagree", which was significant in the following order: (25%) for "work-related problems" and "multiple spouses." Moreover, domestic workers for childcare received (20%); "elder abuse," "incest," and "young adult radicalization" each had (18%), and "financial difficulties" and "adult sexual abuse" each had (15%). (See Table 3 for more details.)

Table 3.2

*Ratings on current status of the mental health in Saudi Arabia*

| Domains relate to Mental Health | %Excellent | %Good | %Satisfactory | %Poor |
|---|---|---|---|---|
| 1-Clinical Training | 0.7 | 18.8 | 41.7 | 38.9 |
| 2-Academic Qualification | 2.2 | 37.0 | 32.6 | 28.3 |
| 3-Professional Collaboration | 2.1 | 24.6 | 43.0 | 30.3 |
| 4-Referral System | 2.1 | 24.1 | 37.6 | 36.2 |
| 5-Resources for Clients/Families | 1.4 | 17.5 | 33.6 | 47.6 |
| 6-Resources for Professional | 2.3 | 13.2 | 41.9 | 42.6 |
| 7-Malpractice Regulations | 1.5 | 5.3 | 21.8 | 71.4 |
| 8-Client’s Confidentiality | 20.3 | 31.9 | 31.9 | 15.9 |
| 9-Faith healers' Knowledge about MH | 3.7 | 13.2 | 36.0 | 47.1 |

Regarding gender differences, more females “disagreed” than ‘agreed” that gender discrimination is a mental health concern in KSA. Moreover, more females had higher responses with “neither” compared to ‘disagree”on the following items: multiple spouses (30%) “neither” versus (12%) “disagree”; work related problems with (29%) “neither” versus (13%) “disagree”; abuse of male guardian with (23%) “neither” versus (20%) “disagree”; marital affairs, (12%) “neither” versus (10%) “disagree”; and lastly equal “neither” and “disagree” responses on substance abuse with (8%) each.

More male participants “disagreed” than ‘agreed” that young adult radicalization, sexual abuse of adults, multiple spouses, and bullying is a mental health concern. Male participants responded with “neither” response more than “disagree” on the following items: bullying, incest, abuse from a male guardian, and substance abuse. Moreover, they have an equal response to discrimination with (30%) each, and (39%) who agreed that discrimination is a mental health concern in KSA. (See Table 3.3 for more details on overall ratings and gender differences ratings.) These findings indicate significant gender differences in the perceptions of mental health issues in KSA.

**Identified Strength in Saudi Families**

In this question, participants were asked the following open-ended question: List what you see as the strengths in Saudi Arabian families that are assets for mental health? There were two main themes that emerged from this questions: the first theme was family *cohesion and resources*, the second theme was *family and cultural customs and values*. The two themes overlapped in many ways since aspects of family strengths are very interconnected and interdependent and it is difficult to view them in isolation.

**Family cohesion and resources theme.** This theme demonstrates participants sense of kinship and societal connectivity and supportive resources. Overall, participants viewed Saudi families as close and cohesive. Cohesiveness and resourcefulness were indicated by words or references to family bonds, ties, communications, solidarity, cohesion, care, and support that family members provided each other, as well as to members of the larger society. One participant described support as: "The robustness of the social structure of the Saudi society ... rather than seeking a psychologist, [Seeking others such as] grandfather, paternal uncle, maternal uncle, in-law relative and others because the ties are strong and may contribute to solving problems…" Solidarity and cohesion were considered strengths and was described as: "An acceptable degree of family solidarity still exists," and "Family cohesion and its extension from the nuclear family unit to the extended family."

Regarding communication and its role in keeping families strongly connected, one participant described indirect ways of staying connected to all the extended family members by daily inquiry about one another via one of the family members who communicate back and forth among them; one participant illustrated the communications by stating that, "Continuous communication, even indirectly, or on a daily basis by asking about family members through one of the parents." Moreover, bonds and ties were demonstrated as a strength in descriptions of family members participating in events; one participant states that, "Attendance and participation in happy and sad events and attending to other's feelings."

Another contributing factor for family strength is resources. Some of the mentioned contributing factors to family strength were indicated by references to factors such as financial resources, education resources, being patient, and resilience. An example of resources is the

financial resources, one participant states that, “Next is the economic situation and standard of living which is excellent to average which helps to meet the needs that help the country and its members regarding mental health.” Another factors relating to family strength is being resilient, one participant wrote, “In the general context the coping mechanism during trauma.”

**Family and Cultural customs and value theme.** This second theme is illustrated by specific contributing factors that are derived from values tied to specific cultural and custom practice, values from faith, and religiosity of families. Many references were made by participants about the strengths that are derived from Islamic religion including morals, values, and principles. One participant wrote, “The foundation is in the religion which set criteria and standards for maintaining the rights [and] responsibilities; and balances the duties when it comes to giving and taking, and having a sense of responsibility”. Religion is tied to responsibilities toward maintaining family bonds, looking after elders, parents, children, wives, and those who need care as demonstrated by a participant who wrote: “The religious disposition which calls for filial piety and respect for parents and calls for fathers [husbands] to give attention to wife and children.” Also, there were references to the degree of religiosity using terms to reference religion and religiosity as follow: “Adhere to religion,” “Rational religiosity,” and “high degree of religiosity.” One participant described the levels of religiosity by saying: “religious morals, which range in magnitude among Saudi families but the strength point that exists, and the existence of its seed that only needs an awakening of it in the soul.”

Another illustrations of family and cultural values as relates to elders, extended family members, and how this extends into different life cycles. Family values and members’ relationships as strength were discussed in connection with the support received from the

Table 3.3

*Overall Ratings and Gender Differences Ratings for 21-Items List of Areas of Concerns*

| Areas of Concerns | %Overall Ratings | | | %Gender Differences Ratings | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Agree | Disagree | Neither | Agree | | Disagree | | Neither | |
| | | | | M | F | M | F | M | F |
| 1-Parenting | 83.8 | 10.3 | 5.9 | 89 | 80 | 7 | 12.5 | 4 | 7.5 |
| 2-Partner Relational | 96.5 | 2.3 | 1.2 | 95 | 98 | 2.5 | 2 | 2.5 | 0 |
| 3-Child Abuse & Neglect | 92.7 | 7.3 | 0 | 94 | 92 | 6 | 8 | 0 | 0 |
| 4-Financial Difficulties | 56.5 | 29 | 14.5 | 67 | 50 | 29 | 29 | 4 | 21 |
| 5-Sexual Difficulties | 86.3 | 8.2 | 5.5 | 91 | 83 | 6 | 10 | 3 | 7 |
| 6-Gender Inequality | 50 | 37.5 | 12.5 | 48 | 51 | 39 | 37 | 13 | 12 |
| 7-Child Physical Abuse | 84.7 | 9.7 | 5.6 | 79 | 88 | 14 | 7 | 7 | 5 |
| 8-Adult Physical Abuse | 54.5 | 34.5 | 10.9 | 42 | 61 | 37 | 33 | 21 | 6 |
| 9-Adult Sexual Abuse | 45.8 | 39 | 15.3 | 35 | 53 | 43 | 36 | 22 | 11 |
| 10-Child Sexual Abuse | 89 | 5.3 | 5.3 | 87 | 91 | 6 | 5 | 6 | 5 |
| 11-Marital Affairs | 80.6 | 10.4 | 9 | 84 | 79 | 12 | 10 | 4 | 12 |
| 12-Substance Abuse | 84 | 6.7 | 9.3 | 83 | 85 | 6 | 8 | 11 | 8 |
| 13-Work Related Problems | 54.4 | 21.1 | 24.6 | 47 | 58 | 37 | 13 | 16 | 29 |
| 14-Discrimination | 37.7 | 39.3 | 23 | 39 | 37 | 30 | 45 | 30 | 18 |
| 15-Male Guardian Abuse | 63.6 | 16.7 | 19.7 | 73 | 58 | 12 | 20 | 15 | 23 |
| 16-Elder Abuse | 41.9 | 40.3 | 17.7 | 35 | 46 | 48 | 36 | 17 | 18 |
| 17-Domestic Workers for Childcare | 60 | 19.7 | 19.7 | 55 | 64 | 24 | 17 | 21 | 19 |
| 18-Multiple Spouses | 49.2 | 25.4 | 25.4 | 38 | 58 | 42 | 12 | 19 | 30 |
| 19-Incest | 64.8 | 16.9 | 18.3 | 61 | 67 | 14 | 19 | 25 | 14 |
| 20-Young Adult Radicalization | 53.2 | 29 | 17.7 | 36 | 65 | 44 | 19 | 20 | 16 |
| 21-Bullying | 68.3 | 14.3 | 17.5 | 56 | 76 | 12 | 16 | 32 | 8 |

*Note.* M = male and F= female

extended family members and the authority of elders and parents. For example, one participant wrote, “Somewhat the connection between the small family and the extended family, and following up with children even after they go beyond the age of 18 years old, and financial and emotional support of children even after they get married.” Other described authority of the members as a strength as: “Clarity of the authority and importance of the senior siblings” and also through participants describing filial piety who said, “Symbols of father and the mother in maintaining filial piety and appreciation and ensure being constantly in their presence.”

In addition, there were specific cultural and custom particular strengths that were illustrated by references made about conservatism and related words such as: “modesty,” “conceal and discreet”, and “female’s discretion.” Moreover, references to maintaining customs or some of the customs were identified as strengths, one participant wrote; “Traditional marriages and holding to it.” Moreover, strengths were derived from specific cultural values and customs about gender roles. An examples given included was that: “… the lack of the number of working women, and the responsibility of men to spend on the home and family.” Another participants also wrote that, “Man's full responsibility toward his family members.”

## Discussion

This current study aims to explore Saudi MHPs views on nine domains of mental health services, awareness of mental health concerns, and identifies strengths of Saudi Arabian families. Those findings address a gap in research about mental health field in KSA and help identify needs for the growth of marital and family interventions.

There are almost equal distribution of gender, with 55% female participants; participants that hold bachelor’s degrees account for 42% in the survey. These findings are in line with

previous literature that states that most psychologists and social workers hold bachelor's degrees (Al-Habeeb & Qureshi, 2010). Moreover, participants identified more than one job title and specialization; the findings might be due to the fact that job positions do not necessarily match the specialization, for example, a counselor or psychologist could be hired as a social worker.

Overall, participants provided more ratings of "poor" and "satisfactory"in about nine areas of mental health in KSA. Disturbingly, malpractice regulations got rated as "poor" by 71% of the participants. Furthermore, client's confidentiality, which is an identified form of malpractice got the most diverse participants ratings ranging from 20% "excellent" to 16% "poor". These findings are alarming since KSA professionals have divided opinions on this crucial aspect of mental health services. If this is how professionals view client's confidentiality, then on the other hand, clients cannot be blamed for their fear and mistrust toward mental health providers. Previous literature has indicated that privacy matters related to health records in KSA are a concern and a barrier to treatment (Al-Shahrani, 2003); it is essential that these issues be addressed in the immediate future.

Notable issues also emerged around marital and family interventions. The majority of MHPs refer their clients to marital and family therapy providers, yet 91% are not satisfied with the current services that are available to children, couples, and families. With such an enormous indication of professionals' dissatisfaction with these treatment options, I can only speculate that clients will have even lower satisfaction rates. Even in cases where clients may not be aware of the qualifications of the provider, the quality of services is sure to be substandard for many according to these views. It is essential that an increased amount of training is provided for those who are working with these often difficult issues.

There are some differences in MHPs perceptions as to what extent do the 21-items list of topics is presenting critical mental health concerns in KSA; issues such as partner relationship, and child abuse and neglect offers some distinct substantial agreements. On the other hand, there are clear splits on important concerns among professionals as well as gender differences. For examples, elder abuse, discrimination, and gender inequality are topics fully charged with powerful situations of power, control, privilege, and oppression. However, there are currently no statistics on elder abuse, discrimination, or ways to consider gender inequality. Furthermore, in the global mental health literature, there are calls to pay attention to the importance of social exclusion and discrimination in the healthcare system (Collins et al., 2011). In step with this, the mental health care system in KSA will benefit from paying attention to preparing the mental health workforce to encounter the global mental health challenges that are existing in the realm of social exclusion and discrimination when it comes to working with clients and their families in the mental health care system.

Regarding the strengths of Saudi Arabian families, two main themes were identified: Family cohesion and resource themes and Family and culture and custom values theme. Family cohesion and resource themes included descriptions of the valuable notion of kinship and social connectivity and support. Family and culture and custom values theme, on the other hand, describes specifically particular family values and members' relationships toward one another: faith and religiosity, as well as, cultural and custom specific factors. Perhaps those strengths are important for providers to be aware of since identifying strengths, and instilling hopes are important components in the work of mental health care providers.

Religious values were also highly endorsed as a strength; these values were seen to guide and strengthen family life. This is similar to the view of Koenig et al., (2013), who in describing the influence of religion on people of KSA stated, "By far, the strongest influence is religion. Muslim beliefs and Islamic law (Sharia) help to guide and structure every aspect of life, including work, play, dress, diet, social relationships, and behaviors, including ways of dealing with stress" (p.233). Therefore, understanding the strength that is driven from faith is important. Furthermore, this can complicate the client-provider relationship if providers are not aware and accept the diversity that exists within the way people understand and practice the religious faith or the culture itself. It is necessary not to pathologies differences or impose superiority of one way of existence over another. Platt and Laszloffy (2013) discussed the importance of incorporating training that aims to increase self-knowledge about national identity, patriotism, and nationalism in MFT training; adopting similar exploration in trainings will be necessary to prepare a more competent psychotherapist in KSA. However, it should also be important to note that for any mental health provider working within families in Saudi culture, that there is an important intersection between religious beliefs and topics such as gender, gender roles, sexuality, and values, to name a few. In this survey, respondents shared views around these topics and some of them clashed with those religious views of Saudi culture. More work is needed in understanding how to address these issues with families, while at the same time supporting long held religious beliefs.

**Strengths and Limitations.** The strength of this study is that it explored different areas of mental health in KSA, and highlighted domains of where it will benefit from initiating the growth of MFT profession in the country will be a great asset to the current trend of fostering

and expanding mental health to meet the needs of the people. The present study explores topics of concerns that contributed to the mental health that is finally starting to get attention: domestic violence, child abuse and neglect, partner-relationship concerns, and substance abuse. The study assesses MHPs width of knowledge about the different contributing factors for mental health issues. Also, it assesses MHPs satisfactions of the services provided to children, couples, and families, as well as, assessed psychotherapists' general sense of their satisfaction with the training and supervision they receive. Additionally, gender differences regarding the topics of concerns and satisfaction of training were introduced, and this will be a great asset to culturally adapted training and supervision while keeping an eye on the gender differences and accessibility to different populations.

It is important to note that the present study findings can only be an indication of the current trends in the perception of MHPs and psychotherapists who volunteered for this study. There is a need for a larger sample size, for these findings to be generalized to the field. Furthermore, there is a need to ask further questions regarding the curriculum of training that the psychotherapist undergo. Additionally, the 21-items list of questions about the extent of importance of the listed mental health issues in KSA may have caused some confusions and needs further clarification. This current study explored strengths of Saudi Arabian families, yet a limitation that exists was that it did not explore any negative or weakness factors for families that contribute negatively to the overall mental health.

**Future Direction and Implications.** This current study illustrates areas of presenting concerns where professionals may have struggle with in regard to assessment of those critical issues relating to mental health; It might be an unseen area for professionals due to being brought

up with similar societal and cultural messages without examining cultural scripts of gender inequality and power imbalance. Also, professionals might be blinded to realm of social justices and power imbalance existence due to lack of clinical training experience. Therefore, exploring self-of-the-therapists of the providers is an important aspect of the training.

# APPENDICES

Appendix C1

Study Two: Psychotherapists and MFTs Survey

Q1 I have read the previous information about this study, and I consent to participate in the Study.

❍ Yes

❍ No, If No Is Selected, Then Skip To End of Survey

Q2 Are you currently a practicing psychotherapist and /or marital and family therapist in Saudi Arabia? (Including other applicable specialties delivering psychotherapeutic and/or marital and family therapeutic interventions)

❍ No

❍ Yes

Q3 Please list the degree(s) that allows you to practice delivering psychotherapeutic and/ or marital and family therapy interventions?

Q4 Please indicate the followings:

Q5 Age?

❍ Less than 21
❍ 21-24
❍ 25-30
❍ 31-35
❍ 36-40
❍ 41-45
❍ 46-50
❍ 51-55
❍ 56-60
❍ 61 or above

Q6 Gender?

❍ Male

❍ Female

Q7 How long have you been delivering psychotherapy and/or couple and family therapy?

❍ 3-6 months
❍ 6-12 months
❍ 1-2 years
❍ 2-5 years
❍ More than 5 years
❍ More than 10 years
❍ More than 15 years
❍ Other, Specify _____

Q8 Professional job title and specialty?

❑ Mental Health Counselor
❑ Clinical Social Worker
❑ Psychiatrist
❑ Marriage and Family Therapist

❑ Clinical psychologist ❑ Medical Social Worker ❑ Other, please specify _____
❑ Social Worker

Q9 Highest academic qualification?

❍ PhD/ PsyD or equivalent ❍ MD
❍ Master's degree or equivalent ❍ Bachelor's degree
❍ None of the above

Q10 Do you currently provide psychotherapeutic services to children and/or couples and families?

❍ YES
❍ NO

Q11 Do you offer on-line psychotherapeutic services?

❍ YES
❍ NO

Q12 Have you received any clinical training outside of Saudi Arabia?

❍ YES
❍ NO

Q13 Please write the name of the country/countries where you received your overseas clinical training to provide psychotherapy and/or couple and family therapy?

Q14 How long was the duration of your clinical training and supervision overseas to foster and develop your psychotherapeutic and/or couple and family interventions to be practiced independently? (Independently refers here to delivering psychotherapeutic interventions without live or direct supervision during the session).

❍ Week(s), specify_____
❍ Month(s), specify _____
❍ Year(s), specify _____

Q15 How long was the duration of your clinical training and supervision to foster and develop your psychotherapeutic and/or couple and family interventions to be practiced independently? (Independently refers here to delivering psychotherapeutic interventions without live or direct supervision during the session).

❍ Week(s), specify _____
❍ Month(s), specify _____
❍ Year(s), specify _____

Q16 How do you rate your proficiency for practice as a result of the clinical training and the supervision you have received for delivering interventions to individual clients?

❍ Excellent ❍ Fair ❍ Not applicable
❍ Good ❍ Poor

Q17 How do you rate your proficiency for practice as a result of the clinical training and the supervision you received to deliver interventions to children, couples, and families?
check each category.

| | Excellent | Good | Fair | Poor | Not Not applicable |
|---|---|---|---|---|---|
| Children | | | | | |
| Couples | | | | | |
| Families | | | | | |

Q18 Please indicate the type(s) of supervision you have received prior to working independently with your clients (individuals, children, couples, and families)?
(Independently refers here to delivering psychotherapeutic interventions without live or direct supervision during the session).

❑ Shadowing
❑ Direct live supervision via audio
❑ Two-way mirrors or television monitors
❑ Individual Case consultation supervision
❑ Group Case consultation supervision
❑ Videotape supervision
❑ Classroom role-playing
❑ Others, please specify_____

Q19 Are you satisfied with the clinical training that you received prior to working independently with your clients (individuals, children, couples, families)? (Independently refers here to delivering psychotherapeutic interventions without live or direct supervision during the session).

❍ Satisfied
❍ Somewhat Satisfied
❍ Dissatisfied

Q20 If you could have some training added, what are the best training practices and needs that will foster proficiency in psychotherapeutic interventions to children, couples, and families in Saudi Arabia? (list some of the needed growth).

Q21 What are your top theoretical orientation that you deliver with excellent to good proficiency? (List 1-3).

Q22 Do you provide clinical supervision for other psychotherapist/couple and family therapist or trainees on the job? (Clinical supervision focus on the growth of the trainees and therapists to foster clinical implications range from using specific interventions to focusing on the client-therapist relationship)

- ❍ YES
- ❍ NO

Appendix C2

Study Two: Psychotherapists and MFTs Survey (Arabic)

Q1 لقد قرأت المعلومات السابقة حول هذه الدراسة وأوافق على المشاركة في الدراسة.

❍ نعم

❍ لا

Q2 هل أنت حالياً معالج نفسي و / أو معالج زواجي وأسري في المملكة العربية السعودية؟

❍ لا

❍ نعم

Q3 من فضلك أذكر المؤهل أو المؤهلات التي تسمح لك بممارسة تقدِيم التدخل العلاجي النفسي و /أوالاسري والزواجي؟

Q4 الرجاء الإشارة إلى الأتي:

Q5 الفئة العمرية التي تنتمي اليها؟

| | | |
|---|---|---|
| ❍ أقل من 21 | ❍ 36-40 | ❍ 56-60 |
| ❍ 21-24 | ❍ 41-45 | ❍ 61 وما فوق ذلك |
| ❍ 25-30 | ❍ 46-50 | |
| ❍ 31-35 | ❍ 51-55 | |

Q6 ما هو جنسك؟

❍ ذكر (1)

❍ أنثى (2)

Q7 منذ متي وانت تمارس العلاج النفسي أو العلاج الزواجي والأسري؟

| | | |
|---|---|---|
| ❍ 6-3 أشهر | ❍ 5-2 سنة | ❍ أكثر من 15سنوات |
| ❍ 12-6 أشهر | ❍ أكثر من 5 سنوات | ❍ أخرى، حددها |
| ❍ 2-1 سنة | ❍ أكثر من 10 سنوات | _____ |

Q8 يرجى الإشارة الي المسمى الوظيفي وتخصصك؟

| | | |
|---|---|---|
| ❑ أخصائي أرشاد نفسي | ❑ معالج أسري و زواجي | ❑ أخصائي إجتماعي طبي |
| ❑ معالج إجتماعي إكلينيكي | ❑ معالج نفسي إكلينيكي | ❑ أخرى، الرجاء التحديد |
| ❑ طبيب نفسي | ❑ أخصائي إجتماعي | _____ |

Q9 أخر مؤهل أكاديمي حصلت عليه؟

❍ دكتوراه أو ما يعادلها ❍ بكالوريس في الطب والجراحة ❍ ليس ضمن الخيارات السابقة

❍ ماجستير أو ما يعادلها ❍ بكالوريوس

Q10 هل حالياً تمارس تقدِيم تدخلات العلاج النفسي لكلاً من للأطفال و/ أو الأزواج والأسر؟

❍ نعم

❍ لا

Q11 هل تُقدِيم أي خدمات للتدخل العلاجي النفسي عبر الإنترنت؟

❍ نعم

❍ لا

Q12 هل حصلت علي اي تدريب عيادي/إكلينيكي خارج المملكة العربية السعودية؟

❍ نعم

❍ لا

Q13 الرجاء ذكر اسم البلد أوالبلدان التي تحصلت فيها علي تدريبك العيادي/الإكلينيكي للعلاج النفسي و/أو العلاج الزواجي والأسري؟

Q14 الرجاء الإشارة الي مدة التدريب في الخارج التي امضيتها لدعم وتطوير مهاراتك لمزاولة التدخلات العلاجية النفسية و/ اوالاسرية والزواجية باستقلالية؟ (الممارسة باستقلالية تعني أن تباشر العلاج من غير وجود إشراف مباشر أو حي خلال الجلسة).

❍ حدد عدد الأسابيع _____

❍ حدد عدد الأشهر_____

❍ حدد عدد السنين _____

Q15 الرجاء الإشارة الي مدة التدريب التي امضيتها لدعم وتطوير مهاراتك لمزاولة التدخلات العلاجية النفسية و/اوالاسرية والزواجية باستقلالية؟ (الممارسة باستقلالية تعني أن تباشر العلاج من غير وجود إشراف مباشر أو حي خلال الجلسة).

❍ حدد عدد الأسابيع _____

❍ حدد عدد الأشهر _____

❍ حدد عدد السنين _____

Q16 ما تقيمك لكفاءتك للممارسة العلاجية التي تقدمها نتيجة للتدريب العيادي والإشراف المهني الذي تلقيته في تقديمك للتدخلات العلاجية لعملائك الأفراد؟

❍ ممتاز ❍ مقبول ❍ غير قابل للتطبيق

❍ جيد ❍ ضعيف

Q17 يرجى الاشارة الي مدي تقديرك لكفاءتك حيال تقديم التدخلات العلاجية إلى كل من هذه الفئات التالية الأطفال، والأزواج، والأسر؟ أشرلكل فئة.

| الأسر | الأزواج | أطفال | |
|---|---|---|---|
| | | | ممتاز |
| | | | جيد |
| | | | مقبول |
| | | | ضعيف |
| | | | غير قابل للتطبيق |

Q18 يرجى الإشارة إلى نوع أو أنواع الإشراف العيادي والمهني الذي تلقيته قبل العمل بشكل مستقل مع العملاء من (الأفراد، والأطفال، والأزواج والأسر)؟ (الممارسة باستقلالية تعني أن تباشر العلاج من غير وجود إشراف مباشر أو حي خلال الجلسة)

- ❑ الملازمة الصيقة للمشرف أو معالج ذا خبرة
- ❑ إشراف حي عبرالإستماع للجلسة
- ❑ الإشراف المباشر عبر المرآة العاكسة أو التلفاز
- ❑ إشراف إنفرادي للحالة/حالات
- ❑ إشراف جماعي للحالة/حالات
- ❑ إشراف عبر الجلسات المسجلة للمتدرب
- ❑ تبادل الأدوار في ورش العمل أو داخل الفصل الدراسي
- ❑ أخرى، الرجاء التحديد _____

Q19 ما مدى رضاك عن مستوى التدريب العيادي الاكلينيكي الذي حصلت علية قبل البدء في ممارسة العمل العلاجي بشكل مستقل لعملائك لأحد الفئات التالية (أفراد، أطفال، أزواج، أو أسر)؟ (الممارسة باستقلالية تعني أن تباشر العلاج من غير وجود إشراف مباشر أو حي خلال الجلسة.)

- ❍ راضي
- ❍ راضي الى حد ما
- ❍ غير راضي

Q20 إذا كان بإمكانك إقتراح بعض طرق التطويرالمطلوب في التدريب، ماهي أفضل الطرق التدريبية التي من شأنها رفع مستوى كفاءات الممارسات العلاجية لفئة الأطفال، الأزواج، أوالأسر في السعودية والمهارات الإكلينكية للمعالج ؟
عدد بعض نقاط التطويرالمطلوبة.

Q21 ماهي النظريات العلاجية التي تستخدمها بكفاءة جيدة او ممتازة في مجال التدخل العلاجي؟
عدد من3-1

Q22 هل تقدم خدمة الإشراف العيادي المهني لكل من المعالجين النفسيين أو المتدربين في العلاج النفسي لمن هم علي رأس العمل؟ ) الإشراف العيادي المهني يركز علي تطورو نمو مهارات المعالج من تعزز للتدخلات العلاجية إلي التركيز علي العلاقة العلاجية بين العميل و المعالج.

- ❍ نعم
- ❍ لا

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# CHAPTER 4: MANUSCRIPT III

## Professionals Training and Services in Mental and Social Health in Saudi Arabia: A Modified Delphi Study


## ABSTRACT

Evolving efforts to improve mental health and social health care is recently taking place in the Kingdom of Saudi Arabia (KSA). However, training and cultural challenges for providing services for marital and family therapeutic interventions have yet to be understood. This study utilized a modified Delphi methodology to identify the common training barriers and solutions for mental and social health services and identified cultural challenges for working with relationally based concerns. Panelists from KSA with various mental and social health backgrounds were sought to determine and reach consensus on barriers and solutions to mental healthcare challenges. In the study findings, panelists strongly endorsed barriers for access to professionals, availability of services and facilities, the current status of collaborative care, and other related needed supports. Although cultural challenges were identified as a problem, there remains widespread confusion as to how to deal with these issues as only a few topics and solutions reached consensus from the panel. In addition, implications and future direction are discussed.

*"Starting with the practice can lead to the creation of a profession once it is determined that the body of knowledge and requisite competence is truly unique."* (Northey, 2009, p. 313).

## Introduction

Providing proper therapeutic supports, such as marriage and family therapy (MFT), to foster human beings' psychological and emotional needs, is an important medium to cultivate and enrich mental and family health around the world. In the development of any of the helping professions, obstacles prevail, yet any profession grows in spite of the barriers by taking concrete and strategic steps. There are a number of studies that examine MFT in a global and international context, including many of the encountered obstacles and needed solutions for MFT success across the globe (See DuPree, et al., 2012; Ng, 2005; Roberts et al., 2014). Despite the previously mentioned literature, there are shortages in studies of marital and family therapeutic interventions in the context of the Kingdom of Saudi Arabia (KSA).

Some forms of MFT practice in KSA have begun to occur, yet these growing sprouts are in danger of a rapid expansion, resulting in a way of working that carries the title of the profession yet falls short of the needed regulations and competencies that ensure envisioned outcomes. This current study aims to identify barriers and solutions to delivering psychological interventions to individuals, couples, and families in KSA. Moreover, the study intends to fill the gap in the literature about the needs that are particular to KSA as a country located geographically in the Middle East, with an Arabic-speaking population and culture, and home to individuals living in an Islamic conservative and collectivist society. Therefore, a review of some of the challenges and identified needs in services and professionals' training will be considered.

## Challenges and Needs

For the purpose of this present study, barriers are challenging elements that hinder the development of psychotherapeutic interventions for individual as well as relationship based concerns such as intimate relationships and the parent-child relationship. The following section will present some of the current cultural and societal barriers, mental health professional qualifications, and available training in KSA.

### Cultural and Societal Contextual Challenges

There are numbers of constraints that stem from societal, cultural practices, and beliefs. In a review of 22 published studies on Arab countries in the Middle East; 54% of the barriers to psychosocial treatment implementations are obstacles concerning acceptance of interventions within the cultural context (Gearing et al., 2012). Some of the mentioned local cultural contexts in the previous reviews are in the forms of beliefs and values, stigma, and alternative help seeking tendencies.

Sewilam et al. (2014), in their reviews of literature on societal stigma related to mental health and its treatment, conclude that that although individuals are more aware of mental health difficulties, stigma still exists, and it has substantial effects on the treatment of those who need mental health interventions. Another more recent research study, also from Arab countries, indicates that stigma associated with mental conditions influence clients and their families' overall health and well-being as they are unlikely to acknowledge their difficulties and receive the treatments they need (Dardas & Simmons, 2015).

In KSA, a focus group study explored the topic of stigma with general females attendees' of primary health care centers in one of the cities in KSA (Koura et al., 2012). Participants in the

study reveal that traditional and cultural norms during early life stages of development, fearfulness of psychiatry, and clients who they viewed as angry and violent all contributed to stigma. Moreover, participants believe that mental health disorders are not curable and are hereditary. Additionally, participants are fearful that in legally conflictual cases, medical records may get used against the patient in the courts. Furthermore, Shahrour and Rehmani (2009) investigated psychiatric stigma with general hospital staffs in KSA, and concluded that medical personnel hold an overall medium index of stigma relating attitudes on a nine-point Likert scale as follows: Fear (4/9), avoidance (4.89/9), and dangerousness (4.3/9). In another article describing mental health in KSA, the authors conclude that: "Mental health care also takes place within the nuclear and extended family, and such problems are often kept a secret." (Koenig et al., 2014, p. 120).

A possible challenge to the therapeutic alliance is the cultural and societal attitude of maintaining privacy in KSA. Al-Shahrani (2003) points out that in KSA, some individuals reject sharing and are reluctant to get involved in getting services due to wanting to maintain personal matters private to safeguard personal privacy. Also, Tashkandi and Rasheed (2009) found that only one-third of the participants who are Saudi females attending primary care centers discuss the incident of abuse with their providers. Stigma, maintaining privacy, and secrets are among the words used to refer to societal and cultural reasonings that address possible obstacles to accessing help for individuals and families.

Previous studies highlight that the first line of help seeking for mental health needs usually involves non-mental health professionals such as faith and traditional healers. An example from one study highlighted that among the 321 visitors to faith healers in KSA, many

included individuals experiencing mental health concerns, especially depression and anxiety (Alosaimi et al., 2014). Another study by Al-Solaim and Loewenthal (2011) indicated that the most common explanation given by faith healers to clients with Obsessive-Compulsive Disorder (OCD) was that the symptoms were causes by an evil eye (an evil eye, in the Islamic religion, is explained as symptoms in which resulted by admiration of an object or a personal attribute by someone who has shown admiration unaccompanied by reciting the name of God). Therefore, the authors claim that individuals approach faith healers for psychological symptoms that resemble some religious and cultural specific concerns. Spiritual disorders in the form of the evil eye, jinn (possession), and magic are all common patterns of symptoms presented, in another study composed of 45 faith healers (Al-Habeeb, 2003). Individuals approach faith healers for the following symptoms: Anxiety, fearfulness to develop a disease, obsessive thinking, insomnia, depressive symptoms, chest oppression, talkativeness, hyperactivity, family conflicts, family estrangement, psychotic disturbances, and violent behaviors (Al-Habeeb, 2003). As it appears from previous studies, people seek traditional and faith healers for mental health concerns including relationally base concerns.

Seeking out faith healers is problematic in that they may have little knowledge of mental health, and may delay the connection of individuals with a competent treatment provider. An illustration of this issue comes from a study of 15 Saudi females with OCD, the participants indicate that they spend six months to one year consulting a faith healer before deciding to seek help from a mental health professional (Al-Solaim & Loewenthal, 2011). Other problems with the current practice of providing faith and traditional healing are not only on their limited knowledge of mental health but overall on their competencies, which are beyond the discussion

of this present review.

The above explored previous literature findings are only some of the examples of cultural and societal beliefs and norms that hinder seeking and receiving mental health services in KSA. Provider qualifications and training are another areas of challenge to mental health service delivery in KSA.

**Provider Qualifications**

Professionals who are working under the umbrella of the healthcare sector in KSA, get their licensure through the Saudi Commission for Health Specialties (SCHS), which has established a manual spelling out qualifications required of professionals who provide services in the healthcare sectors (SCHS, 2014). The professional specialization manual states that a graduate with a bachelor's degree and a three-month internship focused on practical training is classified as an assistant psychologist; furthermore after three years of working under supervision from a senior specialist or consultant is due to a promotion to be a specialist psychologist (SCHS, 2014). Along the same line, individuals with bachelor's degree in sociology or social work are classified as a sociologist or social worker without specification of training; those with a master's degree in social work or sociology are classified as senior specialists. Additionally, consultant classifications requires a Ph.D. degree or equivalent (SCHS, 2014).

Some private practitioners fall under the healthcare sector, while some private practitioners and agencies who provide interventions for relationship based concerns fall under the Ministry of Social Affairs. Moreover, life and health coaches are starting to emerge in KSA, and there is an absence of information on their qualifications in the country due to the recency of this practice.

**Current Training Programs.** A variety of diverse and disconnected training programs currently exist in KSA. An example of psychology curriculum taught in KSA reported in El-Naggar (2012) article. The author describes that at King Saud University, there are two tracks: the first track prepares students to teach psychology at the high school level and the second track is the psychologist track, which is established at an undergraduate level to prepare students to be psychologists. Furthermore, in medical curricula in KSA, behavioral sciences receive less attention (Chur-Hansen et al., 2008). There is an urgent need to reform medical education and to add more behavioral science knowledge to meet the demands for mental health care (Chur-Hansen et al., 2008). Additionally, there is a family counseling diploma degree at Al-Imam Muhammad Ibn Saud Islamic University, but this is the only one in the country.

**Concerns with the Current Status of Qualifications and Training.** Some of the previous studies have referenced the inadequate clinical training in mental health in KSA. For example, previous study findings on professionals' views on their qualifications indicate that counselors criticized their education which is described as being heavily focused on theories (Al-Bahadel, 2004). In another study of social workers, 54.8% of participants reported that they are expected to perform tasks, despite the fact that they feel that the training is short of meeting the responsibilities assigned, and they feared that it would affect their role performance (Albrithen & Yalli, 2013). In another study, social workers indicated dissatisfaction with the learning curricula (Al-Shahrani, 2003).

Due to the lack of enough academic literature that provides more details on the current psychological interventions provided, Saudi Arabian newspaper articles illustrate the public and government officials' perceptions of some reality of mental health status and concerns. The

newspaper articles highlight concerns such as: chaotic practices of professionals when it comes to delivering psychological interventions, professionals lacking proper qualifications, malpractice, lack of services for psychiatric clients, and discussed problems with the current practice of family counseling and MFT (See Al-Baamer, 2016; Al-Moflah, 2008; 2010; 2012; Al-Sadhan, 2012; Alriyadh Newspaper, 2013; Bashtah, 2004).

**Needs.** The discussion of inadequacies and potential solutions in the previous literature often offers suggestions for the stigma, privacy, and dependency on faith healers as the first line of help seeking. Dardas and Simmons (2015) recommend overcoming the stigma of mental illness in Arab families by promoting mental health through awareness implementations in academic curricula, media, and to integrating mental health services in general health settings. Moreover, Alosaimi, et al. (2014) suggest the involvement of non-governmental agencies, universities, and the use of media to decrease stigma.

Additionally, Gearing et al. (2013) believe that more awareness will lead to greater utilization and acceptance of mental health treatments. In previous literature, the need for implementing awareness is not mentioned exclusively for the clients. For example, Sewilam et al. (2014) proposed involving family members in supporting one another to overcome shame, to get faith or traditional healers and religious leaders involved, and to utilize social media. Moreover, it is crucial to educate faith-healers on common psychiatric symptoms and the necessity to refer patients for mental health interventions (Alosaimi et al., 2014). Other researchers suggest that education and direct contact is the best way to tackle stigma for general medical staff (Shahrour & Rehmani, 2009).

Regarding adequate training and qualifications, some of the previous studies have called

for urgency in improving the current training and skills by advancing the universities' curricula to develop a more concentrated clinical preparation (See Al-Bahadel, 2004; Albrithen & Yalli, 2013; Al-Habeeb & Qureshi, 2010; Al-Shahrani, 2003; Bin Hussein, 2003). Globally, some research on MFT in other countries has emphasized the demands for training materials, supervision, and support networks to develop further the profession of MFT (Roberts et al., 2014). Additionally, some of these other countries are facing challenges related to accreditation and recognition of the MFT profession (DuPree, et al., 2012; Ng, 2005; Roberts et al., 2014).

Based on the disjointed state of mental health in KSA, in the current study I set out to explore the following items: 1) To identify common barriers and solutions to services and training for mental and social health services for individuals, couples, and families in KSA; and 2) To identify cultural challenges and therapist needs to work successfully with relational concerns. Using a Delphi method, I aimed to poll a panel of KSA mental health experts on their views of these two questions in KSA.

## Method

Dawson and Brucker (2001) highlight the utilization of Delphi method in MFT research, specifically where there is dissension and confusion. The Delphi methodology is a good fit for this current study since it is investigating an area of exploration that does not have a clear conceptualization of the barriers and solutions to implementing psychotherapy and MFT as coherent professions in KSA. "The Delphi method attempts to negotiate a reality that can be useful in moving a particular field forward, planning for the future, or even changing the future by forecasting its events" (Stone Fish & Busby, 2005, p. 239).

This current study is the final phase of the multiphase study and it utilizes the modified Delphi methodology to poll, via means of two rounds of surveys, a panel of identified experts, and arriving at a consensus on questions of interest. The Delphi method will help in providing a consensus of what local experts in KSA recognize as disparities in current marital and family therapeutic interventions provided as a result of deficiencies in preparing professionals to face the challenges of mental and family health needs in a fast evolving society.

The Delphi approach has been applied in some areas of research including curriculum development, training, and supervision (Hovestadt, Fenell, & Canfield, 2002; Israel, Ketz, Detrie, Burke, & Shulman, 2003; Sburlati, Schniering, Lyneham, & Rapee, 2011). For example, in a study by White and Russell (1995), a modified version of the Delphi was used to get a consensus on supervisory variable in training of MFTs, and in another study by Blow and Sprenkle (2001), the Delphi method was used to establish consensus about common factors across theories of marital and family therapy. A Delphi study has two or more rounds of surveys that build on each other. Usually in the first round, participants respond to open-ended questions about the topic of interest. In the second round, participants respond to questions generated from first round responses and rate their agreement with these responses on a seven-item Likert scale. Median scores and interquartile ranges are then used to identify areas of consensus in the responses of participants.

**Panel Selection**

For an effective Delphi study, it is important to have a panel of experts related to a particular topic. Experts in KSA were approached to participate based on their expert knowledge of current mental health prevalence and services provided in KSA. According to (Nelson &

Allred, 2005) this form of sampling is "purposive" or "expert." Panelists were a heterogeneous group of those working in academia and mental healthcare settings in KSA. A list of 55 potential panelists was generated based on publications, national reputation, web searches for university faculty, and mental health professionals in the field of social science. Furthermore, participants in earlier phases of the overall study were asked to provide recommendations of mental health experts in KSA. Moreover, contacted panelists were invited to list names of others who fit the criteria. Panelists needed to meet at least four of the following criteria: (1) Hold a qualifying degree (MA, MS, Ph.D.); (2) Have at least five years of clinical mental health related experience working with individuals, children, couples and families in KSA; (3) Have at least five years of teaching experience in the area of clinical work, diagnosis, and treatment in KSA; (4) Have experience supervising a psychology/social work student trainee in KSA; (5) Have conducted workshops/courses in provide training on specific approach/interventions in KSA; (6) Hold a license from the Saudi Commission for Health Specialties, or any other alternative accreditation; and (7) Have peer-reviewed publications regarding KSA mental health and social health services.

Panelists were first asked to fill in a short demographic form to gather information about their age group, degrees of qualification, years of experience, current jobs title, work setting, and information about where they completed their training and education. This information was essential to help explain unusual distributions appearing in the data (Stone Fish & Busby, 2005).

An email with the study invitation was sent to 55 potential panelists with diverse expertise in disciplines related to mental health in KSA. For round one, invited panelists were sent a message describing the written purpose of the study and the need to seek professional input on a series of questions related to mental health in KSA. In addition, participants were

oriented to the confidentiality procedures of the study and were informed that their names or the institutions that they belong to would not be a part of any publication or presentation related to the study. Moreover, since the process of completing the survey was lengthy, panelists were informed that they would be included in a drawing for one iPad mini as an incentive for their time and for sharing their knowledge.

**Procedures for Delphi**

All of the questions and items listed were translated into Arabic; data were collected in both Arabic and English, and Arabic responses were translated back to English when necessary. The two rounds of the survey were administered via Qualtrics software. The first round Delphi questions were generated based on the literature review along with data collection and descriptive analysis responses to surveys distributed during phase one of this multiphase study. The six inquiries that were asked in round one are as follow:

(1a) List the most common barriers that hinder seeking mental and social health services for individuals, couples, and families in KSA?

(1b) List the necessary solutions to foster more effective mental and social health services for individuals, couples, and families in KSA?

(2a) List the most common training barriers for professionals who deliver/or desire to deliver effective therapeutic interventions to individuals, couples, and families in KSA?

(2b) List the necessary solutions for improved training of professionals who deliver/or desire to deliver therapeutic interventions to individuals, couples, and families in KSA?

(3a) A recent web survey was conducted about professional's perception concerning Saudi Arabia mental health in general, and specifically about marital and family

therapeutic practices. The majority of the participants in the study agreed that there are a number of important presenting mental health concerns in Saudi Arabia, many of which require marital and family therapeutic interventions. What do you see as the biggest cultural challenges working with individual, couples, and families in working with family related mental health problems? Provide examples.

(3b) What do therapists need in order to successfully treat these types of presenting problems?

In round one, out of the 55 potential panelists who were initially invited to participate in the study, 28 panelists provided responses to these six questions. A lower response rate is normal and expected in research studies in KSA. Responses to these questions were summarized and collapsed in cases of redundancy, to ensure that the list of items included non-overlapping responses. Moreover, the summary of the responses from the first round was circulated among other graduate students before the commencement of the second round of Delphi to ensure that the questions were posed with clarity. The translated version of the items was reviewed extensively by myself and three other Arabic speaking individuals to ensure its clarity and readability in Arabic. In round two, a list of 135 items compiled from round 1 was sent to the 28 panelists. Twenty panelists completed the second wave of the Delphi; these panelists were asked to respond to each item on a seven-point Likert-type scale indicating their agreement, disagreement, or neutrality related to each particular item.

**Data Analysis for Delphi Method**

According to Stone Fish and Busby (2005), Delphi analysis procedures involve computing "medians" and "interquartile ranges" to find out agreements among the panelists.

Findings were determined based on the following: strong consensus on items as indicated by a median of six and above and interquartile range (IQR) of 1.5 or less (Stone Fish & Busby, 2005). In addition, consensus criteria determined for this study were as follows: Moderate consensus is achieved when the median is in the range of 6.50 to 7 and IQR above 1.5 - 2.0; also when medians are in the range of 6 to 5.50 and IQR equals 1.75 or less. Other items that did not make the strong or moderate consensus are classified as weak or no consensus.

## Results and Discussion

The following section cover the results and discussion of the findings on the participants' characteristics and the Delphi method results. The results and findings discussion section is combined for this paper, which is a common practice for the Delphi method studies in MFT (See Blow & Sprenkle, 2001; Fish & Piercy, 1987; Sori & Sprenkle, 2004).

### Participants Characteristics

Only 28 out of the 55 experts invited to the study responded to all or parts of the six questions. The second round response rate is 71% where 20 out of the 28 invited completed the two rounds. The first round had 61% male participants and 39% female participants; while the second round had 60% male participants and 40% female participants. Eighty-six percent identified their highest educational degree as Ph.D. or equivalent, and the others as master's degree holders in the first round. The second round had 85% panelists with Ph.D. or an equivalent degree.

Demographic data gathering from the first round indicated that panelist ages ranged from 31 to over 60. The majority of panelists identified their work setting as an academic institution with (n = 17; 61%); followed by hospital setting (n = 14; 50%), and private practice (n = 3;

11%). At least 25% of the panelists in the first round indicated more than one work settings. The average years of clinical experience were 16 years, teaching were 14 years, and supervision were 13 years.

Moreover, panelists came from diverse fields such as academicians in social science fields, clinical psychologists, counselors, MFTs, psychiatrists, and social workers. The majority of the panelists indicated that they had at least one degree from KSA but most had degrees from other countries as well including from Western nations, countries in the Middle East, and from South Asia. Only two identified that they obtained their degrees from KSA exclusively. Eighteen percent (n = 5) of the panelists were not Saudi nationals but are presently working in KSA. Additionally, all the participants indicated that they have conducted workshops or given courses about clinical training on specific approaches or interventions. Furthermore, 36% (n = 10) of the participants reported that they have publications regarding mental health and social health in KSA.

Regarding the type of licenses and accreditations held, over 50% indicated that they have a licensure to practice from the Saudi Commission for Health Specialists, while others noted overseas licensure, belonging to an organization, and some just included a country name or their professional title. An example of a panelist response is: “No licensure available in my country.”

**Delphi Results**

The six questions that were asked for round one generated 135 items that were used for round two of Delphi. Forty-six percent (n = 62 items) made it into the final items list with strong consensus (Table 4.1, 4.2, 4.3, 4.4 and 4.6). The findings and discussion of these six areas are provided in the following order: Common barriers that hinder seeking help, solutions to fostering

effective services, common training barriers, the necessary solution to improve training, biggest cultural challenges, and therapist needs.

**Common barriers that hinder seeking help.** In the first category a total of 28 items, 11 items received strong consensus; and three received moderate consensus (Table 4.1). Items that were endorsed with strong consensus as common barriers that hinder seeking mental and social health services were as follow: stigma, access to professionals, availability of services and facilitators, and the current status of collaborative care and related support. Moreover, items that were endorsed with moderate agreements consensus were the lack of awareness regarding understanding the different roles that each professional plays and that unawareness about the beneficial aspects of counseling and psychotherapy and early interventions. In addition, the item that received moderate consensus was also on the access to professionals; specifically concerning that most qualified competent professionals are hired by specific government or corporate hospitals that serve only specific populations.

***Stigma.*** Stigma as a barrier, reached strong consensus when it comes to clients/families' experiences of fear related to their social reputation and image. These findings are consistent with previous research on social stigma (See Dardas & Simmons, 2015; Koura et al., 2012; Sewilam et al., 2014; Shahrour & Rehmani, 2009;). Findings did not reach consensus on items on stigma as it relates to clients or families experiencing feelings of shame and disgrace or fear of being seen as defective.

***Access to professionals.*** Items that received strong endorsement were about the existence of the shortage of competent and adequately trained practitioners, and not attaining the needed help for distinctive problems due to the limited number of professionals with specializations. The

results are in agreement with previous literature that discussed the shortage of professionals in KSA ( Al-Habeeb & Qureshi, 2010; Al-Shahrani, 2003; Albrithen & Yalli, 2013; Alghamdi & Riddick, 2011; Almoshawah, 2005; Bin Hussein, 2003; Koenig et al., 2014).

Moderate agreement was endorsed for the statement that most qualified professionals are hired by a specific government agency or corporate hospital. This finding from previous report on mental health system in KSA, that 80% of the psychiatrists work in public health facilities, and about 60% of the psychosocial staff (psychologists, social workers, occupation therapists) work in government agencies (Qureshi, Al-Habeeb, & Koenig, 2013); however, no previous studies linked their qualifications with the place of practice.

***Availability of services and facilities.*** High consensus was reached for the high cost of treatment, quality of services provided, low availability of community mental health services and addiction focused centers, lack of support for establishing psychological clinics, and clarity and procedures related to pharmacological psychiatric treatments. According to previous study findings by Al-Shabrain and Alhabib (2015), clients attending private psychological clinics in KSA reported that they are dissatisfied treatment fees, short allocated times for their visits, and for waiting for their appointments. In addition, previous studies also discussed the need for community mental health services (Al-Habeeb & Qureshi, 2010; Qureshi, Al-Habeeb, & Koenig et al., 2013).

***Current status of collaborative care and related support.*** There was strong consensus when it came to barriers as in the limited connection between professionals and school, as well as more support were needed from the Ministry of Health for developing mental health services. These issues are equivalent to the outlined needs in the mental health system in KSA that

reported the lack of financial support from the government (See Al-Habeeb & Qureshi, 2010; Qureshi, Al-Habeeb, & Koenig, 2013; Koenig et al., 2013; & Koenig et al., 2014). Previous studies focused on the needs of school counselors concerning support that comes from school principles, teachers, and parents (Alotaibi, 2014; Alghamdi & Riddick, 2011). More collaborative work is needed to be in place for school counselors and other mental health professionals.

***Lack of awareness.*** Moderate consensus was reached for items of clients' understandings of the role of psychiatrists versus psychotherapists and of being unaware of the beneficial aspects of seeking counseling or psychotherapy and the importance of early interventions. Lack of awareness has been discussed in some previous literature as it was related to a pattern of seeking faith healers before seeking mental health help (Al-Habeeb, 2003; Al-Solaim & Loewenthal, 2011; Alosaimi et al., 2014).

Additionally, no consensus was reached for items concerning privacy, confidentiality, the lack of trust, and existing misconceptions about the field as a common barrier with lower medians of 4 and 5 and with a larger IQR, which indicates this area that panelist has a larger dispersion of responses when it comes to identified barriers. Although previous literature illustrates that some studies indicate that problems are usually kept as a secret (Koenig et al., 2014), and maintaining privacy in KSA is a potential barrier to the therapeutic relationship (Al-Shahrani, 2003). Perhaps the way the statements is written has given the impression that it is generalizable to the entire field, which not necessarily true. This item was generated from panelists from round one and got large dispersion of response that might indicate that it is an area that needs attention. In a more recent study that surveyed clients attending private psychological

clinics, participants reported satisfaction toward their physicians keeping their confidential information private (Al-Shabrain & Alhabib, 2015). Confidentiality is a wide spectrum and there are laws and regulations that may protect confidential communication.

Misconceptions did not get any consensus, which is surprising finding. This nonconsensual result signals that there are more awareness about mental health by clients in the view of the panelists.

**Solutions to fostering effective services.** Panelists showed strong consensus on 16 out of the 24 items listed in this section; one item received moderate consensus (Table 4.2). Panelists had reached a strong consensus and endorsed all the identified necessary solutions to foster professionals, implement solutions as related to clients/families, services expansions, collaboration, and increasing awareness. The strongest consensus with (median = 7; IQR = 0) was for a finding relating to the need for the development of community mental health services across the nation.

***Professionals delivering the interventions.*** Important strong endorsements were allocated to concerns of more training and supervision needs, which is in line with previous literature that was cited under access to professionals in the earlier section about the needs to increase training, more graduates of postgraduate programs, more psychologists, and more social workers. Panelists have endorsed measuring clinical performance and restrict the practice to qualified professionals.

***Solutions related to clients/families.*** There was strong consensus for enforcing patient's rights by prioritizing confidentiality through securing their information. These results are surprising when compared with the findings from the first category about common barriers,

which reached no consensus for items concerning privacy, confidentiality, and the lack of trust. A previous study showed that clients reported that they agree that their providers maintained their information confidentiality (Al-Shabrain & Alhabib, 2015). Perhaps when the statement is written as a solution versus barriers it got more acceptance. The regulation for implementing the mental health systems (Ministry of Health, 2016) has recently came out during the writing of this manuscript and did address different aspects of securing the clients medical record and release of information, as well as set consequences for those who break them.

Additionally, panelists reached moderate consensus on training qualified specialists who represent both genders to allow for more availability of same-gender providers for clients and families. These findings are reflective of the cultural and societal gender segregation and interactions that often prefer same-gender interactions. Previous literature review on the gender of therapists in the MFT profession indicated that the therapist gender is relevant when it comes to family members reactions toward the therapist; it also indicated that it is possible that if therapists do not mediate gender tensions successfully in therapy, they will lose the opportunity to help the family their concerns (Blow, Timm, & Cox, 2008).

***Service expansion.*** There are some strong and some moderate consensus on recommended solutions for service expansions. The strongest consensus was related to the need for the development of community mental health services across the nation. It is possible that these findings are similar to the previous report that emphasized the needs for community mental health services (Qureshi, Al-Habeeb, & Koenig et al., 2013).

***Collaboration.*** There was a strong consensus on collaborations needed with government agencies such as courts and the Ministry of Health to provide a strong mental health system.

Recent existing literature shows that there is some improvement in the courts; divorce and child custody case are presented in court after being assessed by a social worker and psychologist (Aloud, 2015). More of these collaborations is needed as suggested by the findings from this present study.

***Increasing awareness.*** There was strong consensus on the need to increase awareness of mental health through working with the media and the religious institutions. Similar to previous findings from earlier sections of this study, the lack of awareness was only endorsed with a moderate agreement. Sewilam et al. (2014) suggested that involving religious leaders might be useful to bring more awareness to mental health in KSA.

**Common training barriers.** In the third category, panelists reached consensus on nine out of the 23 items listed in this section (Table 4.3). There was a strong consensus on the common barrier identified as lack of competent trainers (median = 7; IQR = 1). Concerning training sites as barriers, a strong consensus was concerned with issues related to the lack of explicit criteria, regulations, and procedures in sites as well as inadequacies in the available settings, and the lack of training institutions with a good understanding of the role of marital and family counseling. Additionally, all the items on the supervision questions were endorsed as common training barriers with (median = 6; IQR = 1). Moreover, there was a strong consensus on barriers related to education when it comes to the scarcity of local training program and availability of training materials in Arabic.

There was no consensus when it came to identified barriers as related to funds gap, future employment, accreditation and licensure, and clarity in professionals' roles. There was a large dispersion of panelists reaching consensus for endorsing issues related to lack of licensure in

regard to regulating mental health standards and standards for the profession as a whole (median = 5; IQR = 4).

***Lack of competent trainers.*** There was strong consensus for common training barriers as the existences of pseudo-professionals who profit out of training others. There is scarcity of peer-reviewed literature about this topic. However, there are plenty of references to this concerns in newspaper and media that discuss unqualified individuals who practice such as family counselors and consultants without proper qualifications (See Al-Moflah, 2008; Al-Moflah, 2010; Al-Moflah, 2012; Baamer, 2016; Bashtah, 2004).

***Few training sites, supervision, and education***. Those three sections are highly interconnected therefore the findings will be discussed collectively. Panelists reached strong agreements that there are needs for more sites and for psychological clinics that offer state of the art training and supervision. Previous literature has also emphasized the need for more training for mental health professionals including psychologists and social workers in KSA (Al-Habeeb & Qureshi, 2010; Al-Shahrani, 2003; Albrithen & Yalli, 2013; Alghamdi & Riddick, 2011; Almoshawah, 2005; Bin Hussein, 2003; Koenig et al., 2014). Furthermore, previous literature on global mental health, has indicated that one of the top global mental health challenges is building human resource capacity by providing a model of training that enhance providers skills to deliver evidence-based services (Collins et al., 2011).

Moreover, all the items under supervision that ranged from the scarcity of qualified supervisors and training programs that offer sufficient clinical supervision and have clear criteria to what constitutes clinical supervision were strongly endorsed. The prior literature discussed training in general and the needs of more practical versus theoretical, yet no studies were found

that discussed what defines and articulates what constitute clinical supervision.

Concerning education, a strong consensus was reached that there is a scarcity of local training for post-graduates who desire to get training to go abroad as well as an insufficiency of Arabic training materials. The cultural adaptation framework for treatment delivery points out several elements that are essential. Among them is language, for its importance elements of being syntonic to the culture (Bernal & Saez-Santiago, 2006). The findings from this study indicate that there is a need to create localized training that offer training materials in Arabic to fill the current gap of trained professionals. Cultural adaption extended to those who provide the services, therefore, making training available in Arabic is essential.

Some of the items that did not reach consensus and were barriers as related to gaps in funding, future employment, accreditation and licensure, and clarity in professionals' roles. Needs of further funding of mental health services was reported in the previous study discussing mental health systems in KSA (Qureshi et al., 2013). Additionally, lack of licensure regarding regulating mental health standards and the profession as a whole, received a broad range of distribution of panelists agreement to these statements. Perhaps the findings came out with a dispersion since some of the panelists listed overseas licensure, belonging to an organization, or wrote the country name or their professional title instead of listing licensure; nearly a little more than half hold licensure of practice from the Saudi Commission for Health Specialists.

**Necessary solutions to improve training.** In the fourth category, 15 items out of the 22, received high consensus, and one item received moderate consensuses (Table 4.4). Panelists had strong consensus on the need for professionals to deliver interventions, details on enhancing collaborative efforts, needed logistical changes, ways of enhancing training programs, and

professionals' development, and supervision. Necessary solutions to enhance training programs and professional development received strong consensus for increasing hours of clinical training and providing practical training workshops with (median = 7; IQR = 1). Additionally, similar strong consensus reached for the need to have a qualified training headquarters with a clearly defined set of requirements and also to emphasize the need to establish trust, protect patient's right to privacy and confidentiality, and to discuss ways to break through stigma, privacy, and trust barriers during training.

Among the items that received nonconsensus when it came to improving training was the medium of teaching. Panelists reached nonconsensus with (median = 5; IQR = 4) for suggested solution as improving training, which specified to have all mental health fields medium of teaching to be in English at (median = 5; IQR = 4). Other items that did not reach consensus were to transfer mental health-related major specialties to colleges of "science or applied sciences/ health sciences." Also, among nonconsensus items were needs for adequate funds to be used to develop programs and related materials that would meet the needs of Saudi culture, and to provide trainers with rewarding salaries.

***Professionals delivering the interventions.*** Items on this section of the category were previously endorsed by the panelists of this study under the necessary solutions to foster more effective services findings. Furthermore, the results were similar to previously discussed literature on the needs of more professionals training (See Al-Bahadel, 2004; Al-Habeeb & Qureshi, 2010; Al-Shahrani, 2003; Albrithen & Yalli, 2013; Almoshawah, 2005; Bin Hussein, 2003; Koenig et al., 2013; Koenig et al., 2014; Qureshi, Al-Habeeb, & Koenig, 2013). The addition to this category were items that state the needs for establishing a unified legislative body

that set practice requirements for specialists set clear code of ethics for professionals working on delivering therapeutic interventions to individuals, couples, and families.

Although, there are some existing regulations such as healthcare practitioners code of ethics (SCFHS, 2014) and regulations and rules for eligibility for family counseling centers by the Ministry of Social Affairs (MOSF, 2014). It is possible that the findings of this study signify the needs for a national commission to regulate practices in healthcare and governmental non-healthcare affiliated settings that provide services to couples and families.

***Enhancing collaborative efforts and needed logistical changes.*** Strong endorsements were established for creating a national plan that involves the different ministries involved in training to collaborate, establish accredited local training programs, and create postgraduate programs in collaboration with Western institutions. These findings are in line with previous literature that called for collaborative work among the Ministry of Health and Saudi universities (Alrabiah, 2002).

***Enhancing training programs and professional development.*** Repeatedly this is an area that received strong consensus as barriers, as well as proposed solutions for both receiving services and trainings of professionals. In particular, what distinguishes the findings in this section is that the solutions were endorsed for increasing hours of clinical training, and providing experiential training workshops that focus on competencies. Moreover, endorsement was provided for the need for qualified training headquarters and a surveillance body that monitors the quality of the training curriculum. There are existing bodies that monitor training, such as the one in the Saudi Commission of Health Specialties, which has a general training centers established with accreditation regulations (SCHS, 2014); perhaps more is expected out of these

training programs and centers.

***Supervision.*** In this section, the need for more supervision received strong consensus similar to findings from the common barriers in training category. Panelists endorsed strongly requiring individual and/or group supervision and follow-up supervision after intensive training courses. Also, a moderate consensus was reached concerning standardized training and establishing competencies in supervision from overseas countries.

Regarding items that did not reach consensus with large dispersion are related to having the English language as the medium of teaching as solutions for improving training. Additionally, in the previous section, panelists endorsed strongly that there are few training materials and that overall, trainees have poor English language proficiency. The dispersion of consensus might be explained in that the majority of the panelists received their training overseas likely in English, and it might be easier and more convening for some to provide training in English. This dispersion in the median and IQR, signals a needed attention to be given to self-of-the-trainer/educator/professional work. Similarly, attention to language, persons, metaphors, content, concepts, goals, methods, and context are the eight elements of cultural adaptation for delivering interventions with ethnic populations (Bernal, Bonilla, Bellido, 1995; Bernal & Saez-Santiago, 2006). Elements of the cultural adaptation framework for working with ethnic population are suitable to be utilized in meeting training needs of mental and social health professionals in KSA.

**Biggest cultural challenges.** None of the items in the fifth category got high or moderate consensus in this section. It is important to note that this section received an overall lower median and larger IQR (2-6). Therefore, all items that related to the biggest cultural challenges

for working with individual, couples, and families reached no consensus (Table 4.5). For example, perceptions of women as inferior and minor, and society's perception of psychotherapists as unstable people received (median = 4; IQR = 4). Another example of high dispersion among the panelists occurred in the statements that related to cultural misconceptions about the concept of male dominance with (median = 5; IQR = 5).

***Societal norms around the gender.*** Issues around gender separation, male dominance, restrictions placed on women's freedom, and women and human rights are very charged topics. For example, gender segregation might be accepted and encouraged based on conservative understandings of religion and tradition that promotes and views it at times as the norm. It is also possible that panelists are divided on their evaluation about the concerns. For example, gender segregation might be viewed as religious or cultural requirement, while others see it as an unnecessary limitation.

Another possible explanation is that media representation of Saudi Arabia and especially Saudi women, has often been depicting women as weak and submissive (Kaufer & Al-Malki, 2009). Since this present study is coming from a Western institution, and asking a consensus that some panelists brought up about societal norms around gender, it might steer the attention of panelists from thinking of the context of working with those who seek help for mental health need, and lead to rejecting the statements in its entirety.

Statements such as "perceptions of women as inferior and minor," was proposed by few panelists and was reframed to soften the description, yet it is perhaps culturally too direct and some panelists might disagree for its potential generalizability as a fact. KSA, just like any other society that has wide range of expectations and patterns around gender role, from severely

disempowered and unbalanced to complementarily and egalitarian within the Saudi cultural context. Certainly, there might be women who are mistreated, abused, neglected, and have no voice, however there are also Saudi families and women who have power and voices despite the laws and regulations that act as contextual barriers on women at the current time.

***Societal/Cultural specific challenges.*** None of the items reached consensus in this category. Regarding stigma, on the first category which is common barriers that hinders seeking help, there was a strong consensus found on clients/families experience of fear related to their social reputation and image. It is possible that panelists in this study agree that once clients are involved in the process of treatment or therapy, they are not experienced as unable to engage in the process due to stigma or difficulties opening up. Although previous literature indicated that keep problems as secret and wanting to maintain privacy is a potential societal and cultural barrier for seeking help (Al-Shahrani, 2003; Koenig et al., 2014). Another item that did not reached any consensus is that a biggest cultural challenge is that individuals have difficulty expressing their emotions because of "emotional illiteracy." While Arab clients prefer a more direct therapist (West, 1987, Abu Baker, 2003; Al-Krenawi & Graham, 2000); nevertheless, there were no studies that described Arabs or Muslims clients are "emotional illiterate," perhaps the word in the context of describing clients has been used as a buzzword.

Similarly, statements such as "society still does not accept marital therapy," or the idea that families refuse seeking professional help do not admit or recognize the existence of problems for their family members. Moreover, items listed under the biggest cultural challenges, as people who are being intolerance of other and absence of social awareness. It is most likely that the majority of panelists do not hold such views, and that those characteristics are cultural

challenges, or reject those views altogether. Moreover, the idea of belonging to conservative societies and extended families, is listed as a challenge in this section that did not reach consensus. On the contrary, in the first phase of this research with general mental health professionals their perceptions of strength in Saudi families, findings indicated that being conservative and having extended family are among the strength (Manuscript II). The large dispersion of IQR in the results of this category signals that perhaps the overall panelist rejects some of the statements that had pathologizing connotations toward individuals and families.

***Beliefs and understanding challenges.*** Cultural challenges working with individuals, couples, and families are in lack of societal and community awareness such as attributing mental illness to an evil eye or envy; attributing psychological illness as God's punishment or as an evidence of a lack of commitment to the religion, and perceptions of psychotherapists as unstable are slowly changing, did not gain consensus. Although, those above-mentioned items are part of the stigma and perceptions, yet not all stigma stood in this study except for the societal stigma for help seeking. While previous studies discussed the existing pattern of clients with mental health related needs seek other alternative help such as faith healer to treat psychological symptoms (Al-Solaim & Loewenthal, 2011; Alosaimi et al., 2014).

Another item that reached no consensus on cultural challenge is that "some traditions and norms are blended with religious views which do not reflect the correct understanding of the religion teachings." Perhaps it is likely that nonconsensus stemmed from panelists valuing traditional norms and customs and take pride that they live in the land that hosts the two holy cities for Muslims. Therefore, the statements mentioned above, turn what is pride for some as a cultural challenge. Being conservative and traditional gender roles were the two strengths of the

families which were identified by mental health professionals (Manuscript II).

***Working with societal and cultural gap related to presenting concerns.*** The findings are surprising in this categories, which did not reach any consensuses. Perhaps because panelists in this study have a variety of experiences and expectations with new logistical developments. Another surprising area that did not receive an endorsement as a culture challenges, were in areas related to working with couples dealing with intimacy issues and emotionally distance couples. While previous studies have discussed is challenges around working with couples dealing with sexual related problems in KSA. For example, Al-Sawaf and Al-Issa (2000) stated that sometimes it is necessary to conduct sex therapy with one partner, which is due to cultural factors such as, husbands would not be willing to disclose sexual dysfunction in the presence of his wife or to allow her to be interviewed.

Another topic that did not gain consensus was the items on "working with parents who hold misinterpretation ideas about parents." Although previous studies illustrated in KSA, that parents are perpetrators in the documented cases of child abuse and neglect cases by 48.9% (Al-Eissa & Almuneef, 2010), and that parents often use authoritarian parenting style (Dwairy et al., 2006). The findings of this study on working with couples and parenting needs further exploration since there are contradictions between identified challenges in the previous literature mentioned above. Perhaps exploring those topics through qualitative interviews or focus group is important to understand the divergent in literature and among panelists.

**Therapists' needs.** The last category and all its items have reached high consensus with (median = 7; IQR = 0.25-1) (Table 4.6). The highest reached consensus achieved were for therapists' need for clear guidelines and regulations, as well as standardized steps that allow for

collaborative work to happen (IQR = 0.25). Moreover, regarding items on personal qualities to be empathetic, to be respectful, to be open and accepting of the community, and to adopt to teamwork (IQR = 0.5). No weak or no consensus findings occurred in this section.

***Knowledge and Skills.*** Strong consensuses were endorsed for knowledge and skills, personal qualities of the therapists, clear guidelines and regulations, and professional needs of advocacy work. Concerning knowledge and skills, this study demonstrated the importance of the person of the therapists and competency in lines with previous literature. According to the American Association of Marriage and Family Therapy (AAMFT) task-force developed core competency which consisted of six main domains and five sub-domains (Nelson, et al., 2007). These study findings showed that knowledge and skills endorsed are important ranges from needs of therapists to understand the Islamic religious teaching, cultural and customs background to knowledge about presenting problems and abilities to provide psychoeducation. These spheres of knowledge and skills are in line with the main domains such as admission to treatment, clinical assessment, diagnosis, and treatment planning and case management (Nelson et al., 2007). The knowledge that the therapist has is an important area in the cultural adaptation framework literature. Understanding the cultural values, customs, and traditions of the ethnic and minority in the community is known as the content element, in the cultural adaptation framework (Bernal, Bonilla, & Bellido, 1995; Bernal & Saez-Santiago, 2006). Also, the subdomains skills that were incorporated in the AAMFT task-force core-competency, such as the executive skills of observing personal reaction (Nelson et al., 2007) gained consensus in this present study.

Panelists believed that it was important for the mental health providers in this study to be insightful about their personal opinion and biases. Previous literature in MFT emphasized the

importance of therapists' and trainees' personal views and biases through self-of-the-therapist work (Timm & Blow, 1999), and the importance of the therapists' role. Blow, Sprenkle, Davis (2007) discussed the therapists' role as a common factors for therapeutic change since the therapists may initiate or boost change by the therapists skills and way of intervening which allow for change mechanism to be active via a model that the therapist chooses to use.

***Personal qualities.*** Panelists strongly endorsed the personal qualities of the therapist, such as to be empathetic, respecting, accepting the community, and adopting to teamwork. Previous literature on therapists and building therapeutic alliance demonstrated that a therapist's way of being is the attitude of the therapist on the instant of therapeutic alliance building, which may determine the effectiveness of implementing clinical techniques (Fife, Whiting, Bradford, & Davis, 2013).

***Clear guidelines and regulations.*** Consensuses were reached for the needs of logistical support, standardized steps, and clearer structure to work collaboratively with different parties to handle cases such as domestic abuse and sexual abuse; there were recent laws passed for protecting children and criminalizing abuse laws (Bureau of Experts at the Council of Ministers, 2013; 2014). There are new changes that took place in Saudi courts that are empowering women, and involving social workers and psychologist in custody cases (Aldehaiman, Aloud, & Aldakhil, 2015; Aloud, 2015). Nevertheless, the findings indicate that this is an area that needs further growth and will benefit from joint and collaborative efforts to be in place.

***Professionals advocacy.*** Another finding that gain consensus is the need of professionals advocacy by establishing associations to reach people and to lobby for major presenting concerns. Qureshi et al. (2013) pointed out that there were at least five organizations developed

by those who experienced mental health that advocated for others experiencing mental health problems, and those organizations receive government assistant. More mental health professionals contributing with their expertise and time will be assets to those organization that empowers individuals with mental health to increase their access resources that improve their adjustments and quality of life.

## Strengths and Limitations

This current study's main strength is that it has explored a gap in the literature in the present state of psychotherapy and MFT practice and services in KSA. The modified Delphi method in itself adds to the robustness of this study since it aimed to get experts in the country to achieve consensus on obstacles and solutions. The strength also relies on the panel of participants who are academicians and clinicians, who have clinical and teaching experiences. Additionally, the majority of the panelists attained higher degrees and had the opportunity to receive education in KSA as well as in Western countries. The details mentioned above about the panelists in this study are considered a strength since they have been in the realms of training and service.

The diversity of the characteristics of this study reveals that almost half of the panelists do not hold local licensure since not all the panelists are working in healthcare settings. Therefore, this implies that there are broad spectrums of views on the requirements, needs, and solutions in different contexts of clinical work. Furthermore, there were only 28 panelists in the study, which is a small number considering the importance of this topic. Eight panelists did not continue with the second round, without providing their reasoning for dropping out. Another, potential limitation in the study is that privacy and confidentiality were not clearly separated.

Furthermore, the section on cultural and societal concerns did not reach any strong or

moderate consensus. Additionally, since this study is coming from a Western institution, it might have played a factor in the panelists' openness to acknowledging the importance or agreements about some of the identified cultural and societal norms about gender for mistrusting how non-insiders view the information. Another reasoning, which may be one of the weaknesses of Delphi method is that diversity of opinion gets minimized (Stone Fish & Busby, 2005). Those who brought up the issues regarding cultural and societal barriers did not make it to the list due to the use of the Delphi method.

## Implications and Summary

In this study, the questions that are under exploration are: what are the common barriers and solutions to services and training of mental and social health, and what are the cultural challenges and needs of professionals who work successfully with relational concerns? The panelists suggest that the most common barriers to mental and social health are in the realm of access to professionals, availability of services and facilities, and current status of collaborative care, and other related needed support. The identified barriers to training are as followings: lack of competent trainers, shortage of training sites, concerns with the current supervision, and concerns with the current educational curriculum. The questions the cultural challenges and needs of professionals who work successfully with relational base concerns are partially answered. The large dispersion of consensus regarding cultural challenges are around societal norms about gender, cultural beliefs, understandings, and working with specific concerns that have relational base component.

**Implications.** Given the centrality of issues concerning professionals training and supervision in KSA working with individuals, couples, and families, the followings were

necessary solutions that were suggested by the panelists who participated in this study. They covered four areas: logistical, professional development and training, societal and cultural, and collaborations and service expansion.

First on a logistical level, panelists in this study endorsed that it is essential to establish a unified legislative body that takes the responsibility of setting practice requirements for specialists in the mental health field. Those requirements included developing clearer codes of ethic for professionals who deliver psychotherapeutic interventions, and that restrict the practice to those with valid credentials and approved training. Moreover, to have a surveillance body that monitors the training curriculum and its quality.

Regarding regulations of the practice of mental health delivery, panelists have endorsed needs for a national commission to regulate practices in healthcare and governmental non-healthcare affiliated settings that provide services to couples and families. In addition, panelist recommended and endorsed standardizing clearer structure to work collaboratively with different parties to handle cases such as domestic abuse and sexual abuse.

Second, on professional development and training level, there are many support from panelists who strongly endorsed the urgent need to require continuous clinical supervision of therapists in training and establish intensive training. Some of the endorsed ways to enhance training that will change the current status of training are: to increase hours of clinical training, and provide practical training workshops that focus on developing competencies.

Additionally, panelists also endorsed the needs to improve and increase training sites and provide qualified and competent supervisors. There were strong endorsements for creating localized training that offers to train in Arabic and to make training and resources materials

available in Arabic in order to fill the current gap in resources available for professionals. Moreover, panelists have endorsed the importance not to work with domestic violence or sexual abuse clients, without the appropriate training. Another strongly endorsed necessary solution is to assess clinicians performance and outcomes.

Panelists endorsement also addressed the therapists' needs in working with concerns relates to cultural issues for families and couples by giving consideration to therapists knowledge about the religious teachings and cultural knowledge. Knowledge, skill, and monitoring of personal biases are all among the important aspects of training therapists. Moreover, panelists have endorsed establishing accredited local training programs, and creating postgraduate programs in collaboration with Western institutions.

Third, on a societal and cultural level, the focus is mainly on social stigma and awareness. Panelists recommended as necessary solutions, to utilized the media to counter stigma and increase awareness. Also, panelists have endorsed the need to raise awareness through working collaboratively with religious institutions such as mosques to reduce the stigma.

Fourth, on a collaborations and service expansion level, the panelists have recommended numbers of necessary solutions. For example, to work collaboratively with different government agencies such as courts. Moreover, there are needs to establish reliable information center that identifies services for individuals and families. In addition, more professional advocacy work is needed for organizing associations to reach people with mental health concerns.

**Future direction.** Based on the findings of this study on understanding cultural and societal challenges, future research will benefit from using different methods such as interviews or focus group. The different methods will clarify the differences between the diverse views that

are apparent in this present study and that might exist with many other mental health professionals, such as on couple relationships and parenting. Perhaps similar questions needs to be asked to the consumers of the services, the clients themselves to have an overall understanding of the roles of misconceptions and what type of misconceptions are considered common barriers that hinder help seeking. Besides, future research needs to differentiate tendencies of wanting to maintain privacy and confidentiality practices in different settings.

On a future clinical implication, research future studies will benefit from following the AAMFT emphasis focusing on the competencies and measuring therapists' competencies and outcomes in KSA. Also, preferences toward same-gender providers for clients, needs to be further assessed whether preferences are the same when it is a couple or a family therapy versus individual therapy.

**Recommendations**. Since there was a dispersion on topics such as cultural challenges working with couples dealing with intimacy or challenging about parents holding misconceptions about parenting; therefore, training of future psychotherapists and MFTs in KSA needs to incorporate. Focusing on the strength of societal and cultural beliefs and practices, as well as exploring issues of gender roles, gender equity, power, and oppression in society and the community and how it can come up in sessions. These concepts in training are essential for therapists working in a fast evolving society like KSA. In this way, mental health professionals and therapists, in particular, will be equipped to maneuver power imbalance issues during the therapy session, build an effective therapeutic alliance with the opposite gender in couple and family therapy sessions, and help couples and families reach their mutual goals.

In addition, to meeting training needs of mental and social health professionals in KSA,

not only is the trainee's self-of-the-therapist work is important, but attention is needed to be given to self-of-the-trainer/supervisor/educator. Furthermore, in the training and workshops of therapists working with couples and families, attention needs to be given to pathologizing views about clients, families, and society that stemm from educators as experts and their trainees. Also, particular attention needs to be given to common buzzwords and stereotypes such as "emotionally illiterate"; those are misconceptions that many people might have and unfortunately are also shared by some mental health professionals.

Similarly, attention to the importance of the Arabic language is an essential element to cultural adaptation training in KSA. For mental health professionals and MFTs trained in the West, including myself, and those presently in the workforce or who will be joining the workforce, attention to language, and other elements of cultural adaptation literature are crucial (Bernal, Bonilla, Bellido, 1995; Bernal & Saez-Santiago, 2006). It is critical to reflect continuously as trainer/supervisor/educator and ask oneself, is it more convenient (i.e., training using the English language) or is it tailored enough to meet the needs of our students and future psychotherapists and MFTs.

Lastly, in order to set the stage to implement and introduce the profession of marriage and family therapy in KSA, the Saudi Commission of Health Specialists needs to recognize MFTs and included MFT under one of the classified specialties of the commission. This will give the needed recognition and credibility to those who are qualified and put an end to those who are not.

## Conclusion

Barriers and solutions for training and services for mental and social health occupy the

largest part of the gap in the literature about the needs that are particular to KSA in delivering psychological interventions to individuals, couples, and families. Although, not many societal and cultural barriers and solutions were identified, perhaps the barriers for training are larger than the cultural and societal barriers and challenges. Currently, Saudi Arabia is in its era of “decision and decisiveness" and psychotherapy and MFT development deserve serious, decisive actions when it comes to changing the status quo in training and supervision of mental health professionals in order to meet the needs of mental and social health to Saudi individuals and families.

Table 4.1

*Common Barriers that Hinder Seeking Mental & Social Health Services*

| Agreements Reaching Strong Consensus | Median | IQR |
|---|---|---|
| **Stigma:** | | |
| • Clients/Families experience fear related to their social reputation/image when it comes to seeking help | 6.00 | 1.5 |
| **Access to Professionals:** | | |
| • There is a shortage in the number of competent and adequately trained practitioners in the field to meet the current demands for mental health services | 6.50 | 1 |
| • There exists a difficulty in getting help for distinctive problems since there is a severe shortage of specialists with experience | 6.50 | 1 |
| **Availability of Services & Facilitators:** | | |
| • The cost of seeking services for clients as demonstrated by the high costs of private clinics and insurance companies not covering the costs of psychotherapy | 6.00 | 1 |
| • Poor quality and availability of services. Examples include lack of information about the services that are available, poor professional services, and services established exclusively for the government sector | 6.00 | 1 |
| • Relatively low availability of community mental health services | 6.00 | 1 |
| • Lack of support to develop new psychological service settings such as clinics | 6.00 | 1 |
| • Lack of clarity in the purposes and procedures of psychiatric pharmacological treatments | 6.00 | 1 |
| • Not enough efficient addiction focused centers that are appropriate for the growing numbers of patients with addiction issues | 6.00 | 1 |
| **Current Status of Collaborative Care & Related Support:** | | |
| • There is limited connection between mental health practitioners and schools | 6.00 | 1 |
| • More support is needed from the Saudi Ministry of Health toward the development of mental health | 7.00 | 1 |
| **Moderate Agreement Consensus** | | |
| **Lack of Awareness:** | | |
| • Clients do not understand the different roles that each professional plays in mental health care such as the differences between a psychiatrist versus a psychotherapist | 5.50 | 1 |
| • Potential clients are unaware of the beneficial aspects of counseling and psychotherapy, as well as the importance of seeking early interventions | 6.00 | 1.75 |
| **Access to Professionals:** | | |
| • Most qualified competent professionals are hired by specific government or corporate hospitals that serve only specific populations | 6.00 | 1.75 |

Table 4.2

*Necessary Solutions to Foster More Effective Services*

| Importance Strong Consensus | Median | IQR |
|---|---|---|
| **Professionals Delivering the Interventions:** | | |
| • Professionals need much more training and supervision than what they have currently received | 7 | 1 |
| • Clinicians be held accountable to a clearly defined professional code of ethics | 7 | 1 |
| • Measure clinicians performances and outcomes | 7 | 1 |
| • Providers of services need to be restricted to qualified professionals with appropriate credentials awarded by an accredited legislative body in the country | 7 | 1 |
| **Solutions Related to clients/Families:** | | |
| • Enforce patient's rights by prioritizing confidentiality through securing their information, their privacy, and setting clear procedures for the clients/families to take in cases of violations | 7 | 1 |
| **Services Expansions:** | | |
| • Rebuild the mental health care system in Saudi Arabia | 7 | 1 |
| • Increase the collaborations between mental health professionals in the community. Examples; more collaboration needed from family and community physicians as well as involvement of other providers such as psychologists and social workers | 7 | 1 |
| • Establish a proper referral system that tracks appropriate referral actions | 7 | 1 |
| • Reform and expand mental health services to more sites to include health care institutions as well as general and specialist hospitals. An example that was given is that many public hospitals do not provide mental health services | 7 | 1 |
| • Include mental health hospitals into sections within general hospitals | 7 | 1 |
| • The need for the development of community mental health services across the nation (urban, rural) | 7 | 0 |
| • Establish mental wellness programs that provide preventative care through psychoeducation | 7 | 1 |
| **Collaboration:** | | |
| • To have more collaboration between government agencies such as courts that will result in interventions for troubled families and individuals | 6 | 1 |
| • Establish a reliable information center under the Ministry of Health, which highlights the importance of mental health and the role of those working in the field, and identifies services that are available for individuals/families to seek treatment | 7 | 1 |

Table 4.2 (Cont'd)

| Importance Strong Consensus | Median | IQR |
|---|---|---|
| **Increasing Awareness:** | | |
| • Utilize the media for the following: To increase awareness of mental health, reduce the stigma for seeking help, and familiarize people with services provided for various presenting concerns. The media could target homes, mosques, families as an example and can use multiple forms of communication including regular media, newspapers, and the social media | 7 | 1 |
| • Work collaboratively with religious institutions such as mosques, to reduce mental health stigma | 7 | 1 |
| **Moderate Agreements Consensus** | | |
| • To train qualified specialists who represent both genders in order to allow for more availability of same-gender providers allowing both men and women the opportunity to receive help from specialists who identify in terms of gender | 6.5 | 2 |

Table 4.3

*Common Training Barriers for Professionals*

| Agreements Strong Consensus | Median | IQR |
|---|---|---|
| **Lack of Competent Trainers:** | | |
| • There are plenty of those who claim that they have the knowledge, but who are semi-educated/pseudo-professionals, and who get the certificate in the field for financial gain purposes and are making business out of training others. | 7 | 1 |
| **Few Training Sites:** | | |
| • No clear criteria, regulations, and procedures are set for site training. It is too dependent on the institute itself and the personality of the trainer | 7 | 1 |
| • Lack of training institutions understanding of the role of marital and family counseling and as a result, individuals who want to train students find it hard to locate a place to conduct the trainings | 7 | 1 |
| • Inadequateness of the currently available settings in the psychological clinics for offering state of the art training and supervision | 7 | 1 |
| **Supervision:** | | |
| • Lack of training programs that offer sufficient clinical supervision. | 6 | 1 |
| • The scarcity of qualified supervisors/trainers/educators to oversee or to follow-up with a trainee. | 6 | 1 |
| • No criteria are set that define what constitutes clinical supervision and the clinical supervisor's role in facilitating the growth of young professionals delivering psychotherapeutic interventions | 6 | 1 |
| **Education:** | | |
| • The scarcity of local training programs, an example is the current lack of availability of training programs for post-graduates in Saudi Arabia. Many who desire training need to go internationally to obtain it | 7 | 1 |
| • Insufficiency of training materials; few training materials are available in Arabic, and that overall trainees have poor English language proficiency to make use of available training materials in English | 7 | 1 |

Table 4.4

*Necessary Solutions for Improved Training of Professionals*

| Importance Strong Consensus | Median | IQR |
|---|---|---|
| **Professionals Delivering the Interventions:** | | |
| • Establish a unified legislative body that sets practice requirements for specialists | 7 | 1.25 |
| • Establish a unified legislative body that establishes a clear code of ethics for professionals working on delivering therapeutic interventions to individuals, couples, and families. | 7 | 1 |
| • Establish a unified legislative body that restricts mental health practice to those with valid credentials and approved training | 7 | 1 |
| • Promote, develop, and increase intensive training programs and supervision for professionals to ensure better mental health outcomes for clients and the community | 7 | 1 |
| • To develop a mechanism to measure the performance of working professionals delivering mental health services that allows for evaluating and tracking the outcome of the services | 7 | 1 |
| **Enhance Collaborative Efforts & Needed Logistical Changes** | | |
| • Create a national plan where all the ministries involved in training for mental health services work in collaboration with one another, an example that was given, is to link training with the Ministry of Health and universities' specialization centers. | 7 | 1 |
| Establish local training programs that are accredited, and to take into consideration that the psychological/mental health services are still in the beginning; therefore, it is important to start with a gradually structured plan while taking advantage of existing competencies in the field, such as to involve specialists and train them on how to implement training programs. | 7 | 1 |
| • Health and education authorities should develop quality postgraduate training program in collaboration with Western institutions that have centers specialized in psychotherapy and exchange experiences with them | 7 | 1 |
| **Enhance Training Programs and Professionals Development** | | |
| • To increase the hours of clinical training for students who major in mental health fields | 7 | 1 |
| • To provide practical training workshops, that focus on increasing competencies in specific specializations | 7 | 1 |
| • To urge health sectors to respond to requests for training students, especially in the private sector | 6 | 1 |
| • To have a qualified training headquarters with a clearly defined set of requirements for training that includes a surveillance body that monitors the quality of the training curriculum | 7 | 1 |
| • To emphasize during training the need to establish trust and protect patient's right to privacy and confidentiality, and to discuss ways to break through stigma, privacy, and trust barriers | 7 | 1 |

Table 4.4 (Cont'd)

| Importance Strong Consensus | Median | IQR |
|---|---|---|
| **Supervision:** | | |
| • To require continuous clinical supervision for therapists in training, whether individually or in groups | 7 | 1 |
| • To require ongoing training, such as to establish intensive training courses with supervision and follow-up even after the end of the training course. | 7 | 1 |
| **Moderate Importance Consensus** | | |
| • To establish competencies in supervision from overseas countries as a start, until Saudi Arabia can have a group of qualified supervisors | 7 | 2 |

Table 4.5

*Biggest Cultural Challenges Working with Individuals, Couples, & Families*

| No Consensus | Median | IQR |
|---|---|---|
| **Societal Norms Around Gender:** | | |
| • The complete gender separation is a big cultural challenge | 5 | 6 |
| • Cultural misconceptions around the concept of male dominance | 5 | 5 |
| • Many husbands reject attending therapy sessions | 6 | 3 |
| • Lack of freedom, especially for women to get access to psychological services | 5 | 3 |
| • Perceptions of women as inferior and minor | 4 | 4 |
| • Although the Minister of Justice is working hard to empower women, people in power are not accepting it | 5 | 5 |
| • Absence of community and human rights organizations to ensure women's occupational rights | 5 | 5 |
| **Societal/Cultural Specific:** | | |
| • Stigma around seeking help | 5 | 2 |
| • Clients/Families have difficulties with opening up to others especially to mental health professionals, and being transparent in the experience | 5 | 2 |
| • Society still does not accept marital therapy | 5 | 3 |
| • Difficulties in expressing emotions because of "emotional illiteracy" | 6 | 3 |
| • The nature of extended Saudi families | 4 | 2.5 |
| • Being a conservative society | 4.5 | 3 |
| • The society does not encourage or accept professional help | 4 | 2 |
| • Families reject the idea of seeking professional help for their family members | 5 | 2 |
| • Many families do not admit to/or recognize the existence of problems | 5 | 2 |
| • Discrimination, intolerance of others who are different, and the absence of societal awareness of ways to socialize people into acquiring responsibilities and tolerance | 5 | 3 |
| **Beliefs & Understandings:** | | |
| • Society and community lack awareness about psychological disorders and problems; For example, mixing up some of the notions of evil eye and envy with mental illness etc. | 5 | 3 |
| • Society's perception of psychotherapists as unstable people | 4 | 4 |

Table 4.5 (Cont'd)

| No Consensus | Median | IQR |
|---|---|---|
| **Continue Beliefs & Understandings:** | | |
| • Some traditions and norms are blended with religious views, which at times do not reflect the correct understanding of religion teachings | 5 | 3 |
| • Difficulties in accepting seeking help from non-family members | 5 | 2 |
| **Working with Societal and Cultural Gap Related to Presenting Concerns:** | | |
| • In the matters of divorce, judges in courts do not have the knowledge and familiarity with the importance of marital therapy | 6 | 3 |
| • Working in general with cases that present with sexual disorders, sexual abuses, and domestic abuses, and addictions, for the cultural taboos associated with exploring those concerns | 5 | 3 |
| • Working with couples dealing with intimacy and sexual related problems, emotional distance couples (emotional divorce) | 5 | 4 |
| • Working with parents who hold misinterpretations ideas about parenting | 5 | 3 |
| • Lack of premarital compatibility screening, an example that was given that marriages are conducted randomly and traditionally without ensuring proper ways for couples to assess their compatibilities to one another | 5 | 3 |
| • There is no biggest or smallest challenge, Saudi mental health professionals are very well aware of those issues and there is a strong political will to accept slowly those challenges | 5 | 3 |

Table 4.6

*Therapist Needs to Work with Concerns Relates to Cultural issues in Families & Couples*

| Importance Strong Consensus | Median | IQR |
|---|---|---|
| **Knowledge & Skills:** | | |
| • Knowledge of the Islamic religious teachings, customs and traditions of the Saudi society, and the cultural background of each case and to respect it | 7 | 1 |
| • A precise and in-depth specialization in one of the schools of psychotherapy | 7 | 1 |
| • For mental health providers to be insightful about their personal opinions and biases and to pay attention to them, and to try not to make their personal opinion and biases affect the treatment | 7 | 1 |
| • Good theoretical background on the causes and the contributing factors for these problems | 7 | 1 |
| • To have skills in understanding the presenting concerns, building trust, providing sufficient psychoeducation to the clients at the beginning of the therapy about the therapy process before engaging in problem-solving | 7 | 1 |
| **Personal Qualities:** | | |
| • To be empathetic, to be respecting and accepting of the community, and to adopt to teamwork | 7 | 0.5 |
| **Clear Guidelines & Regulations:** | | |
| • Needs logistic support for therapists such as the existence of a specialized body to protect his/her rights and roles | 7 | 1 |
| • Standardized steps that allow for the collaborative work to happen. For example, joint collaborative efforts by the courts, police, and health and social sectors to address directly cases of domestic violence and to provide safe shelters for those who are assaulted | 7 | 0.25 |
| • A clear structure that gives confidence and trust in working jointly with various parties to cover all aspects of the problem | 7 | 1 |
| • Not to handle cases without appropriate training in working with cases that require special competencies, such as domestic violence and sexual abuse | 7 | 1 |
| **More Advocacy work to take place by professionals:** | | |
| • Establishing associations to reach people and to lobby for major presenting concerns | 7 | 1 |

# APPENDICES

Appendix D1

Study Three: Delphi Study Round One - Invitation Letter

Dear Prospective Panelist,

You are invited to participate in the Delphi study of this multiphase research study about the standard of care in the practice of mental health and marital and family therapeutic interventions. You are selected to receive this email invitation to participate because you have been identified as an expert in the field of mental health in Saudi Arabia. My name is Reham Gassas, and I am a doctoral candidate at Michigan State University, and this research project is conducted in fulfillment of a doctoral dissertation.

The aim of the study is to reach a consensus on how to advance the standard of care in mental health and marital and family therapeutic interventions. Your inputs will be very valuable to us. The first round is 3-6 questions and it will take about (10-12 minutes).

If you are interested in participation or to learn more about the study, please click on the link below, or copy and paste it into the browser. It is best to view the survey from a computer devise.

**Link:** https://hdfs.az1.qualtrics.com/SE/?SID=SV_088geyiFPzjNJBz

**Password:** KSA2015

Your efforts are highly valued. For your questions, we can be reached at gassasre@msu.edu or blowa@msu.edu .

We thank you in advance.

Sincerely,

Reham F. Gassas, MA
Doctoral candidates
Michigan State University

Adrian Blow, Ph.D.
Professor
Michigan State University

Appendix D2

Study Three: Delphi Study Round One - Invitation Letter (Arabic)

عزيزي المشارك المحتمل،

أنت مدعو(ة) للمشاركة في بحث علي طريقة دلفي. هذه الدراسة البحثية المتعددة المراحل عن مستوى مجال الصحة النفسية والتدخلات العلاجية المقدمة للأسر في المملكة العربية السعودية. وقد تما ترشيحك لتلقي هذه الدعوة عن طريق البريد الإلكتروني للمشاركة لكونك خبير في مجال الصحة النفسية في المملكة العربية السعودية. أحب ان اعرف بنفسي اسمي رهام قصاص، مرشحة للدكتوراه من جامعة ولاية متشجين وهذا المشروع جزء من بحثي لرسالة الدكتوراه.

الهدف من هذه الدراسة هو التوصل إلى خلاصة توقعات الخبراء بشأن كيفية المضي قدما في مستوى الرعاية في مجال الصحة النفسية والتدخلات العلاجية الزوجية والأسرية. مشاركتك ستكون في غاية الأهمية وذات قيمة علمية بالنسبة لنا. الجولة الأولى تتكون من 3-6 أسئلة التي قد تستغرق مدة الرد عليها بين (12-10 دقيقة).

إذا كنت ترغب(ين) في معرفة المزيد عن هذه الدراسة والمشاركة، يرجى الضغط على رابط الاستبيان الإلكتروني، او نسخ الرابط في المتصفح. الرجاء استخدام جهازالحاسب الألي للمشاركة.

**الرابط:**
https://hdfs.az1.qualtrics.com/jfe/form/SV_088geyiFPzjNJBz?Q_Language=AR

**كلمة المرور:** KSA2015

نقدر مشاركتك ودعمكم. لطرح أسئلتكم وأستفساراتكم يمكنكم التواصل معانا علي البريد الإلكتروني
blowa@msu.edu
gassasre@msu.edu.

مع خالص التقدير،


أ.رهام قصاص
طالبة دكتورة
جامعة ولاية متشجين

د.إدريان بلو
بروفسور
جامعة ولاية متشجين

Appendix E1

Study Three: Round One Delphi Survey

**Demographics Information**

Please indicate the appropriate age group that represents you:

- ❍ 21-24
- ❍ 25-30
- ❍ 31-35
- ❍ 36-40
- ❍ 41-45
- ❍ 46-50
- ❍ 51-55
- ❍ 56-60
- ❍ 61 or above

What is your gender?

- ❍ Male
- ❍ Female

Please indicate your current work's setting:

- ❑ Academic Institution
- ❑ Hospital Setting
- ❑ Private Practice
- ❑ Private nonprofit agency
- ❑ State/Community agency
- ❑ Other, please specify _____

Please indicate your highest academic qualifications:

- ❍ PhD/ PsyD or equivalent
- ❍ Master's degree
- ❍ MD
- ❍ Bachelor's degree

Please write below your professional job title and specialty?

Please write the name of the country/countries where you received your degree(s) of specialization(s) from?

Please specify how many years of clinical experience do you have working with individuals, children, couples and families since you received your qualifying degree?

Please specify how many years of teaching experience do you have, in the area of clinical work, diagnosis, and treatment?

Have you conducted workshops/courses in providing clinical training on specific approach or interventions?

- ❍ Yes
- ❍ No

Please specify how many years of experience do you have supervising a student or trainees in the field of psychology, social worker, counselor, or couple and family therapy?

Please specify the type of license that you hold, and from where it was accredited(Country/ Institution)?

Do you have any peer-reviewed publications regarding Saudi Arabia mental health and social health services?
❍ Yes
❍ No

Are you from Saudi Arabia?
❍ Yes
❍ No,
Please specify your nationality, and for how long have you been practicing in the field of mental health or social health service in Saudi Arabia?

**Question One:**
Thinking about your experience and understanding of Saudi Arabian Families,

(1a) List and explain what are the most common barriers that hinder seeking mental and social health services for individuals, couples, and families in Saudi Arabia?
(1b) What are the necessary solutions to foster more effective mental and social health services for individuals, couples, and families in Saudi Arabia?

**Question Two:**
(2a) Identify the most common training barriers for professionals who deliver/or desire to deliver effective therapeutic interventions to individuals, couples, and families in Saudi Arabia?
(2b) What are the necessary solutions for improved training of professionals who deliver/or desire to deliver therapeutic interventions to individuals, couples, and families in Saudi Arabia?

**Question Three:**
A recent web survey was conducted about professional's perception concerning Saudi Arabian mental health in general, and specifically about marital and family therapeutic practices. The majority of the participants in the study agreed that the following are important presenting mental health concerns in Saudi Arabia, and identified that those concerns require marital and family therapeutic interventions:

- For partner-relationship concerns: Domestic violence, divorce/separation, marital infidelity, sexual difficulties, abuse from male guardians, and gender inequality.
- For families and children: Parenting, child abuse and neglect, sexual abuse, and bullying.

- Other concerns: Substance abuse, financial difficulties, and work-related problems.

To treat those concerns, professionals need competencies in dealing with issues of power, control, oppression, privilege, safety, gender equity, intersectionalities.

(3a) What do you see as the biggest cultural challenges working with individual, couples, and families in working with those above problems? Provide examples.

(3b) What do therapist needs to successfully treat these types of presenting problems?

Appendix E2

Study Three: Round One Delphi Survey (Arabic)

المعلومات الديموغرافية

يرجى الإشارة إلى الفئة العمرية المناسبة التي تمثلك:

| | | |
|---|---|---|
| ❍ 21-24 | ❍ 36-40 | ❍ 51-55 |
| ❍ 25-30 | ❍ 41-45 | ❍ 56-60 |
| ❍ 31-35 | ❍ 46-50 | ❍ 61 وما فوق ذلك |

ما هو جنسك؟

❍ ذكر

❍ انثي

يرجى الإشارة إلى مكان عملك الحالي:

| | | |
|---|---|---|
| ❑ جامعة | ❑ قطاع خاص غير ربحي | ❑ أخرى، الرجاء التحديد |
| ❑ مستشفي | ❑ قطاع حكومي او اجتماعي | _____ |
| ❑ عيادة خاصة | | |

ماهو أخر مؤهل أكاديمي حصلت عليه:

| | |
|---|---|
| ❍ دكتوراه أو ما يعادلها | ❍ بكالوريوس في الطب والجراحة |
| ❍ ماجستير أو ما يعادله | ❍ بكالوريوس |

يرجى كتابة المسمى الوظيفي وتخصصك؟

الرجاء ذكراسم البلد/البلدان التي حصلت فيها على شهادة/شهادات التخصص؟

يرجى تحديد عدد سنوات الخبرة الإكلينيكية لديك من العمل مع أي من الفئات التالية الأفراد أوالأطفال أوالأزواج والأسر منذ حصولك على شهادة التأهيل؟

يرجى تحديد عدد سنوات الخبرة في مجال التدريس لديك في مجال العمل الإكلينيكي أوالتشخيص والعلاج؟

هل عقدت ورش عمل/ دورات في تقديم التدريب الاكلينيكي على نظريات أوتدخلات علاجية معينة؟

❍ نعم

❍ لا

يرجى تحديد عدد سنوات الخبرة التي لديك في الإشراف على الطلاب أو المتدربين في مجال علم النفس، الخدمة الاجتماعية، الإرشاد، أوالعلاج الزواجي والأسري؟

يرجى تحديد نوع رخصة ممارسة المهنة التي تحملها، ومن اين تم اعتماها(البلد/ المؤسسة)؟

هل لديك إصدارات أكاديمية عن خدمات الصحة النفسية والصحية الاجتماعية في المملكة العربية السعودية والتي خضعت لمراجعة النظراء من المتخصيين؟

❍ نعم

❍ لا

هل أنت من المملكة العربية السعودية؟

❍ نعم

❍ لا

يرجى تحديد جنسيتك، وكم لك وانت تمارس في مجال الصحة النفسية أو الخدمات الصحية الاجتماعية في المملكة العربية السعودية؟

**السؤال الأول:**

فكر في تجربتك وفهمك للأسرة السعودية،

١- (أ) عدد وأشرح ما هي العوائق الأكثر شيوعاً التي تعيق اللجؤ إلى الخدمات الصحة النفسية والاجتماعية للفئات التاليه: الأفراد، الأزواج، والأسر في المملكة العربية السعودية؟

١- (ب) ما هي الحلول الضرورية لتعزيز زيادة فعالية خدمات الصحة النفسية والاجتماعية للفئات التاليه: الأفراد، والأزواج والأسر في المملكة العربية السعودية؟

**السؤال الثاني:**

٢- (أ) حدد حواجز التدريب الأكثر شيوعاً للممارسين الذين يقدمون / أو يرغبون في تقديم تدخلات علاجية فعاله للفئات التاليه: الأفراد، الأزواج والأسر في المملكة العربية السعودية؟

٢- (ب) ما هي الحلول الضرورية لتحسين تدريب الممارسين الذين يقدمون/أو يرغبون في تقديم التدخلات العلاجية للأفراد، والأزواج والأسر في المملكة العربية السعودية؟

**السؤال الثالث:**

في استطلاع بحثي أجرى مؤخراً على شبكة الإنترنت حول وجهة نظر الممارسيين في المملكة العربية السعودية فيما يتعلق بالصحة النفسية بشكل عام، وعلى وجه التحديد حول التدخلات العلاجية للعلاج الزواجي والأسري، الغالبية العظمى من المشاركين في الدراسة اتفقوا على أن ما يلي يتضمن مصاعب حالية مهمة في الصحية النفسية في المملكة العربية السعودية، والتي تتطلب التدخلات العلاجية الزوجية والأسرية التالية:

- مصاعب متعلقة بالعلاقة بين الزوجين: العنف الأسري والطلاق/الانفصال، الخيانة الزوجية، المشاكل الجنسية للزوجين، سوء المعاملة من "الأوصياء"، وعدم المساواة بين الجنسين

- مصاعب متعلقة بالأسرة: تربية الأطفال، والاعتداء على الأطفال وإهمالهم، والاعتداء الجنسي، والتنمر

- مصاعب أخرى: تعاطي المخدرات، والصعوبات المالية، والمشاكل المتعلقة بالعمل

لعلاج تلك المخاوف والمصاعب، الممارسين بحاجة للكفاءات والتأهيل في التعامل مع قضايا مرتبطة بالسلطة والسيطرة وفهم للقمع والتمييز، الأمان، المساواة بين الجنسين، والتقاطعات بين كل هذه المعطيات المختلفة.

٣- (أ) في رأيك ما هي أكبر التحديات الثقافية المتعلقة بالعمل الإكلينيكي مع الأفراد، الأزواج والأسر في التعامل مع المشكلات المذكوره أعلاه؟ أعطي أمثلة.
٣- (ب) ماذا يحتاج المعالج لمعالجة الأعرض/المشكلات بنجاح مع نوعية الأعراض والمشكلات التي تم ذكرها؟

Appendix F1

Study Three: Round Two Delphi Survey

In the Delphi I Questionnaire you were asked to respond to common barriers and solutions to services and training for mental and social health services for individuals, couples, and families, in Saudi Arabia. You were also asked to identify cultural challenges, and therapist needs to work successfully with relational concerns.

The following is a compiled list of your and your colleagues responses. To make this survey as manageable in length as possible, all responses were summarized. You are asked to read the items and check your level of agreement/disagreement, as well as what you consider important/ unimportant, which will inform the results of a final profile that will indicate the consensus related to the most important items for this study. Therefore, please take your time to read each statement carefully.

Thank you so much for your contributions and time.

| Question 1(a) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Panelists were asked to answer the following question:<br><br>List the most Common Barriers that Hinder Seeking Mental & Social Health Services for individuals, couples, and families in Saudi Arabia.<br><br>The following statements represent combined answers from panelists to the above question. Please read each statement carefully, and circle the number that best reflect your level of agreement/disagreement with each statement listed below (on a scale of 1 to 7; 1 = Completely Disagree, and 7= Completely Agree). Please circle the number that best reflect your level of agreement. | | | | | | | | | |
| Panelist identified the followings: | | | | | | | | | |
| 1 | There are specific Saudi Arabian CULTURAL and SOCIETAL reasonings and misconceptions that act as common barriers to seeking help for mental health conditions. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified that STIGMA is a common barrier that hinders seeking help: | | | | | | | | | |
| 2 | Clients/Families experience feelings of shame and disgrace when it comes to seeking help | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3 | Clients/Families experience fear related to their social reputation/image when it comes to seeking help | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 4 | Clients/Families experience fear of being seen as defective (not normal/insane) when it comes to seeking help | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified PRIVACY as a common barrier hindering help seeking in clients: | | | | | | | | |
| 5 | Clients/Families fear opening up because they are concerned that the therapist will disclose their secrets or information; and/or expose their family name | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified TRUST as a common barrier that hinder seeking help, as follow: | | | | | | | | |
| 6 | There are inadequate protections of clients/families confidentiality | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7 | There is a lack of trust in the field, stemming from incompetent practices (a bad reputation) by some of those who provide the services | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified MISCONCEPTIONS as common barriers that hinder seeking help; The common beliefs are that: | | | | | | | | |
| 8 | There is a misconception that all treatments necessitate pharmacological interventions, and that this will result in addiction to the medications | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9 | There is a misconception that clients believe that professional help is only for severely mentally unstable people | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified LACK OF AWARENESS as a common barrier that hinders seeking help: | | | | | | | | |
| 10 | Clients do not understand the different roles that each professional plays in mental health care such as the differences between a psychiatrist versus a psychotherapist | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11 | Psychological interventions are not well publicized in the Saudi society, an example that was given is lack of awareness and attention to the need to seek psychological services and treatment, compared to the amount of attention given to the biological/organic aspects of one’s health | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12 | Potential clients are unaware of the beneficial aspects of counseling and psychotherapy, as well as the importance of seeking early interventions | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Panelist identified ACCESS TO PROFESSIONALS as a common barrier that hindered seeking help: | | | | | | | | |
| 13 | There is a shortage in the number of competent and adequately trained practitioners in the field to meet the current demands for mental health services | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14 | There exists a difficulty in getting help for distinctive problems since there is a severe shortage of specialists with experience | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 15 | Most qualified competent professionals are hired by specific government or corporate hospitals that serve only specific populations | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified AVAILABILITY OF SERVICES & FACILITATORS as a common barrier that hinder seeking help, such as: | | | | | | | | |
| 16 | The cost of seeking services for clients as demonstrated by the high costs of private clinics and insurance companies not covering the costs of psychotherapy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17 | Clients have difficulties scheduling appointments and having consistent therapist contact. Examples include difficulties getting an appointment with a specialist; consistency in attending appointments due to waiting lists; and timing between follow-up appointments | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18 | Poor quality and availability of services. Examples include lack of information about the services that are available, poor professional services, and services established exclusively for the government sector | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19 | Relatively low availability of community mental health services | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20 | Lack of support to develop new psychological service settings such as clinics | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 21 | Lack of clarity in the purposes and procedures of psychiatric pharmacological treatments | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 22 | Challenges related to women’s access to transportation to receive services | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23 | Not enough efficient addiction focused centers that are appropriate for the growing numbers of patients with addiction issues | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 24 | Overall poor services that are provided in mental health treatment | | | | | | | |
| Panelist identified that the CURRENT STATUS OF COLLABORATIVE CARE AND RELATED SUPPORT in services as common barriers that hinder seeking help: | | | | | | | | |
| 25 | There is limited connection between mental health practitioners and schools | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26 | There are many deficiencies in the current mental health care system in the Kingdom of Saudi Arabia | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27 | More support is needed from the Saudi Ministry of Health toward the development of mental health | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28 | There is a lack of sponsors and associations that foster mental health education | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Question 1(b)

Panelists were asked to answer the following question:

List the necessary solutions to foster more effective mental and social health services for individuals, couples, and families in Saudi Arabia?

The following statements represent combined answers from panelists to the above question. Please read each statement carefully, and circle the number that best reflects your level of agreement/disagreement to each statement listed below (on a scale of 1 to 7; 1 = Unimportant and 7= Very Important). Please circle the number that best reflects your view on the item importance.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Panelist identified necessary solutions to foster more effective mental health and social health services related to needs and requirements of the PROFESSIONAL DELIVERING THE INTERVENTIONS | | | | | | | | |
| 29 | Professionals need much more training and supervision than what they have currently received | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30 | That clinicians be held accountable to a clearly defined professional code of ethics | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31 | To measure clinicians performances and outcomes | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 32 | Providers of services need to be restricted to qualified professionals with appropriate credentials awarded by an accredited legislative body in the country | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Panelist identified necessary solutions to foster more effective mental health and social health services related to CLIENTS/FAMILIES, such as: | | | | | | | | |
| 33 | To enforce patient's rights by prioritizing confidentiality through securing their information, their privacy, and setting clear procedures for the clients/families to take in cases of violations | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34 | To train qualified specialists who represent both genders in order to allow for more availability of same-gender providers allowing both men and women the opportunity to receive help from specialists who identify in terms of gender | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified necessary solutions to foster more effective mental health and social health services by recommending the following SERVICES EXPANSIONS: | | | | | | | | |
| 35 | Rebuild the mental health care system in Saudi Arabia | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36 | To reduce the cost of seeking mental health services, by having more providers determine fees by using a sliding-fee scale based on income, and by requiring insurance companies to cover psychotherapy in non-hospital settings. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 37 | To require mental health services screening for all physician visits for any physical illness, and referral if indicated | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 38 | To require screening for mental health prior to marriage. The participants who suggested this item viewed it as more important than the currently required medical examination | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 39 | To provide solutions for the restrictions related to women's transportation to receive services,(for example, the suggestion was for some hospitals to provide transportation services for women) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 40 | To increase the collaborations between mental health professionals in the community. Examples; more collaboration needed from family and community physicians as well as involvement of other providers such as psychologists and social workers | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 41 | To establish a proper referral system that tracks appropriate referral actions | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 42 | To reform and expand mental health services to more sites to include health care institutions as well as general and specialist hospitals. An example that was given is that many public hospitals do not provide mental health services | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 43 | Include mental health hospitals into sections within general hospitals | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 44 | The need for the development of community mental health services across the nation (urban, rural) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 45 | To establish counseling guidance services, particularly counseling centers in every neighborhood | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 46 | To establish mental wellness programs that provide preventative care through psychoeducation | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelists identified COLLABORATION as a necessary solution to fostering more effective mental health and social health services | | | | | | | | |
| 47 | To establish collaborative efforts with schools that run from elementary schools up to universities | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 48 | To have more collaboration between government agencies such as courts that will result in interventions for troubled families and individuals | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49 | To involve educational institutions in constructing plans for psychosocial programs | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 50 | To establish a reliable information center under the Ministry of Health, which highlights the importance of mental health and the role of those working in the field, and identifies services that are available for individuals/families to seek treatment | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified INCREASING AWARENESS as a necessary solution to foster more effective mental health and social health services | | | | | | | | |
| 51 | To utilize the media for the following: To increase awareness of mental health, reduce the stigma for seeking help, and familiarize people with services provided for various presenting concerns. The media could target homes, mosques, families as an example and can use multiple forms of communication including regular media, newspapers, and the social media | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 52 | To work collaboratively with religious institutions such as mosques, to reduce mental health stigma | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Question 2(a)

Panelists were asked to answer the following question:

List the most common training barriers for professionals who deliver/or desire to deliver effective therapeutic interventions to individuals, couples, and families in Saudi Arabia?

The following statements represent combined answers from panelists to the above question. Please read each statement carefully, and circle the number that best reflects your level of agreement/disagreement to each statement listed below (on a scale of 1 to 7; 1= Completely Disagree and 7= Completely Agree). Please circle the number that best reflects your level of agreement.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Panelist identified common training barriers as LACK of COMPETENT TRAINERS: | | | | | | | | |
| 53 | There are plenty of those who claim that they have the knowledge, but who are semi-educated/pseudo-professionals, and who get the certificate in the field for financial gain purposes and are making business out of training others. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified common training barriers as too few TRAINING SITES: | | | | | | | | |
| 54 | No clear criteria, regulations, and procedures are set for site training. It is too dependent on the institute itself and the personality of the trainer. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 55 | Insufficient private sector sites that cooperate and accept trainees in order that they can get clinical experience | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 56 | Lack of training institutions understanding of the role of marital and family counseling and as a result, individuals who want to train students find it hard to locate a place to conduct the trainings | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 57 | Inadequateness of the currently available settings in the psychological clinics for offering state of the art training and supervision | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 58 | Training is not flexible and clashes with the practitioner's work schedule | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelists identified common training barriers related to SUPERVISION: | | | | | | | | |
| 59 | Lack of training programs that offer sufficient clinical supervision. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 60 | The scarcity of qualified supervisors/trainers/educators to oversee or to follow-up with a trainee. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 61 | No criteria are set that define what constitutes clinical supervision and the clinical supervisor's role in facilitating the growth of young professionals delivering psychotherapeutic interventions | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified common training barriers as related to EDUCATION: | | | | | | | | |
| 62 | All programs of study in social sciences are housed in colleges that do not provide even the minimal basis of "sciences" that are required for training in clinical or health sciences. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 63 | Poor undergraduate training programs for social sciences majors, an example provided by panelists is that psychology majors have a short duration of required practicum training hours in a universities' curriculum | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 64 | Training programs focus more on teaching theories than the practice itself | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 65 | The scarcity of local training programs, an example is the current lack of availability of training programs for post-graduates in Saudi Arabia. Many who desire training need to go internationally to obtain it | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 66 | Insufficiency of training materials;  few training materials are available in Arabic, and that overall trainees have poor English language proficiency to make use of available training materials in English | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified common training barriers as relates to a FUNDS GAP: | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 67 | Financial cost for trainees, practitioners, and the paying for the setting. Training is taken over by individual healthcare institutions, and they charge huge fees for a particular course from the participants/trainees. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 68 | Lack of financial gains for trainers | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified common training barriers as relates to FUTURE EMPLOYMENT: | | | | | | | | |
| 69 | Lack of trainees desire because of the neglectful career system | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified common training barriers as relates to ACCREDITATION AND LICENSURE: | | | | | | | | |
| 70 | Scarcity of approved local training programs | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 71 | Absence of a clear scientific body that is responsible and have clear mechanism for approving hours of training for psychotherapists/marriage and family therapists | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 72 | Lack of evaluation to measure effectiveness of the training | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 73 | Lack of licensure to regulate mental health standards and the profession | | | | | | | |
| Panelist identified common training barriers related to CLARITY IN PROFESSIONAL ROLES, described as follow: | | | | | | | | |
| 74 | Absence of distinction between social, and psychological, and psychiatry field in terms of the known scope of practice and specific areas of therapeutic interventions | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 75 | Lack of clear roles in distinguishing between Social, Psychological, and Psychiatry fields | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Question 2(b)

Panelists were asked to respond to the following question:

List the necessary solutions for improved training of professionals who deliver/or desire to deliver therapeutic interventions to individuals, couples, and families in Saudi Arabia?

The following statements represent combined answers from panelists to the above question. Please read each statement carefully, and circle the number that best reflects your level of agreement/disagreement to each statement listed below (on a scale of 1 to 7; 1 =Unimportant and 7= Very Important). Please circle the number that best reflect your view on the item importance.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Panelist identified the PROFESSIONAL DELIVERING the INTERVENTIONS as important and provided necessary solutions to foster both effective services and improved training of professionals: | | | | | | | | |
| 76 | To establish a unified legislative body that grants licensure | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 77 | To establish a unified legislative body that sets practice requirements for specialists | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 78 | To establish a unified legislative body that establishes a clear code of ethics for professionals working on delivering therapeutic interventions to individuals, couples, and families. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 79 | To establish a unified legislative body that restricts mental health practice to those with valid credentials and approved training | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 80 | To promote, develop, and increase intensive training programs and supervision for professionals to ensure better mental health outcomes for clients and the community | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 81 | To develop a mechanism to measure the performance of working professionals delivering mental health services that allows for evaluating and tracking the outcome of the services | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelists identified that necessary solution to improve training is to enhance COLLABORATIVE EFFORTS & NEEDED LOGISTICAL CHANGES as follow: | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 82 | To create a national plan where all the ministries involved in training for mental health services work in collaboration with one another, an example that was given, is to link training with the Ministry of Health and universities' specialization centers. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 83 | To establish local training programs that are accredited, and to take into consideration that the psychological/mental health services are still in the beginning; therefore, it is important to start with a gradually structured plan while taking advantage of existing competencies in the field, such as to involve specialists and train them on how to implement training programs. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 84 | Health and education authorities should develop quality postgraduate training program in collaboration with Western institutions that have centers specialized in psychotherapy and exchange experiences with them | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified necessary solutions to IMPROVING training: | | | | | | | | |
| 85 | To have all mental health fields medium of teaching to be in English | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 86 | To transfer mental health-related major specialties from colleges of "art" into colleges of "science or applied sciences" / or "health sciences." | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified that necessary solutions to improve training is to enhance TRAINING PROGRAMS AND PROFESSIONALS DEVELOPMENT by the following: | | | | | | | | |
| 87 | To increase the hours of clinical training for students who major in mental health fields | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 88 | To provide practical training workshops, that focus on increasing competencies in specific specializations | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 89 | To urge health sectors to respond to requests for training students, especially in the private sector | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 90 | To have a qualified training headquarters with a clearly defined set of requirements for training that includes a surveillance body that monitors the quality of the training curriculum | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 91 | To emphasize during training the need to establish trust and protect patient's right to privacy and confidentiality, and to discuss ways to break through stigma, privacy, and trust barriers | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified that necessary solution to improve training is regarding SUPERVISION, are as follows: | | | | | | | | |
| 92 | To require continuous clinical supervision for therapists in training, whether individually or in groups | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 93 | For training to be standardized, and to be carried out by professional supervisors, academicians, and practitioners in field work. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 94 | To require ongoing training, such as to establish intensive training courses with supervision and follow-up even after the end of the training course. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 95 | To establish competencies in supervision from overseas countries as a start, until Saudi Arabia can have a group of qualified supervisors | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified that necessary solution to improve training is concerning GAPS in FUNDING: | | | | | | | | |
| 96 | To set adequate funds aside for training. These funds would be used to develop programs and related materials that would meet the needs of Saudi culture | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 97 | To provide trainers with rewarding salaries | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Question 3(a)

Panelists were asked to answer the following question:

The biggest cultural challenges working with individuals, couples, and families in working with those above problems? Provide examples.

The following statements represent combined answers from panelists to the above question. Please read each statement carefully, and circle the number that best reflects your level of agreement/disagreement to each statement listed below (on a scale of 1 to 7; 1 = Completely Disagree and 7= Completely Agree). Please circle the number that best reflect your level of agreement.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Panelist identified some of the biggest cultural challenges for working with individuals, couples, and families as related to SOCIETAL NORMS AROUND GENDER: | | | | | | | | |
| 98 | The complete gender separation is a big cultural challenge | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 99 | Cultural misconceptions around the concept of male dominance, for example, ideas about roles and responsibility for both genders, responsibilities of male guardians | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 100 | Many husbands reject attending therapy sessions. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 101 | Lack of freedom, especially for women to get access to psychological services | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 102 | Perceptions of women as inferior and minor | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 103 | Although the Minister of Justice is working hard to empower women, people in power are not accepting it. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 104 | Absence of community and human rights organizations to ensure women's occupational rights | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified SOCIETAL/CULTURAL specific issues among the biggest cultural challenges: | | | | | | | | |
| 105 | Stigma around seeking help | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 106 | Clients/Families have difficulties with opening up to others especially to mental health professionals, and being transparent in the experience | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 107 | Society still does not accept marital therapy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 108 | Difficulties in expressing emotions because of “emotional illiteracy” | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 109 | The nature of extended Saudi families | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 110 | Being a conservative society | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 111 | The society does not encourage or accept professional help | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 112 | Families reject the idea of seeking professional help for their family members | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 113 | Many families do not admit to/or recognize the existence of problems. Therefore, they do not seek help for mental health | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 114 | Discrimination, intolerance of others who are different, and the absence of societal awareness of ways to socialize people into acquiring responsibilities and tolerance | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified some of the biggest cultural challenges as BELIEFS & UNDERSTANDINGS: | | | | | | | | |
| 115 | Society and community lack awareness about psychological disorders and problems; For example, mixing up some of the notions of evil eye and envy with mental illness; attributing mental illness to evil eye or envy; attributing psychological illness as God’s punishment or as an evidence of a lack of commitment to the religion | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 116 | Society’s perception of psychotherapists as unstable people | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 117 | Some traditions and norms are blended with religious views, which at times do not reflect the correct understanding of religion teachings | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 118 | Difficulties in accepting seeking help from non-family members | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified some of the biggest cultural challenges as working with the SOCIETAL AND CULTURAL GAP related to PRESENTING CONCERNS: | | | | | | | | |
| 119 | In the matters of divorce, judges in courts do not have the knowledge and familiarity with the importance of marital therapy, therefore they do not refer cases to the appropriate venue that offers guidance before going through with the divorce | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 120 | Working in general with cases that present with sexual disorders, sexual abuses, and domestic abuses, and addictions, for the cultural taboos associated with exploring those concerns | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 121 | Working with couples dealing with intimacy and sexual related problems, emotional distance couples (emotional divorce) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 122 | Working with parents who hold misinterpretations of ideas about parenting. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 123 | Lack of premarital compatibility screening, an example that was given that marriages are conducted randomly and traditionally without ensuring proper ways for couples to assess their compatibilities to one another | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 124 | There is no biggest or smallest challenge, Saudi mental health professionals are very well aware of those issues and there is a strong political will to accept slowly those challenges and find the most appropriate strategies sensitive to the unique culture of the society | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Question 3(b)

Panelists were asked to answer the following question:

What do therapist need to do to successfully treat these types of presenting problems? [problems related to working with cultural issues in families and couples]

The following statements represent combined answers from panelists to the above question. Please read each statement carefully, and circle the number that best reflect your level of agreement/disagreement to each statement listed below (on a scale of 1 to 7; 1 = Unimportant, and 7= Very Important). Please circle the number that best reflect your view on the item importance.

Panelist identified that for a therapist to successfully work with presenting concerns that require marital and family therapeutic interventions, therapists need to have KNOWLEDGE and SKILLS as follow:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 125 | Knowledge of the Islamic religious teachings, customs and traditions of the Saudi society, and the cultural background of each case and to respect it | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 126 | A precise and in-depth specialization in one of the schools of psychotherapy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 127 | For mental health providers to be insightful about their personal opinions and biases and to pay attention to them, and to try not to make their personal opinion and biases affect the treatment | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 128 | Good theoretical background on the causes and the contributing factors for these problems | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 129 | To have skills in understanding the presenting concerns, building trust, providing sufficient psychoeducation to the clients at the beginning of the therapy about the therapy process before engaging in problem-solving | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified for a therapist to work successfully with presenting concerns that require marital and family therapeutic interventions, therapists must have those PERSONAL QUALITIES: | | | | | | | | |
| 130 | To be empathetic, to be respecting and accepting of the community, and to adopt to teamwork | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelist identified that for a therapist to successfully work with presenting concerns that require marital and family therapeutic interventions, the following CLEAR GUIDELINES and REGULATIONS needs to be in place: | | | | | | | | |
| 131 | Needs logistic support for therapists such as the existence of a specialized body to protect his/her rights and roles | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 132 | Standardized steps that allow for the collaborative work to happen. For example, joint collaborative efforts by the courts, police, and health and social sectors to address directly cases of domestic violence and to provide safe shelters for those who are assaulted | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 133 | A clear structure that gives confidence and trust in working jointly with various parties to cover all aspects of the problem | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 134 | Not to handle cases without appropriate training in working with cases that require special competencies, such as domestic violence and sexual abuse | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Panelists identified that for a therapist to successfully work with presenting concerns that require marital and family therapeutic interventions, therapists need more ADVOCACY work to take place by professionals, such as: | | | | | | | | |
| 135 | Establishing associations to reach people and to lobby for major presenting concerns | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| Feel free to share any comments in the space below |
|---|
| |

Appendix F2

Study Three: Round Two Delphi Survey (Arabic)

في استبيان دلفي الأول قد طلب منكم تحديد العقبات الشائعة(السائدة) وكذلك تحديد الحلول لتقديم خدمات التدريب وخدمات الصحة النفسية والاجتماعية للأفراد، والأزواج، والأسر في المملكة العربية السعودية. و كذلك طلب منكم تحديد التحديات الثقافية وإحتياجات المعالج للعمل بنجاح مع الشكاوي المرتبطة بالعلاقات.

وفيما يلي قائمة بردودكم وردود المشاركين الأخرين، لقد لخصت الردود لإختصار الإستبيان. نرجو منكم قراءة جميع البيانات والاشارة بما تتفقون معه او تختلفون معه، وكذلك مدى أهميتها /أو عدم أهميها. لان ردودكم سوف تساهم في تشكيل النتيجة النهائية لهذه البيانات التي حصلت على مؤشرات عالية من التوافق والأهمية لهذه الدراسة مع شكري **لمساهمتك**م بوقتكم، يرجى أخذ الوقت الكافي لقراءة كل العبارات بعناية.

السؤال الأول (أ)

:لقد طُلب من الاعضاء المشاركين الإجابة على السؤال التالي

عدد الحواجز/ العقبات الأكثر انتشاراً المعيقه للوصول للخدمات الصحية النفسية والاجتماعية للأفراد، والأزواج والأسر في المملكة العربية السعودية؟

تمثل البيانات التالية الإجابات المشتركة بين الأعضاء المشاركين على السؤال أعلاه. يرجى قراءة كل عبارة بعناية والإشارة للرقم الذي يعكس أفضل مستوى من الاتفاق / الاختلاف في كل البيانات الواردة أدناه (على مقياس ليكرت من 1 = لا أوافق تماما و 7 = أوافق تماما). يرجى تحديد الرقم الذي يعكس أفضل ما يتوافق معك.1-7؛

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| لقد حدد الاعضاء المشاركين ما يلي: | | | | | | | | | |
| 1 | هنالك أسباب ثقافية ومجتمعية ومفاهيم خاطئة والتي تشكل حواجز شائعة تعيق طلب المساعدة. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| لقد حدد الاعضاء المشاركين أن وصمة العار، هي من إحدى الحواجز السائدة التي تعيق طلب المساعدة: | | | | | | | | | |
| 2 | العملاء/الأسر تواجه الحرج من الخزي والعار | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 3 | العملاء/الأسر تواجه الخوف على سمعتها الإجتماعية ونظرة المجتمع لهم. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 4 | العملاء/الأسر تواجه مخاوف بأن يشار لهم بوصمة الجنون | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| لقد حدد الاعضاء المشاركين أن الخصوصية، هي من إحدى الحواجز السائدة التي تعيق طلب المساعدة، كما يلي: | | | | | | | | | |
| 5 | العملاء/ الأسر تخشى من المعالج ان يخرج أسرار أومعلومات خاصة بهم؛ و/أو الخوف من فضح اسم عائلتهم | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| لقد حدد الاعضاء المشاركين أن الثقة، هي من إحدى الحواجز السائدة التي تعيق طلب المساعدة، كما يلي: | | | | | | | | | |
| 6 | هنالك قصور في حماية السرية للعملاء/الأسر | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 7 | هناك عدم ثقة في هذا المجال بسبب الممارسات من قبل غير الأكفاء وبعض الذين يقدمون الخدمات مما نجم عن (سمعة سيئة) للممارسين | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 7 |
| لقد حدد الاعضاء المشاركين أن المفاهيم الخاطئة، هي من إحدى الحواجز السائدة التي تعيق طلب المساعدة، كما يلي: | | | | | | | | | |
| 8 | أن جميع أنواع العلاج تتطلب التدخل الدوائي وأن ذلك سيؤدي الى الإدمان على الأدوية | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 9 | يعتقد العملاء أن التدخل العلاجي فقط لبالغي الإضطراب أو الخلل العقلي | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| لقد حدد الاعضاء المشاركين ان قلة الوعي، هي من إحدى الحواجز السائدة التي تعيق طلب المساعدة: | | | | | | | | | |
| 10 | العملاء لا يدركون الأدوار المختلفة التي يلعبها الممارسين في الصحة النفسية كالفرق بين الطبيب النفسي والمعالج النفسي | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 11 | ثقافة التدخل العلاجي النفسي ليست منتشرة بشكل جيد في المجتمع السعودي، على سبيل المثال (قلة الوعي والاهتمام بالخدمات النفسية والعلاجية، بالمقارنة بالنواحي الصحية العضوية) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 12 | العملاء المحتملين ليس لديهم معرفه بالجوانب المفيدة للإرشاد والعلاج النفسي، فضلاً عن أهمية السعي للتدخل المبكر | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| لقد حدد الاعضاء المشاركين أن إمكانية الوصول إلى الممارسين، هي من إحدى الحواجز السائدة التي تعيق طلب المساعدة: | | | | | | | | | |
| 13 | هنالك نقص في عدد العاملين الأكفاء والمدربين تدريبا ملائما في هذا المجال لتلبية الطلبات الحالية من خدمات الصحة النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 14 | هنالك صعوبة في الحصول على المساعدة المطلوبة لشكاوى معينة نظراً لوجود نقص حاد في عدد المختصين من ذوي الخبرة | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 15 | معظم الممارسين المختصين المؤهلين يتم تعينهم في قطاع حكومي معين أو في الشركات والمستشفيات الخاصة التي تخدم فئة معينة فقط | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| لقد حدد الاعضاء المشاركين أن مدى توفير الخدمات والتسهيلات المتعلقة بالخدمات تعد من الحواجز السائدة التي تعيق طلب المساعدة، مثل: | | | | | | | | | |
| 16 | التكلفة للحصول على الخدمات (ارتفاع تكاليف العيادات الخاصة، وأن شركات التأمين لا تغطي تكاليف العلاج النفسي) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 17 | العملاء يواجهون صعوبات في أخذ وتحديد المواعيد و المواظبة على مراجعة معالج ثابت. الأمثلة تتضمن صعوبات في الحصول على موعد مع أخصائي ،والانتظام في حضور الجلسات بسبب قوائم الانتظار، ومواعيد المراجعة بين الجلسات العلاجية | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 18 | ضعف جودة وتوفير الخدمات اللازمه كالأتي: نقص في المعلومات حول الخدمات المتواجدة، ضعف في الخدمات المقدمة، وغالبا ما تتوفر الخدمات بصورة حصرية في القطاع الحكومي | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 19 | نسبيا هنالك نقص في الخدمات المتوفرة لخدمات الصحة النفسية والمجتمعية | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 20 | عدم وجود دعم لتطوير الخدمات النفسية كالعيادات على سبيل المثال | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 21 | عدم توضيح الأهداف والإجراءات المتعلقة بالعلاج الدوائي النفسي للعميل | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 22 | التحديات المتعلقة بوسائل النقل للسيدات/المراجعات لتلقي الخدمات | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 23 | قلة تواجد المراكز ذات الكفاءة التي تركز على علاج الإدمان بشكل كافي والتي تتناسب مع الأعداد المتزايدة من المرضى الذين يعانون من الإدمان | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 24 | بشكل عام هنالك ضعف في الخدمات العامة المتاحة لعلاج الأمراض النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن الوضع الحالي للخدمات التعاونية والدعم تعد من الحواجز السائدة التي تعيق طلب المساعدة: | | | | | | | | |
| 25 | هنالك قصور في التواصل بين العاملين في مجال الصحة النفسية والمدارس | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 26 | هناك العديد من أوجه القصور في نظام الرعاية الصحية النفسية الحالية في المملكة العربية السعودية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 27 | الحاجة للمزيد من الدعم من وزارة الصحة السعودية نحو تطوير الصحة النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 28 | هنالك غياب للجهات الراعية والجمعيات التي يفترض أنها تعزز التثقيف الصحي النفسي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

السؤال الأول (ب)

لقد طُلب من الأعضاء المشاركين الإجابة على السؤال التالي:

عدد الحلول اللازمة لتعزيز فعالية أكثر لخدمات الصحة النفسية والاجتماعية للأفراد، والأزواج والأسر في المملكة العربية السعودية؟

تمثل البيانات التالية الإجابات المشتركة بين ألأعضاء المشاركين على السؤال أعلاه. يرجى قراءة كل عبارة بعناية، والإشارة للرقم الذي يعكس أفضل مستوى من الاتفاق / الاختلاف في كل البيانات الواردة أدناه (على مقياس ليكرت من 1 = غير مهم و 7 = مهم جداً). يرجى تحديد الرقم الذي يعكس رأيك بدقة المتعلق لهذه البيانات1-7.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| لقد حدد الأعضاء المشاركين الحلول الضرورية لتعزيز خدمات أكثر فعالية للصحة النفسية والاجتماعية والتي تتعلق بالاحتياجات والمتطلبات المهنية للمعالج الذي يقدم التدخلات، كالأتي: | | | | | | | | | |
| 29 | المهنيين بحاجة الى المزيد من التدريب العملي والإشراف بزيادة عن ما يتلقونه حالياً | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 30 | إلزام العياديين المختصين بالإلتزام بقواعد واضحة لممارسة المهنة والخضوع للمساءلة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 31 | قياس أداء العياديين المختصين وحصيلة نتائجهم | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 32 | يجب أن تقتصر توفير الخدمات على المختصين المؤهلين المعتمدين من قبل الهيئة التشريعية المعتمدة في الدولة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الأعضاء المشاركين الحلول الضرورية لتعزيز خدمات أكثر فعالية للصحة النفسية والاجتماعية والتي تتعلق بالعملاء/الأسر، مثل: | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 33 | تطبيق وجعل سرية حقوق المريض من الأولويات من خلال تأمين المعلومات الخاصة بهم، وضمان حماية خصوصيتهم، ووضع إجراءات واضحة للعملاء/الأسر لإتخاذها في حالات مواجهة الانتهاكات | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 34 | تدريب المختصين المؤهلين من كلا الجنسين من أجل اتاحة فرص المساعدة المناسبة من حيث نوع الجنس لكل من الرجال والنساء | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الأعضاء المشاركين الحلول الضرورية لتعزيز خدمات أكثر فعالية للصحة النفسية والاجتماعية وذلك عن طريق تنفيذ التوصيات التالية لتطوير الخدمات: | | | | | | | | | |
| 35 | إعادة بناء نظام الرعاية الصحية النفسية في المملكة العربية السعودية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 36 | خفض تكلفة الحصول على خدمات الصحة النفسية، من خلال وجود أكثر من مزودي للخدمات، وبتحديد الرسوم باستخدام جدول مبني على أساس دخل الأسرة/الفرد، و مطالبة شركات التأمين لتغطية العلاج النفسي خارج المستشفيات. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 37 | أن يشترط الفحص النفسي لجميع الزيارات الطبية للخدمات الصحية للأمرض الجسديه، والإحالة إذا تطلب الأمر ذلك | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 38 | أن يشترط تقديم فحص الصحة النفسية قبل الزواج. المشاركون الذين اقترحوا هذا البند ينظرون للفحص النفسي على أنه أكثر أهمية من الفحص الطبي المطلوب حالياً | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 39 | توفر حلول للقيود المعنية على تنقل النساء، على سبيل المثال ، كان هنالك إقتراح أن توفر المستشفيات خدمات وسائل النقل للنساء | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 40 | زيادة التعاون بين العاملين في مجال الصحة النفسية في المجتمع; من الأمثلة المزيد من التعاون مطلوب من أطباء الأسرة والمجتمع، وكذلك إشراك مقدمي الخدمات الآخرين مثل الأخصائيين النفسين والاجتماعيين | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 41 | إنشاء نظام التحويل الذي يتيح تعقب إجراءات التحويل للجهة المناسبة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 42 | توسيع الخدمات الصحة النفسية بزيادة مواقعها وأيضاً ادخالها في مؤسسات الرعاية الصحية وكذلك المستشفيات العامة والمتخصصة. المثال الذي ذكر هو أن العديد من المستشفيات العامة لا توفر خدمات الصحة النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 43 | إدراج مستشفيات الصحة النفسية في أقسام داخل المستشفيات العامة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 44 | الحاجة إلى تطوير خدمات الصحة النفسية المجتمعية في مختلف أنحاء البلاد (في المناطق المدنية والريفية) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 45 | إنشاء خدمات الإرشاد والتوجيه، وعلى وجه الخصوص مراكز الإرشاد في كل حي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 46 | وضع برامج العناية بالصحة النفسية التي تقدم الرعاية الوقائية من خلال التثقيف النفسي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الأعضاء المشاركين أن التعاون، هو من إحدى الحلول الضرورية لتعزيز خدمات أكثر فعالية للصحة النفسية والاجتماعية | | | | | | | | | |
| 47 | بذل جهود و تعاون مع المدارس، حيث تنطلق من المرحلة المتوسطة إلى المرحلة الجامعية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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|---|---|---|---|---|---|---|---|---|
| 48 | أن يكون هنالك المزيد من التعاون بين الجهات الحكومية مثل المحاكم التي من شأنها أن تسفر عن توفير التدخلات العلاجية للأسر والأفراد المتعثرون | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 49 | إشراك المؤسسات التعليمية في بناء خطط للبرامج النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 50 | إنشاء مركز معلومات معتمد تحت إشراف وزارة الصحة، الذي يسلط الضوء على أهمية الصحة النفسية ودور العاملين في هذا المجال، والتي تحدد الخدمات المتاحة للأفراد / والأسر لطلب العلاج | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الأعضاء المشاركين أن زيادة الوعي، هي من إحدى الحلول الضرورية لتعزيز خدمات أكثر فعالية للصحه النفسية والاجتماعية: | | | | | | | | |
| 51 | نشر الوعي بالصحة النفسية عن طريق الإعلام كما يلي: زيادة الوعي بالصحة النفسية، والحد من وصمة العار المرتبطة بطلب المساعدة، وتعريف الناس بالخدمات المتعلقة بالشكاوي المختلفه. وايضاً، إستهداف وسائل الإعلام للمنازل والمساجد والأسر، على سبيل المثال يمكن استخدام أشكال متعددة من وسائل الاتصالات بما في ذلك وسائل الإعلام العادية، والصحف، ووسائل الاعلام الاجتماعية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 52 | العمل بشكل تعاوني مع المؤسسات الدينية مثل المساجد، للحد من الوصمة المرتبطة بالصحة النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

السؤال الثاني (أ)

لقد طُلب من الأعضاء المشاركين الإجابة على السؤال التالي:

عدد العوائق الأكثر شيوعاً لتدريب المهنيين الذين يقدمون / أويرغبون في تقديم تدخلات علاجية فعالة للأفراد، والأزواج والأسر في المملكة العربية السعودية؟

تمثل البيانات التالية الإجابات المشتركة بين الأعضاء المشاركين على السؤال أعلاه. يرجى قراءة كل عبارة بعناية، والإشارة للرقم الذي يعكس أفضل مستوى من الاتفاق / الاختلاف في كل البيانات الواردة أدناه (على مقياس ليكرت من 1-7 1 = لا أوافق تماماً و 7 = أوافق تماماً). يرجى تحديد الرقم الذي يعكس أفضل ما يتوافق معك.

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| لقد حدد الأعضاء المشاركين أن من حواجز التدريب الشائعة هي ندرة المدربين الأكفاء: | | | | | | | | |
| 53 | هناك الكثير ممن يدعي أن لديهم المعرفة، هؤلاء الأفراد هم أشباه المتعلمين/غير المختصين، وأيضاً من هم يحصلون على شهادات في هذا المجال لأغراض تحقيق مكاسب مالية وجعل تدريب الآخرين عمل تجاري. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الأعضاء المشاركين أن من حواجز التدريب الشائعة هي قلة عدد مواقع التدريب: | | | | | | | | |
| 54 | عدم وضوح المعايير والأنظمة والإجراءات لمواقع التدريب، كما هو موضح في مثال أن المعايير تعتمد على المعهد نفسه وشخصية المدرب. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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| 55 | تعاون غير كافي من مراكز القطاع الخاص في استقبال المتدربين للحصول على الخبرة الإكلينيكية. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 56 | ندرة وجود مؤسسات للتدريب التي تفهم دور الإرشاد الأسري والزواجي، ونتيجة لذلك يوجد صعوبة في تحديد المكان لإجراء التدريب للأفراد الذين يرغبون في تدريب طلابهم | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 57 | نقص في الأماكن المتوفرة حالياً في العيادات النفسية التي تقدم أحدث طرق التدريب والإشراف | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 58 | عدم وجود مرونه في أوقات التدريب التي قد تصطدم مع جدول عمل المختصين | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن من حواجز التدريب الشائعة تتعلق بالإشراف: | | | | | | | | |
| 59 | عدم وجود برامج التدريب التي تقدم إشرافً عيادياً بالشكل الكافي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 60 | ندرة المؤهلين تأهيلاً كافي للإشراف أو متابعة المتدربين من المشرفين/ المدربون/ والتربويون | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 61 | لا يوجد معايير محددة التي تُعرف بماهية الإشراف العيادي ودور المشرفين الإكلينيكيين لتسهيل وتطوير المختصين المبتدئين لتقديم التدخلات العلاجية النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن التعليم هو من إحدى حواجز التدريب الشائعة: | | | | | | | | |
| 62 | جميع برامج العلوم الاجتماعية الدراسية موجودة في كليات التي لا تتوفر فيها الحد الأدنى لأساسيات "العلوم" المطلوبه للتدريب في العلوم الإكلينكية أو الصحية. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 63 | ضعف برامج التدريب الجامعي لخريجي تخصصات العلوم الاجتماعية، على سبيل المثال، قصر مدة التدريب الإلزامي في ساعات المنهج الجامعي لتخصص علم النفس | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 64 | برامج التدريب تركز على النظريات أكثر من الممارسة نفسها | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 65 | ندرة البرامج التدريبية المحلية، ومثال على ذلك هو النقص الحالي في توفر البرامج التدريبية للدراسات العليا في المملكة العربية السعودية. فالعديد من الذين يرغبون في التدريب يلجؤن للذهاب للخارج للتدريب | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 66 | عدم وجود مواد تدريبية كافية لقلة المواد التدريبية باللغة العربية، وضعف إجادة اللغة الإنجليزية للكثير من المتدربين مما يقلل الاستفادة من المواد التدريبية المتوفرة بشكل عام باللغة الإنجليزية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الأعضاء المشاركين أن من حواجز التدريب الشائعة تتعلق بالفجوة في الموارد المالية؛ كالأتي: | | | | | | | | |
| 67 | التكلفة المالية للمتدربين، والممارسين، والتكلفة المتعلقة بإعداد مكان التدريب. وأن مؤسسات الرعاية الصحية الفردية هي المسؤولة عن التدريب، وأنها تتقاضى رسوما ضخمة لدورات معينة من المشاركين/المتدربين | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 68 | عدم وجود مكاسب مالية للمدربين | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن من حواجز التدريب الشائعه تتعلق بالمستقبل الوظيفي: | | | | | | | | |
| 69 | عدم وجود رغبة ودافع لدى المتدربين بسبب القصور الحالي في نظام التوظيف | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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| لقد حدد الاعضاء المشاركين أن من حواجز التدريب الشائعة تتعلق بالاعتماد والترخيص: | | | | | | | | |
| 70 | ندرة برامج التدريب المحلية المعتمدة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 71 | عدم وجود هيئة علمية واضحة مسؤولة ولها آلية واضحة للموافقة على الساعات التدريبية للمعالج النفسي /أو المعالج الأسري والزواجي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 72 | عدم وجود تقييم لقياس فعالية التدريب | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 73 | عدم وجود ترخيص ينظيم معايير الصحة النفسية وممارسة المهنة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن من حواجز التدريب الشائعة تتعلق بالوضوح في الأدوار المهنية، وصفت كما يلي: | | | | | | | | |
| 74 | غياب نطاق تعريف حدود التدخلات العلاجية لكل مجال ومعرفة الفرق بين المجالات الاجتماعية والنفسية، ومجال الطب النفسي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 75 | عدم وجود أدوار واضحة بين (مجالات العلوم الاجتماعية والنفسية، ومجال الطب النفسي) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

السؤال الثاني (ب)

لقد طُلب من الأعضاء المشاركين الإجابة على السؤال التالي:

تحديد الحلول اللازمة لتحسين تدريب المهنيين الذين يقدمون / أويرغبون في تقديم التدخلات العلاجية للأفراد، والأزواج والأسر في المملكة العربية السعودية؟

تمثل البيانات التالية الإجابات المشتركة بين الأعضاء المشاركين على السؤال أعلاه. يرجى قراءة كل عبارة بعناية، والإشارة للرقم الذي يعكس أفضل مستوى من الاتفاق / الاختلاف لكل البيانات الواردة أدناه (على مقياس ليكرت من 1-7؛ 1 = غير مهم و 7 = مهم جداً). يرجى وضع دائرة حول الرقم الذي يعكس رأيك بدقة لهذه البيانات.

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| لقد حدد الاعضاء المشاركين أن الممارس المهني الذي يقدم التدخلات هو من الحلول الهامة والضرورية والتي تعزز فعالية الخدمات وتُطور التدريب للمهنيين | | | | | | | | |
| 76 | إنشاء هيئة تشريعية موحدة تمنح التراخيص | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 77 | إنشاء هيئة تشريعية موحدة تضع شروط الممارسة للمختصين | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 78 | إنشاء هيئة تشريعية موحدة تضع رموز واضحه لقواعد أخلاقيات ممارسة المهنه للعاملين على تقديم التدخلات العلاجية للأفراد، والأزواج، والأسر | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 79 | إنشاء هيئة تشريعية موحدة تُقيد ممارسة تقديم خدمات الصحة النفسية لمن لديهم أوراق اعتمادية سارية المفعول وتدريب معتمد | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 80 | تعزيز وتطوير وزيادة البرامج التدريبية المكثفة والإشراف على المحترفين لضمان أفضل النتائج للصحة النفسية للعملاء والمجتمع | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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| 81 | وضع آلية لقياس أداء المهنيين العاملين لتقديم خدمات الصحة النفسية التي تسمح لتقييم وتتبع نتائج الخدمات | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن من الحلول الضروريه لتحسين التدريب هي تعزيز الجهود التعاونية والتغيرات اللوجستية على النحو التالي: | | | | | | | | | |
| 82 | وضع خطة وطنية حيث تكون فيها جميع الوزارات المعنية في التدريب تتعاون مع بعض من أجل تقديم خدمات الصحة النفسية،( على سبيل المثال الذي ذكر هو ربط التدريب بين وزارة الصحة بمراكز الجامعات ومراكز التخصصات) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 83 | وضع برامج تدريبية محلية معتمدة، والأخذ في عين الاعتبار أن الخدمات الصحة النفسية/ لا تزال في بدايتها ولذلك، من المهم أن تبدأ من خطة هيكلية تدريجية مع الاستفادة من الكفاءات الموجودة في الميدان، على النحو الأتي: وهو إشراك المختصين وتدريبهم على كيفية تنفيذ البرامج التدريبية. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 84 | يجب على الجهات الصحية والتعليمة أن تطور برامج تدريب لتكون بجودة عالية لما بعد التخرج وذلك بالتعاون مع المؤسسات الأجنبية التي لديها مراكز متخصصة في العلاج النفسي وتبادل الخبرات معها | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن من الحلول الضرورية هي تحسين التدريب: | | | | | | | | | |
| 85 | أن تكون لغة التدريس في جميع مجالات الصحة النفسية هي اللغة الإنجليزية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 86 | أن تنتقل جميع التخصصات النفسية الرئيسية المتعلقة بالصحة من الكليات "الأدبية" إلي "كليات العلوم أو العلوم التطبيقية" / "العلوم الصحيه". | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن من الحلول الضرورية لتحسين التدريب هو تعزيز برامج التدريب وتطوير المهنيين من خلال ما يلي: | | | | | | | | | |
| 87 | زيادة ساعات التدريب العيادية للطلاب في التخصصات المتعلقة بخدمات الصحة النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 88 | تنظيم ورش عمل للتدريب العملي والتي تركز على زيادة الكفاءة في تخصصات معينة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 89 | حث القطاعات الصحية على الاستجابة لطلبات الطلاب للحصول على التدريب، وخاصة في القطاع الخاص | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 90 | إيجاد مقر للتدريب مؤهل يؤمن مجموعة من المتطلبات الواضحه للتدريب وتكون هنالك هيئة مراقبة تشرف على نوعية المناهج التدريبية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 91 | التأكيد من خلال التدريب على الحاجة إلى بناء الثقة وحماية حقوق المريض من حيث الخصوصية والسرية. وايضاً مناقشة سبل اختراق الحواجز المتعلقة بوصمة العار، الخصوصية، وبناء الثقة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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| لقد حدد الاعضاء المشاركين أن من الحلول الضرورية لتحسين التدريب المتعلقة بالإشراف، كما يلي: | | | | | | | | | |
| 92 | أن يشترط الإشراف العيادي المستمر للمعالجين تحت التدريب، سواء بشكل فردي أو جماعي | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 93 | أن يكون التدريب موحد، ويتعين تنفيذه من قبل مشرفين عياديين وأكاديمين، وممارسين من المختصين في العمل الميداني. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 94 | الحاجة إلي إشتراط التدريب المستمر، مثل إنشاء دورات تدريبية مكثفة مع الإشراف والمتابعة حتى بعد انتهاء دورة التدريب. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 95 | كبداية الإستعانه بكفاءات من بلدان أجنبية متقدمة في هذا المجال لدعم الإشراف، حتى يتهيأ للمملكة العربية السعودية مجموعة من المشرفين المؤهلين | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| لقد حدد الاعضاء المشاركين أن من الحلول الضرورية لتحسين التدريب تتعلق بالثغرات في الموارد المالية: | | | | | | | | | |
| 96 | وضع موارد مالية كافية للتدريب. وإستخدم هذه الأموال لتطوير البرامج ومواد التدريب ذات الصلة التي من شأنها تلبية احتياجات التدريب بما يتناسب مع الثقافة السعودية | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 97 | إعطاء المدربين رواتب مجزية | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |

السؤال الثالث (أ)

لقد طُلب من الأعضاء المشاركين الإجابة على السؤال التالي:

عدد العوائق الثقافية الأكثر شيوعاً لتقديم التدخل العلاجي مع الأعراض المذكورة أعلاه للعمل مع الأفراد، والأزواج والأسر؟

تمثل البيانات التالية الإجابات المشتركة بين الأعضاء المشاركين على السؤال أعلاه. يرجى قراءة كل عبارة بعناية، والإشارة للرقم الذي يعكس أفضل مستوى من الاتفاق / الاختلاف لكل البيانات الواردة أدناه (لمقياس ليكرت من 1-7= 1 أوافق تماماً و 7 = لا أوافق تماماً). يرجى وضع دائرة حول الرقم الذي يعكس أفضل مستوى من الاتفاق لديك.

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| لقد حدد الاعضاء المشاركين أن من أكبر التحديات الثقافية للعمل مع الأفراد، والأزواج، و الأسر ترتبط بمعايير اجتماعية حول الجنسين: | | | | | | | | | |
| 98 | من التحديات الثقافيه الكبرى هي الفصل التام بين الجنسين | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 99 | المفاهيم الخاطئة الثقافية حول مفهوم قوامة الرجل علي المرأة، من الأمثلة (مثل الأفكار حول الأدوار والمسؤوليات لكلا الجنسين، ومسؤوليات ولي الأمر) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |

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|---|---|---|---|---|---|---|---|---|---|
| 100 | الكثير من الأزواج يرفضون حضور جلسات العلاج. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 101 | قلة الحرية، لا سيما للمرأة بالنسبة لإمكانية الوصول إلى الخدمات النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 102 | الأفكار/النظره المتعلقة بالمرأة على انها أقل شأناً وقاصر | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 103 | على الرغم من أن وزارة العدل تعمل جاهدة لتمكين المرأة، إلا أن الأفراد في مراكز السلطة لا يقبلون ذلك. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 104 | غياب المنظمات المجتمعية وحقوق الإنسان لضمان الحقوق المهنية للمرأة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن النواحي الإجتماعية/ والثقافية من أكبر التحديات الثقافية: | | | | | | | | |
| 105 | وصمة العار المرتبطة بطلب المساعدة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 106 | العملاء/الأسر يواجهون صعوبات في الانفتاح على الاخرين وخاصة على المختصين في مجال الصحة النفسية، وأن يخوضو العملاء التجربة العلاجية بشفافية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 107 | المجتمع لم يتقبل العلاج الزواجي بعد | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 108 | صعوبات في التعبير عن العواطف بسبب "الأمية العاطفية" | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 109 | طبيعة الأسر السعودية (أسر ممتدة) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 110 | كونه مجتمع محافظ | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 111 | المجتمع لا يشجع أو يقبل بفكرة المساعدة من مختصين | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 112 | رفض الأسر فكرة اللجوء لطلب المساعدة من المختصين لأفرادها | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 113 | الكثير من الأسر لا تعترف/ تقر بوجود مشكلة، بالتالي، لا تطلب المساعدة الضرورية للصحة النفسية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 114 | التمييز وعدم قبول (من هم مختلفون عنهم)، وغياب الوعي المجتمعي لطرق الاختلاط مع الأخرين لإكتساب/تعلم مفهوم التسامح والمسؤولية | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن المعتقدات والمفاهيم من أكبر التحديات الثقافية: | | | | | | | | |
| 115 | يفتقر المجتمع للوعي حول المشاكل والاضطرابات النفسية؛ على سبيل المثال، الخلط بين بعض مفاهيم المرض النفسي وإسناد المرض النفسي إلى العين أو الحسد. وايضاً تعليل المرض النفسي كعقاب من الله أواعتباره دليلاً على عدم الإلتزام الديني | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 116 | نظرة المجتمع للمعالجين النفسيين على انهم أشخاص غير طبيعيين | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 117 | يتم مزج بعض التقاليد والأعراف مع وجهات النظر الدينية، والتي في بعض الأحيان لا تعكس الفهم الصحيح لتعاليم الدين | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 118 | هنالك صعوبات في طلب المساعدة من غير أفراد الأسرة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين ان بعض من أكبر التحديات الثقافية اتتعلق بالفجوات الثقافية و المجتمعية المتعلقة باعراض الشكاوي: | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|
| 119 | في مسائل الطلاق، لا يملك القضاة في المحاكم المعرفة والإلمام التام بأهمية العلاج الأسري، وبالتالي فلا يتم إحالة القضايا إلى المكان المناسب الذي يوفر التدخل الإرشادي قبل الطلاق | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 120 | العمل بشكل عام مع الحالات التي تشكو من الاضطرابات الجنسية، الاعتداءات الجنسية، العنف الأسري، والإدمان، لإعتبار هذه المواضيع مرتبطة بالمحظورات الثقافية والتي قد تعيق الإستفسار عن هذه الشكاوي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 121 | العمل مع الشكاوي الزواجية التي تتناول العلاقة الحميمية والمشاكل الجنسية ذات الصلة، والبعد العاطفي للأزواج (الطلاق العاطفي) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 122 | العمل مع الأباء والأمهات الذين لديهم تفسير خاطئ للأفكار حول الأبوة و الأمومة. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 123 | عدم وجود فحص لتوافق الشريكين قبل الزواج، (على سبيل المثال الذي ذكر هو أن الزواج يكون عشوائي وتقليدي دون الأخذ بالأسباب لتقييم التوافق بينهم) | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 124 | ليس هناك تحدي كبير أو صغير، العاملين في مجال الصحة النفسية السعوديين يدركون جيداً هذه القضايا، وهناك إرادة سياسية قوية لقبول تلك التحديات التي تعمل ببطء لإيجاد أنسب الاستراتيجيات الفريدة والحساسة بثقافة المجتمع | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

السؤال الثالث (ب)

لقد طُلب من الأعضاء المشاركين الإجابة على السؤال التالي:

ماذا يحتاج المعالج للعمل بنجاح لعلاج هذه النوعية من الشكاوي؟ [المشاكل المرتبطة بالعمل مع القضايا الثقافية للأسر والأزواج ].

تمثل البيانات التالية الإجابات المشتركة بين الأعضاء المشاركين على السؤال أعلاه. يرجى قراءة كل عبارة بعناية، والإشارة للرقم الذي يعكس أفضل مستوى من الاتفاق / الاختلاف لكل البيانات الواردة أدناه (على مقياس ليكرت من 1-7؛ 1 = غير مهم و 7 = مهم جداً). يرجى تحديد الرقم الذي يعكس رأيك بدقة لهذه البيانات.

لقد حدد الأعضاء المشاركين أن التعامل بنجاح مع الشكاوي الحالية التي تتطلب تدخلات علاجية للأزواج والأسر، يحتاج المعالج المعرفة والإلمام بالمهارات على النحو التالي:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 125 | معرفة التعاليم الدينية الإسلامية وعادات وتقاليد المجتمع السعودي، والخلفية الثقافية لكل حالة واحترامها | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 126 | التخصص الدقيق والمتعمق في إحدى مدارس العلاج النفسي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 127 | على مقدمي خدمات الصحة النفسية أن يكونوا مستبصريين حول آرائهم الشخصية والإنتباه لإنحيازاتهم، و محاولة عدم جعل أرائهم الشخصية والانحيازات الشخصيه أن تؤثر على العلاج | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

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|---|---|---|---|---|---|---|---|---|
| 128 | خلفية جيدة عن النظرية وعلى الأسباب والعوامل المساهمه في خلق هذه الشكاوي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 129 | لديهم مهارات في فهم الشكاوي الحالية المعروضة عليهم، وبناء الثقة، وتوفير التثقيف النفسي الكافي للعملاء في بداية العلاج المتعلق بالعملية العلاجية قبل الشروع في حل المشكلة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الأعضاء المشاركين أن التعامل بنجاح مع الشكاوي الحاليه التي تتطلب تدخلات علاجية للأزواج والأسر، يحتاج المعالج أن تكون لديه هذه الصفات الشخصية: | | | | | | | | |
| 130 | متعاطف، يحترم ويتقبل المجتمع، ويتأقلم مع العمل الجماعي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن التعامل بنجاح مع الشكاوي الحاليه التي تتطلب تدخلات علاجية للأزواج والأسر، يحتاج المعالج أن تكون هذه الأجراءات موضوعه وواضحة: | | | | | | | | |
| 131 | الحاجة إلي الدعم القانوني مثل وجود مظلة لهيئة متخصصة لحماية حقوق المعالج ودوره | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 132 | خطوات موحدة تسمح للعمل التعاوني أن يحدث. على سبيل المثال، الجهود التعاونية المشتركة بين المحاكم والشرطة والصحة والقطاعات الاجتماعية لمعالجة القضايا و المباشرة الفورية لقضايا العنف الأسري وتوفير ملاجئ آمنة للذين أُعتدى عليهم | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 133 | وضوح هيكلية الخطوات المتبعه التي تعطي الثقة والطمأنينة للعمل المشترك مع مختلف الأطراف لتغطية جميع جوانب المشكلة | | | | | | | |
| 134 | عدم التعامل مع الحالات دون التدريب المناسب والتي تتطلب كفاءات خاصة، مثل حالات العنف الأسري وحالات الاعتداء الجنسي | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| لقد حدد الاعضاء المشاركين أن التعامل بنجاح مع الشكاوي الحالية التي تتطلب تدخلات علاجية للأزواج والأسر، يحتاج المعالج الى المزيد من العمل في مجال الدعم والتأييد للقضايا الهامة للمرضه، مثل: | | | | | | | | |
| 135 | إنشاء جمعيات للوصول إلى لأشخاص الذين يحتاجون الدعم والضغط من أجل طرح وتقديم الشكاوي/ للقضايا الهامة | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| لا تتردد في مشاركتنا بأي تعليق في المكان المخصص أدناه |
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# CHAPTER 5: CONCLUSION

In this multiphase mixed methods dissertation research study, I set out to provide the first systematic account of the current status of marital and family therapeutic practices within the realm of mental and social health care in the Kingdom of Saudi Arabia (KSA). I conducted the first phase of the data gathering by means of two online surveys. The first survey was directed toward mental health professionals (MHPs), and the second survey was undertaken by psychotherapists/MFTs participants. The second phase consists of two rounds of the modified Delphi approach conducted with a group of experts from various mental health backgrounds in KSA.

In the current study, I aimed to gain insights into the present state of mental and social health care in KSA, including marital and family therapeutic intervention practices, needs, and solutions, and the training and preparedness of the professionals when delivering interventions for individual and relational-based concerns. Also, in this study, I set out to determine the cultural challenges, barriers, and solutions in the context of seeking help.

The next sections will provide a summary on the status quo of marital and family therapeutic practice concerning MFT meaning and difficulties management, as well as the results on the views of East/West conflict and families' strengths. Also, on the status of mental health (barriers, current, & solutions), I will categorize the results into the following areas: professional qualifications and principles; important mental health concerns; barriers and solutions for services; referral, satisfaction, and resources; professional training; professionals' availability and preparedness; supervision; training needs; and sociocultural needs and challenges.

## The Status Quo of Marital and Family Practices in KSA

### MFT Meaning and Difficulties Management

The first survey findings revealed that overall, MHPs hold vigorous and realistic expectations of MFT as articulated in their responses about MFT significance and importance, and their understanding of the procedures of MFT processes, their knowledge of who receives treatment, and the prerequisites to practice in the field.

When MHPs discussed the meanings of MFT, some of the participants used the word "Irshaad," which is an Arabic term that refers to advising, guiding, consulting, and providing direction. Perhaps, this may contribute to some of the existing practices of non qualified individuals, such as faith healers or other family members, who provide marital and family interventions, such as counseling, that do not require clinical skills. However, the largest description of meaning attached to the understandings of MFT, reflects similar objectives that are highlighted in providing MFT interventions within the lines of the MFT profession (AAMFT, 2015). However, it is notable that some of the described MFT goals and aims in the present study showed descriptions of reforming and correcting as part of the treatment goals of MFT. Also, the findings on culture-related family difficulties indicated by the views of MHP participants revealed that MFT could be useful with a range of concerns, including helping families to be flexible with one another to help the individual to conform to the Saudi customs and traditions.

### Views on East/West Conflict and Families Strength

The findings of this study indicate that 49% of the MHPs agree that there are inherent conflicts between Western theories and may pose a challenge to their applicability to the Saudi society. Those who agreed with the existence of the differences, also viewed Westernized

approaches as completely incongruent with the Saudi Arabian culture. Other participants articulated the possibilities of adapting the interventions. The need for adaptation is also supported by the previous studies that stressed the importance of informing the adaptation of theories and interventions with the Islamic principles (Al-Mosharraf, 1990; Al-Bahadel, 2004).

Regarding family strength, MHPs identified two themes: family cohesion and resources, and the family and cultural customs and values. These themes demonstrate the participants' sense of kinship and societal connectivity, solidarity, cohesion, and support in terms of resources (financial and educational), as well as patience and resilience. Moreover, some of the values are tied to particular cultural and custom practices such as the Islamic religion morals, values, and principles that are seen as contributing factors for family strengths. Furthermore, family and cultural values are illustrated by rituals that relate to elders and extended family members, and values that are related to discreetness and conservatism.

## Mental Health (barriers, current status, and solutions)

### Professional Qualifications and Principles

Concerns as related to professionals themselves were represented in some of the findings in this research. While, MHPs have indicated that there are prerequisites for the practice of delivering MFT, some MHPs have their concerns about unqualified individuals and non-professionals who are engaged in the practice and are delivering interventions. Also, some MHPs stated the issue of clients being fearful of the lack of the therapist commitment to keeping confidentiality. In the USA, the profession of MFT requires professionals to undergo at least 24 months of clinical training and have a clear set of ethical codes and principles (AAMFT, 2015). At the heart of this code is the issue of confidentiality.

The status of the availability of professionals is illustrated by findings from the Delphi panelists who give a strong endorsement for common barriers for seeking help and for training as the shortage of competent and adequately trained professionals, and the existence of pseudo-professionals who do business by training others even though they are not qualified. Moreover, panelists reached a strong consensus on the need to assess the clinical performance and to restrict the practice to qualified professionals. These findings are in line with the largest international Delphi study conducted on global mental health challenges, which found a need to build human resources capacity and trained professionals to deliver evidence-based services (Collins et al., 2011).

On the issue of clients' confidentiality, findings from the same survey with MHPs ratings on the current status on nine domains concerning different aspects of the mental health care in KSA show that client confidentiality is endorsed as excellent by 20% of the MHPs. However, this is the one domain that also received the most distribution of ratings that ranged from poor to excellent. Furthermore, findings from the Delphi study reached no consensus and had larger dispersion among the panelists on topics concerning privacy and the lack of trust, as a common barrier for seeking help. Previous studies discuss that maintaining privacy and tendencies not to disclose to non-family members may act as a potential challenge (Koenig et al., 2014; Al-Shahrani, 2003) while in another study illustrated that clients are satisfied with their providers regarding confidentiality (Al-Shabrain & Alhabib, 2015).

Concerning professionals' knowledge and skills, the Delphi panelists identified and endorsed the importance of the therapist being insightful about their personal issues, opinions, values, and biases. These are in line with previous literature on MFT that emphasized the

importance of the therapists' role, and self-of-the-therapist work (Timm & Blow, 1999; Blow, Sprenkle, Davis, 2007).

**Important Mental Health Concerns**

In the first survey, MHPs showed high ratings of agreements on the importance of partner relational problems, child abuse and neglect, child sexual abuse, sexual difficulties, child physical abuse, parenting, substance abuse, and marital affairs as important presenting mental health concerns in KSA. Almost equal agreements and disagreements ratings were allocated for elder abuse. High disagreement ratings were found with concerns of discrimination, adult physical abuse, gender inequality, financial difficulties, and young adult radicalization. Also, there were some gender differences in agreement and disagreement ratings on the importance of some of the listed items relating to mental health concerns. Previous literature indicated the existence of child abuse and neglect, parenting issues, and domestic violence, sexual difficulties, and substance abuse (see Albrithen, 2006; Al-Eissa & Almuneef, 2010; Al-Sawaf & Al-Issa, 2000; Bassiony, 2013; Dwairy et al., 2006; Elarousy & Al-Jadaani, 2013; Fageeh, 2014). Although the results of this study showed that there were divided agreements and disagreements on gender inequality and financial difficulties, previous literature identified it as potential stressors placed on the families (Al-Habeeb, Qureshi, & Al-Maliki, 2012; Mobaraki & Söderfeldt, 2010).

**Barriers and Solution for Services**

In the first phase, findings on MHPs' ratings on various domains of mental health showed ratings of poor by 71% of the participants for the domain of malpractice regulations and 30% for the professional collaboration domain. In the second phase of this research, Delphi panelists give

strong endorsements for the barriers to seeking help, as follows: the high cost of treatment, the quality of services provided, the low availability of community mental health services across the nation, and the need for addiction-focused centers. Also, strong endorsement was found for the lack of support for establishing psychological clinics, the lack of awareness of the procedures of pharmacological psychiatric treatments, the insufficient connection between professionals and school, as well as the need for the Ministry of Health to support for mental health.

Both needs for community mental health services and collaborations with government agencies such as courts and Ministry of Health have reached strong consensus by the Delphi panelists as solutions to fostering effective services. Previous literature has found similar barriers and solutions for services (see Alghamdi & Riddick, 2011; Al-Habeeb & Qureshi, 2010; Al-Shabrain & Alhabib, 2015; Alotaibi, 2014; Koenig et al., 2014; Qureshi, Al-Habeeb, & Koenig et al., 2013).

**Referral, Satisfaction, and Resources**

The findings on the referral system domain received ratings of 36% for poor, and 38% for satisfactory by MHP participants in this study. The same survey results indicated that 69% of MHPs stated that they refer their clients for marital and family interventions, yet 91% are not satisfied with the current services that are available to children, couples, and families. Results on the availability of resources showed that MHPs give high ratings of poor and satisfactory for available resources for the domains of professionals' resources and clients/families resources availabilities.

**Professionals Training**

In the first survey, findings showed that on the domains of professional clinical training

and the professional academic qualification, ratings are indicated as poor by 39% and 28%, in this corresponding order. In the second survey, while nearly half of psychotherapists/MFTs reported providing supervision, they have stated that there is a need to improve training due to therapists lacking efficiency and clinical experience. Regarding satisfaction, the second survey with psychotherapists/MFTs findings of their degree of satisfaction with the clinical training experienced before working independently with clients are as follows: 41% satisfied with the training, 44% somewhat satisfied, and 15% dissatisfied.

**Professionals' Availability and Preparedness**

Findings from the first survey by MHPs indicated a major concern raised as related to the profession of MFT, such as the limited available resources in the form of available training centers and professionals. Furthermore, these research findings show that the highest rating received on personal proficiency is "good" for psychotherapists/MFTs as a result of the training and the supervision that they have received. Good ratings on personal proficiency for working with different populations are allocated as follows: 63% for Individuals, 50% for families, 48% for couples, and 45% for children. Further, there were some gender differences exists among participants on their perceptions of their own personal proficiency working with different populations.

Concerning the professionals' use of theories, findings from the MHPs' survey indicated that participants, in their understanding of MFT, described MFT as linked to particular models and theories or interventions, such as CBT, or behavioral modification. The second survey showed that psychotherapists named their main theoretical orientation as CBT, behavioral, psychoanalytic, and cognitive therapy, and only a few therapists did mention MFT theories as

their primary theoretical orientation. These findings from phase one are similar to the recommendations made about available modalities of care in previous publications (Al-Haidar, 2003; Mahfouz et al., 2009; Al-Gelban, 2007).

**Supervision**

The second survey findings indicated that case consultation and shadowing are the most common types of supervision as reported by the therapist in this study. Previous literature on case consultation supervision discusses that it does not replace the effectiveness of direct live supervision (Stewart, 2002). Moreover, direct supervision and follow-up meetings with supervisors were identified by psychotherapists/MFTs as existing needs in training that foster proficiency in psychotherapeutic interventions. Psychotherapists/MFTs discussed that supervisors need to be qualified and credentialed. The Delphi panelists reached strong consensuses for the scarcity of qualified supervisors. Also, a strong endorsement by panelists was reached for barriers as training programs that offer sufficient clinical supervision, and the absence of clear criteria set for clinical supervision.

**Training Needs**

In the second survey, six areas that emerged from the open-ended question about identifying training needs for fostering proficiency of working with children, couples, and families. Those areas of needs are identified by psychotherapists/MFTs as follows: Field/ practical experience; duration of training; supervision; needs that are particular to the specialists and supervisors and trainers themselves, workshops, and establishing centers/programs. There were various suggestions for completing a full year, to obtaining over thousand hours, and to receive ongoing training.

Also, psychotherapists/MFTs identified the needs for field training, and an intensive training curriculum. Furthermore, results from the Delphi panelists endorsed the essential solutions for improving the current training provided by increasing the hours of clinical training and providing experiential workshops that concentrate on competencies. Also, they have reach consensuses for the need to establish qualified training headquarters and a surveillance system that monitors the quality of the training curriculum.

Moreover, results show that Delphi panelists have reached strong consensus on the current shortages in the training sites; lack of explicit criteria, regulations, and procedures, inadequacies in the training settings. Also, the lack of Arabic training materials reached a strong consensus. Further, Delphi panelists reached a strong consensus on the need for establishing logistical support, standardizing steps, and setting clearer structures to work collaboratively with different parties to handle cases such as domestic abuse and sexual abuse.

**Sociocultural Needs and Challenges**

As discussed earlier, MHPs have articulated the possibilities of adapting interventions when they answered the questions on the inherent conflict between Western theories and their applicability on the Saudi society. Further, findings from the Delphi panelists identified needs related to the personal quality of the therapists, which reached a strong consensus on the importance of the therapist's knowledge. The therapists' knowledge identified in the Delphi study included the Islamic religious teaching and the cultural and customs understanding as essential skills for providing psychoeducational interventions. A previous study has discussed the importance of the Islamic principal in informing the adaptation (Al-Mosharraf, 1990; Al-Bahadel, 2004). These findings are also supported by the literature on the cultural adaptation

(Bernal, Bonilla, Bellido, 1995; Bernal & Saez-Santiago, 2006), which discussed the importance of the content element of the adaptation referring to knowledge about the population cultural values, customs, and traditions.

While, some results demonstrate the existence of sociocultural challenges, at the same time, those findings were manifested as areas of diversion among some of the experts in the Delphi study. In the first survey, evidence of the existence of difficulties as related to gender power differences in relationships was evident in findings that related to concerns that MFTs manage, as described by MHPs. Also, the participants in the same survey gave ratings of disagreement toward significant mental health concerns regarding items on gender inequality, discrimination, elder abuse, and the practice of having multiple spouses. In the Delphi study, the panelists did not endorse societal norms around gender as cultural challenges. Previous literature described the cultural challenges faced by women due to the existence of gender inequality (Pharaon, 2004; Mobaraki & Söderfeldt, 2010).

Furthermore, issues of privacy, stigma, awareness, acceptance, and fearfulness of being exposed by a breach of confidentiality were the concerns of MHPs as they described conflicts around the practice of marital and family interventions in KSA. Also, the Delphi panelists have reached a high consensus on stigma only as it related to clients and families not seeking services for fear that their social reputation and personal image would get affected. On the other hand, the Delphi panelists did not reach a consensus on the different challenges as compared to other forms of stigma. Also, the panelists did not reach a consensus on the acceptance of treatment. Maintaining privacy and not to disclosing to professional helper, letting only family members knows about the issue, was discussed as a potential challenge in previous literature (Koenig et

al., 2014; Al-Shahrani, 2003). There was one study that showed that clients are satisfied with their providers regarding confidentiality (Al-Shabrain & Alhabib, 2015), and this illustrates that perhaps fearfulness of a breach of confidentiality is not a cultural challenge. It is possible that if confidentiality procedures are communicated fully, the challenge will disappear.

## Recommendations

This study has the broadest scope as far as documenting the present needs, barriers, and solutions for training and supervision for the psychotherapeutic practice of marital and family interventions in KSA. The findings are relevant to the mental and social health field, educators, clinical supervisors, and training program directors and policy advocates in KSA. This study provides several recommendations for clinical practice and clinical training, along with related logistical considerations.

### Clinical and Training Recommendations

In light of the findings concerning the status quo of marital and family practice in KSA, several recommendations will be discussed for the field and the training of future MFTs. First, it is essential to highlight that professional help provided through psychotherapy or MFT is not an ordinary guiding or counseling "Irshaad"; but it is informed by best practices, has a distinct set of principles and ethical codes, and that it requires competencies exhibited in assessing and administering professional help. However, some individuals with excessive knowledge in Islamic studies or through life experiences might know a lot about Islamic principles or about couples' and families' optimal relationships. MFTs and psychotherapists require undergoing extensive training and supervision, which develop competencies to intervene clinically. Therefore, the clinician is distinguished by a unique lens to assess for what is not told and knows

how to intervene based on informed best practice and evidenced-based approaches. Currently, MFT is still in its early development in KSA, and many unqualified professionals are involved in providing services to couples and families. As a start, the researcher believes that recognizing present MFTs in KSA, and establishing MFT as one of the Saudi Commission for Health Specialties (SCHS) classified specialties is essential to give recognition and credibility to those who are currently qualified.

Second, it is essential to assess during training any presumptions that exist about the practice of MFT or psychotherapy with children, couples, and families and its applicability and adaptability in the Saudi society by opening the dialogue with the trainees/supervisees about their concerns. Further, it is essential to engage trainees in the conversations and projects of cultural adaptation to help them to be an active and continuous contributors in the cultural adaptation process for the services that they will provide. Also, trainees/supervisees need to be encouraged to obtain the required knowledge about the religious teachings and cultural understanding, while also highlighting the critical requirements of accepting the diversity of how people practice their religious faith or the culture in itself. Through training and supervision, there is a need to help trainees/ supervisees to monitor their personal biases that may underlie a pathologizing view of others or superiority of one way of existence over another.

Concerning the training and professional preparedness, in addition to the previously mentioned recommendations, here is a list of some recommendations for the training of psychotherapists/MFTs:

1-To focus on trainees/supervisees trust building skills as well as ways to elicit and clarify misconceptions about the therapeutic process; to assess for stigma and acceptance for treatment.

2-To incorporate self-of-the-therapist work with trainees/supervisees.

3-Engage trainees/supervisees in examining their assumptions and blind spots as narrated by cultural gender role expectations, and how it may present in the clients-therapist therapeutic relationship and alliance with the different family members or partners.

4-Implement workshops and activities that help trainees/supervisees acquire the needed knowledge about the different intersectionalities of power, control, privilege, and oppression, which might play out in the society and the relationships, (e.g., attention to elder abuse, discrimination, and gender inequality).

5-Broadening male and female trainees'/supervisees' experiential training by working with different populations, in particular for therapists working with children and couples, since a large percentage of the therapists in this study felt less proficiency compared to working with individuals and families.

6-Focus on teaching common factors and evidence-based theories, to prepare trainees/ supervisees with a range of different approaches to help clients and families.

7-Provide the trainees/supervisees with a variety of supervision experiences to ensure their preparedness for working independently with individuals, children, couples, and families.

8-Measure therapists and trainees/supervisees performance and outcomes. It might be helpful to establish supervision procedures that involve written descriptions of the responsibilities of a supervisor and supervisee. Moreover, to determine the goals and outcomes of supervision, provide feedback on clinical performance and areas of growth.

Furthermore, there are some logistical considerations to be implemented based on the findings of this research on the training and supervision needs. The recommendations are as follows:

1-Expand on the number of available training sites

2-Increase hours of clinical training, and provide practical training workshops that focus on developing trainees/supervisees competencies.

3-Establish accredited regional training programs (e.g., setting postgraduate programs in collaboration with Western institutions).

4-Provide qualified and competent supervisors.

5-Require continuous clinical supervision of therapists in training and establish intensive training.

6-Designate support for resources that will help in advancing the localized training of psychotherapists and MFTs in Arabic. Further to allocate efforts to fulfill an Arabic and Islamic society cultural adaptation of the language and content in the realm of training, workshops, and teaching materials. Tailoring cultural adaptation of training and supervision is a necessary step to meet the needs of the future psychotherapists and MFTs.

Moreover, findings of this research have highlighted some general needs for mental and social health care and services in KSA. The following are some of the recommendations:

1-To establish a national commission to regulate practices in healthcare and governmental non-healthcare affiliated settings that provide services to couples and families.

2-To institute a reliable information center that identifies mental health care services for children, individuals, couples, and families.

3-To promote professional advocacy commitments for organizing associations to empower individuals with mental health concerns.

4-To work collaboratively with different schools and government agencies such as courts to develop partnerships that bring more awareness to mental health services by promoting media constructive efforts to reduce stigma.

5-To work collaboratively with different schools and government agencies such as courts.

**Strength and Limitation**

**Strength.** Although the findings should be interpreted with caution, this study has several strengths. A key strength of this study is that it offers a comprehensive examination of the current status of the marital and family therapeutic practices and training within the mental and social health care in KSA. This study has attempted to add to the literature on services and providers status on the mental and social health care in KSA toward children, couples, and families. Furthermore, it gives an overview of the barriers, need, and solution for the developing practice

of MFT in KSA; provided an overview of how psychotherapists in general and MFTs view their training, supervision, proficiency in practice, and identified needs and solutions.

The use of a mixed multiphase method, which consisted of two surveys and a Delphi approach allowed for the triangulation of the data from three informative sources of participants: MHPs, psychotherapists/MFTs, and Delphi experts panelists in the mental health field in KSA. The spectrums of views on the requirements, needs, and solutions in different contexts of clinical work were obtained from professionals in KSA who are educated and trained in the country and abroad, and work in various settings. Also, the modified Delphi method on its own enhanced the robustness of this present study since it obtained a consensus from the experts in KSA on obstacles and solutions.

**Limitations.** This current research has some limitations. There are some limitations with the first phase, which consisted of two surveys, one directed toward MHPs and the second toward psychotherapists/MFTs. First, the survey data gathering was carried out online where some mental health professionals and psychotherapists/MFTs who are not active on social media might have been missed. Therefore, there is a possibility of a limitation because of convenience sampling. Second, there is a possibility of self-selecting bias since those who choose not to participate might offer insights that this study did not cover. Third, although there were screening questions, errors in the representation of the sample are possible with online surveys. Fourth, there were technical issues such as, the two surveys were conducted simultaneously at one point and shared the same advertisement flyer. There were some technical difficulties experienced with using Qualtrics software on the mobile devices, which might explain some of the dropouts.

A limitation with phase two of the study perhaps for reasoning that one of the discussed weaknesses of Delphi method is that the diversity of panelists' views gets minimized (Stone Fish & Busby, 2005). This weakness perhaps contributed to the fact that cultural and societal barriers identified by some panelists did not make it for endorsement in the final items that reached consensus.

An overall limitation is that this research is coming from a Western institution; it might have played a factor for the participants' openness to acknowledging some of the cultural and societal norms about gender for reasons related to being mistrustful about how non-insiders might view the information.

Another possible limitation is the personal bias of the researcher. Although, the researcher is a Saudi couple and family therapists who practiced in the USA and KSA, yet her entire academic educational attainment is obtained from the United States, and she was exposed to a robust and structured trainings and supervisions. The researcher has taken specific measures by sending the questions to other graduate students to assess the content and the use of language. She has reevaluated the translations of the participants answered from Arabic to English, several times during coding to eliminate self-bias interpretation and translation.

**Future direction.** Further research needs to determine the effectiveness of the current credentialed programs trainings which could shed more light on identifying current training outcomes, and highlight needed areas of improvement. It will be important to explore the potential use of the cultural adaptation framework to target the specific procedures and modalities of conducting training and supervision (e.g. exploring self-of-the-therapists, direct live supervision) to inform the needed cultural adaptations.

Further work is required to identify the cultural challenges in psychotherapy or MFT to work successfully with relational base concerns, using different methodologies such as qualitative interviews or focus group discussions. Also, future work could identify the types of misconceptions that are considered common barriers that hinder people with mental health concerns rom help seeking help, from the perspective of families and their roles in the acceptance of seeking help.

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