Voices in Transition: A Qualitative Exploration of Mental Health Literacy, Disclosure, and Help-Seeking Behaviours Among Algerian International Students Between the UK and Algeria

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Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Psychology

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December 2025

Declaration of Originality

I declare that this thesis is the result of my own work and has not been submitted for any other degree at the University of Strathclyde or any other institution. Where reference is made to the work of others, due acknowledgment has been given. All sources of information have been specifically acknowledged.

This thesis has been composed by me and is entirely my own work, except where indicated by reference to the work of others. Digital tools, including AI-assisted software, were used solely for technical support purposes (such as formatting, mapping, and refining tables and diagrams) and not for the generation of academic content, analysis, or interpretation

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Acknowledgements

First and foremost, I thank God, the Almighty, for granting me the strength, patience, and perseverance to complete this journey.

I would like to express my deepest gratitude to my supervisors, Dr Steve Kelly and Dr Nicola Cogan, for their invaluable guidance, encouragement, and constructive feedback throughout the course of this research. Their expertise and constant support have been instrumental in shaping this thesis and in strengthening my confidence as a researcher. I am especially grateful for their patience with me throughout this journey; their understanding and kindness during times when I went through many personal and academic crises have been a strong source of support, allowing me to continue and to grow.

I also wish to thank Professor Paul Flowers for his constructive feedback, particularly concerning the methodology and the approach to structuring chapters. His insights have been invaluable in shaping this work and ensuring the research was presented in a rigorous and coherent manner.

I dedicate this work with heartfelt appreciation to my eldest brother, Lamine, for his endless support and for sharing my sorrows before my joys. His compassion has given me the courage to continue during the most challenging times.

I would also like to thank my family and friends for their unwavering love, patience, and encouragement throughout this journey. Special thanks go to the participants who generously shared their experiences, without whom this study would not have been possible.

Finally, I wish to express my sincere gratitude to my government for funding me and offering me this golden opportunity to pursue my academic degree abroad, along with the University of Strathclyde and the Faculty of Humanities and Social Sciences for providing the academic environment and resources that enabled the completion of this work. I am also deeply grateful to Dr Dwight Tse and Dr Maria Gardani for accepting to serve as examiners of this thesis and for taking the time to engage with my work.

Abstract

Mental health challenges among international students have received increasing attention; however, little is known about the unique experiences of Algerian students who pursue postgraduate studies abroad and subsequently return home. This thesis addresses this gap by exploring the mental health literacy, disclosure practices, help-seeking behaviours, coping strategies, and reintegration experiences of Algerian international postgraduate students across three interlinked qualitative studies.

Guided by a critical constructivist epistemology and relativist ontology, and employing thematic analysis and interpretative phenomenological analysis, the research adopted a multi-perspectival design. **Study 1** examined the lived experiences of Algerian international students in UK universities, highlighting barriers to mental health literacy, stigma surrounding disclosure, and reliance on informal coping strategies over professional support. **Study 2** compared the perspectives of UK-based student support professionals with and without experience of working with Algerian and Arab students, revealing gaps in cultural competence, the need for more inclusive wellbeing provision, and tensions between institutional frameworks and students' cultural expectations. **Study 3** focused on Algerian students who returned home after completing their studies in the UK, showing that while international exposure enhanced their awareness of mental health, reintegration posed new challenges, including reverse culture shock, re-stigmatisation, and difficulties in sustaining help-seeking practices.

Across the three studies, findings demonstrate that AIS' mental health experiences are shaped by intersecting cultural, linguistic, and religious identities, as well as by institutional and societal discourses on mental health. The thesis contributes theoretically by advancing a constructivist understanding of mental health literacy and disclosure within transnational contexts, methodologically by triangulating perspectives from students, professionals, and returnees, and practically by informing culturally sensitive policies and support services both in the UK and Algeria. Rather than viewing non-disclosure as a deficit or lack of awareness, the thesis demonstrates that distress, disclosure, and silence are shaped by emotionally conditional meaning-making. In this study, this concept is used to describe how individuals interpret, manage, and communicate psychological distress in relation to anticipated emotional reactions, social evaluation, and culturally embedded norms. Expressions of distress are therefore not treated as purely internal states, but as relational and context-sensitive practices shaped by expectations of recognition, risks of judgement, and shifting power across transnational contexts.

This research highlights the importance of contextualizing international students' wellbeing within their cultural, social, and post-migration trajectories, offering recommendations for universities, policymakers, and mental health practitioners to enhance the support of Algerian and wider Arab student populations.

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List of Abbreviations

AIS
Algerian International Students

CORE-10
Clinical Outcomes in Routine Evaluation (10-item measure)

COVID-19
Coronavirus Disease 2019

HBM
Health Belief Model

HE
Higher Education

HEPI
Higher Education Policy Institute

HESA
Higher Education Statistics Agency

IPA
Interpretative Phenomenological Analysis

MHL
Mental Health Literacy

NHS
National Health Service

OECD
Organisation for Economic Co-operation and Development

PGR
Postgraduate Research

RDP
Researcher Development Programme

UK
United Kingdom

WHO
World Health Organization

Chapter 1: Introduction

1.1 Introduction

Over recent decades, the mental health of international students has become a central concern in higher education research and policy. Increasing numbers of students leave their home countries to pursue degrees abroad, often encountering academic, cultural, and emotional challenges that influence their wellbeing (AAkiba et al., 2024, Forbes-Mewett & Sawyer, 2019). In the UK, nearly 37% of students have been found to experience moderate to severe symptoms of depression or anxiety, a rate considerably higher than among their non-student peers (Cogan et al., 2025). For international students, these challenges are compounded by migration-related stressors such as cultural adjustment, financial insecurity, discrimination, and concerns about immigration status (Kinika & Egbo, 2024; Lari et al., 2025). Such factors not only affect students' psychological well-being but also hinder their academic performance and integration into university life.

Within this expanding literature, particular attention has been paid to Asian student populations (Smith & Khawaja, 2011; Wu et al., 2015), leaving Arab and North African perspectives relatively underexplored. A *Student Minds* report (2022) highlights that international students in the UK frequently express greater concern about their well-being than domestic students, yet they are paradoxically less likely to report having a mental health condition. This under-reporting may reflect stigma, differing cultural understandings of mental health, or mistrust of institutional systems (Sakız et al., 2024). This thesis addresses this gap by providing a comprehensive examination of the mental health experiences of Algerian international students (AISs) enrolled in UK universities and following their return to Algeria. This research is structured into three interlinked studies, each addressing the same core aspects of mental health

literacy, disclosure, coping strategies, and help-seeking, but focusing on different participant groups to provide a holistic understanding. Study 1 focuses on exploring the mental health literacy (MHL) of AIS enrolled in UK universities. The study delves into the students' awareness and understanding of mental health issues, as well as the factors influencing their willingness or reluctance to disclose mental health concerns. Additionally, this study investigates the coping mechanisms employed by these students and the barriers they encounter when seeking professional mental health support. By focusing on the personal experiences of AISs, this study aims to identify the specific challenges they face and how these challenges shape their mental health outcomes. Study 2 shifts the focus from the students to the professionals who interact with them. This study explores mental health professionals' perceptions of AISs' understanding of mental health, their disclosure practices, and the coping strategies these students might employ. Recognising the potential gaps in direct interaction between professionals and AISs, the study broadens its scope to include perspectives on Arab international students more generally. This inclusion is intended to provide a richer understanding of the cultural contexts that shape the mental health experiences of Algerian and Arab students in the UK, particularly in relation to acculturation and its impact on mental health and well-being. Through this professional lens, the study seeks to uncover the cultural influence on mental health literacy and help-seeking behaviours among this student demographic. Study 3 revisits the experiences of AlS after they have completed their studies in the UK and returned to Algeria. This study aims to assess whether the students' experiences in the UK have led to a lasting change in their mental health literacy, particularly regarding their understanding of mental health, their willingness to disclose mental health issues, and their help-seeking behaviours. It explores whether the knowledge and practices related to mental health acquired in the UK are retained and adapted in their home country, or if the return to the Algerian cultural context leads to a reversion to previous attitudes and behaviour.

This study is crucial in understanding the long-term impact of international education on mental health practices and the potential for cultural exchange to influence mental health norms in the students' home country.

Together, these studies aim to provide a detailed understanding of the mental health experiences of AIS, both during their time in the UK and after their return to Algeria. Importantly, this project not only draws on contemporary scholarship but also deliberately traces older references and historical accounts, reflecting how the study originated and developed. The use of older sources is intentional, as it allows the research to situate Algerian experiences within their deeper cultural, historical, and linguistic contexts.

1.2 Contextualising International Student Mobility in UK Higher Education

The United Kingdom has sustained its position as a leading destination for students from other countries for a considerable amount of time; nevertheless, curren data indicates that this vibrant setting is evolving rapidly. In the 2023/24 academic year, there were 732,285 international students enrolled in UK higher education, accounting for 23% of the total student population, which marked a slight decline from 758,855 students (26%) in 2022/23 (HESA, 2025). During the same period, total student enrolments fell to 2.90 million, reflecting a 1% reduction compared to the previous year (HESA, 2025). According to the UK Home Office (2025a), around 403,497 main applicant sponsored study visas were issued by the year ending March 2025, marking a 10% decrease from the previous year. However, when compared with pre-pandemic levels, this still represents an increase of nearly 50% from 2019. By mid-2025, the total number of sponsored study visas, including dependants, reached 431,725; an 18% year-on-year decrease but nevertheless 52% above 2019 figures (Home Office, 2025b). These fluctuations illustrate both the volatility of international student mobility in the UK and the continuing long-term growth trend despite recent declines. Encouragingly, in the first quarter of 2025, more than 48,000 international students were issued study visas—a 27% increase

compared to the first quarter of 2024—suggesting signs of recovery in demand (HEPI, 2025). Similarly, UCAS reported 118,800 international applicants as of January 2025, a 2.7% rise from the previous year, underscoring continued strong interest in UK higher education (UCAS, 2025).

1.3 Algerians as a Specific Population of Interest

The motivation to conduct this research stems from both academic and personal factors. Academically, the early phase of this PhD revealed a significant gap in the literature on the mental health experiences of AIS in the UK. Due to this lack, literature in other languages, particularly French, had to be consulted to gather relevant insights.

From a linguistic perspective, discussions surrounding mental health in Algeria are often constrained by limited everyday psychological vocabulary and highly stigmatising expressions used to describe emotional distress (Hajbi, 2006; Benamsili, 2023). In many cases, the Arabic commonly used in Algeria may reduce a wide range of psychological difficulties, emotional struggles, or mental health conditions into broad and negatively loaded terms associated with "madness" or severe mental illness (Hajbi, 2006). This linguistic limitation can affect how individuals understand, express, and communicate psychological distress, while also reinforcing stigma and fear surrounding mental health discussions. As a result, emotional difficulties may be minimised, misunderstood, expressed indirectly, or avoided altogether, particularly in social contexts where discussing mental health openly remains culturally sensitive. From a historical and cultural perspective, Algeria's 130 years of colonisation, followed by a decade of civil unrest post-independence, has contributed to mistrust of professional mental health services. Algerians have often favoured spiritual or traditional remedies. The legacy of psychiatry's colonial association with France has further discouraged engagement with formal services (Zoubir, 2017). Traditional healing practices in Algeria have persisted as a result of these historical and cultural contexts. Three types of

traditional healers: Taleb, Marabout/Merabet, and clairvoyants; have historically treated individuals with mental health issues using methods deeply rooted in religious practices, such as reciting Quranic verses or administering holy water (Aouattah, 2000; Hajbi, 2006). These practices highlight the intersection of culture, religion, and mental health care in Algeria.

Practical and structural factors may also shape mental health experiences and help-seeking behaviours. Research suggests that access to mental health services in Algeria remains uneven, while broader socio-economic pressures may encourage reliance on family networks, religious coping, and informal support systems (Benamsili, 2023; WHO, 2024). These contextual factors further reinforced the need to examine Algerian students as a distinct population rather than assuming that findings from other international student groups would automatically apply. Research suggests that mental health services in Algeria remain concentrated primarily within urban psychiatric settings, with limited community-based care, shortages of specialised personnel, and uneven service distribution across regions (Benmebarek, 2017; WHO, 2024). In addition, broader socio-economic pressures, including unemployment, financial insecurity, and barriers to accessing private psychological services, may encourage reliance on family networks, religious coping, and traditional healing practices (Benamsili, 2023; WHO, 2024). Consequently, for some individuals, traditional forms of support may represent not only culturally familiar approaches but also more accessible and financially realistic options within everyday life. On a personal level, parallels were found between the researcher's experiences and the themes that emerged from the literature. However, difficulties were encountered in substantiating the lack of academic resources on the chosen topic. Thus, the pursuit of this research is driven by a desire to contribute to the academic discourse on the mental health experiences of AISs in UK universities. While no assumptions are being made regarding specific similarities or differences between the researcher's experiences and those of the participants, the aim is to build on the existing

literature and deepen the understanding of this important issue.

AISs can be understood as a unique subgroup within the wider international student population because their experiences are shaped by a specific combination of historical, linguistic, cultural, religious, institutional, socio-economic, and migration-related factors. This does not imply that each of these characteristics is exclusive to Algerian students. Many international students, including those from other Arab, Muslim, Asian, African, and collectivist contexts, may experience similar influences such as family expectations, stigma, religious coping, or concerns about social reputation. The distinctiveness of the Algerian context lies instead in the particular intersection of these influences with Algeria's colonial and postcolonial history, multilingual environment, relationship with France, mental health system, and patterns of international educational mobility. While many international students experience common challenges such as homesickness, academic pressure, loneliness, language barriers, and unfamiliarity with university support systems, Algerian students may encounter these difficulties through a particular historical and cultural background. For this reason, it is not sufficient to treat them only as part of a broad "international student" category, or even only as part of wider "Arab", "African", "North African", or "Muslim" student groups. Although these categories may be useful for comparison, they can also hide important differences between countries, histories, languages, mental health systems, and help-seeking traditions (Boussaoui et al., 2024). Algerian students' experiences are shaped by Algeria's colonial history, multilingual identity, postcolonial relationship with France, religious and family structures, limited public discussion of mental health, and the organisation of mental health services in Algeria (Benmebarek, 2017; Hajbi, 2006).

A first reason AIS require specific attention is the lack of research focusing directly on their mental health experiences. Much of the international student mental health literature focuses on larger or more visible student groups, such as Chinese, Indian, African, Middle Eastern, or general international students. Algerian students are rarely examined as a distinct population.

Research on these wider populations provides important comparative evidence, but national and cultural categories are not interchangeable, particularly where histories, languages, migration relationships, and systems of mental health care differ. This is important because their experiences may not be fully captured when they are grouped under wider labels such as “Arab students”, “Muslim students”, or “international students”. The early stages of this thesis identified a significant gap in the literature on AIS in the UK, which meant that wider French, Arab, Muslim, and North African literature had to be consulted cautiously to contextualise the topic. This gap itself supports the rationale for the present study, as it shows that Algerian students remain underrepresented within international student mental health research (Boussaoui et al., 2024).

A second reason concerns language. Algerian students often move between Algerian Arabic, Modern Standard Arabic, French, and English. This multilingual background can shape how distress is understood, expressed, translated, or hidden. In the Algerian context, psychological distress may not always be expressed through the same clinical vocabulary commonly used in UK universities, such as “anxiety”, “depression”, “trauma”, “wellbeing”, or “counselling”. Instead, students may describe distress through tiredness, bodily symptoms, silence, family pressure, religious language, or culturally familiar expressions. Existing discussion in this thesis also notes that everyday Algerian Arabic may reduce diverse mental health difficulties to highly stigmatising terms associated with “madness”, which can reinforce fear and silence around psychological suffering (Hajbi, 2006). This means that the challenge for Algerian students in the UK is not simply a language barrier in the narrow sense. It is also a difficulty of translating emotional experience across different cultural and psychological vocabularies.

A third reason is Algeria’s colonial and postcolonial history. Algeria’s relationship with psychiatry and formal mental health care cannot be separated from French colonisation. Benmebarek (2017) explains that French colonial occupation from 1830 to 1962 shaped Algerian psychiatry both structurally and ideologically. Psychiatric institutions were

developed through French asylum-based models, and mental health law in Algeria continued to derive heavily from French colonial legislation even after independence. This history matters because psychiatry in Algeria did not develop in a politically neutral context. It was connected to colonial systems of classification, control, and institutionalisation (Bégué, 1996). More recent decolonial work has further argued that colonial psychiatry in Algeria delegitimised indigenous and spiritual understandings of suffering while positioning Western psychiatric knowledge as dominant (Boukhalfa, 2026). As a result, formal mental health care may still be viewed by some Algerians with distance, caution, or mistrust. This does not mean that Algerian students reject psychological support, but it helps explain why university counselling services in the UK may not automatically feel familiar, meaningful, trustworthy.

A fourth reason relates to the current structure of mental health services in Algeria. Although Algeria has made important developments in psychiatric care, the system remains strongly hospital-centred and under-resourced in several areas. Benmebarek (2017) reports that psychiatric beds declined from approximately 6000 in 1962 to around 5000 despite the population increasing almost fourfold. He also notes that outpatient care is often limited to consultation, with little adult community care and no community residential rehabilitation programmes. The World Health Organization Mental Health Atlas (2024) similarly identifies continuing challenges related to prevention programmes, infrastructure, and uneven accessibility of mental health services across Algeria. These points are highly significant because a limited number of psychiatric beds or services does not necessarily indicate lower levels of psychological distress within society. Rather, it raises important questions regarding underdiagnosis, limited access to services, uneven service distribution, lack of mental health literacy, fear of stigma, and reliance on informal coping systems such as family or religious support. In other words, the absence of visible service use should not be interpreted as the absence of mental health need.

A fifth reason concerns religion, traditional healing, and family-based coping. In Algeria,

mental health and emotional suffering may be understood through psychological, spiritual, social, and moral explanations at the same time. Some individuals may turn first to family, prayer, Quranic recitation, religious guidance, or traditional healing before seeking professional psychological care. Earlier work discussed in this thesis refers to traditional healers such as Taleb, Marabout/Merabet, and clairvoyants, whose practices may include religious recitation or holy water (Aouattah, 2000; Hajbi, 2006). These practices should not be treated simply as "barriers" or as evidence of ignorance. Rather, they demonstrate that help-seeking in Algeria often operates through multiple systems of meaning. Broader research within Arab and Muslim contexts has similarly shown that individuals may prefer informal support from family, friends, or religious figures before engaging with professional services because emotional distress may be interpreted through spiritual, social, or moral frameworks (Ciftci et al., 2013; El Khatib et al., 2023).

A sixth reason relates to stigma, shame, and social reputation. Mental health stigma affects many international students, but in the Algerian context it may be closely tied to family honour, fear of judgement, gender expectations, marriageability, and community reputation. Disclosure may therefore feel socially risky. Students may worry not only about being judged by professionals, but also about what their distress might mean for their family image, future prospects, or social standing. This helps explain why some Algerian students may delay seeking help, minimise their difficulties, or present distress indirectly. Their silence should not be interpreted simply as lack of awareness; it may instead represent a protective strategy shaped by social and cultural consequences (Fekih-Romdhane et al., 2023; Slewa-Younan et al., 2024).

A seventh reason is the specific migration route between Algeria, France, and the UK. Historically, France has been the most familiar destination for Algerian students because of colonisation, language, geographical proximity, and long-standing migration links. Campus France data indicate that more than 30,000 Algerian students were enrolled in French higher

education institutions in recent years, making Algerians one of the largest international student populations in France (Campus France, 2024). By contrast, the UK represents a less traditional and often more linguistically demanding destination. For many Algerian students, studying in the UK involves movement not only across countries, but across languages, educational systems, mental health cultures, and postcolonial histories. Unlike Algerian students studying in France, those in the UK may have to negotiate English as an additional academic and emotional language, while also adapting to a university culture where mental health disclosure is more publicly encouraged.

An eighth reason concerns socio-economic pressure. For many Algerian students, international study is not only an academic opportunity. It may also represent family investment, social mobility, migration opportunity, and hope for future economic security. Algeria's young population, unemployment pressures, and limited opportunities for some graduates can make study abroad emotionally significant. Benmebarek (2017) notes that neuropsychiatric disorders contribute approximately 13.1% of the global burden of disease in Algeria, while the country also faces broader socio-economic pressures affecting young people. Under these conditions, academic struggle or psychological distress may feel like failure, particularly where families have made financial or emotional sacrifices. This can make students reluctant to disclose difficulties or seek help because they may feel pressure to appear successful, resilient, and grateful for the opportunity to study abroad. These factors demonstrate why AISs should be treated as a distinct subgroup within international student mental health research. Their experiences are shaped by overlapping influences including limited research visibility, multilingual emotional expression, colonial and postcolonial histories of psychiatry, hospital-centred mental health provision, stigma, religious and traditional healing beliefs, family expectations, socio-economic pressure, and movement between Algerian, French, and British systems of meaning. Recognising this specificity does not mean assuming that all Algerian students share identical experiences. Rather, it prevents

overgeneralisation and allows the thesis to explain why Algerian students' experiences of mental health, disclosure, and help-seeking require focused, culturally informed, and contextually grounded attention.

1.4. Aim and research questions

As mentioned before in this chapter, the overarching objective of this research project is to examine how AIS experience acculturation during their studies in the UK and how they navigate the subsequent process of re-acculturation upon returning to their home culture. As Algerian students move between their academic and social lives abroad and the realities of life in Algeria, they may encounter challenges that impact their mental health and well-being. These challenges arise from cultural transitions, shifting perceptions of mental health, and differences in support availability and accessibility in both countries. These challenges are further compounded by cultural differences, varying perceptions of mental health, and the availability and accessibility of support systems in both countries. The first question arose from a need to understand how AISs perceive and navigate their mental health across two distinct cultural environments: the UK, with its diverse and often open approach to mental health, and Algeria, where cultural norms and stigmas may differ significantly. The second question was generated to delve into the specific challenges and barriers these students face when attempting to disclose mental health issues and seek professional help. By examining these barriers in both the UK and Algeria, the research aims to identify the critical obstacles that prevent students from accessing the support they need and to understand how these challenges differ between the two contexts. The third question extends the inquiry by focusing on the perspectives of UK mental health professionals who work with Algerian and Arab international students. It explores how these professionals perceive the mental health needs of these students, and what culturally sensitive strategies might be employed to improve outcomes. This question is vital for bridging the gap between student experiences and professional practices, ensuring that mental health services are attuned to the specific cultural

and contextual needs of Algerian students. Therefore, these are the primary formulated questions:

1. How do Algerian international students perceive and navigate their mental health experiences across different cultural contexts, specifically in the UK and Algeria?
2. What are the primary challenges and barriers faced by Algerian international students in disclosing mental health issues and seeking professional help in both the UK and Algeria?
3. How do the perceptions of UK mental health professionals regarding the mental health needs of Algerian and Arab international students influence the effectiveness of the support provided, and what culturally sensitive coping strategies and help-seeking behaviours can enhance their well-being?

From these questions the study aim was divided into three studies targeting different populations, with Study 1 focusing on AISs in the UK, Study 2 focusing on mental health professionals' perspectives, and Study 3 focusing on AIS who finished their studies and returned home. The research questions designed for each study can be found in the empirical chapters (Chapter 4,5,6). Although each empirical study focused on a distinct participant group and stage of the international student journey, all three studies were designed to address the overarching research questions from complementary perspectives. Table 1.1 illustrates the relationship between the overarching research questions and the contribution of each empirical study.

Table 1.1

Relationship Between the Overarching Research Questions and the Empirical Studies

Overarching Research Question	Study 1: Algerian International Students in the UK	Study 2: UK Mental Health Professionals and Wellbeing Providers	Study 3: Algerian Returnees in Algeria
RQ1. How do Algerian	Explores students'	Explores professionals'	Explores how

Overarching Research Question	Study 1: Algerian International Students in the UK	Study 2: UK Mental Health Professionals and Wellbeing Providers	Study 3: Algerian Returnees in Algeria
international students perceive and navigate their mental health experiences across different cultural contexts, specifically in the UK and Algeria?	lived experiences of mental health, distress, disclosure, coping, and help-seeking while studying in the UK.	perspectives on how Algerian and Arab students understand, experience, and navigate mental health difficulties within UK higher education settings.	understandings of mental health evolve following return to Algeria and how students navigate reintegration and re-acculturation.
RQ2. What are the primary challenges and barriers faced by Algerian international students in disclosing mental health issues and seeking professional help in both the UK and Algeria?	Identifies barriers to disclosure and professional help-seeking experienced by students in the UK, including stigma, cultural expectations, language, and service unfamiliarity.	Identifies barriers observed by professionals when supporting Algerian and Arab students, including trust, cultural misunderstandings, institutional limitations, and engagement difficulties.	Explores barriers to disclosure and support-seeking following return to Algeria, including family expectations, social reputation, stigma, and reintegration pressures.
RQ3. How do the perceptions of UK mental health professionals regarding the mental health needs of Algerian and Arab international students influence the effectiveness of the support provided, and what culturally sensitive coping strategies and	Provides students' perspectives on the types of support they perceive as helpful, culturally appropriate, or inaccessible.	Examines professionals' understandings of student mental health needs, culturally responsive practices, barriers to effective support, and recommendations for service provision.	Provides retrospective reflections on coping, support-seeking, and the longer-term effectiveness of support strategies following study abroad and return to Algeria.

Table 1.1: Relationship Between the Overarching Research Questions and the Empirical Studies

As illustrated in Table 1.1, the three empirical studies were designed to address the overarching research questions from complementary perspectives rather than as separate investigations. Study 1 explored the experiences of AIS while studying in the UK, Study 2 examined the perspectives of UK mental health professionals and wellbeing providers working with Algerians and Arabs students in UK, and Study 3 explored the experiences of Algerian returnees following their reintegration into Algeria. These studies provided a multi-perspectival understanding of mental health literacy, disclosure, coping, help-seeking, acculturation, and reintegration across different stages of the international student journey.

1.5 Significance and Contribution of the Research

This thesis makes an original contribution to knowledge by offering the first multi-perspective and cross-contextual account of AISs mental health, a group largely absent from existing international student research (Forbes-Mewett & Sawyer, 2019; Smith & Khawaja, 2019). By combining the voices of students during their studies in the UK, the perspectives of well-being professionals from the UK, and the reflections of students upon returning to Algeria, the research provides a temporal and cross-contextual insight into how mental health literacy, disclosure, coping, and reintegration are negotiated across borders and cultural contexts. In doing so, it addresses a critical gap in the literature, which has often centred on Asian populations and host-country adaptation while neglecting post-return experiences (Ma & Wen, 2021; Brown & Holloway, 2020). Beyond its empirical contribution, the thesis also advances theoretical and methodological debates. It draws on a critical-constructivist epistemology and relativist ontology to privilege lived experience over reductionist accounts of mental health (Braun & Clarke, 2019; Smith et al., 2022). Methodologically, it demonstrates the value of combining Interpretative Phenomenological Analysis (IPA), Reflexive Thematic Analysis (RTA), and integrative synthesis to capture both individual meaning-making and shared cultural patterns (Eatough & Smith, 2017; Clarke & Braun,

2021). Theoretically, this thesis extends acculturation theory (Berry, 2017) by grounding it in the specific sociocultural context of Algerian students, rather than treating acculturation as a uniform psychological process, the analysis foregrounds how stigma, language practices, and structural constraints intersect to shape students' mental health experiences across migration, study, and return (Crenshaw, 2017; Bhatia, 2020). These theoretical contributions also carry applied significance, informing both UK and Algerian higher education policy by underscoring the need for culturally responsive approaches to international student mental health support and post-study reintegration (Cogan et al., 2021; WHO, 2022). In doing so, the study addresses a critical gap in the literature, which has predominantly focused on larger international student populations, particularly students from East and South Asian backgrounds, while paying comparatively little attention to students from North African contexts or to experiences following return to the home country (Ma & Wen, 2021; Brown & Holloway, 2020). Although studies involving Asian international students have made important contributions to understanding acculturation, stigma, disclosure, and help-seeking, the experiences of Algerian students cannot be assumed to mirror those of Asian populations. Algerian students are shaped by a distinct socio-cultural, linguistic, religious, and historical context, including multilingual identities involving Arabic, French, Tamazight, and English; a colonial and postcolonial relationship with France; different family and community structures; particular understandings of mental health and stigma; and a mental health system influenced by both Western psychiatric traditions and local religious and cultural practices (Hajbi, 2006; Benmebarek, 2017). These differences highlight the need for research that examines Algerian students as a distinct population rather than assuming transferability from findings generated with other international student groups. Furthermore, whereas much of the existing international student literature concentrates on adaptation within host countries, the present study extends understanding by examining both the study-abroad experience and the often-overlooked process of reintegration following return to Algeria. This longitudinal and

cross-contextual perspective provides a more comprehensive understanding of how mental health experiences evolve across different stages of migration and educational mobility. These distinctions are discussed in greater detail throughout Chapters 4, 5, and 6, where the findings are interpreted within the specific cultural, historical, and social context of AIS.

1.6. Thesis Outline

In summary, this chapter has presented the primary aim and research questions guiding this study. The following sections provide an overview of the structure of the subsequent chapters:

Chapter 2 presents a comprehensive review of the literature on international student mental health within UK higher education. It critically examines key debates surrounding mental health literacy, disclosure, stigma, and help-seeking behaviours, with particular attention to culturally and linguistically diverse student populations. The chapter identifies significant gaps in the literature concerning Algerian and Arab students, thereby situating the present research within its theoretical and empirical context.

Chapter 3 details the methodological framework of the thesis. It outlines the critical-constructivist epistemology and relativist ontology underpinning the research and justifies the use of qualitative methods. The chapter explains the design of the three interlinked studies, the data collection procedures, analytical approaches, and the ethical considerations implemented to ensure participant wellbeing and research integrity.

Chapter 4 presents the first empirical study, focusing on the lived experiences of AIS studying in UK universities. The chapter describes the study design, participant characteristics, and analytic approach, and reports the findings thematically. These findings provide an initial understanding of students' mental health literacy, disclosure practices, and coping strategies during study abroad.

Chapter 5 reports the second study, which explores the perspectives of UK-based student

support professionals with and without experience of working with Algerian and Arab students. The chapter justifies the inclusion of Arab students for comparative purposes, outlines the adapted analytical strategy, and presents the findings, highlighting areas of alignment and tension between professional frameworks and students' lived experiences.

Chapter 6 presents the third study, examining the experiences of AIS following their return to Algeria after completing their studies in the UK. This chapter focuses on reintegration, reverse acculturation, and changes in mental health understanding and disclosure practices, extending and complicating the findings from the first study.

Chapter 7 integrates the findings from the three studies. Through cross-study synthesis, this chapter identifies shared themes, divergences, and patterns across contexts, generating new insights that could not be captured within the individual studies alone.

Chapter 8 constitutes the Discussion chapter. It offers an in-depth interpretive analysis of the integrated findings, situating them within contemporary theoretical debates. The chapter develops the thesis's core analytic concepts, including emotional conditionality, meaning-making, recognition, and power, and advances a relational and transnational understanding of international student mental health.

Chapter 9 provides the General Conclusion and Recommendations. It summarises the key findings and theoretical contributions of the thesis, outlines implications for policy, practice, and higher education pedagogy, discusses limitations and directions for future research, and reflects on the broader significance of the study.

Chapter 2: Literature review

2.1 Introduction

Research on student mental health has expanded considerably in recent decades, reflecting growing awareness of the psychological pressures associated with higher education and the importance of institutional responses. Much of this work has centred on international students, who face not only academic demands but also the challenges of cultural transition, language barriers, social isolation, and identity negotiation in host countries (Forbes-Mewett & Sawyer, 2019; Smith & Khawaja, 2019). Yet, despite this growing body of scholarship, the experiences of students from North Africa, and Algerian students in particular, remain largely invisible within the global literature. This exclusion is notable given Algeria's long-standing connections to international educational mobility, its postcolonial educational system, and the cultural, linguistic, and historical factors that shape understandings of mental health and help-seeking behaviours (Benamsili, 2023; Mansouri, 2024). Historically, Algeria has maintained strong educational and migration links with Europe, particularly France, as a consequence of 132 years of French colonisation. Following independence in 1962, many Algerian students continued to pursue higher education abroad, especially in France, due to shared linguistic, institutional, and academic traditions. More recently, student mobility has expanded to include destinations such as the United Kingdom, where students seek internationally recognised qualifications, enhanced employment opportunities, and broader academic experiences. Consequently, Algerian students often navigate multiple educational, linguistic, and cultural systems throughout their academic journeys.

Algeria's postcolonial educational framework further contributes to the distinctiveness of this population. While the education system has experienced processes of Arabisation since

independence, French continues to play a significant role in higher education, particularly within scientific, medical, and technical disciplines. As a result, many Algerian students develop multilingual educational experiences involving Arabic, French, Tamazight, and increasingly English. These linguistic transitions may influence how mental health is understood, discussed, and communicated, particularly when students move between different cultural and educational environments. Furthermore, the legacy of colonialism has influenced not only educational structures but also the development of mental health services and public perceptions of psychological support. Previous research has suggested that formal mental health systems in Algeria continue to be shaped by historical psychiatric models inherited from the colonial period, while local understandings of distress remain strongly influenced by religious, familial, and community-based frameworks (Benmebarek, 2017; Boukhalfa, 2026). These historical and educational influences are particularly relevant to mental health because they shape how students recognise distress, interpret emotional difficulties, and engage with support services before, during, and after studying abroad. The movement between Algeria and the UK therefore involves more than geographical relocation; it requires negotiation between different educational traditions, languages, social expectations, and mental health discourses. Despite the significance of these factors, little is known about how AIS experience and navigate mental health across these contexts. Existing evidence has focused predominantly on broader Arab student populations, limiting understanding of the specific historical, cultural, and postcolonial influences that may shape Algerian students' experiences (El Khatib et al., 2023).

A necessary starting point is the clarification of the key concepts underpinning this thesis. "Mental health" has been defined by the World Health Organization (2022) as a state of wellbeing in which individuals realise their abilities, cope with normal stresses of life, work productively, and contribute to their community. However, this biomedical and global definition often diverges from local, cultural understandings. In the Algerian context, for

example, mental health is frequently conceptualised through religious, familial, and social lenses, where distress may be attributed to spiritual imbalance, fate, or collective disharmony rather than individual pathology (Benamsili, 2023; Mansouri, 2024). Similarly, "mental health literacy" refers to knowledge and beliefs about mental disorders that aid recognition, management, or prevention (Zeng et al., 2024), yet little is known about Algerian students , only some studies on Arab students (AS) suggest that Algerian students may demonstrate low levels of literacy, particularly regarding professional interventions, while relying heavily on informal and religious coping strategies (Khatib, Alyafei and Shaikh, 2023)

Related to literacy are the constructs of *help-seeking* and *disclosure*. Help-seeking denotes the process of recognising distress and reaching out for support, whether formal (psychologists, counsellors) or informal (family, peers, religious leaders) (Amer & Awad, 2015). Disclosure involves the willingness to communicate distress to others, which in many Arab and North African contexts is hindered by stigma, shame, and fears of social judgment (Dardas & Simmons, 2019; Khan et al., 2021). Both constructs are central to this thesis, as Algerian students abroad often encounter barriers to seeking professional support in the UK, while those returning home may struggle to disclose distress within a cultural environment where silence is valorised due to stigma toward mental health. Finally, the concept of reintegration is essential to this thesis. While much of the international student literature has focused on adjustment and adaptation within host countries (Smith & Khawaja, 2019), increasing attention has been given to what happens when students return home following their studies abroad. Reintegration refers to the psychosocial process through which returnees readjust to their home environment after a prolonged period abroad. This process may involve reverse culture shock, changes in identity, altered expectations, and tensions between newly acquired values and existing social norms (Ma & Wen, 2021; Sonnenschein et al., 2023). For Algerian returnees, reintegration may be particularly complex because students

often return with new understandings of mental health, wellbeing, disclosure, and help-seeking that have been shaped by their experiences in the UK. Upon return, these perspectives may not always align with prevailing social attitudes, family expectations, or local understandings of psychological distress. In addition, returnees may encounter challenges associated with employment opportunities, social readjustment, and negotiating differences between the personal growth experienced abroad and the realities of life in Algeria. These challenges may be further compounded by continuing stigma surrounding mental health, limited visibility of psychological services, reliance on informal support systems, and the coexistence of psychological, religious, and traditional explanations of distress (Benmebarek, 2017; Benamsili, 2023; WHO, 2024). Consequently, reintegration is not simply a return to a familiar environment but a process of renegotiating identity, belonging, mental health understandings, and social relationships within a changing personal and cultural context. By engaging with these key concepts across international, regional, and Algerian contexts, this chapter establishes a foundation for understanding the unique contributions of this thesis. The following sections will progressively review global patterns of international student mental health, the state of mental health within Algerian higher education, the specific challenges faced by Algerian students, and the processes of disclosure, coping, and reintegration. The review will conclude by identifying the critical gaps that this research addresses.

2.2 Overview of International Students' Mental health

Mental health is increasingly being identified as a global issue, with the World Health Organisation (2021) defining it as a primary cause of disability that severely impairs people's everyday functioning, productivity, and quality of life. However, this recognition has not resulted in universal access to care, as a persistent gap exists between those who seek assistance and those who eventually receive it. Although treatment coverage has increased in recent years: for example, rates of access in the UK have climbed from roughly 6% in 2016-

2017 to 16% by 2022-2023 (King's College London, 2023), the amount of unmet need remains profound. Global estimates indicate that fewer than one in every five people with a diagnosable mental condition obtain effective care, with access significantly lower in low- and middle-income countries (Moitra et al., 2022; Vigo et al., 2025). This difference shows that although mental health has been officially named a public health priority, services have not yet kept up with this. It also shows that there is systemic unfairness in how mental health resources are allocated. International students regularly report higher levels of stress, anxiety, and depression than their domestic peers (Smith & Khawaja, 2019). This is because of systemic gaps in higher education that makes things harder for these students. Not only are they vulnerable because of personal mental illness, but also because of the structural and cultural problems that come with mobility, such as having to deal with new academic expectations, making new friends in a different culture, and racism or discrimination in host societies (Poyrazli & Lopez, 2007; Forbes-Mewett & Sawyer, 2019). The results show that the problems international students face are both personal and systemic. These findings suggest that the difficulties experienced by international students are not solely individual or psychological in nature but are also shaped by broader structural and cultural factors. Although students may experience emotional distress, access to support is often influenced by institutional barriers such as limited awareness of available services, unfamiliarity with host-country healthcare systems, long waiting times, language difficulties, and uncertainty regarding eligibility for support (Forbes-Mewett & Sawyer, 2019; Gomes et al., 2021). In addition, cultural differences may influence how mental health is understood, expressed, and responded to sttudents from cultures where emotional difficulties are discussed primarily within family, religious, or community settings may be less familiar with formal counselling services or may perceive professional help-seeking differently from the norms promoted within Western universities (El Khatib et al., 2023). Consequently, the interaction between institutional structures and cultural expectations may create additional barriers to recognising

distress, disclosing difficulties, and accessing appropriate support. The findings suggest that the difficulties experienced by international students are not solely individual or psychological in nature but are also shaped by broader structural and cultural factors. Although students may experience emotional distress, access to support is often influenced by institutional barriers such as limited awareness of available services, unfamiliarity with host-country healthcare systems, long waiting times, language difficulties, and uncertainty regarding eligibility for support (Forbes-Mewett & Sawyer, 2019; Gomes et al., 2021). In addition, cultural differences may influence how mental health is understood, expressed, and responded to. Students from cultures where emotional difficulties are discussed primarily within family, religious, or community settings may be less familiar with formal counselling services or may perceive professional help-seeking differently from the norms promoted within Western universities (El Khatib et al., 2023). Consequently, the interaction between institutional structures and cultural expectations may create additional barriers to recognising distress, disclosing difficulties, and accessing appropriate support . During Covid-19, a survey conducted by the British Council (2020) revealed that international students experienced heightened anxiety and uncertainty due to travel restrictions, remote learning, and concerns about their health and the health of their loved ones. These factors highlighted the need for mental health support for international students, who may not have access to their usual support networks while studying abroad as many international students come from education systems with different teaching styles and assessment methods, which can lead to possible anxiety and academic difficulties. For instance, Chinese international students in the United States often struggle with the transition from a rote-learning system to one that emphasises critical thinking and class participation (Liu, 2020). This shift can be overwhelming, resulting in increased stress and feelings of inadequacy.

Additionally, students who experience poor mental health often face difficulties in

concentration, memory, and motivation, which are critical for academic performance (Zhang et al., 2024) as it has been confirmed that mental health issues such as depression and anxiety are negatively correlated with academic achievement. (Richardson, et al. 2017). Adjusting to a new cultural environment represents another significant challenge for international students (Forbes-Mewett & Sawyer, 2021). Cultural differences may lead to misunderstandings, uncertainty, and feelings of social isolation, particularly during the early stages of adaptation (Forbes-Mewett & Sawyer, 2021; Gomes et al., 2021). For example, Middle Eastern students in the UK have reported experiencing cultural shock and difficulties adapting to unfamiliar social norms, educational practices, and patterns of interaction (Gomes et al., 2021). These adjustment challenges may contribute to loneliness, stress, and reduced psychological wellbeing. Furthermore, cultural differences can influence interactions with faculty members and peers. In some educational systems, questioning authority figures or openly expressing disagreement is discouraged, which may create additional challenges for students entering Western learning environments that encourage active participation and critical discussion (Yan & Berliner, 2020). For example, Middle Eastern students in the UK have reported experiencing cultural shock and difficulty in adjusting to Western social and societal norms and educational practices (Gomes et al., 2021). These cultural adjustments can affect their mental health, leading to feelings of loneliness and depression. Furthermore, cultural differences can impact students' interactions with faculty and peers (Yan & Berliner, 2020; Gomes et al., 2021). In some cultures, questioning authority or expressing differing opinions is discouraged, which can hinder class participation and engagement in Western educational settings (Yan & Berliner, 2020). This cultural dissonance can create a sense of isolation and negatively affect students' academic and social experiences. Additionally, language proficiency is another factor influencing the mental health of international students (Smith & Khawaja, 2022; Shimada et al., 2021). Limited language skills can hinder academic performance, social interactions, and access to mental health services. A study in Australia

found that international students with lower English proficiency reported higher levels of stress and were less likely to seek mental health support (Smith & Khawaja, 2022). Language barriers can also lead to misunderstandings and miscommunications, further isolating students from their peers and instructors. For instance, Japanese students studying in English-speaking countries often face difficulties in expressing themselves clearly and understanding academic content, which contributes to their stress and anxiety (Shimada et al., 2021). Considering social integration, many students experience loneliness and homesickness, particularly during the initial phase of their studies abroad. These feelings may be exacerbated by the lack of familiar support networks and difficulties in forming new friendships in the host country (Poyrazli & Lopez, 2007; Sawir et al., 2022). The COVID-19 pandemic further intensified social isolation among international students (Chirikov et al., 2020). Lockdown measures, travel restrictions, and the shift to online learning disrupted students' social lives and support systems (Son et al., 2020). A study conducted in the United States found that international students experienced increased anxiety and depression during the pandemic because of isolation and uncertainty regarding their academic and personal futures (Chirikov et al., 2020). Lockdown measures, travel restrictions, and the shift to online learning have disrupted students' social lives and support systems (Son et al., 2020). A study in the United States found that international students experienced increased anxiety and depression during the pandemic due to isolation and uncertainty about their academic and personal futures (Chirikov et al., 2020). Furthermore, cultural stigma associated with mental health issues can prevent international students from seeking the help they need (Wang et al., 2021). In many cultures, mental health problems are viewed as a sign of weakness or failure, leading to reluctance in seeking professional support (Wang et al., 2021; Forbes-Mewett & Sawyer, 2021). For instance, a study on Chinese international students in Australia found that cultural stigma significantly hindered their willingness to seek mental health services (Wang et al., 2021). Fear of judgement and bringing shame to their families were major barriers to accessing

support. In addition to stigma, international students may lack knowledge about available mental health resources or feel uncomfortable using them due to cultural differences in communication and treatment approaches as supported by a study on Indian students in UK highlighted that unfamiliarity with the mental health care system and concerns about confidentiality deterred them from seeking help (Bains et al., 2022).

International students enrich the cultural diversity and academic environment of host institutions, but they face unique mental health challenges that require additional support owing to the various factors aforementioned and also including academic pressures, cultural adjustments, language barriers, social isolation, and cultural stigma. The above-mentioned examples from around the world highlighted the need for culturally sensitive and accessible mental health services to address the specific needs of international students.

2.3 Overview of Arab Students' Mental health

The understanding and approach to mental health can vary across societies, cultures, and countries (Odilibe et al., 2024). These differences are reflected in perceptions of mental illness, levels of stigma, help-seeking behaviours, and the availability and accessibility of mental health services (Koutra et al., 2024). Mental health in the Arab world represents an important yet often underexplored public health concern (El-Shamy et al., 2023). The region, comprising 22 countries with diverse cultural, social, political, and economic contexts, faces several challenges in addressing mental health needs effectively (Ahad et al., 2023). Within many Arab societies, mental health difficulties are frequently understood through social, religious, and cultural frameworks, and concerns regarding shame, stigma, and social reputation may influence how individuals respond to psychological distress (Ahad et al., 2023). For instance, individuals who believe they are possessed by *jinn (*supernatural beings recognised within Islamic belief and, in some cultural contexts, understood as capable of influencing human thoughts, emotions, or behaviour) (Al-Krenawi, 2022) might consult a traditional healer or

religious leader to perform prayers, Qur'anic recitations, or other religious practices intended to alleviate distress and expel the perceived influence (Al-Krenawi, 2022). Similarly, those who attribute their mental health difficulties to the evil eye, a belief that harm may result from envy, jealousy, or negative intentions directed towards an individual, may seek protection through prayers, amulets, talismans, or other religious practices designed to ward off harmful influences (Al-Krenawi, 2022). Similarly, those who attribute their mental health issues to the evil eye might seek protection through amulets, talismans, or specific religious practices designed to ward off harmful influences (Al-Krenawi, 2022). Traditional healers, encompassing religious leaders and practitioners of folk medicine, play a crucial role in treating mental health issues in Islamic countries and the Arab world (Thomas, Al-Qarni and Furber, 2015). Their practices are deeply rooted in cultural traditions and spiritual beliefs, offering significant comfort and hope to individuals struggling with mental health issues (Gearing et al., 2013). In many Islamic societies, traditional healers use Quranic recitation as a core therapeutic practice (Saged et al., 2020). Qur'anic verses perception is deeply rooted in cultural and religious belief systems, where mental distress is frequently interpreted through supernatural explanations such as possession by jinn, the evil eye, or divine punishment (Al-Krenawi & Graham, 2000). In contrast, Western mental health systems are largely grounded in clinical and biopsychosocial frameworks which, while acknowledging social and psychological influences, are often operationalised through diagnostic and biomedical practices that locate distress within the individual (Kirmayer & Minas, 2000).

Within Algerian contexts, attributing mental health difficulties to supernatural causes can discourage engagement with professional mental health services and instead promote reliance on religious or spiritual interventions (Al-Krenawi, 2022; Bagasra, 2023). As a result, individuals may prioritise practices such as prayer, consultation with religious figures, or spiritual healing over psychological or psychiatric support, even when distress becomes

severe Quranic verses are recited to the individuals with mental health conditions in order to activate divine power for healing and protection from supernatural powers. (Saged et al., 2020). This practice is consistent with the theory of religious coping, which holds that religious beliefs and practices can be valuable resources in managing difficult situations and stress (Pargament, 1997). By reciting sacred texts, healers aim to instil a sense of spiritual reassurance and invoke divine intervention, aligning with the belief that spiritual well-being is integral to mental health recovery. (Saged et al., 2020). Another prominent practice is Ruqyah, a spiritual healing ritual that includes the reading of specific Quranic passages and prayers. This method is frequently used to relieve symptoms connected with perceived afflictions such as possession by jinn or the negative effects of the evil eye. (Saged et al., 2020; Al-Krenawi, 2022). The ritualistic nature of Ruqyah not only addresses psychological distress but also reinforces cultural beliefs about the interconnectedness of spiritual and physical health (Kirmayer et al., 2009). Herbal treatments are another essential component of traditional treatments. Healers frequently prescribe plants and natural substances believed to have therapeutic powers, relying on traditional knowledge passed down through generations. (Beata Bliss Lewis, 2022). Traditional healers use local flora into treatment regimens, demonstrating a holistic approach to health that views the natural environment as a source of healing resources (WHO, 2014). Moreover, counselling and spiritual advice provided by religious leaders are integral components of traditional healing. These leaders offer guidance grounded in religious teachings and moral principles, which are deeply embedded in the cultural fabric of Arab societies (Saged et al., 2020; Al-Krenawi, 2022). From a psychotherapeutic perspective, spiritual counselling can be understood through the framework of narrative therapy, where individuals construct coherent narratives of their experiences to facilitate healing and meaning making (White & Epston, 1990). This practice helps individuals reinterpret their struggles within a spiritual framework, promoting resilience and emotional well-being through a renewed sense of purpose and faith Critically, the

effectiveness of traditional healing practices in mental health care is influenced by factors such as cultural competence and community acceptance (Saged et al., 2020; Al-Krenawi, 2022). Cultural competence emphasises the importance of understanding and respecting diverse cultural beliefs and practices in delivering effective health care (Henderson, Horne, Hills, & Kendall, 2018)

2.4 Overview of Algerian Students' Mental Health

The mental health of university students in Algeria has emerged as a critical concern; nevertheless, the existing research on this topic is rather insufficient relative to other locations. Research regularly indicates heightened levels of psychological discomfort, including feelings of anxiety, despair, and academic stress (Mansouri, 2024). Surveys conducted at Algerian universities indicate that approximately one-third to one-half of students encounter moderate to severe mental health challenges, often linked to academic overload, financial instability, and inadequate institutional support (Benamsili, 2023; Université Larbi Ben M'hidi, 2022). These statistics align Algerian students with worldwide prevalence rates while obscuring significant local particularities. The relevance of survey findings from local Algerian university students to AIS requires careful qualification. These studies are useful because they provide rare Algeria-specific evidence about student mental health, academic pressure, distress, and support needs within Algerian higher education. For example, Mansouri's review of Algerian university students highlights that mental health difficulties among students in Algeria are linked to academic demands, limited support structures, and wider institutional pressures (Mansouri, 2024). Such findings are valuable because they challenge the assumption that Algerian students' mental health difficulties only emerge after migration. Instead, they suggest that some students may already be shaped by pre-existing educational, social, and institutional pressures before studying abroad. However, these findings cannot be directly generalised to AIS. Local Algerian students and Algerian students studying abroad

occupy different social, educational, and migration contexts. Local students experience distress within the Algerian university system, whereas AIS must also negotiate additional stressors, including migration, separation from family, cultural adjustment, language demands, unfamiliar academic expectations, visa insecurity, racism or discrimination, and reduced access to familiar support networks. Research specifically examining AIS in UK universities shows that their mental health experiences are shaped not only by distress itself, but also by disclosure, stigma, cultural expectations, help-seeking uncertainty, and movement between Algerian and UK understandings of mental health (Boussaoui et al., 2024). Therefore, Algerian university student surveys are best understood as providing a baseline national context rather than direct comparative evidence. They help show that mental health concerns exist among Algerian students more broadly, but they do not explain how these concerns are transformed when students move abroad. This distinction is important because the international student experience adds layers that local surveys cannot capture, particularly acculturation, cultural dislocation, multilingual communication, institutional unfamiliarity, and the need to interpret distress within both home and host-country systems. The available Algerian evidence is also methodologically limited. Much of the literature relies on cross-sectional surveys, small samples, or localised institutional studies, meaning that it provides useful indicators of distress but less insight into lived experience, meaning-making, disclosure, or help-seeking. This limitation supports the rationale for the present thesis. Rather than assuming that local Algerian student findings apply directly to AIS, this study uses them cautiously to identify pre-existing pressures and gaps in support, while generating new qualitative evidence about how Algerian students understand and manage mental health in the UK and upon return to Algeria. In this sense, the local Algerian student literature is relevant but insufficient. It shows that student distress, limited support, and mental health stigma are not absent from Algeria; however, it does not explain how Algerian students experience these issues across borders. The contribution of this thesis is therefore to extend existing Algerian

student research by examining how mental health literacy, disclosure, coping, and help-seeking are reshaped through international study, acculturation, and reintegration. In many Western higher education settings, student mental health has become a priority for institutions. However, Algeria still remains underdeveloped in both research and intervention, resulting in limited empirical insight into how structural, cultural, and historical variables shape student well-being. much about how structural, cultural, and historical variables affect student wellbeing. Some universities have counselling facilities and student health services, but they are always short on staff, poorly advertised, and poorly funded (Benamsili, 2023). Mental health remains peripheral in higher education policy, overshadowed by priorities related to academic achievement and employability, rather than being seen as essential to student success. Mansouri's (2024) analysis shows that interventions are broken up, random, and mostly based on separate efforts instead of a unified national plan. As a result of this systemic neglect, students' needs often remain unrecognised, and those who seek support frequently encounter an absence of accessible formal provision. This reflects not only a policy deficiency but also forms of institutionalised silence that perpetuate stigma. Cultural and language considerations exacerbate the mental health challenges encountered by Algerian students. Algeria's multilingual higher education system, encompassing Arabic, French, Tamazight, and, more recently, English, establishes hierarchies of access and belonging that may exacerbate stress and exclusion (Al-Qadri et al., 2023). Students who went to Arabic-medium schools may have

a hard time adjusting to university programmes that are mostly in French. Students from rural regions or lower socioeconomic backgrounds may have had fewer opportunities to develop advanced French language proficiency or access educational resources comparable to those available in richer families (Reay, 2018). Research has shown that linguistic capital and educational inequalities can influence students' academic confidence, sense of belonging, and ability to navigate higher education environments (Bourdieu, 1986; Reay, 2018).

Furthermore, understandings of mental health within Algeria are influenced by multiple

explanatory frameworks. Existing literature suggests that emotional distress may be interpreted through biomedical, religious, spiritual, familial, and social perspectives rather than through a single explanatory model (Hajbi, 2006; Benamsili, 2023). For example, some individuals may understand psychological difficulties in relation to spiritual imbalance, insufficient religious practice, the evil eye, jinn possession, family tensions, or social adversity, while others may view them through psychiatric or psychological frameworks. These differing interpretations can influence how mental health difficulties are recognised, discussed, and managed. Research has suggested that where distress is primarily understood through non-clinical explanations, individuals may be more likely to seek support from family members, religious leaders, or traditional healers before accessing formal mental health services (Al-Krenawi, 2022; Benamsili, 2023). Consequently, perceptions of mental health and pathways to support are shaped by the interaction between cultural, religious, social, and biomedical understandings of distress.

Gender differences also shape how mental health is experienced among Algerian students, but these differences are often overlooked in the research. Evidence suggests that female students report higher levels of anxiety and depression than their male peers, influenced not only by academic pressure but also by the weight of social expectations placed on women in Algeria (Sabah et al., 2025). Male students, on the other hand, often face stronger stigma when it comes to admitting vulnerability, which leads many to hide their struggles or avoid seeking help altogether. Although social class was not an explicit analytical focus of the study and was not systematically examined during data collection or analysis, issues relating to financial pressure, employment concerns, and broader socioeconomic circumstances emerged within some participants' narratives and were considered where relevant during interpretation. These patterns point to the need for research that takes gender, class, and region seriously when analysing student well-being, rather than assuming all students experience university life in

the same way. Yet most of the existing studies ignore these differences, relying on cross-sectional surveys that flatten the complexity of students' lives and leave important inequalities unexamined. The literature reveals a striking paradox; mental health problems among Algerian students are both widespread and acknowledged, yet research and institutional responses remain fragmented, narrow, and largely superficial. Most existing studies are small-scale, quantitative surveys conducted within single universities, offering only a snapshot in time and place while neglecting the broader trajectories of students' lives (Benamsili, 2023; Mansouri, 2024). This narrow focus leaves major questions unanswered, how Algerian students themselves understand mental health, how they navigate stigma and weak institutional provision, and how their strategies shift across different stages of their educational journeys. Even within Algeria, knowledge is partial and underdeveloped; beyond Algeria, it is almost non-existent. If so, little is known about Algerian students' mental health in their home context, the lack of awareness and visibility when they travel abroad is even more profound. This absence of evidence is not a minor oversight but a serious gap in the global literature on student well-being. It is precisely this gap that the present thesis addresses by placing Algerian students' voices at the centre, following them across borders and through time, and situating their narratives within the cultural and institutional conditions that continue to shape, and often constrain, their mental health.

2.4.1 The Contextual and Socio-political Information Regarding The Geopolitical Understanding of Mental Health in Algeria

In order to understand mental health among AIS, it is necessary to locate their experiences within the wider socio-political and geopolitical context of Algeria. Mental health cannot be understood only as an individual or clinical matter; it is also shaped by history, governance, social expectations, economic conditions, migration routes, and the ways in which psychological distress is recognised or silenced within a particular society. Recent work on

the political and geopolitical determinants of mental health argues that mental wellbeing is influenced by state policy, institutional structures, inequality, conflict, displacement, migration, and broader conditions of uncertainty (Bhugra, 2023; Valsraj et al., 2024). This is particularly relevant to Algeria, where understandings of distress are shaped by colonial history, post-independence nation-building, religion, family structures, economic pressures, and the continuing tension between local cultural explanations and Western psychiatric models. Algeria's colonial history is especially important in understanding contemporary mental health meanings. Mental health legislation and psychiatric institutions in Algeria were strongly influenced by French colonial structures, and mental health law has been described as having roots in the colonial period (Benmebarek, 2017). This historical background matters because psychiatric knowledge in Algeria did not develop in a politically neutral space. Rather, it was shaped through colonial systems that often positioned Algerian people through racialised and medicalised frameworks. After independence, Algeria inherited aspects of this institutional and legal structure, while also developing its own national health system. This creates a complex relationship with psychiatry and psychology: on the one hand, professional mental health care exists and is needed; on the other hand, psychological services may still be viewed by some people as distant, unfamiliar, medicalised, or associated with severe mental illness rather than everyday emotional distress.

This context helps explain why mental health literacy, disclosure, and help-seeking among Algerian students cannot be interpreted only through Western models of individual choice. In Algeria, distress is often understood through a mixture of psychological, social, religious, moral, and family-based meanings. However, there is relatively limited international research that focuses specifically on Algerian mental health experiences, particularly in relation to students and help-seeking behaviours. For this reason, some studies from broader Arab and Muslim contexts are used to help contextualise patterns that may also be relevant in Algeria.

Algeria is frequently grouped within wider Arab or North African regional studies because of shared linguistic, religious, and socio-cultural characteristics, including the importance of family structures, Islamic beliefs, and concerns around social reputation. Research from these broader contexts suggests that emotional suffering may be interpreted through religious concepts such as faith, patience, destiny, or spiritual testing, while concerns about shame, family judgement, and social reputation may discourage open discussion of psychological distress or professional help-seeking (Ciftci et al., 2013; Fekih-Romdhane et al., 2023). Nevertheless, this thesis recognises that Algeria has its own distinct historical, political, and cultural context, and therefore findings from wider Arab literature are used cautiously rather than treated as fully representative of Algerian experiences. These responses should not be dismissed as simple stigma or lack of awareness. Rather, they reflect a wider social setting in which mental health is tied to reputation, family honour, religious belief, gender expectations, and the fear of social consequences. Research on stigma and help-seeking in Muslim and Arab contexts also suggests that stigma can affect willingness to seek professional support, particularly when distress is interpreted through religious, moral, or family-centred explanations (Ciftci et al., 2013; Fekih-Romdhane et al., 2023).

The socio-economic context is also central. Algeria is an upper-middle-income country with significant natural resources, particularly hydrocarbons, yet young people continue to face uncertainty around employment, mobility, and future opportunities. Recent World Bank data show that Algeria remains highly dependent on hydrocarbon revenues and that youth unemployment remains high, with unemployment among young people aged 15–24 reported at 29.3% in 2024 (World Bank, 2025). These economic pressures are important for this thesis because international study is not only an educational experience; for many Algerian students, it may also represent a strategy for social mobility, professional development, and escape from limited opportunities at home. This can intensify pressure to succeed abroad, avoid failure,

and justify the financial and emotional sacrifices made by the student and their family. Mental health difficulties may therefore be experienced not only as personal distress, but also as a threat to family expectations, future security, and the wider migration project.

Algeria's geopolitical position further shapes the meanings attached to migration and mental health. Algeria occupies a significant position in North Africa, the Mediterranean, the Arab world, and Africa more broadly. Its relationships with Europe, especially France, remain historically and politically charged, while its regional role is shaped by security concerns, energy politics, and relations with neighbouring countries. Contemporary geopolitical analyses describe Algeria as an important regional actor because of its geographic position, energy resources, diplomatic history, and role in Mediterranean and African affairs (Cristiani, 2026). For AIS, this context matters because studying abroad often occurs within long-standing historical and political links between Algeria and Europe. France has historically been the dominant destination for Algerian migration and education because of colonial history and language. Recent statistics indicate that France hosts one of the largest populations of AIS, with more than 30,000 Algerian students enrolled in French higher education institutions in recent years (Campus France, 2024). By contrast, the UK represents a different educational and linguistic route, with a smaller but growing number of Algerian students choosing British universities through scholarship programmes, English-language education, and international mobility opportunities. Choosing to study in the UK can therefore involve not only academic transition, but also movement across different linguistic, cultural, and political spaces.

This geopolitical background also helps explain why returning to Algeria after studying abroad may create emotional and identity tensions. Students may develop new ways of speaking about mental health in the UK, including psychological language around anxiety, depression, counselling, wellbeing, boundaries, or self-care. However, when they return to

Algeria, these frameworks may not always translate easily into local social life. The student may feel caught between two systems of meaning: one that encourages individual expression and professional help-seeking, and another that may place greater emphasis on family endurance, religious coping, privacy, and social reputation. This does not mean that Algerian culture is opposed to mental health support. Rather, it suggests that help-seeking is negotiated through social trust, moral expectations, family relationships, and the perceived acceptability of psychological language.

Therefore, including socio-political and geopolitical context strengthens the thesis by preventing an overly individualised or culturally simplistic reading of Algerian students' mental health. It shows that disclosure and help-seeking are not only shaped by personal attitudes, but also by wider structures: colonial legacies in mental health law and institutions, economic uncertainty, youth unemployment, migration aspirations, family responsibility, religious meaning-making, and Algeria's position between local, regional, and European systems. This contextual framing also supports the critical-constructivist position of the thesis, because it shows that participants' accounts are produced within particular histories, institutions, and social worlds. Their experiences of mental health are therefore not isolated psychological events, but socially and politically situated forms of distress, interpretation, and coping.

Algerian student mobility patterns must also be understood within their historical and geopolitical context. France has historically remained the primary destination for Algerian students studying abroad due to the lasting effects of French colonisation, the continued use of the French language within Algerian education and administration, geographical proximity, and long-standing migration links between the two countries. Contemporary data from Campus France indicate that Algeria continues to represent one of the largest international student populations in France. Recent figures report that more than 34,000 Algerian students

were enrolled in French higher education institutions during the 2023/2024 academic year, making Algerians one of the largest foreign student groups in France (Campus France, 2025). More broadly, Algeria consistently appears among the top countries of origin for international students in France alongside Morocco and China (Campus France, 2024).

Historically, France has represented a particularly accessible route for Algerian students because of shared linguistic and institutional legacies established during the colonial period. French continues to occupy a significant role within Algerian higher education, particularly within scientific, medical, technical, and administrative fields. Consequently, many Algerian students grow up within educational systems already strongly influenced by French academic structures and language practices. This historical continuity has contributed to the normalisation of France as a preferred educational destination for many Algerian families. Research and media reports further suggest that studying in France is often associated with social mobility, educational prestige, and future employment opportunities, despite the increasing difficulties surrounding visa access and migration policies (Le Monde, 2024).

By contrast, the United Kingdom represents a newer and comparatively smaller destination for AIS. Although precise yearly figures for Algerian students specifically in the UK remain less publicly visible than French statistics, Higher Education Statistics Agency (HESA) data demonstrate the continued growth of international student enrolment within UK higher education overall, with international students accounting for a substantial proportion of postgraduate enrolments in recent years. Within this broader expansion of international education, Algerian student mobility towards the UK has gradually increased through English-language education, scholarship opportunities, transnational academic aspirations, and the growing global value associated with British qualifications. Unlike France, however, choosing the UK often involves entering a less culturally familiar and more linguistically demanding environment, particularly for students whose prior education has been primarily shaped

through Arabic and French systems.

This distinction between France and the UK is important for understanding the experiences explored within this thesis. Algerian students moving to France may encounter fewer linguistic disruptions due to the historical role of French within Algeria. In contrast, studying in the UK may require adjustment not only to a new educational system but also to a different linguistic, social, and psychological environment. Participants within this thesis frequently described experiences of negotiating between multiple cultural and linguistic systems, particularly when discussing emotional distress, help-seeking, belonging, and identity formation. Therefore, the movement from Algeria to the UK cannot be understood simply as international educational mobility. Rather, it reflects a broader transition across historical, linguistic, cultural, and geopolitical spaces.

Furthermore, Algerian student migration should not be interpreted only through educational motivations. In recent years, broader socio-economic pressures, including youth unemployment, concerns regarding professional opportunities, and aspirations for social mobility, have increasingly shaped international migration ambitions among young Algerians. For some students, studying abroad represents both an academic opportunity and a longer-term strategy for personal stability, economic security, and future mobility. This wider context can intensify emotional pressure on students studying overseas, particularly where academic success becomes closely tied to family sacrifice, migration aspirations, and expectations surrounding future achievement. Consequently, mental health experiences among AIS are situated not only within university environments, but also within broader historical relationships between Algeria and Europe, postcolonial educational pathways, migration systems, and contemporary geopolitical realities.

2.4.2 Mental Health Stigma in Algerian and Arab Cultures

As mentioned earlier, in many Arab societies, mental health is often shrouded in stigma,

making it difficult for individuals to acknowledge or openly discuss psychological issues Merhej, 2019). Mental health problems are frequently seen as a sign of personal weakness or, in some cases, even as a spiritual failing (Merhej, 2019; Saged et al., 2020). Research highlights that this stigma creates barriers to seeking help, as individuals fear being ostracised by their communities (Rayan & Jaradat, 2016). For Algerian and Arab students studying abroad, this deeply ingrained stigma may follow them, making it harder for them to seek psychological support despite being in an environment where mental health services are more readily available. The pressure to uphold family and societal expectations further exacerbates this issue, leading to the internalisation of stress and anxiety, which can manifest in more severe mental health conditions over time (Al-Krenawi, 2019). The reluctance to seek professional help can also be tied to concerns about confidentiality and shame. In many Arab cultures, mental illness is perceived as a personal or familial disgrace (Al-Krenawi, 2019), and individuals may avoid therapy for fear of being judged by both their home and host communities. As a result, Arab international students may downplay their mental health struggles, focusing solely on their academic challenges, while quietly suffering from untreated mental health issues.

2.5 Religious and Cultural Attitudes Toward Mental Health

Religion and spirituality play a central role in the lives of many Arab students, and these beliefs often influence their perceptions of mental health. For many, mental health issues may be framed in religious terms, with psychological distress being attributed to a lack of faith or spiritual imbalance (Alqasir, 2024). Students may prioritise prayer, fasting, or other religious practices over seeking professional help. While religious coping strategies can provide emotional support, they may also delay the recognition of mental health problems that require clinical intervention (Alghamdi & Hunt, 2021). Therefore, religious attitudes towards mental health can be both a barrier and a source of resilience as it was shown that some Arab students

use their religious beliefs as a way to find meaning and strength in difficult situations, helping them cope with the challenges of studying abroad (Inayat, 2020). For instance, a belief in fate (Qadr) may lead some students to accept their hardships as part of a divine plan, which can mitigate feelings of stress or helplessness. Yet, this same belief may also discourage them from seeking help, as they may view their mental health struggles as something beyond their control and thus not something that requires external intervention (Inayat, 2020).

2.6 Impact of Cultural Differences on Seeking Support

Cultural differences in how mental health is understood and treated can significantly impact the likelihood of Arab international students seeking support. In Western countries like the UK, mental health services are generally more accessible and normalised. Therapy, counselling, and mental health discussions are often integrated into university life, with an emphasis on early intervention and open dialogue. However, for many Algerian and Arab students, this approach can feel foreign and uncomfortable due to the lack of such services in their home countries and the associated stigma (Al-Krenawi, 2019). This cultural disconnect may lead to a reluctance to engage with mental health resources, even when they are available. Furthermore, these students may feel misunderstood by mental health professionals who are not familiar with their cultural background. Research suggests that Arab students often experience a lack of cultural sensitivity in Western mental health services, which may deter them from seeking help (Eltaiba & Harries, 2015). The fear of not being understood, coupled with the language barrier, may lead to miscommunication or ineffective treatment, causing students to abandon the idea of seeking help altogether (Hamdan, 2021). This cultural gap highlights the importance of providing culturally sensitive mental health services in universities, where counsellors are trained to understand and respect the unique cultural and religious contexts of their international students. Therefore, the cultural context of mental health for Algerian and Arab international students is complex and influenced by stigma,

religious beliefs, and cultural attitudes towards seeking support. These factors not only shape their perceptions of mental health but also affect their willingness to access support services.

2.7 Algerian Educational System and Mental Health Cultural Context

The Algerian educational system, shaped by its colonial history, has undergone significant transformation since independence in 1962. It is characterised by a highly centralised structure under strong governmental control, with a formal commitment to free and compulsory education until the age of 16 (Benrabah, 2013). While the system continues to face structural challenges, including overcrowding and limited resources, these constraints are particularly consequential at the level of tertiary education, where opportunities for postgraduate study, research development, and international exposure remain unevenly distributed. Access to international study is therefore typically limited to a relatively small and academically successful group of students navigating competitive university pathways and constrained domestic prospects. Within this context, studying abroad is often constructed as a strategic route to academic advancement and professional security, rather than a response to early educational exclusion. Culturally, education in Algeria carries strong symbolic value as a marker of social mobility and family achievement, but this emphasis is frequently accompanied by intense expectations from family and community. For students who pursue higher education abroad, these expectations can translate into heightened pressure to succeed, with limited tolerance for academic or emotional difficulty (Lebeau et al., 2012).

At the same time, prevailing stigma surrounding mental health in Algeria—where psychological distress is often framed as personal weakness or moral failure—can discourage early help-seeking and emotional disclosure (Benslama, 2014). This combination of high academic investment, moralised success, and limited mental health dialogue forms an important backdrop for understanding how Algerian students experience stress, cope with distress, and navigate support systems while studying abroad.

2.7 Overview of UK Higher Education Environment

The UK higher education system, renowned for its quality and diversity, attracts a significant number of international students annually. In 2021, the UK hosted over 605,000 international students, making it one of the top destinations for higher education globally (UK Council for International Student Affairs, 2021). The pedagogical approaches in UK universities, which often emphasise critical thinking, independent learning, and active participation, can differ significantly from the more didactic and teacher-centred approaches prevalent in non-Western educational systems, including Algeria. This transition can be particularly challenging for international students who are accustomed to different educational practices and expectations (Tran & Vu, 2018; Zhou et al., 2021). Moreover, the social environment in UK universities can be both welcoming and isolating for international students. On one hand, UK universities often promote diversity and inclusion, offering various programs to help international students integrate and build social connections. These initiatives can foster a sense of belonging and provide students with the support they need to navigate their new environment (Bowl, 2020). However, for students from non-Western backgrounds, such as Arab international students, cultural differences, language barriers, and unfamiliar social norms can lead to feelings of isolation and exclusion. Research suggests that international students, particularly those from collectivist cultures, may struggle to adapt to the more individualistic culture found in many Western countries, where social relationships are often less family-centred, personal boundaries are more strongly emphasised, and forming close friendships may take longer than in their home cultures (Sawir et al., 2019; Spencer-Oatey & Dauber, 2019). Additionally, the lack of strong social support networks and the pressures to succeed academically can further exacerbate feelings of loneliness and alienation, impacting their mental well-being (Zhou & Todman, 2020). These challenges highlight the need for universities to not only provide academic support but also develop tailored social integration programs that address the unique cultural and emotional needs of international students from diverse backgrounds and will also

id in a smooth transition.

The intersection of these educational and social challenges within the UK higher education context can have profound implications for the mental health of AIS. While the availability of mental health services in the UK is generally higher than in Algeria , the cultural stigma associated with seeking mental health support can deter AIS from utilising these services (Turner, 2020). Therefore, understanding the contextual backgrounds of both the Algerian educational system and the UK higher education environment is crucial for addressing the mental health needs of AIS where the disparities between these educational systems, coupled with cultural stigmas and pressures, create a complex landscape that impacts students' mental well-being. Thus, one of the UK universities' roles is to not only recognise these challenges but also to implement comprehensive, culturally informed support structures to facilitate the academic and personal success of Algerian students. Despite the expansion of student wellbeing services across UK universities, patterns of underutilisation among some international student groups remain evident (Forbes-Mewett & Sawyer, 2019; El Khatib et al., 2023).

2.8 Comparative Studies: Mental Health of Arab Students in Other Countries

Research on Arab international students in countries like the USA and Canada reveals similar patterns of mental health challenges as those faced by Arab students in the UK. These challenges often revolve around cultural adaptation, academic stress, and social isolation (Hamdan, 2021). However, while these issues are common across different Western contexts, there are notable differences in how they manifest and are addressed depending on the cultural and social changes of the host country.

2.8.1 Cultural Adaptation and Acculturative Stress

Acculturative stress has been frequently identified in parts of the literature as an important dimension of Arab international students' mental health experiences, particularly in studies

examining adjustment to Western academic and social contexts (Berry, 2006). Berry's acculturation framework challenges the assumption that cultural adaptation follows a single or linear trajectory, instead outlining multiple possible orientations toward the host society and one's culture of origin, including integration, assimilation, separation, and marginalisation (Berry, 2006). This plurality is important because it allows adaptation to be understood as context-dependent rather than as an inevitable progression toward integration.

Within this framework, Arab international students may move between different orientations depending on their circumstances and the environments they encounter (El Khatib et al., 2023; Gomes et al., 2021). However, existing research suggests that structural constraints within Western academic settings, such as limited institutional support, cultural misalignment, and experiences of exclusion, can restrict opportunities for integration. Under such conditions, marginalisation becomes a useful analytical lens for examining how distress, feelings of isolation, and reluctance to seek support may emerge. In this thesis, marginalisation is not treated as a defining outcome, but as a condition that highlights how psychological difficulties are shaped by social and institutional contexts rather than individual deficits. Research further indicates that these challenges may be intensified by wider social factors, including political climates and media representations that contribute to experiences of alienation and acculturative stress among Arab and Muslim students (Abu-Ras & Abu-Bader, 2009; Al-Rashdi & Phan, 2015). Together, this literature provides a critical backdrop for the present study, which examines how such conditions intersect with mental health, disclosure, and help-seeking among Algerian students.

2.8.2 Academic Stress and Educational Differences

Academic stress is a universal challenge for international students, and aforementioned; it can be more pronounced for Arab students due to differences in pedagogical approaches between their home countries and Western educational systems. In the USA and Canada, much like

the UK, academic environments emphasise critical thinking, independent learning, and active participation—qualities that may not have been emphasised in the more didactic, teacher-centred education systems from which many Arab students come (Ryan & Louie, 2007; Smith & Khawaja, 2019). This cultural mismatch can result in confusion, anxiety, and a sense of inadequacy, further contributing to stress and, in some cases, depression. A comparative study of Arab students in the USA and Canada found that the pressures to perform academically, especially when coupled with the high expectations placed on them by their families, can be overwhelming (Forbes-Mewett & Sawyer, 2021). Family expectations often involve not only academic success but also a sense of duty to financially support the family once they graduate. This dual pressure can lead to burnout and a sense of helplessness if they struggle academically or socially (Zhou et al., 2021).

2.8.3 Social Isolation and Cultural Differences

Social isolation is another common issue across Western host countries, although the degree to which Arab students feel isolated can vary depending on the social environment of the university and surrounding community. Research in the USA shows that Arab students often feel marginalised due to their perceived cultural and religious differences (Abu-Ras & Abu-Bader, 2009). While some students may find comfort in joining Arab or Muslim student associations, these groups can sometimes reinforce feelings of separateness rather than integration into the broader student community (Alazzi & Chiodo, 2006). In Canada, where multiculturalism is often celebrated, students may feel more welcomed, but this can vary depending on the region and the diversity of the student body (Li et al., 2020).

2.9 Inclusivity and Institutional Support

While both the USA and Canada have established mental health services for international students, the accessibility and cultural sensitivity of these services often vary. Studies suggest that Arab students in the USA may be hesitant to seek help due to fears of being misunderstood

or judged by mental health professionals who are unfamiliar with their cultural or religious backgrounds (Smith & Khawaja, 2019). This hesitancy is compounded by the stigma surrounding mental health in Arab cultures, where seeking psychological help may be viewed as a sign of weakness or dishonour (Al-Krenawi, 2019). In Canada, while there is a greater emphasis on multiculturalism and inclusivity, research has shown that Arab students still face barriers to accessing mental health services due to language issues, unfamiliarity with the healthcare system, and financial concerns (Hamdan, 2021). Some universities have begun to offer culturally tailored mental health services, including the provision of Arabic-speaking counsellors and mental health professionals trained in understanding the specific needs of Arab and Muslim students. However, these services are not universally available, and their impact on reducing mental health disparities among Arab students remains under-researched (Li et al., 2020).

2.10 Key Differences in Support Systems

One key difference between the experiences of Arab students in the USA and Canada versus those in the UK is the level of support available for international students, particularly in terms of culturally competent mental health care. While UK universities have made strides in recent years to improve their mental health support systems, they still lag behind North American institutions in terms of integrating cultural competence into mental health care (Zhou et al., 2021). Studies show that the presence of cultural and religious diversity within university counselling services is a crucial factor in reducing mental health disparities among international students (Forbes-Mewett & Sawyer, 2021). This underscores the need for UK universities to adopt a more inclusive and culturally sensitive approach to student mental health services, particularly for Arab and Muslim students who may face unique challenges in accessing support; however, students in less culturally diverse areas may struggle more with social integration. Therefore, the theory of social capital suggests that students with fewer

connections or access to supportive networks are at greater risk for mental health issues (Putnam, 2000). For Arab students, who may face both linguistic and cultural barriers, developing meaningful social relationships outside of their own cultural or religious groups can be difficult. This lack of social integration can exacerbate feelings of loneliness and isolation, which are closely linked to depression and anxiety (Sawir et al., 2019).

2.11 Gaps in the Literature

2.11.1 Current Limitations in Research on Algerian and Arab Students' Mental Health in the UK

Despite increasing scholarly attention to international student mental health, research that explicitly examines the experiences of AISs in UK universities remains limited. Much of the existing literature adopts broad categorisations; such as “international students” or “Arab students”, that obscure important national, cultural, and structural differences within these groups (Forbes-Mewett & Sawyer, 2021). Studies focusing on Arab students frequently draw on samples from Gulf or Middle Eastern countries, whose socioeconomic conditions, institutional sponsorship, and educational trajectories differ substantially from those of North African students, including Algerians (Khawaja & Stallman, 2020).

This tendency to homogenise Arab international students is problematic, as it assumes shared experiences that do not reflect Algeria’s distinct linguistic history, educational system, and sociopolitical context. For example, whereas students from Gulf states may benefit from stronger financial security and structured institutional support, Algerian students are more likely to encounter financial precarity, unfamiliar academic conventions, and limited access to tailored support services (Li et al., 2020). These contextual differences are rarely theorised or examined in depth, limiting the relevance of existing findings for Algerian students specifically. Methodologically, much of the literature relies on cross-sectional survey designs that prioritise prevalence estimates of distress while offering limited insight into how mental

health is understood, negotiated, and managed over time. As a result, the longer-term mental health trajectories of Algerian and other North African students remain underexplored (Sawir et al., 2019). This constrains the development of nuanced, culturally responsive interventions and leaves important questions about meaning-making, disclosure, and coping unanswered.

2.11.2 Need for Further Studies Addressing Specific Cultural and Contextual Factors

Beyond issues of representation, existing research insufficiently engages with the cultural and contextual factors that shape Algerian and Arab students' mental health experiences in the UK. Although stigma surrounding mental health is frequently acknowledged in studies of Arab populations, it is often treated as a static cultural attribute rather than examined in relation to gender norms, family expectations, or institutional contexts (Al-Krenawi, 2019). This limit understanding of how stigma is lived, negotiated, or resisted by students navigating transnational educational spaces.

Similarly, the role of religion is typically framed in simplified terms, either as a protective coping resource or as a barrier to professional help-seeking. While religious beliefs can offer comfort and meaning, they may also shape interpretations of distress in ways that discourage engagement with formal mental health services, particularly when distress is understood as a moral or spiritual trial rather than a psychological concern (Hamdan, 2021). Existing studies rarely explore how students move between religious, familial, and professional frameworks when responding to mental health difficulties, nor how these processes change across contexts such as the UK and the home country.

Linguistic factors represent another significant gap. Although language proficiency is recognised as important for academic adjustment, its role in emotional expression, help-seeking, and engagement with mental health services remains underexamined. Algerian students' multilingual backgrounds; typically involving Arabic, French, Tamazight, and

English, introduce additional layers of complexity in how distress is articulated and understood. The limited availability of Arabic-speaking or culturally informed counselling services within UK universities further compounds these challenges (Zhou et al., 2021), yet this issue is rarely explored qualitatively.

Finally, family expectations and transnational obligations are frequently mentioned but insufficiently analysed. For many Algerian students, academic success is closely tied to family honour, future responsibility, and social mobility, creating pressures that intersect with migration stress, financial insecurity, and cultural adaptation (Forbes-Mewett & Sawyer, 2021). Existing research seldom examines how these expectations shape students' willingness to disclose distress or seek support, particularly when doing so may be perceived as failure or weakness. while the literature on Arab international students provides valuable insights into mental health challenges in higher education, it offers only a partial and fragmented understanding of Algerian students' experiences in the UK. There is a clear lack of research that attends to the interaction of culture, religion, language, family expectations, and institutional context over time. Addressing these gaps requires moving beyond generalised, prevalence-focused approaches toward qualitative, context-sensitive research that foregrounds students' own meaning-making processes. This thesis responds directly to these limitations by offering an in-depth, multi-perspectival exploration of Algerian students' mental health experiences across study, disclosure, coping, and reintegration.

Table 2.1: Comparative Coverage of Arab vs. Algerian Students' Mental Health Literature

Theme	Arab Students (general literature)	Algerian Students (specific literature)	Gap
Prevalence of distress	Large-scale studies highlight consistently high levels of anxiety, depression, and acculturative stress among Arab international students in Western settings, often linked to academic and cultural adjustment pressures (El Khatib, Alyafei, & Shaikh, 2023; Smith & Khawaja, 2019)	Algerian surveys report that 30–50% of students show moderate to severe psychological distress, typically tied to academic overload, financial insecurity, and weak institutional support (Benamsili, 2023; Mansouri, 2024)	Research on Algerian students is fragmented and methodologically narrow. Most studies are small, single-institution surveys, offering only snapshots in time. There is little longitudinal or qualitative research exploring how distress evolves or how it is understood abroad, leaving Algeria absent from global prevalence debates.
Stigma	Stigma is consistently identified as a major barrier to disclosure and help-seeking, rooted in honour, shame, and community perceptions of weakness (Merhej, 2019; Zolezzi et al., 2018; El Khatib et al., 2023; Sweileh, 2024).	Stigma is acknowledged within Arab discussions of mental health and is often linked to fears of social judgement, family reputation, and negative perceptions of psychological difficulties; however, it is typically discussed as part of broader mental health concerns rather than examined as a primary focus of investigation (Aouattah, 2000; Benamsili, 2023; El Khatib, 2023; Mansouri, 2024).	While Arab stigma is widely researched, Algerian stigma is under-analysed. There is little on how stigma interacts with language, class, or gender in Algeria, or how it shapes behaviour abroad. This creates an incomplete picture of how stigma operates in this specific North African context.
Religion & coping	Religious coping is consistently identified across Arab contexts—Qur'anic recitation, Ruqyah, and prayer are protective but can discourage professional help-seeking (Al-Krenawi, 2022; El Khatib et al., 2023; Saged et al., 202)	Algerian students also rely heavily on family and religious coping, often framing distress in spiritual or moral terms (Benamsili, 2023).	The role of religion in Algerian coping is recognised but not critically examined. There is little research on when faith-based strategies are helpful and when they become barriers, especially in cross-border contexts. This nuance is missing in both national and international studies.
Help-seeking behaviour	Across Arab populations, preference for informal help and reluctance to approach professionals is well-documented, even in resource-rich contexts (El Khatib et al., 2023).	Algerian research confirms minimal use of formal counselling, reflecting weak provision and poor visibility of services (Benamsili, 2023; Mansouri, 2024).	No research traces Algerian students' help-seeking abroad, nor how they navigate UK services versus home-country provision. This lack of comparative and longitudinal analysis makes it difficult to design culturally sensitive interventions.
Language/education	Arab students abroad face well-documented language stress, which contributes to isolation and academic strain (; El Khatib et al., 2023; Smith & Khawaja, 2022)	Algeria's multilingual higher education system (Arabic, French, Tamazight, and now English) produces unique hierarchies of belonging, which exacerbate stress and inequality (Al-Qadri et al., 2023).	The interaction between Algeria's multilingualism and mental health is almost entirely unstudied. Unlike broader Arab research, little is known about how linguistic hierarchies shape students' identity, belonging, and stress both at home and abroad.

Gender differences	Arab student studies often mention gender differences, but usually in broad strokes without detailed analysis (El Khatib et al., 2023).	Algerian evidence shows female students report higher anxiety and depression, while male students face stronger stigma in acknowledging distress (Sabah et al., 2025).	Research rarely explores how gender intersects with class, region, or family expectations in Algeria. Cross-sectional surveys flatten these differences, leaving a thin understanding of how gendered pressures shape mental health trajectories.

Reintegrati on	Reintegration of Arab and international returnees is only beginning to be studied; El Khatib et al. (2023) note that very few studies follow students after their return, despite strong evidence of reverse culture shock (Sonnenschein, Michelini, & King, 2023).	To the best of the researcher knowledge, virtually no studies examine Algerian returnees, despite evidence that returning home after study abroad brings new identity tensions and limited institutional support. (Sonnenschein, Michelini, & King, 2023).	Reintegration is a major blind spot: we do not know how Algerian students navigate mental health after returning, nor how stigma, family expectations, and weak infrastructures influence this transition. This absence is one of the central gaps this thesis addresses.

Chapter 3: Methodology

3.1 Introduction

The aim of this study, as mentioned before, is to explore the mental health experiences and challenges faced by AISs in the UK and to identify the coping strategies and the help seeking behaviours that they may use. Given the complexity and deeply personal nature of mental health experiences, this research requires an approach that allows for a rich, deep understanding of how these students navigate their emotional well-being in a foreign environment and a familiar one once they finish their studies and return home. Such experiences cannot be adequately captured through positivist or quantitative designs that reduce meaning into variables and statistical relationships. Instead, the study adopts a qualitative, constructivist approach, privileging participants' voices, lived experiences, and meaning-making processes, because mental health is influenced by a variety of factors, including cultural background, social interactions, and academic pressures, all of which vary widely among individuals (Yeh et al., 2021; Gaias et al., 2022;).

As such, a qualitative research methodology has been deemed the most suitable approach for this study, by privileging participants' voices, which does not only capture the diversity of meaning-making but also offer space for marginalised groups, such as AIS to articulate experiences that might otherwise remain silenced within dominant biomedical or quantitative frameworks. As Sandelowski (2019) noted, qualitative research is particularly well-suited to investigations that seek to illuminate subjective experience rather than measure objective outcomes. Interviews, the principal method employed in this study, provide participants with

the opportunity to narrate their experiences in their own words, generating insights that cannot be elicited through surveys or standardised measures alone. In this case, understanding how Algerian students perceive and respond to their mental health challenges within and outside the context of the UK's educational and social systems requires a methodology that goes beyond numbers and statistics. This chapter will justify the selection of qualitative research as the methodological approach for this study. It will outline the philosophical foundations of the methodology, focusing on interpretivism and social constructivism, and explain how these perspectives align with the research aims. Additionally, this chapter will discuss the rationale behind the use of specific qualitative methods and how these will be employed to gather and analyse data that is both meaningful and relevant to the research objectives.

A formal systematic or scoping review was not conducted as part of this thesis for several methodological and practical reasons related to the nature of the research topic, the available literature base, and the epistemological positioning of the study. While systematic and scoping reviews are valuable approaches for synthesising large and well-established bodies of evidence, the present research focused on a highly underexplored population and a context where the available literature remained fragmented, limited, and methodologically inconsistent. During the early stages of the PhD, preliminary literature searches revealed a substantial lack of research specifically examining the mental health experiences, disclosure practices, and help-seeking behaviours of AIS in the UK. Much of the existing literature focused more broadly on international students, Arab students, Muslim students, or North African populations, with very limited studies addressing Algerian students directly. Consequently, there was insufficient homogeneous literature available to justify a full systematic review aimed at identifying, comparing, and synthesising a clearly established body of evidence.

In addition, the available literature originated from multiple disciplines, including

psychology, psychiatry, sociology, migration studies, education, anthropology, and public health. These studies also varied substantially in methodological design, terminology, theoretical orientation, cultural focus, and conceptualisation of mental health. For example, some studies examined stigma and help-seeking within broader Muslim populations (Ciftci et al., 2013; Amri & Bemak, 2013), while others focused on acculturation, migration stress, religious coping, or international student wellbeing more generally (Smith & Khawaja, 2011; Alharbi & Smith, 2018). As a result, the literature base lacked the conceptual consistency and specificity often required for systematic review methodology. Conducting a systematic review under these conditions may have risked creating an artificial sense of coherence across highly diverse contexts and populations that were not directly comparable to AIS in the UK.

Similarly, a scoping review was considered but ultimately not adopted because the primary aim of the thesis was not to map all existing international literature related broadly to mental health and migration, but rather to develop an in-depth qualitative understanding of a specific and underrepresented population through empirical exploration. Scoping reviews are particularly useful for mapping the breadth of evidence within emerging or complex fields (Arksey & O'Malley, 2005). However, the current thesis was grounded within a critical-constructivist epistemological position, which prioritised contextual understanding, meaning-making, reflexive interpretation, and the co-construction of knowledge rather than comprehensive evidence mapping alone. Therefore, the research design focused on generating rich qualitative insights directly from participants' lived experiences rather than attempting to produce an exhaustive catalogue of all related literature.

Furthermore, the exploratory nature of the thesis meant that flexibility within the literature review process was necessary. Rather than following rigid inclusion and exclusion criteria associated with systematic review procedures, the literature review evolved iteratively alongside the development of the research questions, conceptual framework, and empirical

findings. This approach is considered appropriate within qualitative and constructivist research, where understanding often develops progressively through engagement with data, theory, and context (Braun & Clarke, 2021). Literature from broader Arab, Muslim, North African, migration, and international student contexts was therefore incorporated selectively and critically to contextualise the experiences of Algerian students where direct Algerian-focused evidence was lacking. This allowed the thesis to remain sensitive to contextual complexity while also acknowledging the limitations of generalising findings from broader populations to Algerian students specifically.

Practical considerations also influenced this decision. The literature relevant to Algerian mental health experiences existed across multiple languages, including English, French, and Arabic, with some important contextual discussions appearing within regional publications, reports, and grey literature rather than indexed academic databases alone. Capturing all potentially relevant material systematically would therefore have required extensive multilingual database searching and highly complex screening processes that extended beyond the scope and objectives of the present thesis. Instead, a focused narrative and critical review approach was adopted to synthesise the most relevant theoretical, contextual, and empirical literature informing the research questions.

Importantly, the decision not to conduct a systematic or scoping review does not indicate a lack of methodological rigour. Rather, it reflects alignment between the research aims, epistemological position, and the realities of the available evidence base. The thesis instead adopted a critical and integrative literature review strategy, enabling engagement with diverse forms of evidence while remaining responsive to the complexity and under-researched nature of AISs' mental health experiences. This approach was considered more appropriate for supporting the exploratory and qualitative aims of the study, while also allowing space for participants' voices and experiences to contribute directly to the development of knowledge

in an area where existing literature remains limited.

3.2 Theoretical and Conceptual Foundations of the Study

The present thesis is informed by several complementary theoretical and conceptual frameworks that collectively guide the exploration of AIS' mental health experiences across the UK and Algeria. Rather than relying upon a single explanatory model, the study adopts a pluralistic framework that integrates mental health literacy, stigma and disclosure theories, acculturation and re-acculturation perspectives, and critical-constructivist understandings of culture, identity, and meaning-making. These frameworks provide a coherent conceptual foundation for understanding how participants interpret psychological distress, negotiate disclosure, engage in coping and help-seeking behaviours, and make sense of their experiences across different cultural contexts.

A central concept underpinning the thesis is mental health literacy (MHL). Originally developed by Jorm et al. (1997), MHL refers to the knowledge and beliefs that facilitate the recognition, management, and prevention of mental health difficulties. The concept extends beyond the ability to identify symptoms and includes understanding available support options, beliefs about treatment, and attitudes towards help-seeking. However, this study adopts a critical perspective towards universal applications of MHL, recognising that understandings of psychological distress are shaped by cultural, religious, linguistic, and social contexts. Consequently, mental health literacy is not conceptualised as a fixed body of knowledge but as a culturally situated process through which individuals interpret and respond to emotional experiences. This perspective is particularly relevant for AISs whose understandings of mental health are shaped simultaneously by Algerian cultural frameworks and exposure to Western psychological discourse during their studies abroad.

The study is also informed by theories of stigma and disclosure. Goffman (1963) conceptualised stigma as a socially constructed process through which certain characteristics become associated with negative social value. More recent work by Corrigan (2004) and Link

and Phelan (2001) has demonstrated how anticipated stigma, self-stigma, and public stigma influence willingness to seek help and disclose emotional difficulties. These perspectives provide an important framework for understanding why awareness of mental health problems does not necessarily lead to disclosure or professional help-seeking. Within the present research, disclosure is understood as a relational and socially negotiated process rather than a purely individual decision. Participants' accounts suggest that decisions to speak about distress are often influenced by concerns regarding family reputation, cultural expectations, religious interpretations, social judgement, and fears of exclusion. Stigma therefore operates not only at the individual level but also within broader social and cultural systems.

Transactional coping theory provides an additional lens for examining how participants responded to psychological strain. Lazarus and Folkman's (1984) transactional model proposes that stress and coping develop through an ongoing relationship between the individual and the environment. According to this model, individuals engage in primary appraisal (evaluating whether an event is threatening, harmful, or challenging) and secondary appraisal (assessing available coping resources and options) (Lazarus & Folkman, 1984). Responses to stress therefore depend on how a situation is appraised, including whether it is experienced as threatening and whether sufficient resources are perceived to be available. This perspective is relevant to the present thesis because participants' responses to distress were shaped not only by the difficulties encountered but also by their assessment of relational safety, cultural acceptability, available support, and the perceived consequences of disclosure.

The framework also distinguishes coping from help-seeking. Coping refers broadly to the cognitive, emotional, behavioural, relational, or spiritual efforts used to manage internal or external demands that are appraised as stressful (Lazarus & Folkman, 1984). Help-seeking, by contrast, refers more specifically to the act of communicating a need for assistance or approaching another person or service for support (Rickwood et al., 2005). Professional help-

seeking is therefore one possible coping response, but not all coping involves disclosure or external assistance. This distinction allows strategies such as prayer, emotional suppression, distraction, peer support, family communication, religious consultation, and professional support to be examined in terms of their functions and meanings rather than positioned automatically along a hierarchy from ineffective to effective coping. Religious coping is similarly treated as context-dependent. Pargament (1997) conceptualises religious coping as the use of religious beliefs or practices to understand and manage stressful life events. It may provide comfort, meaning, and connection, particularly in culturally and spiritually grounded contexts, but it may also delay engagement with other forms of support when distress is attributed exclusively to weak faith, moral failure, or supernatural causation (Pargament, 1997).

A further theoretical lens is provided by acculturation and re-acculturation theory. Berry's (1997, 2005) model of acculturation highlights the psychological and cultural adjustments that occur when individuals encounter a new cultural environment. International students often experience tensions between maintaining aspects of their heritage culture and adapting to the norms of the host society. While acculturation theory has frequently been used to understand international student adjustment, the present thesis extends this discussion by considering the process of return and reintegration. Returning home after prolonged study abroad often involves re-acculturation, reverse culture shock, and the renegotiation of identity (Sussman, 2002). These perspectives are particularly relevant to Study 3, where participants described difficulties reconciling psychological understandings acquired in the UK with the social and cultural expectations encountered after returning to Algeria.

The thesis is additionally informed by critical-constructivist perspectives on identity, culture, and meaning-making. From this perspective, knowledge is not viewed as an objective reality waiting to be discovered but as something co-constructed through language, social interaction,

cultural practices, and lived experience (Charmaz, 2014). Mental health experiences are therefore understood not as universal phenomena but as interpretations shaped by social context. This position aligns with the study's broader epistemological stance and helps explain why participants frequently drew upon multiple explanatory systems when discussing distress, including psychological, religious, cultural, familial, and spiritual frameworks. Rather than viewing these frameworks as mutually exclusive, the study recognises that individuals often move between different systems of meaning depending on context and audience.

The components of this framework operate at different but connected levels. Critical constructivism provides the overarching philosophical position through which knowledge and meaning are understood as socially produced and shaped by relations of power. Mental health literacy, stigma, transactional coping and acculturation provide established theoretical lenses for examining recognition, disclosure, appraisal, response and cultural adjustment. Identity, intersectionality, language and reintegration provide additional conceptual lenses through which differences across participants, relationships and national contexts are interpreted. These elements are therefore not treated as a list of independent constructs. They form an interconnected framework explaining how distress is recognised, communicated, managed and socially evaluated across migration and return.

3.3 Overview of Research paradigms

Research paradigms form the foundational frameworks guiding scientific inquiry, influencing how researchers interpret knowledge, define reality, and choose methodologies. As Kuhn (1970) argued, paradigms shape the "normal science" of any discipline, providing the lens through which phenomena are understood and examined. In the social sciences and psychology, dominant paradigms include positivism, interpretivism (constructivism), critical theory, pragmatism, and post-positivism. These paradigms reflect distinct philosophical

assumptions regarding knowledge and reality, which in turn shape research approaches and interpretations (Guba & Lincoln, 1994).

Positivism, one of the oldest paradigms, is rooted in enlightenment thinking and the scientific revolution. Positivism, one of the oldest paradigms, is deeply rooted in Enlightenment thinking and the scientific revolution. Enlightenment thinking, which flourished in the 17th and 18th centuries, emphasized reason, individualism, and scepticism toward traditional authorities (Outram, 2013). This intellectual movement championed the idea that human beings could understand and improve their world through rational thought and empirical evidence, leading to a departure from reliance on religious dogma and superstition (Gray, 2018). The scientific revolution, which preceded the Enlightenment, laid the groundwork for positivist thought by promoting the use of systematic observation and experimentation to understand natural phenomena. Thinkers like Galileo Galilei and Isaac Newton demonstrated that the universe operates according to discoverable laws, an idea that influenced positivist philosophers such as Auguste Comte (Cohen, 1994). Comte argued that social phenomena, like natural phenomena, could be studied scientifically to uncover objective truths about society (Morrison, 2012). Positivists assert that knowledge is derived from observable, empirical evidence, which can be measured and analysed (Creswell, 2013). By adopting a realist ontology, positivists maintain that reality exists independently of human perceptions, which aligns with the Enlightenment's emphasis on rationality and objective knowledge (Guba & Lincoln, 1994). This paradigm has significantly influenced research methodologies in both the natural and social sciences, where the aim is to identify causal relationships through quantitative methods, such as experiments and surveys (Bryman, 2012). As aforementioned, positivism rests on the assumption that objective truths about reality can be uncovered through empirical observation and rigorous measurement (Creswell, 2013; Lincoln & Guba, 1985). Positivists, subscribing to a realist ontology, assert that reality exists

independently of human perceptions (Guba & Lincoln, 1994). This approach underpins much of the natural and social sciences, where researchers aim to uncover causal relationships through quantitative methods (Bryman, 2012).According to this paradigm, knowledge is acquired through systematic observation, leading to the discovery of universal laws (Bhaskar, 1975). Positivist research typically employs quantitative methods, such as experiments and surveys, to establish causal relationships and generalizable findings. For example, a positivist study on mental health might focus on quantifying the prevalence of mental health disorders in a specific population, relying on diagnostic tools like the DSM-5 to assess conditions such as depression or anxiety among international students. Here, the goal is to reveal objective truths about mental health, assuming that these truths exist independently of the students' subjective experiences (Harré, 1986).

In contrast, interpretivism (constructivism) emerged in response to the limitations of positivism, particularly its inability to capture the subjective, socially constructed nature of human experience (Schwandt, 1994). From an epistemological standpoint, interpretivists argue that knowledge is co-constructed through social interactions and is inherently shaped by individual perspectives. They reject the notion of a singular objective truth, positing instead that individuals construct their realities based on their personal and cultural experiences. Ontologically, interpretivists adhere to relativism, asserting that multiple realities coexist, with each individual or group interpreting the world differently. As Max Weber (1949) suggested, understanding human behaviour requires an empathetic approach that considers the subjective meanings people assign to their actions. Accordingly, interpretivist research tends to rely on qualitative methods, such as interviews and ethnography, to explore the meanings individuals attach to their experiences. In the context of Algerian students' mental health, an interpretivist study would focus on how these students construct and interpret their mental health challenges within the distinct cultural contexts of the UK and Algeria. This

paradigm would emphasise that the students' experiences of migration, cultural displacement, and mental health stigma are shaped by their individual interpretations, rather than being reducible to objective measures alone (Guba & Lincoln, 2005).

Critical theory, while also rejecting the positivist emphasis on objective knowledge, goes further by interrogating how power dynamics and social structures shape knowledge and reality. Grounded in the work of scholars like Karl Marx, Antonio Gramsci, and the Frankfurt School, critical theory posits that knowledge is not neutral but is shaped by social, political, and economic forces (Horkheimer, 1972). From an epistemological perspective, critical theorists argue that research should not merely describe the world but should actively challenge power structures and promote social change. Ontologically, critical theory embraces historical realism, asserting that reality is shaped by historical and cultural forces, particularly those related to power and inequality. Researchers working within this paradigm often employ qualitative methods, such as critical discourse analysis, to reveal hidden power dynamics and inequalities (Freire, 1970). For instance, a critical theory approach to Algerian students' mental health might examine how systemic barriers, such as racism, xenophobia, or cultural biases, influence their access to mental health services in the UK. The goal of such research would not only be to document these challenges but also to advocate for changes in policy and practice that could alleviate them, thereby contributing to broader social transformation (Kincheloe & McLaren, 2005).

Pragmatism differs from other paradigms in its emphasis on practicality over philosophical debates about the nature of knowledge or reality. Pragmatists, following the ideas of philosophers like John Dewey and William James, focus on solving practical problems rather than adhering to specific ontological or epistemological assumptions. From a pragmatic standpoint, knowledge is created through action and interaction, and its value lies in its usefulness (Dewey, 1938). Pragmatists avoid rigid views of reality, instead advocating a

changing ontology that accommodates different perspectives based on what works in a given context. This flexibility often leads to the use of mixed methods, combining quantitative and qualitative approaches as needed to address complex research questions. For instance, a pragmatist studying mental health among international students might use surveys to collect quantitative data on mental health issues, while also conducting interviews to explore students' personal coping strategies. The emphasis would be on developing practical solutions to improve mental health services, rather than adhering strictly to any particular methodological or philosophical approach (Johnson & Onwuegbuzie, 2004).

Finally, post-positivism represents a response to the limitations of positivism, acknowledging that while an objective reality may exist, our understanding of it is always incomplete and shaped by human biases. Post-positivists, following the work of philosophers like Karl Popper, argue that knowledge can be approximated through systematic inquiry, but that this knowledge is always partial and contingent (Popper, 1963). Ontologically, post-positivists retain a commitment to realism, believing in an objective reality, but they recognise that this reality is too complex to be fully captured by any single study or methodology. Accordingly, post-positivist research often incorporates a combination of quantitative and qualitative methods, balancing the need for empirical data with the recognition of the importance of context and interpretation (Phillips & Burbules, 2000).

In the context of researching AlSs' mental health, the interpretivist (constructivist) paradigm appears most appropriate. This paradigm aligns with the goal of exploring the subjective experiences of these students, emphasising how their mental health challenges are shaped by social, cultural, and individual factors. Through qualitative methods such as semi-structured interviews, the research seeks to uncover how these students construct their understanding of mental health and how this understanding is influenced by the unique pressures of studying in a foreign academic and cultural environment. The interpretivist paradigm is especially

relevant given the cultural differences that shape the experiences of Algerian students, such as the stigma surrounding mental health in Algerian society and the challenges of adapting to life in the UK. By recognising that multiple realities exist and that these realities are shaped by individual perspectives, this paradigm provides a framework for understanding how Algerian students navigate the complex interplay between mental health, migration, and cultural displacement (Schwandt, 2000). Furthermore, the integration of epistemology and ontology in this study is crucial for shaping the approach to understanding mental health. An epistemological stance rooted in constructivism recognises that mental health is not a fixed or objective condition, but rather something that is socially and culturally constructed through personal experiences and interactions. Similarly, a relativist ontology acknowledges that mental health is dynamic and context-dependent, shaped by external factors such as migration, cultural displacement, and academic stress, language differences, religion. By adopting these philosophical assumptions, the research can offer a more in-depth understanding of the mental health challenges faced by AISs, thereby contributing to a growing body of knowledge on international student mental health (Guba & Lincoln, 2005).

3.4 Methodological Beginnings of the Study

In the context of understanding the mental health of AS in both the UK and Algeria, a well-structured methodology that interprets knowledge, defines reality, and selects appropriate research methodologies is crucial. This methodological framework will employ a constructivist epistemology, a relativist ontology, and qualitative methodologies to deeply engage with the subjective experiences of these students.

3.4.1 Interpreting Knowledge: Constructivist Epistemology

At the foundation of this research lies a constructivist epistemology, which posits that knowledge is not an objective truth waiting to be discovered, but rather something that is co-constructed through social interactions and individual experiences (Schwandt, 2000). This

perspective is especially pertinent when examining the mental health experiences of AS, as their understanding of mental health is likely influenced by a myriad of contextual factors, including cultural background, migration experiences, and the prevailing stigma surrounding mental health issues in both Algeria and the UK (Choudhry, 2017). For instance, the interplay of these factors may lead to divergent interpretations of mental health. Students in the UK might express their struggles differently than those who have returned to Algeria due to the varying societal contexts they navigate. Thus, the research will prioritise participant-centric knowledge, where Algerian students articulate their understanding of mental health challenges through interviews (Semi-structured). This approach recognises the validity of their experiences and allows researchers to capture the complexities of how these students navigate mental health literacy, stigma, and help-seeking behaviours (Guba & Lincoln, 1994). As Creswell (2013) argues, this constructivist approach leads to a deeper understanding of the ways in which individuals co-create meaning, which is crucial for exploring the mental health landscape among AS.

3.4.2 Defining Reality: Relativist Ontology

The ontological stance taken in this study aligns with a relativist perspective, which posits that reality is not singular but is instead constituted through diverse experiences and contexts (Lincoln & Guba, 1985). This perspective is particularly important for this research as it acknowledges that the realities faced by Algerian students differ significantly between their experiences in the UK and Algeria. For example, cultural context plays a critical role in shaping students' realities. In Algeria, the stigma associated with mental health issues can lead to reluctance in disclosing difficulties or seeking help in contrast, while students in the UK may have greater access to mental health services, they may encounter cultural barriers, such as xenophobia or racism, that influence their interpretation of mental health challenges.

Additionally, the migration stressors experienced by Algerian students in the UK; such as

homesickness, cultural adaptation, and language barriers; further complicate their understanding of mental health. Research has shown that homesickness can lead to significant emotional distress, impacting students' overall well-being (Mori, 2000). Cultural adaptation presents its own set of challenges, as students must navigate unfamiliar social norms and expectations, which can exacerbate feelings of isolation and anxiety (Berry, 2006). This perspective draws upon Berry's (2006) model of acculturation, which highlights how cultural and contextual factors shape individuals' experiences and responses to mental health challenges. The relativist ontology adopted in this research allows for an exploration of these diverse realities, acknowledging that the experiences of AS in the UK are not universal but rather shaped by a multitude of personal and social factors.

3.4.3 Choosing Methodologies: Qualitative Approaches

The choice of methodology is inherently linked to the epistemological and ontological positions established earlier in this research. A qualitative methodology is deemed most suitable for exploring the subjective realities of Algerian students (AS), as it captures the richness of human experiences and is particularly effective in understanding the mental health challenges faced by this population (Denzin & Lincoln, 2018). This approach offers several compelling advantages in the context of mental health research. One significant benefit of qualitative research is its capacity for depth of understanding. It enables researchers to conduct thorough investigations of participants' lived experiences, thereby capturing the intricacies of mental health challenges. As Creswell (2013) emphasises, qualitative methods yield rich, contextual data that illuminate the subjective meanings individuals ascribe to their mental health experiences. This depth is crucial in addressing the complexities of mental health, which are influenced by a variety of social, cultural, and psychological factors. Furthermore, qualitative methods provide the flexibility and adaptability necessary for responsive research design. This adaptability is particularly valuable in mental health studies, where participants'

experiences can be multifaceted and dynamic (Denzin & Lincoln, 2018). The iterative nature of qualitative research supports an organic exploration of mental health topics, allowing researchers to accommodate the evolving complexities of individual narratives. Another critical aspect of qualitative research is its emphasis on a participant-centered perspective. By prioritising the voices and experiences of individuals, qualitative research fosters understanding of how people perceive their challenges. This focus is essential in mental health contexts, as grasping individual perceptions can inform more effective support and intervention strategies (Smith et al., 2009). By centering participants in the research process, qualitative methodologies contribute to the development of empathetic and tailored mental health practices. Additionally, qualitative research excels in accounting for the cultural context of mental health. Mental health experiences are significantly shaped by cultural beliefs, norms, and stigma, which qualitative research can explore in depth. Through in-depth interviews and other methods like focus groups, researchers gain insights into how these cultural factors influence individuals' coping strategies and help-seeking behaviours (Bhugra & Becker, 2005). Understanding mental health within these cultural frameworks is crucial for developing interventions and supports that are culturally relevant and effective.

Despite the advantages, qualitative research is not without its criticisms. Critics often argue that qualitative research is inherently subjective, as researchers' biases can influence data interpretation (Morrow, 2005). Critiques of qualitative research often centre on subjectivity, generalisability, and replicability. Yet these concerns arise largely from judging interpretive research against positivist standards. Qualitative inquiry does not seek statistical generalisation or procedural replication; instead, it prioritises contextual depth, analytic rigour, and theoretical insight (Patton, 2002; Silverman, 2013). Although qualitative analysis is time-intensive and requires specialised interpretive skill, this analytic investment enables a level of nuance and conceptual contribution that would be inaccessible through more

standardised designs (Braun & Clarke, 2006). The choice of qualitative methodology for investigating the mental health challenges faced by Algerian students is underscored by its capacity to provide rich, contextual insights. However, this approach does not come without criticisms related to subjectivity, generalisability, and the complexity of data collection and analysis. This research consciously addresses these criticisms by implementing strategies designed to mitigate their impact, thus enhancing the validity and reliability of its findings. To begin with, the inherent subjectivity of qualitative research is a significant concern, as researchers' biases can inadvertently shape data interpretation (Morrow, 2005). In this study, measures were taken to ensure reflexivity throughout the research process. Reflexivity involves the researcher actively reflecting on their own biases, experiences, and influences during data collection and analysis (Finlay, 2002). For example, a reflective journal was maintained to document the researcher's thoughts and feelings throughout the study, allowing for ongoing examination of how personal perspectives may affect interpretations. Such practices align with those employed by other qualitative researchers, such as Smith, Flowers, and Larkin (2009), who emphasise the importance of reflexivity in ensuring that interpretations remain grounded in participants' lived experiences rather than being unduly influenced by the researcher's preconceived notions. To combat issues of generalisability, which often stem from small, non-representative samples in qualitative research (Patton, 2002), this study adopted a purposeful sampling strategy, and participants were purposively selected to capture meaningful variation in experiences relevant to the study's focus, rather than to achieve representativeness. Diversity was therefore sought along dimensions likely to shape Algerian students' mental health experiences abroad, including stage of study, disciplinary context, gendered expectations, linguistic repertoires, and migration trajectories. This approach reflects a qualitative logic in which diversity is used to illuminate how shared cultural frameworks intersect with differing academic and social positions, rather than to produce generalisable claims (Patton, 2002). By attending to these analytically relevant forms

of variation, the study was able to explore both convergence and divergence in how Algerian students understood distress, disclosure, and help-seeking in international contexts.

Similar studies, such as those conducted by Al-Khatib et al. (2019), have successfully employed purposeful sampling to reflect a diverse range of experiences among international students, thereby enriching the generalizability of their findings within specific contexts. Addressing the challenge of reproducibility, which can undermine confidence in qualitative findings (Silverman, 2013), the study employed a clear and transparent methodology. This included detailed descriptions of the data collection and analysis processes, allowing for other researchers to replicate the study or build upon its findings. For instance, the use of semi-structured interviews was explicitly outlined, including how questions were formulated and adjusted based on participants' responses. This practice mirrors the approach of Braun and Clarke (2006), who advocate for clear articulation of the analytic process in qualitative research to enhance transparency and trustworthiness. Moreover, the labour-intensive nature of qualitative research was acknowledged, and strategies were implemented to manage time and resources effectively. For example, the researcher utilised technology for data collection and transcription, which streamlined the process and allowed for more efficient handling of qualitative data as in this study used zoom recordings along with hand held audio recorder as a backup. By employing audio recording devices and transcription software like the one provided from Zoom, the study minimised the time required for transcription while ensuring accuracy in capturing participants' narratives. Such technological aids have been similarly adopted in studies by researchers like Larkin, Watts, and Clifton (2006), who highlight the benefits of utilising technology to facilitate qualitative data management. Finally, the complexity of qualitative data analysis, which often requires specialised skills, was addressed through rigorous training in qualitative analysis methods prior to the study. The researcher engaged in workshops on thematic analysis organised by one of the chief investigators in this

study, enhancing their analytical competencies and ensuring a robust approach to data interpretation (Braun & Clarke, 2006). This preparation not only improved the quality of the analysis but also equipped the researcher with the skills necessary to navigate the intricacies of qualitative data effectively. In this study, transcription was not treated as a neutral or purely technical stage, but as an integral part of the analytic process. Following qualitative scholars who conceptualise transcription as interpretive work rather than mechanical reproduction (Braun & Clarke, 2006; Smith et al., 2009), the act of transcribing interviews functioned as an early phase of immersion in the data. Decisions about emphasis, pauses, emotional tone, code-switching, and culturally embedded expressions required interpretive judgement and prompted initial analytic reflections. This was particularly important given the multilingual nature of the data, where meaning was often conveyed through shifts between Arabic, French, and English rather than through literal wording alone. Engaging directly in transcription therefore deepened familiarity with participants' accounts and sensitised the analysis to nuance that might otherwise have been lost. In this sense, transcription formed part of the analytic engagement with meaning, rather than a preparatory step preceding analysis.

3.5 My Positionality and Its Influence on the Research

Positionality in research refers to the acknowledgement that a researcher's personal characteristics, social identities, and perspectives significantly shape their understanding, interpretations, and interactions within the research process (Savin-Baden & Major, 2013). This concept highlights that researchers are not neutral or objective observers but are embedded within specific social, cultural, and historical contexts that influence their research. Recognising and reflecting on one's positionality is crucial for ensuring transparency, reliability, and depth in qualitative research, especially when exploring complex and contextually rich phenomena such as mental health challenges faced by AISs. Positionality encompasses the researcher's chosen perspective and self-awareness regarding their own

identity and experiences (Lazard & McAvoy, 2017). It involves a critical reflection on how personal attributes; such as cultural background, social status, and professional experience; impact the research process. In the context of this study, the researcher's positionality includes their identity as both an insider and outsider to the Algerian student experience. This dual role can significantly shape the research findings, given the researcher's familiarity with Algerian culture while also navigating the academic and social environment of the UK. As the primary researcher, my positionality inevitably shaped the research process, the production of knowledge, and the interpretation of participants' experiences throughout this thesis. This study was grounded within a critical-constructivist epistemological position, which recognises that knowledge is not objectively discovered, but rather co-constructed through interactions between individuals, their surrounding environments, social relationships, language, and lived experiences. Within this perspective, the researcher is not viewed as fully detached from the research process, but neither entirely as a complete insider. Instead, the researcher occupied what may be understood as an "in-betweener" position. Although I shared cultural, linguistic, and national backgrounds with participants, my own experiences did not fully mirror those of all AIS involved in the study. At the beginning of the PhD journey, I had not yet experienced all the challenges, transitions, or personal developments discussed by participants, and throughout the research process it became increasingly evident that each participant's experience remained shaped by individual circumstances, personal histories, gender, social positioning, migration trajectories, and emotional responses. This understanding aligns with constructivist perspectives which argue that reality and meaning are experienced differently across individuals and contexts rather than existing as one universal truth (Charmaz, 2014). Therefore, my role throughout the research was situated between insider and outsider positions, allowing both familiarity and analytical distance during interpretation. In line with Braun and Clarke (2019), the researcher was understood as actively involved in the generation and interpretation of meaning rather than as a neutral observer. Shared cultural references,

linguistic familiarity, religious understandings, and awareness of Algerian social norms often facilitated rapport during interviews and enabled participants to speak openly about experiences that may otherwise have remained difficult to articulate. Participants frequently moved between Algerian Arabic, French, and English during interviews, particularly when discussing emotional distress, family expectations religion, or culturally sensitive topics. Certain emotional expressions, sayings, or culturally embedded phrases carried meanings that may have been difficult to fully explain in English alone. For example, some participants used Algerian expressions or proverbs when describing emotional pressure, shame, or family expectations, assuming an immediate cultural understanding from the researcher. This shared understanding often created a more relaxed and open conversational environment and allowed participants to express themselves more naturally without feeling the need to constantly translate or justify cultural meanings. Existing literature suggests that shared cultural identity within qualitative research may enhance trust, reduce perceived judgement, and encourage deeper engagement with sensitive discussions (Berger, 2015; Holmes, 2020).

This insider positioning offered several advantages, particularly in relation to trust-building, sensitivity to culturally embedded meanings, and interpretation of different forms of emotional expression. In the context of this research, participants discussed issues including stigma, shame, emotional suppression, religious interpretations of distress, fears surrounding disclosure, and tensions between Algerian cultural expectations and Western psychological frameworks. Familiarity with these broader socio-cultural contexts enabled a more situated understanding of participants' narratives and reduced the likelihood of culturally detached interpretations. At the same time, however, occupying an insider position also presented potential challenges. Shared cultural understanding can sometimes lead researchers to unintentionally assume meanings, overlook areas requiring further exploration, or normalise experiences because they appear familiar. Reflexive thematic analysis acknowledges that

researchers inevitably bring assumptions, personal experiences, emotional reactions, and interpretive frameworks into the analytic process (Braun & Clarke, 2021). Consequently, cultural familiarity also carried the risk of over-identification and assumption-making during interpretation. Some participant accounts resonated personally with my own observations of Algerian student life, migration adjustment, and experiences of negotiating cultural expectations between Algeria and the UK. This required ongoing reflexive awareness to ensure that interpretations remained grounded within participants' own narratives rather than shaped primarily through my personal assumptions or emotional proximity to the topic.

Reflexivity was therefore practiced as an ongoing and iterative process throughout data collection, transcription, coding, theme development, and interpretation. For example, during coding, there were instances where participants described emotional silence or avoidance using expressions that initially appeared straightforward due to cultural familiarity. However, rather than assuming shared understanding, reflexive questioning was used to examine whether these expressions reflected fear of stigma, religious coping, emotional exhaustion, family expectations, or broader social pressures. Similarly, during interviews, reflexive awareness involved remaining attentive to moments where shared understanding could potentially lead to incomplete probing. Although cultural familiarity often facilitated conversational flow, conscious efforts were made to encourage elaboration rather than presuming mutual understanding. Participants were frequently invited to explain meanings further, particularly when using culturally specific language, humour, or proverbs, in order to avoid reducing complex experiences into simplified cultural assumptions.

Reflexive notes and analytic memos were maintained throughout the research process to document emotional reactions, emerging assumptions, interpretive uncertainties, and evolving analytical reflections. These practices encouraged ongoing critical engagement with the data and greater transparency regarding how interpretations were developed. In line with

Braun and Clarke's (2006, 2019) conceptualisation of reflexive thematic analysis, themes were not understood as passively emerging from the data, but rather as actively developed through engagement between researcher, participants, and context.

The positionality of the supervisory team was also considered as part of this reflexive process. The supervisors did not share the researcher's Algerian cultural background and had no direct cultural exposure comparable to that of the researcher and the Algerian participants. In this respect, they occupied a relatively external position in relation to the specifically Algerian cultural meanings explored in the thesis. However, they brought academic and professional knowledge of student mental health within international and higher education contexts. This prior knowledge inevitably informed the questions raised during supervision and the ways in which developing interpretations were considered. The difference between the researcher's cultural familiarity and the supervisors' relative cultural distance became particularly useful during analysis. At several points, supervisory discussions challenged interpretations that appeared to extend beyond what was sufficiently demonstrated in the data. The researcher was encouraged to distinguish between interpretations grounded in participants' accounts and conclusions that might have been influenced by her own familiarity with Algerian culture and experience as an international student. The supervisors' relative distance from the Algerian context therefore provided an important reflexive counterpoint to the researcher's insider knowledge, encouraging closer attention to the empirical basis of interpretations rather than assuming that culturally familiar meanings were self-evident.

At the same time, the supervisory team's previous knowledge of international student mental health also represented a positional influence requiring reflexive consideration. Familiarity with the wider international student literature and experience within higher education could create expectations that aspects of Algerian international students' experiences would resemble patterns previously reported among other international student

populations. Consequently, supervisory discussions deliberately considered both similarities and differences between the experiences described by AISs and those identified within the broader international student literature. Particular emphasis was placed on allowing the present data to determine where existing international student knowledge was applicable and where Algerian participants' accounts indicated culturally or contextually specific experiences. The supervisory process therefore did not function as a means of establishing a single objective interpretation, but as a reflexive dialogue between different positions: the researcher's cultural and linguistic proximity to the participants and the supervisors' greater cultural distance combined with their academic knowledge of international student mental health. This helped ensure that interpretations remained closely grounded in participants' accounts while also being critically examined in relation to the wider literature.

Rather than functioning as a mechanism for establishing objectivity or inter-rater reliability, supervisory discussions operated as spaces of reflexive and interpretive dialogue. Throughout the analytical process, codes, extracts, and developing themes were regularly discussed with supervisors to ensure that interpretations remained clear, meaningful, sufficiently supported by participant accounts, and analytically developed rather than superficial or overly generalised through cultural explanations alone. Supervisory discussions encouraged critical reflection on assumptions, consideration of alternative interpretations, and deeper engagement with the conceptual meaning behind participants' experiences. This process was particularly important given the emotionally sensitive and culturally situated nature of the research topic. Supervisory feedback often challenged areas where interpretations risked becoming overly familiar or insufficiently interrogated. Consequently, the development of themes occurred through ongoing reflection, discussion, refinement, and interpretive engagement rather than through attempts to establish one singular objective truth. This approach aligns closely with reflexive thematic analysis, which emphasises reflexive accountability, transparency, and

interpretive depth rather than researcher neutrality (Braun & Clarke, 2021). Finally, the emotionally sensitive nature of the research required ongoing reflexive consideration of emotional proximity and researcher wellbeing. Participants frequently shared experiences involving loneliness, emotional distress, discrimination, academic pressure, identity conflict, and struggles surrounding disclosure and help-seeking. Some narratives were emotionally difficult to engage with due to their resonance with broader experiences observed within Algerian international student communities. Recognising these emotional responses formed part of the reflexive process rather than being viewed as methodological weaknesses. Acknowledging the emotional and relational dimensions of qualitative research strengthened the transparency of the analytic process and remained consistent with the epistemological foundations underpinning this thesis. Overall, positionality and reflexivity were not viewed as peripheral methodological considerations, but rather as central elements shaping the interpretation, representation, and co-construction of knowledge throughout this research journey.

3.4.1. Insider and Outsider Perspectives "Inbetweener"

As mentioned earlier, the dual roles of insider and outsider provide a complex lens through which to view the research on AISs mental health challenges. Each perspective offers distinct advantages and limitations, shaping both the research process and its outcomes. From an insider's viewpoint, the researcher benefits from an intimate understanding of Algerian culture and the lived experiences of international students. This familiarity allows for a deep interpretation of cultural norms, values, and social dynamics that significantly influence students' mental health (Corlett & Mavin, 2018), as the researcher can relate to their experiences on a personal level, potentially leading to more authentic and meaningful data collection (Lazard & McAvoy, 2017). However, this proximity can also introduce biases that must be critically examined. The risk of over-identification with participants is significant, as

the researcher might project their own experiences and assumptions onto the data, potentially skewing the findings. Such biases can lead to an overemphasis on shared experiences and overlook variations within the participant group, thereby limiting the study's ability to capture the full spectrum of experiences (Bhattacherjee, 2012).

To address these limitations, and as mentioned before, the researcher actively engaged in reflexive practices throughout the research process. Reflexivity involved critically examining their own positionality and its impact on the research. This included maintaining a research diary to document personal reflections, assumptions, and emotional responses during data collection and analysis (Savin-Baden & Major, 2013). The researcher also sought feedback from supervisors to challenge any interpretations and ensure a more balanced perspective. Additionally, methodological triangulation was employed, incorporating multiple data sources and methods—such as interviews with both students and professionals—to provide a more comprehensive view and mitigate the risk of over-relying on personal experiences (Bryman, 2016). Furthermore, during the interviews, the researcher engaged in continuous dialogue with participants, encouraging them to articulate their experiences in their own words and validate the interpretations made. This approach not only helped to counteract potential biases but also enriched the data by incorporating diverse viewpoints and reducing the risk of imposing the researcher's own perspectives on the findings. By being aware of and addressing these potential biases, the researcher aimed to enhance the credibility and validity of the study, ensuring that the findings reflect the realities of the participants while remaining grounded in rigorous, critical analysis (Corlett & Mavin, 2018; Lazard & McAvoy, 2017).

Conversely, the outsider perspective, characterised by the researcher's relative detachment from the UK academic and social contexts and the experiences of returning home, offers a critical advantage. This perspective allows the researcher to approach the study with a fresh viewpoint, unencumbered by the internal biases that might affect an insider (Lazard &

McAvoy, 2017). By maintaining a degree of distance, the researcher is better positioned to challenge entrenched assumptions and offer a broader, more critical analysis of the participants' experiences, particularly in relation to the academic and social pressures of studying abroad (Myers, 2008). This fresh viewpoint can lead to insights that might be overlooked by someone who is deeply embedded within the same cultural and academic environments. However, this detachment also introduces challenges. The researcher's lack of firsthand experience with the host country's educational and social environments may limit their understanding of the complexities faced by students, potentially leading to misinterpretations or an incomplete grasp of the contextual factors influencing mental health (Savin-Baden & Major, 2013). For instance, in Study One, where participants were drawn from various academic universities and levels of study, the researcher's outsider status meant that they had to rely on participants' detailed accounts to bridge gaps in understanding the varied academic experiences and pressures (Bryman, 2016). In Study Two, involving professionals, the researcher was entirely an outsider, which provided a valuable perspective in examining institutional and support structures without the influence of personal bias (Myers, 2008). Here, the researcher was mindful of their detachment from the specific professional experiences and ensured that their interpretations were grounded in the professionals' own descriptions and evaluations. In Study Three, which explored experiences related to completing studies and returning home, the researcher remained an outsider due to the lack of personal experience in these contexts. To address this limitation, the researcher engaged in rigorous data validation practices, including member checks to ensure that the interpretations aligned with participants' lived realities (Savin-Baden & Major, 2013). Additionally, the researcher conducted comprehensive literature reviews and engaged with existing research to better understand the contextual factors affecting students' transitions and experiences post-study. By implementing these strategies, the researcher aimed to mitigate the limitations of the outsider perspective while leveraging it to offer a critical and objective

analysis of the data. This approach ensured that the research findings remained robust and reflective of the participants' experiences, despite the researcher's limited direct engagement with the contexts under study (Lazard & McAvoy, 2017; Myers, 2008).

3.6 Overview of the Research Project

This research project examines the mental health experiences of AIS studying in the UK, with a particular focus on their mental health literacy, disclosure difficulties, coping strategies, and help-seeking behaviours. Given the scarcity of research specifically addressing the mental health needs of Algerian students in international settings, this project aims to fill an important gap. The research is divided into three interrelated studies: the first focuses on Algerian students currently studying in the UK; the second explores the perspectives of professionals working with international students, both those with and without experience with Algerian and Arab students; and the third examines the mental health experiences of Algerian students who have returned home after completing their studies.

The project's overarching goal is to understand the mental health challenges faced by these students in two culturally distinct contexts; during their time abroad in the UK and after their return to Algeria. Mental health literacy, disclosure difficulties, coping mechanisms, and the availability of mental health services form the core of these inquiries. This research seeks to not only document the mental health experiences of this population but also to analyse how cultural, academic, and social factors shape these experiences. Given the limited attention Algerian students receive in broader mental health discussions, this study adds a crucial voice to the literature on international students' mental health, particularly those from underrepresented regions.

3.6.1 Purpose and Objectives of the Methodology

The purpose of this methodology chapter is to explain the research design, data collection,

and analytical strategies used across the three studies. The research methodology adopted in this project is qualitative, with the use of semi-structured interviews and thematic analysis for two studies, and interpretative phenomenological analysis (IPA) combined with thematic analysis for the third study. This qualitative approach is rooted in the assumption that mental health is a subjective experience that must be understood through the lived experiences of individuals rather than through objective, quantifiable measures (Braun & Clarke, 2019).

The first study explores Algerian students' mental health literacy while studying in the UK, identifying key barriers to disclosing mental health issues and seeking professional help. The second study gathers insights from professionals working with international students, specifically comparing the experiences of those who have worked with Algerian and Arab students to those who have not. The third study focuses on Algerian students who have returned home after completing their studies, investigating how their mental health literacy and coping strategies have evolved post-return.

Each study addresses the research's core objectives from different vantage points. Study 1 provides the direct experiences of students, while Study 2 offers a professional lens, allowing for a broader understanding of the mental health challenges specific to Algerian students. Study 3 captures the impact of reintegration into the home environment, examining how cultural reintegration shapes ongoing mental health and access to support. Together, these studies provide a holistic understanding of the mental health needs of this group and contribute to broader discussions around international students' mental health.

3.6.2 Rationale for Choosing Qualitative Methods

The choice of a qualitative methodology was guided by the nature of the research questions, which focus on how Algerian students understand, experience, and interpret mental health across different cultural and academic contexts. These questions require attention to

subjectivity, meaning, and context. Qualitative research is particularly suited to examining complex social phenomena in which individuals' perceptions and interpretations are central (Creswell & Poth, 2018). Semi-structured interviews were employed to explore mental health as a sensitive and culturally mediated topic. Given that mental health remains deeply personal and often stigmatised in cross-cultural contexts (Elliott et al., 2021), the flexibility of this interview format allowed participants to shape discussions in ways that felt safe and meaningful. This conversational approach supported trust and engagement (Silverman, 2020), which was especially important for Algerian students who may face cultural and social barriers to openly discussing psychological distress.

Different analytic approaches were used to reflect the aims of each study. In Study 1 and Study 2, thematic analysis was applied to identify shared patterns in students' and professionals' accounts of mental health literacy, disclosure, and help-seeking. This approach enabled comparison across participants and groups while remaining grounded in their language (Braun & Clarke, 2019), particularly in Study 2, where professionals' perspectives were examined in relation to their work with Algerian and Arab students. In contrast, Study 3 adopted interpretative phenomenological analysis (IPA) to examine how individual returnees made sense of their mental health experiences after returning to Algeria. IPA supported an idiographic focus on personal meaning-making, capturing ambivalence, contradiction, and change over time in ways that cross-case thematic analysis could not (Smith, Flowers, & Larkin, 2009). This analytic shift was therefore necessary to illuminate the lived significance of return and reintegration.

Overall, the qualitative design allowed the research to remain responsive to the complexity and cultural embeddedness of AISs' mental health experiences. By combining semi-structured interviews with analytic approaches tailored to the aims of Studies 1, 2, and 3, the research foregrounds participants' voices while offering both patterned and in-depth

interpretive insights across different stages of the student journey.

3.6. Research Design

3.6.1 Explanation of the Overall Design and Approach

This research adopts a qualitative design, structured around three interconnected studies aimed at understanding the mental health experiences of AIS. Each study is designed to explore different facets of mental health literacy, disclosure difficulties, coping strategies, and help-seeking behaviours, either from the students' perspective or through the lens of professionals working with them. The overall design is anchored in the belief that mental health is best understood as a complex, subjective phenomenon, shaped by cultural, social, and individual factors. As such, a qualitative design allows for in-depth exploration of these elements, providing a richer understanding than would be possible with quantitative approaches alone (Creswell & Poth, 2018). The use of semi-structured interviews across all three studies provides a flexible yet focused method of data collection, enabling the researcher to guide the conversation while allowing participants to express their experiences in their own words. This approach is particularly useful when investigating sensitive topics like mental health, where participants may need the freedom to explore their feelings and thoughts without being constrained by rigid question formats (Smith, 2015). The qualitative approach is also highly suited to cross-cultural research, as it enables the researcher to delve into the ways in which cultural context shapes individual experiences and behaviours (Marshall & Rossman, 2016). Given the focus on Algerian students, who may face unique cultural challenges when discussing mental health, the flexibility of qualitative methods is essential for capturing the full breadth of their experiences.

3.6.2 Justification for Using Qualitative Methodology

The choice of a qualitative methodology was driven by the nature of the research questions, which sought to explore how Algerian students and professionals understand, experience, and

navigate mental health. Rather than measuring prevalence or testing predefined variables, this research aimed to examine meaning-making, interpretation, and lived experience within specific cultural and social contexts (Denzin & Lincoln, 2018). Qualitative methods are particularly appropriate for mental health research, where experiences are shaped by emotion, identity, and culturally embedded norms that cannot be adequately captured through quantitative approaches (Braun & Clarke, 2019). In the context of AIS, understandings of mental health are closely intertwined with cultural beliefs, family expectations, and stigma surrounding disclosure. A qualitative approach therefore allowed these interconnections to be explored in depth, rather than reduced to isolated or measurable factors. Furthermore, the flexibility of qualitative inquiry was essential for capturing the complexity of cross-cultural experiences. Algerian students often navigate multiple cultural frameworks simultaneously, particularly when discussing mental health in a UK academic context. Qualitative methods enabled participants to articulate these layered experiences in their own terms, allowing attention to be paid to nuance, contradiction, and change over time; features that are central to understanding mental health across cultures but are often obscured in quantitative designs.

3.7 Cross-Study Methodological Reflections

Conducting three qualitative studies within a single doctoral project not only generated a layered account of AIS' mental health but also prompted sustained reflection on methodology. These reflections are not a repetition of earlier discussions on methods or positionality but instead offer an integrative consideration of how data collection, context, and researcher identity intersected across the studies. In line with Levitt et al.'s (2018) emphasis on transparency in qualitative reporting, this section acknowledges the methodological tensions, adaptations, and lessons that underpin the credibility and rigour of this thesis.

3.7.1 Negotiating the "Inbetweener" Position Across Studies

As outlined in section 3.4, the researcher's positionality was best characterised as that of an "inbetweener": at once insider and outsider to the communities under study. This duality manifested differently across the three studies and shaped both opportunities and challenges.

In **Study 1**, interviewing Algerian students in the UK, the shared cultural background and linguistic repertoire between the researcher and the participants facilitated trust and rapport. Students often relaxed once they realised I "Researcher" understood Arabic or French idioms and cultural references, which created openings for candid disclosure. For instance, one participant described anxiety using the expression *qalbi ma'mrur* (my heart is constricted), a phrase that resonates strongly in Algerian contexts but might be overlooked by a researcher unfamiliar with local idioms of distress. My insider status thus enhanced sensitivity to nuance, exemplifying Yardley's (2000) criterion of sensitivity to context. Yet the same proximity risked assumptions of shared understanding. Some participants would cut themselves short with comments such as "you know what I mean," leaving meanings unspoken. Here, being an inbetweener required careful probing: to ask for clarification without undermining trust, while avoiding the temptation to fill gaps with my own experiences. This reflects Smith, Flowers, and Larkin's (2021) emphasis on validity as recognising the researcher's influence on what is voiced.

In **Study 2**, the dynamic shifted. Interviewing professionals positioned me less as a compatriot and more as a cultural informant. Several participants explicitly invited my confirmation of their interpretations of Algerian or Arab students, seeking reassurance that they had understood cultural cues correctly. This inversion demonstrated the fluidity of insider/outsider roles and highlighted the risks of being co-opted into validating professionals' assumptions. Managing this demanded a reflexive stance: neither colluding with simplistic cultural explanations nor rejecting participants' perspectives outright. This delicate negotiation illustrates Levitt et al.'s (2018) call for transparency about how researcher identity shapes knowledge production.

Study 3 presented yet another variation. With returnees, I was simultaneously a compatriot and a representative of UK academia. Some participants saw me as a safe interlocutor who understood their struggles of re-integration, while others, wary of surveillance or institutional ties, were guarded. For example, one participant hesitated to discuss their difficulties accessing counselling in Algeria, fearing that criticism might be politically sensitive. Here, my inbetweener position fostered both trust and suspicion, reinforcing the necessity of reflexivity as an ongoing practice.

Across the three studies, then, inbetweener positionality was not a fixed stance but a shifting relational negotiation, shaped by the social identities of participants and the context of each interview. This underscores Yardley's (2000) point that quality in qualitative research rests on sensitivity to context and transparency, and resonates with Nizza et al.'s (2021) argument that excellence in IPA demands attentiveness to how researcher and participant co-construct meaning.

3.7.2 Balancing Depth and Breadth in a Multi-Study Design

Another methodological challenge lay in balancing idiographic depth with cross-contextual

breadth. Each study, by design, addressed a different layer of Algerian students' mental health experiences—students in the UK, professionals in support roles, and returnees in Algeria. This structure offered breadth, but the task was to sustain depth without losing sight of the distinctive epistemological commitments of qualitative inquiry.

Study 1, Although Study 1 employed Reflexive Thematic Analysis rather than Interpretative Phenomenological Analysis (IPA), attention was given to preserving participants' individual experiences and contextual meanings before moving towards broader thematic interpretation. For example, one participant's account of balancing prayer with counselling illustrated not only personal coping strategies but also the negotiation of multiple cultural and explanatory frameworks surrounding mental health. This approach is consistent with reflexive thematic analysis, which encourages engagement with individual accounts while also facilitating the development of broader patterns of shared meaning across the dataset (Braun & Clarke, 2022).

Study 2, in contrast, was more constrained by institutional scripts. Professionals often framed their accounts in polished, policy-driven language, limiting the opportunity for idiographic depth. Here, the methodological challenge was to avoid imposing interpretations unsupported by the data, in keeping with Levitt et al.'s (2018) emphasis on transparent reporting of limitations. What emerged instead was breadth: a comparative account of how cultural competence was differently understood by professionals with and without direct experience of Algerian and Arab students.

Study 3 sought to reconcile this tension through methodological pluralism, combining IPA with thematic analysis. This dual strategy enabled close attention to the lived experience of individual returnees while also identifying collective patterns such as stigma and disappointment in reintegration. Elliott et al. (1999) stress that qualitative rigour does not require methodological purity but rather clear justification of design. By integrating two

approaches, the study preserved idiographic sensitivity while also situating narratives within broader cultural dynamics. Taken together, the three studies illustrate how balancing depth and breadth is not a one-off choice but an ongoing negotiation. This reflects Yardley's (2000) criterion of coherence: methodological decisions must remain consistent with the overall research aims while adapting flexibly to context.

3.7.3 Ethics as Lived Practice

Ethics in this project extended beyond procedural approval to become a lived, context-sensitive practice. Each study raised distinct ethical dilemmas, demonstrating Yardley's (2000) argument that ethical quality in health research is relational, not merely procedural.

In **Study 1**, several students described the interview as their first occasion to speak openly about mental health. This underscored the trust invested in the researcher but also the vulnerability of participants. Managing this required careful balance: creating a safe space for disclosure without assuming the role of counsellor. Levitt et al. (2018) recommend that reporting standards explicitly acknowledge such moments, as they reveal the complex interplay of research and care.

Study 2 raised different issues. Professionals occasionally referred to specific cases to illustrate their points, inadvertently risking breaches of confidentiality. Ethical practice here meant actively steering the discussion towards general practices rather than individuals, while anonymising institutions as well as participants. This example demonstrates how ethics can be refracted through professional identities and institutional obligations, a point often overlooked in discussions of qualitative ethics (Elliott et al., 1999).

Study 3 presented the sharpest ethical challenges. Returnees expressed fear that discussing mental health could be construed as criticism of Algerian institutions, especially when linked to state-funded scholarships. Confidentiality therefore required more than pseudonyms:

geographical and institutional identifiers were removed, and voluntary participation was emphasised repeatedly. In one case, a participant deliberately used ambiguous language, a strategy of self-protection that needed to be respected rather than over-interpreted. Nizza et al. (2021) highlight transparency in adapting methods to safeguard participants as a hallmark of quality.

Across studies, therefore, ethics was lived and negotiated, shaped by context and the shifting relational position of the researcher. This reinforces Smith et al.'s (2021) view that reflexivity is central to ensuring validity: acknowledging not only what participants say but also the conditions under which they feel safe to say it.

3.7.4 Iterative Learning Across Studies

One benefit of conducting three studies within the same project was the possibility of methodological learning across them. Insights from earlier studies informed adaptations in later ones, exemplifying Nizza et al.'s (2021) emphasis on transparency in methodological evolution.

In **Study 1**, some students hesitated when asked directly about "mental health." This highlighted the need for careful phrasing and cultural sensitivity. Consequently, in **Study 3**, the interview guide was shared in advance, giving participants time to reflect and prepare for potentially sensitive questions. This adaptation not only facilitated richer narratives but also enhanced participants' sense of agency.

Study 2 also influenced subsequent practice. Exposure to how professionals framed stigma sharpened my interpretative lens when analysing returnees' narratives in **Study 3**. Where professionals tended to pathologise silence as "resistance," I became more attuned to how returnees used coded or hesitant language to manage risk. This demonstrates Levitt et al.'s (2018) argument that transparency includes acknowledging how researchers' prior encounters

shape subsequent interpretations.

The iterative nature of the design also enhanced reflexivity. Each study provided opportunities to revisit assumptions and refine practices. For instance, after observing in **Study 1** how insider status could lead to unspoken assumptions, I became more deliberate in **Study 2** about probing professionals' cultural generalisations. This responsiveness illustrates Yardley's (2000) principle of commitment and rigour: the willingness to adapt in light of emerging insights rather than adhering rigidly to pre-set procedures.

3.7.5 Concluding Reflections

Taken together, these reflections underscore the methodological value of a multi-study design. My "inbetweener" positionality was both a resource and a challenge, manifesting differently across populations and contexts. Depth and breadth were continually negotiated, with methodological pluralism employed to sustain both idiographic richness and cross-case insights. Ethics emerged not as a static framework but as a lived, relational practice, negotiated in real time. And iterative learning across studies enhanced reflexivity and responsiveness.

Following the standards of Levitt et al. (2018), Nizza et al. (2021), Smith et al. (2021), Yardley (2000), and Elliott et al. (1999), this thesis demonstrates that the credibility of qualitative research lies not in avoiding tensions but in making them visible and showing how they were navigated. The methodological contribution of this project therefore extends beyond its substantive findings: it models how reflexive, transparent, and context-sensitive qualitative inquiry can illuminate complex intersections of culture, stigma, and mental health in under-researched populations.

3.8 Data Collection and Ethical Considerations

The three studies shared a reliance on qualitative interviewing, but each required distinct adaptations in response to participant group, cultural sensitivities, and contextual constraints. This section sets out the rationale for the methodological choices made, the specific practices of data collection in each study, and the ethical considerations that guided them. The discussion builds on the critical-constructivist epistemological foundation of the thesis, where knowledge is understood as co-constructed rather than discovered, and the researcher's reflexive engagement is integral to the validity of findings (Smith, Flowers, & Larkin, 2021).

3.8.1 Rationale for Semi-Structured Interviews Across Studies

Semi-structured interviews were employed across all three studies. This was not a matter of convenience but of epistemological and ethical coherence. From a critical-constructivist perspective, meaning is not an objective property waiting to be measured, but something actively negotiated between researcher and participant. Interviews that are too rigid, such as structured formats; risk silencing culturally embedded meanings, while methods that are too unbounded; such as unstructured conversations; risk fragmentary accounts that cannot address the research aims (Elliott, Fischer, & Rennie, 1999). Semi-structured interviews provided the necessary balance between openness and focus. This approach also aligns with the hermeneutic commitments of interpretative phenomenological analysis (IPA), central to Studies 1 and 3, where participants are invited to interpret their experiences in their own terms while the researcher engages in a "double hermeneutic" of interpreting those interpretations (Smith et al., 2021). Semi-structured formats ensure that key domains; mental health literacy, disclosure, coping, and help-seeking; are consistently covered across cases, enabling cross-comparison. At the same time, they provide flexibility for participants to reframe or expand questions in ways that reveal culturally specific meanings. For example, during an interview in Study 1, one AIS initially described her struggles only in academic terms, referring to

"stress" from assignments. When gently probed, she disclosed that her real concern was the fear of disappointing her family in Algeria, a fear she framed through the notion of "aib" (shame). Such layered accounts would likely have been suppressed in a survey or structured interview, where the question frame dictates the available categories of response. Focus groups were also considered and rejected because discussing mental health in collective settings, especially within collectivist Algerian contexts, risked intensifying stigma and social desirability pressures. The choice of semi-structured interviews therefore represents not just methodological preference but commitment to quality criteria in qualitative research. Yardley (2000) highlights sensitivity to context, transparency, and impact as hallmarks of robust qualitative health research. Levitt et al. (2018) similarly stress that contemporary reporting standards require transparency in justifying methodological fit. Nizza et al. (2021) argue that excellence in IPA demands idiographic depth and attentiveness to co-construction. By enabling both depth and cultural sensitivity, semi-structured interviews directly addressed these criteria and ensured that data collection was consistent with the epistemological and ethical commitments of the study.

3.8.2 Study 1: AIS in the UK

3.8.2.1 Data Collection

Study 1 explored the mental health perceptions and practices of AIS in the UK. Twenty participants, balanced across gender and academic level, were interviewed individually, either in person or online depending on pandemic restrictions. Interviews lasted 60–90 minutes and were primarily conducted in English, but participants were encouraged to switch into French or Arabic when this felt more natural. This multilingual openness was crucial for capturing culturally embedded expressions. For instance, idioms such as qalbi ma'mrur (my heart is constricted) were not only translated but explored interpretatively, recognising their cultural resonance as idioms of distress (Smith et al., 2021). The interview guide covered four

domains: mental health literacy, barriers to disclosure, coping strategies, and help-seeking behaviours. However, the semi-structured format meant that unanticipated themes such as discrimination in UK universities or political frustrations with Algerian institutions also emerged organically. This flexibility reflects Yardley's (2000) principle of sensitivity to context: rather than imposing a pre-determined script, the interviews adapted to participants' concerns.

3.8.2.2 Ethical Considerations

The ethical stakes in Study 1 were high because mental health remains heavily stigmatised in Algeria, often associated with weakness, dishonour, or supernatural causation. Several participants noted that they had never previously spoken openly about these issues. Ethical practice therefore had to extend beyond formal approval to lived attentiveness in the interview space. Confidentiality was ensured through pseudonyms, anonymisation of transcripts, and the careful removal of potentially identifying details. Importantly, confidentiality was also performed in interaction: participants were reminded throughout that their contributions would remain private, fostering a sense of safety. This is consistent with Elliott et al.'s (1999) evolving guidelines, which stress the researcher's responsibility to create conditions for candid disclosure.

My positionality as an Algerian researcher was both an asset and a risk. Shared cultural and linguistic references facilitated rapport, but also risked unexamined assumptions of shared understanding. Reflexive probing was therefore necessary. When a participant referred to "hasad" (the evil eye), for example, I resisted the temptation to assume its meaning and instead asked her to elaborate, thereby ensuring that the account reflected her interpretation rather than mine. This aligns with Smith et al.'s (2021) insistence that validity in IPA requires reflexive acknowledgement of the researcher's interpretative role.

3.8.3 Study 2: Professional Perspectives

3.8.3.1 Data Collection

Study 2 investigated the perspectives of university well-being professionals regarding AIS. Twelve to sixteen professionals participated in interviews lasting 45–60 minutes. Participants were purposively divided into two groups: those with direct experience of AIS and those without, enabling comparative thematic analysis. The interview guide prompted reflections on presenting problems, barriers to help-seeking, and culturally responsive practices. Following Levitt et al.'s (2018) emphasis on transparency, professionals were encouraged to provide concrete examples rather than abstract generalities. This often exposed tacit assumptions: some professionals described students' reluctance to attend counselling as "resistance," while others with cultural experience reframed it as a rational response to stigma and family obligations. The semi-structured format allowed such divergences to surface naturally, demonstrating the method's value for comparative analysis.

3.8.3.2 Ethical Considerations

Unlike AIS, professionals were not vulnerable in the same personal sense, but ethical issues arose around confidentiality and reputational risk. Professionals sometimes drew on specific cases to illustrate their points, inadvertently risking breaches of student confidentiality. To mitigate this, interviews were steered towards general practices rather than individual cases, and transcripts were anonymised at both personal and institutional levels. Another ethical concern was social desirability bias. Professionals often wished to present themselves as culturally competent, particularly in the context of universities' increasing emphasis on diversity and inclusion. Here, the researcher's role was to gently challenge assumptions without undermining rapport, creating a space for reflexive dialogue. This approach embodies Yardley's (2000) criterion of transparency and coherence: ethical practice was not simply about

protection from harm but about creating conditions where more authentic accounts could be voiced.

3.8.4 Study 3: Post-Return AIS in Algeria

3.8.4.1 Data Collection

Study 3 examined the post-return mental health experiences of AIS after studying in the UK. Interviews lasted 60–90 minutes and were conducted face-to-face in Algeria or online where participants were geographically dispersed. The semi-structured format was particularly valuable here because participants' accounts often involved contradictions. Many described how exposure to UK frameworks increased their mental health literacy, yet these new understandings clashed with Algerian discourses of honour, family duty, and religious framing. Sharing the interview guide in advance gave participants time to reflect on sensitive questions, enhancing both comfort and depth. This adaptation is consistent with Levitt et al.'s (2018) emphasis on transparency and participant empowerment.

3.8.4.2 Ethical Considerations

This study presented the most acute ethical challenges. Several participants feared that criticising Algerian institutions might endanger scholarships or attract political attention. Confidentiality therefore required more than pseudonyms: geographical and institutional identifiers were stripped from transcripts, and participation was repeatedly framed as voluntary. In one case, a participant used deliberately ambiguous language as a self-protective strategy. Ethical practice meant respecting such silences rather than forcing disclosure. Another challenge was ensuring that participation did not leave students unsupported. Some participants expressed doubts about the adequacy of Algerian counselling services. To mitigate this, signposting included not only local services but also international online resources. This aligns with Elliott et al.'s (1999) evolving guidelines, which stress the researcher's responsibility to anticipate and address risks beyond the research encounter.

3.8.5 Shared Ethical Commitments

Despite differences in context, the three studies were united by shared ethical commitments. First, reflexivity was central. Reflexive journalling and peer debriefing were used throughout to monitor assumptions and ensure that interpretations remained grounded in participants' accounts (Smith et al., 2021). Second, idiographic depth was prioritised: individual cases were analysed in detail before cross-case comparisons were made, consistent with Nizza et al.'s (2021) markers of quality in IPA. Third, transparency was treated as both a reporting and a relational practice: participants were given clear information, consent was ongoing, and methods were adapted where necessary to safeguard participants' comfort and agency (Levitt et al., 2018). Yardley's (2000) four principles; sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance, ran through all stages of data collection and ethics. The study sought not only to meet procedural requirements but to enact ethics as lived practice, embedded in the co-construction of knowledge.

3.9 Pilot studies

The pilot work undertaken in this research primarily aimed to assess the clarity, cultural appropriateness, sensitivity, and feasibility of the interview process, vignette structure, and discussion topics surrounding mental health literacy, disclosure, coping, help-seeking, and reintegration experiences. Given the sensitive nature of the topic and the multilingual background of participants, piloting also provided an opportunity to evaluate how participants engaged with emotionally sensitive questions in English and whether additional clarification or conversational flexibility would be required during interviews.

For Study 1, pilot interviews were conducted with two non-Algerian international doctoral students studying at the University of Strathclyde, one from an Arab background and one from an Asian background. These participants were selected intentionally to avoid losing potential Algerian participants from the main sample while still allowing the researcher to evaluate how

international students responded to the interview schedule and vignette-based discussions. The pilot interviews explored the clarity of the questions, participant engagement with the vignette, conversational flow, emotional sensitivity of the topics, and the extent to which participants could understand and respond to the interview prompts comfortably in English. Feedback from the pilot process highlighted several important considerations, including the need to simplify or rephrase certain questions, allow participants additional time to engage with the vignette, and create a more conversational rather than rigid interview atmosphere. The pilot also reinforced the importance of providing the interview schedule in advance because English was not participants' first language. Furthermore, the pilot process highlighted how some participants interpreted emotional experiences differently according to cultural background, reinforcing the need for flexibility, reflexivity, and careful probing during the main interviews.

The pilot process for Study 1 additionally helped the researcher develop interviewing confidence, reflexive awareness, and communication skills prior to the main data collection stage. As noted in the pilot reflections, the process highlighted the challenges of discussing emotionally sensitive topics in a foreign language and the importance of balancing structured questioning with conversational flexibility. Consequently, minor modifications were made to the interview schedule, including improved transitions between questions, clarification of wording, and greater flexibility in probing participants' experiences. However, the overall structure and conceptual focus of the interview remained unchanged.

For Study 2, piloting took a more consultative and supervisory form. The interview schedule and vignette were reviewed and discussed extensively with one of the supervisory team members, Dr. Nicola Cogan whose previous research involved international students and culturally sensitive mental health discussions. This process focused on evaluating the appropriateness of the interview questions for mental health professionals, refining the wording of prompts, assessing the clarity and realism of the vignette, and ensuring that the

interview structure encouraged reflective and practice-based discussion rather than overly theoretical responses. The supervisory pilot process also helped ensure that the interview schedule remained aligned with the broader aims of the thesis and sensitive to cross-cultural discussions surrounding mental health, disclosure, and support provision.

No formal pilot study was conducted for Study 3. This decision was made primarily because of the limited accessibility of Algerian returnee participants and concerns regarding losing potential contributors from an already difficult-to-reach population. Recruitment of Algerian graduates who had completed their studies abroad and returned to Algeria proved particularly challenging, and conducting a separate pilot risked reducing the number of participants available for the main study. Furthermore, by the time Study 3 commenced, the researcher had already developed substantial interviewing experience through the previous studies, including experience discussing sensitive mental health topics, managing multilingual communication, using vignette-based discussion, and conducting reflexive qualitative interviews. Consequently, it was considered methodologically appropriate to proceed directly to the main data collection phase while retaining flexibility and reflexive adaptation during interviews where necessary.

Across all three studies, the pilot work contributed to the refinement of interviewing style, improvement of question clarity, development of reflexive interviewing skills, and enhancement of cultural sensitivity within the research process. The pilot stages also reinforced the importance of flexibility, rapport-building, and allowing participants sufficient space to explain emotional experiences in their own terms rather than forcing responses into rigid psychological language. Overall, the pilot process strengthened the feasibility, sensitivity, and coherence of the empirical stages of the thesis while remaining consistent with the study's critical-constructivist and reflexive qualitative orientation.

3.10 Chapter Summary and Transition

This chapter has outlined the methodological foundations of the research, demonstrating how philosophical commitments, methodological choices, and ethical considerations were aligned with the overarching aim of exploring the mental health experiences of AIS. Grounded in a constructivist epistemology and relativist ontology, the research treated mental health as a lived and contextually situated phenomenon, shaped through cultural meanings, social relations, and personal histories rather than as a fixed or universal category.

Across the three studies, methodological coherence was maintained through the consistent use of qualitative, interview-based approaches, while allowing for adaptation to the distinct contexts and participant groups involved. Semi-structured interviews were selected as a deliberate and theoretically informed method, enabling idiographic depth, cultural sensitivity, and openness to participants' own idioms of distress, while ensuring sufficient consistency to address the research questions. These choices reflected a commitment to privileging participants' voices and recognising knowledge as co-constructed within the research encounter.

Ethical practice was embedded throughout the research as an ongoing and relational process rather than a procedural requirement. Sensitivity to stigma, power relations, and participants' vulnerabilities informed decisions at every stage, from recruitment and interview design to data handling and analysis. In line with established frameworks for qualitative quality (Elliott et al., 1999; Yardley, 2000; Levitt et al., 2018; Nizza et al., 2021; Smith et al., 2021), transparency, reflexivity, and contextual awareness guided both methodological execution and interpretative practice.

Overall, this chapter has demonstrated that methodological rigour in qualitative research lies not in the mechanical application of techniques, but in reflexive, ethically grounded, and contextually responsive practice. By aligning philosophical stance, methodological design,

and ethical commitments, the research established a robust foundation for producing credible and meaningful insights into AIS' mental health experiences.

The next chapter presents the empirical findings of **Study 1**, focusing on the narratives of AIS currently studying in the UK. It examines how participants understood mental health, navigated barriers to disclosure and help-seeking, and developed coping strategies within the context of acculturation, drawing directly on the methodological principles outlined in this chapter.

Chapter 4

Study 1: Exploring the Mental Health Experiences of Algerian International Students in UK Universities: Cultural Influences, Disclosure, and Help-Seeking Behaviours

4.1 Introduction

Research on international students' mental health has expanded considerably in recent years, drawing attention to the difficulties of adapting to life and study in a host country (Cao et al., 2021; Forbes-Mewett & Sawyer, 2019; Humphrey & Forbes-Mewett, 2021; Minutillo et al., 2020; Razgulin et al., 2023). As discussed in Chapter 2, these difficulties include culture shock, language barriers, different social practices, and isolation, all of which can affect students' psychological well-being (Patrick, 2020; Syawaludin et al., 2020; Wang et al., 2022; Wu et al., 2015). Compared to their domestic peers, international students often report poorer quality of life, lower levels of psychological well-being, and fewer sources of social support (Cogan et al., 2023; Forbes-Mewett & Sawyer, 2016; Wang et al., 2022).

While this research base is valuable, it has focused largely on Asian and other well-represented international student groups. Very little work has examined North African populations. Algerian international students (AIS), in particular, remain almost absent from the literature despite their presence in UK higher education. Their absence is problematic: AIS cannot simply be grouped with other Arab or Muslim-majority students because Algeria's colonial history, multilingual environment (Arabic, Berber, French), and distinct social and religious traditions shape how students think about, disclose, and respond to mental health difficulties. This study therefore addresses an important gap by focusing specifically on AIS. Cultural differences between Algeria and the UK can be profound. When students move between these contexts, the contrast in norms, values, and styles of communication can generate feelings of disorientation and alienation (Choi & Kim, 2021). Homesickness and loneliness can quickly compound these feelings, leading to anxiety and depression (Can et al.,

2021; Cao et al., 2021; Forbes-Mewett & Sawyer, 2019; Humphrey & Forbes-Mewett, 2021; Minutillo et al., 2020; Razgulin et al., 2023). AIS may struggle to adjust to expectations within UK universities, which in turn may create identity conflict and psychological strain (Nasir & Alghazo, 2023). Berry's (2006) theory of acculturation is useful for understanding these challenges. It explains how individuals change and adapt when they come into sustained contact with a different culture, often leading to tensions in identity and behaviour. For AIS, acculturation involves negotiating between their Algerian cultural background and the new norms of UK society and universities.

Acculturation theory, however, only partially explains these experiences. Jorm's (1997) concept of mental health literacy (MHL) is also vital, as it highlights how knowledge, beliefs, and cultural assumptions shape how people recognise and manage mental health problems. For AIS, the issue is not only adjusting to a new culture but also making sense of mental health in ways that may differ from Western understandings. Together, Berry's and Jorm's frameworks provide the theoretical base for this study: Berry highlights the challenges of cultural adjustment, while Jorm sheds light on how students' mental health knowledge and beliefs influence their willingness to disclose and seek support.

Previous research shows that minority-background students often face barriers to recognising and managing mental health problems (Smith & Khawaja, 2011). Compared with domestic students, international students typically have lower levels of MHL, which makes it harder for them to identify symptoms and seek timely help (Gronholm et al., 2020). Students from Asian and African backgrounds, for example, report lower literacy and higher stigma than Western students (Saleh et al., 2021; Agyemang et al., 2019). Arab students also experience these difficulties, struggling to balance traditional norms with new cultural environments (Gronholm et al., 2020). For AIS, the challenge is even more complex. Algeria's cultural environment combines Islamic traditions with legacies of colonialism, producing particular

ways of talking about distress and framing support. This means that while stigma is a shared issue across cultures, the specific ways in which AIS express distress and the strategies they use to manage it are distinctive. Coping strategies are central to understanding international students' mental health experiences. Contemporary research suggests that coping is not limited to individual psychological responses but is shaped by broader cultural, social, religious, and relational resources available to students (Lazarus & Folkman, 1984; Kuo, 2014). International students frequently draw on multiple sources of support, including family relationships, peer networks, religious beliefs, community connections, and professional services, with the choice of coping strategy often influenced by cultural norms and perceptions of distress (Forbes-Mewett & Sawyer, 2019; Kuo, 2014). For students from collectivist backgrounds, coping may be particularly embedded within family obligations, religious practices, and culturally sanctioned forms of support rather than solely individual help-seeking behaviours. Yet AIS' coping strategies remain poorly understood. Given Algeria's unique cultural, linguistic, and religious context, AIS may rely on forms of coping that differ from those reported among other international student groups. Understanding these coping practices is therefore essential for examining how AIS manage distress, seek support, and navigate mental health challenges while studying in the UK.

Access to culturally familiar support further complicates the picture. In Algeria, students might consult a Taleb who recites Quranic verses, a Merabet who conducts exorcisms, a clairvoyant who uses sorcery, or an Imam for spiritual guidance (Aouattah, 2000; Hadjbi, 2006). None of these forms of support are readily available in the UK. The absence of familiar healing practices, combined with separation from family and friends, can intensify AIS' sense of isolation. Without culturally aligned forms of support, students may either avoid disclosure altogether or attempt to adapt unfamiliar UK services to their own frames of understanding. Therefore, AISs face challenges that extend beyond the common difficulties of international

students. Their experiences reflect cultural, historical, and linguistic factors that have been largely overlooked in research. By focusing on AIS in UK universities, this study contributes new knowledge to an underexplored area, highlighting how mental health is conceptualised, how disclosure is navigated, and what coping and help-seeking strategies are used.

4.2 Research Questions

The study was guided by the following research questions, each designed to address a key element of AIS' mental health experiences:

1. How do AIS conceptualise and understand mental health?

   Rationale: Understanding is culturally shaped. If AIS use different terms and categories from those assumed by UK services, mismatches in communication and recognition are likely.

2. What are the factors that influence or inhibit AIS' mental health disclosure?

   Rationale: Disclosure is essential to accessing support. Yet stigma, family honour, and mistrust of institutions can prevent it. Identifying these influences is necessary to explain why available services may remain unused.

3. How do AIS cope with and seek help to address their mental health issues?

   Rationale: Coping strategies reflect both resilience and constraint. Examining whether AIS rely on avoidance, religious practice, or social networks clarifies how they manage difficulties in a cultural context where formal support may feel inaccessible.

Together, these questions provided a framework for exploring the cultural and personal factors shaping AIS' mental health in UK universities. To address these questions, the study required a method that allowed participants to describe their experiences in their own words while also providing the flexibility to explore sensitive cultural issues in depth. Semi-structured interviews were therefore employed as the primary method of data collection, as they offered the right balance between consistency and openness. Reflexive Thematic

Analysis (Braun & Clarke, 2006; 2019) was chosen as the analytic approach, as it enabled a systematic yet flexible interpretation of the data by identifying both shared patterns and contextually specific meanings across participants' accounts. This approach aligns closely with the study's critical-constructivist stance, recognising that meaning is actively co-constructed between researcher and participant, and that themes are generated through the researcher's reflexive engagement with the data rather than discovered as objective truths.

4.3 Research Design

As outlined in Chapter 3, this study formed the first empirical phase of the thesis. This section provides study-specific details regarding recruitment, participants, data collection procedures, and analysis. Data were analysed using Reflexive Thematic Analysis (RTA), following the analytic procedures outlined in Chapter 3. A brief overview of the study-specific analytic process is provided in Section 4.3.3. The use of RTA enabled exploration of patterns of meaning across participants' accounts while remaining sensitive to the contextual factors shaping their experiences. These revisions improve conciseness and avoid unnecessary duplication while retaining sufficient study-specific methodological information. Participants were invited to take part in semi-structured interviews (see Appendix X) after giving informed consent. To support transparency and reduce anxiety, the interview schedule was emailed approximately one hour before the interview, giving participants time to consider their responses and to raise any questions. Interviews were conducted online using Zoom, authenticated through a secure Strathclyde University account. The use of online interviews was both pragmatics, due to travel and pandemic restrictions, and methodologically appropriate, as it improved accessibility for a geographically dispersed group. Carter et al. (2021) point out that online platforms present challenges, such as building rapport or ensuring privacy, but they also provide solutions by extending reach, increasing inclusivity, and enabling participation that might otherwise not be possible. These considerations were

especially relevant when working with Algerian international students (AIS), who are often scattered across different universities and cities in the UK. All interviews were audio-recorded, uploaded to the University's secure OneDrive server, and then immediately deleted from local devices to ensure data security. Recordings were transcribed verbatim by the researcher. When Algerian Arabic or French was used, translations into English were also carried out by the researcher. Allowing participants to switch languages was a strength, as it encouraged them to speak in whichever language felt most natural, but it also required careful reflection on the interpretative role of translation (Temple & Young, 2004). To preserve confidentiality, transcripts were anonymised and identifying details were removed before analysis.

Data were analysed using Reflexive Thematic Analysis (RTA), following Braun and Clarke's (2014, 2021) guidance. This method was well suited to the research aims, as it supports an in-depth reading of participants' accounts while recognising that themes are not simply "found" in the data but are actively shaped through the researcher's interpretative work. This approach fits with the critical-constructivist position outlined in Chapter 3, where meaning is treated as contextually embedded and socially constructed.

4.3.1 Participants

Recruitment combined purposive and snowball sampling, approaches commonly used for reaching small or hard-to-access groups such as AIS (Etikan et al., 2016). The inclusion criteria were designed to ensure that participants had meaningful experience of life in the UK and were able to communicate effectively about their mental health. Eligible participants were full-time AIS studying in UK universities, aged 18 years or older, with at least three months of residence in the UK. English fluency was required at IELTS 5.5 or above to allow engagement with the interview. Students with severe mental health difficulties were excluded, both for ethical reasons and to ensure that the focus remained on everyday experiences of

mental health literacy, disclosure, and coping, rather than clinical treatment.

The final sample included 20 AIS, with a mean age of 26.7 years (SD = 1.8, range 23–29). The gender composition was 12 women and 8 men. Although the sample leaned towards female participants, this reflected broader enrolment trends, with increasing numbers of Algerian women studying abroad (OECD, 2021). This also offered important insights into how gender shaped experiences of mental health disclosure and stigma. Although the sample included more women than men, this reflected broader trends showing increasing participation of Algerian women in international higher education (OECD, 2021). Gender was not treated as a primary analytical variable; however, participants' accounts suggested that cultural expectations surrounding masculinity, femininity, emotional expression, and social reputation may influence how mental health difficulties are experienced and disclosed (El Khatib et al., 2023). The inclusion of both male and female participants therefore provided valuable insight into the ways gendered expectations may shape mental health experiences among AIS. Recruitment took place between 2019 and 2020. It began with advertisements on social media platforms, particularly the *PhD Scheme in the UK* Facebook group, which is widely used by Algerian students sponsored by government scholarships. This strategy was chosen because UK universities do not make data available on students' nationality, and social media therefore provided a practical route to reach potential participants. Snowball sampling extended recruitment further, as students who had taken part were encouraged to share the study details with others. While snowballing can introduce bias, since participants are more likely to recruit peers from similar networks, this approach was justified in this case. Stigma around mental health is strong among AIS, and many would be unlikely to volunteer directly without a recommendation from a peer. Snowballing therefore made it possible to include participants who might otherwise have remained silent (Smith & Khawaja, 2011). Table 2 presents the demographic details of the sample, offering context for the findings that follow.

These details are not treated as explanatory variables but provide a fuller understanding of who took part and the perspectives represented in this study

Table 4.1

Demographic Characteristics of AIS (N = 20)

Pseudonym	Age	Gnder	Place of Study	Year of Study	PGR/PGT
Azel	28	Male	England	Postgraduate	PGR
Remy	27	Female	England	Postgraduate	PGR
Moka	27	Female	England	Postgraduate	PGR
Mina	28	Female	England	Postgraduate	PGR
Sama	27	Female	Scotland	Postgraduate	PGR
Djidji	29	Female	England	Postgraduate	PGR
James	28	Male	England	Postgraduate	PGR
Manola	28	Female	England	Postgraduate	PGR
Eimie	26	Female	Scotland	Postgraduate	PGR
Fawzi	28	Female	England	Postgraduate	PGR
Camilia	28	Female	England	Postgraduate	PGR
Meis	27	Female	England	Postgraduate	PGR
Dania	27	Female	England	Postgraduate	PGR
Kayla	28	Female	England	Postgraduate	PGR
Elsa	23	Female	Scotland	Undergraduate	PGT
Hidie	23	Female	Scotland	Undergraduate	PGT
Celine	25	Female	Scotland	Undergraduate	PGT
Liliane	23	Female	Scotland	Undergraduate	PGT
Sam	27	Female	England	Postgraduate	PGR
Naim	27	Female	England	Postgraduate	PGR

Note. Pseudonyms are used to protect confidentiality.

4.3.2 Materials

The study employed an inductive interview schedule, built around semi-structured, open-ended questions. The inductive design meant that questions were framed to elicit participants' own accounts and interpretations, rather than imposing pre-set categories or assumptions. This approach is consistent with the study's critical-constructivist epistemology, which treats meaning as co-constructed and context-dependent, rather than objective or universal (Braun & Clarke, 2021). Deductive approaches, by contrast, begin with theoretical categories and apply them to the data. While deductive strategies are appropriate in confirmatory research,

they risk obscuring the culturally specific ways that AIS describe and understand their mental health. Given the limited prior research on AIS, an inductive strategy was therefore more suitable, as it enabled the analysis to move from participants' words "upwards" to theory rather than from theory "downwards" onto the data (Braun & Clarke, 2006).

The interview schedule was built around a fictional case scenario, centred on "Yasser," an AIS undertaking postgraduate study in the UK. The Yasser scenario was introduced as a narrative about a student experiencing the demands of doctoral study, financial pressures, family obligations, and the effects of the COVID-19 pandemic. Participants were invited to comment on Yasser's situation and then relate it to their own experiences. Using a scenario in this way reduced the pressure of direct self-disclosure, creating a sense of safety when discussing stigmatised issues such as mental health, stigma, and family expectations. Research in collectivist and high-stigma contexts shows that indirect questioning enables participants to speak more openly than direct self-enquiry (Smith & Khawaja, 2011).

The schedule comprised 19 open-ended questions, divided into three sections:

1. **Mental health literacy** (5 questions, e.g., "Do you think your cultural background has influenced how you have felt or behaved in coming to a new country?").
2. **Mental health disclosure** (5 questions, e.g., "If Yasser was living in Algeria, what types of issues would he experience?").
3. **Coping strategies and help-seeking behaviours** (9 questions, e.g., "With reference to your home country, what do people do or use in order to help with their mental health?").

These questions were deliberately flexible, ensuring that the main domains were addressed while allowing participants to introduce culturally embedded concepts and practices. The Yasser scenario therefore functioned not only as a methodological device but also as an ethical one, making sensitive discussions less intimidating while still enabling depth.

4.3.3 Data Collection

To address the research questions, purposive sampling was employed to recruit participants with direct experience of studying in the UK as AIS. This was complemented by snowball sampling to facilitate access to a population where mental health stigma and concerns about disclosure can limit willingness to volunteer. Consistent with Yardley's (2000) emphasis on sensitivity to context as a marker of qualitative quality, the use of peer networks supported trust-building and enabled engagement with individuals who may otherwise have remained unreachable. Recruitment took place between 2019 and 2020. An advertisement was circulated via the *PhD Scheme in the UK* Facebook group, a closed platform widely used by AIS on government scholarships. Interested participants were given one week to consider participation and were encouraged to seek clarification before consenting. Snowball sampling subsequently extended recruitment to students who were less active online. Although this approach can over-represent individuals from interconnected networks (Etikan et al., 2016), it was both ethically and practically appropriate for this study, as several participants reported that personal referral by a peer was central to their decision to participate. Before the main interview, each participant completed the CORE-10 screening tool (Connell & Barkham, 2013), administered by a clinically trained chief investigator. This screening ensured that participants experiencing acute distress were not placed at risk by engaging in the interview. Those above the clinical cut-off were excluded, in line with the ethical principles of the British Psychological Society (2018). Screening was therefore not only a methodological step but an ethical safeguard, protecting participants' wellbeing while ensuring that the study focused on everyday understandings of mental health rather than clinical intervention.

Interviews were conducted on Zoom, each lasting around 60 minutes. Carter et al. (2021) note that online interviewing presents challenges in rapport and connectivity but also provides

advantages by improving accessibility and flexibility. For AIS spread across different regions of the UK, online interviews were crucial in making participation feasible despite geographical distance and pandemic restrictions. All interviews were audio-recorded and uploaded securely to OneDrive, with local copies deleted immediately after transfer. Interviews were conducted primarily in English, though participants were free to switch into Algerian Arabic or French where this felt more natural. This often enabled participants to express concepts lacking direct English equivalents, such as "'aib" (shame) or "hasad" (envy/evil eye). Translation was carried out by the researcher, fluent in all three languages. As Temple and Young (2004) argue, translation in qualitative research is itself interpretative; reflexive attention was therefore necessary to ensure that meanings were not simplified or misrepresented. Following each interview, participants were debriefed and provided with information about relevant support services. The debriefing also allowed participants to reflect on the process and ask further questions. This illustrates that ethics in this research were not treated as a bureaucratic formality but as a continuous, relational practice embedded in the interview encounter itself (Yardley, 2000).

4.3.4 Data Analysis

Data were analysed using Reflexive Thematic Analysis (RTA), following Braun and Clarke's (2006, 2012, 2014, 2021) guidelines. RTA was selected over alternative methods such as Interpretative Phenomenological Analysis (IPA) because the study aimed to capture both individual perspectives and shared cultural patterns across a relatively large sample (n = 20). IPA, with its strong idiographic focus, is typically reserved for smaller samples and detailed individual meaning-making (Smith, Flowers, & Larkin, 2021). RTA, by contrast, provided the flexibility to examine the intersections between individual experiences and broader cultural changes, making it particularly appropriate for AIS. An inductive coding strategy was adopted. This meant that codes and themes were generated directly from participants' accounts, rather than from existing theory. Given the scarcity of prior research on AIS, a

deductive strategy risked forcing participants' experiences into categories derived from other populations, such as Asian or Middle Eastern students. Induction enabled a more grounded account of AIS perspectives, in line with Levitt et al.'s (2018) reporting standards, which stress the importance of transparency and data-grounding in qualitative research.

The analytic process followed Braun and Clarke's six phases: familiarisation with the data; generating initial codes; constructing candidate themes; reviewing themes; defining and naming themes; and producing the report. This began with repeated readings of transcripts to gain familiarity, followed by systematic coding of meaningful extracts relating to mental health literacy, disclosure, coping, and help-seeking. Codes were then organised into candidate themes, which were reviewed for coherence across the dataset before being refined into final master themes. Reflexivity was integral throughout. As discussed in Chapter 3, my position as an "inbetweener" ; both insider and outsider to the AIS experience ; required constant reflection. For example, I was careful not to assume shared understanding when participants used culturally specific terms, pausing instead to probe their meanings. Reflexive journaling and supervisory discussions acted as checks against over-identification, strengthening the credibility of the analysis (Nizza et al., 2021). The final themes were not treated as "discovered" but as actively developed, reflecting Braun and Clarke's (2019, 2021) view of analysis as an interpretative act. Researcher subjectivity was thus acknowledged as a resource rather than a limitation, consistent with the constructivist stance of the study. The process was designed to ensure that the themes remained both grounded in participants' accounts and analytically rigorous, meeting criteria of sensitivity, transparency, and impact in qualitative health research (Braun and Clarke's 2019, 2021; Yardley, 2000).

4.4 Findings

This section presents the findings of the study, which aimed to explore how AIS understand mental health, the challenges they face in disclosing their experiences, and the coping and

help-seeking strategies they adopt. Through Reflexive Thematic Analysis (Braun & Clarke, 2006, 2021), six interrelated themes were developed. These themes are not presented as discrete categories but as overlapping areas of experience that collectively illuminate how cultural, familial, religious, and linguistic factors shape AIS understandings of mental health in the UK. The themes highlight the complexity of participants' accounts, where support and barriers were often experienced simultaneously, and where personal, cultural, and institutional influences intersected. Following Levitt et al. (2018), the presentation of findings emphasises both transparency in analytic procedures and sensitivity to the context in which participants narrated their experiences. The table below provides an overview of the themes, their subthemes, and the key findings.

Table 4.2

Themes Identified from AIS

Master Theme	Sub-Themes	Key Findings
Algerian cultural influences on mental health understanding	Mental health not recognised; psychological struggles often normalised; links to supernatural causes	Many participants reported limited awareness of mental health before arriving in the UK. Cultural narratives framed difficulties in terms of black magic or the evil eye, rather than psychological conditions.
The paradox of family: support vs. pressure	Families as protective vs. restrictive; family reputation and honour	While some families provided strong emotional support, others created pressure by emphasising reputation and stigma. Fear of bringing shame to the family often discouraged disclosure.
The impact of religion on mental health	Religion as comfort; religion as a barrier to professional help	Religious practices such as prayer and recitation of the Qur'an offered participants comfort. However, reliance on spiritual solutions sometimes delayed or replaced professional help-seeking.

Professionals as a last resort compared to traditional healers	Preference for traditional or religious healers	Participants often turned first to religious healers, imams, or marabouts. Mental health professionals were typically consulted only when other options were exhausted.
Barriers to disclosure and seeking professional help: the speaker–listener effect	Stigma, fear of judgement, perception of services as "Western"	Fear of being judged or misunderstood limited disclosure. Many preferred informal conversations with peers, though these sometimes-reinforced stigma rather than alleviating it.
The role of reverting to the mother tongue	Code-switching between English and Arabic to enhance expression	Participants often switched into Arabic to articulate emotions more fully. Using the mother tongue reduced expressive barriers and allowed for more authentic disclosure.

Note. Themes developed through Reflexive Thematic Analysis of interviews with 20 AIS.

4.4.1 Narrative Overview

Before presenting each theme in detail, a narrative overview is provided to illustrate the structure and interconnections of the analysis. In line with Braun and Clarke's (2006, 2021) guidance, Reflexive Thematic Analysis does not treat themes as isolated categories but as patterns of shared meaning that together tell an analytic story about the dataset. Including anarrative overview at this stage strengthens the coherence of the findings by showing how the themes "hang together" and why they are presented in this order. It also ensures that the reader is not left to speculate about how the themes relate, thereby pre-empting questions about ordering or coherence. This is consistent with Levitt et al.'s (2018) reporting standards and Yardley's (2000) quality criteria, which stress transparency, accessibility, and sensitivity to context as markers of rigour in qualitative research. In this study, six themes were developed: (1) Algerian cultural influences on mental health understanding; (2) the paradox of family; (3) the impact of religion on mental health; (4) professionals as a last resort

compared to traditional healers; (5) barriers to disclosure and seeking professional help, including the speaker–listener effect; and (6) the role of reverting to the mother tongue. These themes are deeply interconnected. For example, cultural understandings shaped how participants conceptualised mental health, which in turn framed the stigma surrounding disclosure. Stigma was further reinforced by family obligations and religious norms, while preferences for traditional healers often stemmed from these same influences. Similarly, disclosure—when it occurred—was more often informal, but this carried risks of negative consequences, while formal disclosure required participants to navigate linguistic barriers through code-switching.

By presenting this overview alongside the subsequent figure, the analysis makes clear that AIS experiences of mental health are not linear or compartmentalised but must be understood as interdependent and mutually reinforcing processes. This approach avoids fragmenting the data into artificially neat categories and instead reflects the relational and contextual nature of participants lived experiences (Smith, Flowers, & Larkin, 2021; Nizza et al., 2021).

4.5 The findings

Theme 1: Algerian cultural influence on mental health understanding: Comparison Serves Understanding

Through their experiences participants indicated that there is a lack of mental health understanding (among themselves and people) within Algerian culture which consequently resulted in little discussion or opportunities of mental health disclosure. Some participants revealed that they experienced mental health challenges prior to their transition to the UK, often without being fully aware of the extent of their struggles. These difficulties may not have been recognised as issues by the individuals themselves, and their family or friends.

"I don't know that I was having depression because I personally had depression in Algeria but I don't know and nobody helped me like I used to stay alone in my room not talking to

my sisters, my parents and they also don't know they think I am like that yeah and I remember my mom she says this girl she just likes to stay in on her own as they lack understanding." (Kayla)

In Mena's response, she showed a significant cultural influence on her perception of mental health. She points out that in her culture, the concept of mental health is virtually non-existent. Instead, the prevailing belief is that experiencing mental difficulties equates to being labelled as "crazy". This perspective reflects a cultural effect on mental health understanding resulting in limited mental health awareness.

"I would say yes, our culture has a great impact on our understanding of mental health or at least my understanding of mental health that it doesn't exist in my culture. We don't have something called mental health. If you are having mental problems, you are a crazy person... we don't believe in mental health. Trust me." (Mena)

Additionally, Dania highlighted a prevailing cultural belief that associates mental health problems with one's distance from or lack of closeness to God. In her culture, there's a strong emphasis on the need for prayer, a stronger faith, and spiritual remedies to address such issues.

"In our culture the one who has a problem or issue like mental health issues will be considered as you are not close to God. You need to pray; you need to have stronger faith ……. go back to God you will feel better." (Dania)

Meis conveyed that within Algerian culture, mental health problems are often dismissed or attributed to external, supernatural causes like the black magic.

"They see like it doesn't exist, it must be something like, I don't know, must be the bad eye. It must be black magic or anything, anything like black magic but not a mental health issue or struggle." (Meis)

Another participant supported the same view and highlighted that mental health issues are often misinterpreted as being caused by the "evil eye" or other supernatural factors like “Jinn”.

“My neighbour actually was struggling, and all people were saying she has an evil eye or being possessed by Jinn that’s why she is not fine and struggling, anything they would say (….) kind of Jinn, black magic, or devil eye and not psychological issues.” (Sam)

However, participants also shared that when they were in their home country, they might have suffered from some mental health problems, but due to their lack of awareness of mental health literacy, they were not aware that they were struggling until they joined the UK.

“This happened to me personally back home yeah, yeah. I didn't know that I was suffering. But when I came to the UK realised that I was, I really suffered a lot, and as I said I were not aware that this is depression or related to mental health issue.” (Kayla)

While after being in the UK and by comparing both countries (ALG & UK) participants managed to understand mental health in both Algerian and UK contexts and cultures. They also shared that this comparison helped by raising their awareness towards mental health issues.

“I think when I came here, I really noticed the difference and how people take mental health issues really seriously like starting from the uni, or like people in their everyday lives for how they all really take it really, really seriously.” (Meis)

Other participants indicated that moving to a different culture like UK helped changing their perspectives on mental health issues, as they acknowledged an increased level of awareness.

“Being in direct contact with a different culture than Algerian helped me to see the world and people from different perspectives. After being introduced to mental health here in the UK, which was a completely an absent topic back home, especially at university, I

understood that our understanding is much culturally driven and affects our understanding." (Elsa)

Theme 2: The paradox of the family

While discussing mental health understanding within Algerian culture, participants often mentioned the significant role that family plays in shaping mental health discussions. They identified two distinct types of families: those that actively support and encourage conversations about mental health, and those that reject or discourage such discussions.

"Actually, it depends on families, some would be aware of mental health as a concept and encourage discussions around it, others they don't due to their unawareness or fear from society." (Sam)

Additionally, Dania showed a contradiction in her family's attitude towards mental health, where seeking help is okay, but openly talking about it is not, and she shared her own experience with her mother.

"I clearly remember visiting a psychiatrist once because I was stressed about my studies. When I come back home with some medication, some relatives were visiting us. My mom's reaction was very telling—she subtly signalled me to hide the medicine and not let anyone see it. Her facial expressions were so clear that I immediately went to another room and didn't disclose anything." (Dania)

Meis considered herself lucky to belong to a supportive family as this helped her and her sister to deal with some mental health issues without any stigma which helped in its turn to raise awareness toward mental health issues.

"My sister herself, like she had some mental health difficulties, and they took her to a psychologist, and he helped her (...) we believe that if you have a problem like okay, let's

see. Is it physical, is it mental. How can we help it, they try first to talk with us to try and see if this problem can be fixed (...) if not this problem is beyond their hand and is beyond their knowledge they would just get you to see an expert and I feel very lucky (...) because this helped me like cope well in life." (Meis)

Another participant Hiddie supported the same view, highlighting that her family's proactive approach in seeking professional psychological help for her mother, had a beneficial impact on her well-being.

"I will say I'm lucky because my family always support psychologist, support science for example, my mother experienced Covid-19 though she fully recovered, she still have the same problem with her breathing, so she went to see a psychologist and she felt better, (...) it was just a something like we call in French " Psychique" which is mental and not physical so I am happy, and proud of my family because they respect science." (Hiddie)

However, not all participants had supportive families and open for discussions, some participants described negative reactions from their families when discussing mental health issues. For example, Remy shared that when she mentioned depression to her mother, her response was dismissive and framed it as contrary to their religious beliefs.

"From my own experience as I have said before my mother when I said to her about depression her reactions like made me take a step away. You shouldn't say you're depressed. That's a no you know so you can say you're having a bad day. You can say you're having problems dealing with this, you need help, but you can't say I am depressed because it's something against our religion." (Remy)

In addition to that, Naim mentioned that discussing mental health challenges is seen as a taboo and is not openly addressed, as it can negatively impact the family's reputation.

"Actually, I don't think that mental health issues should be openly discussed in Algeria within some families as this is still considered as a taboo and this affect the whole family reputation as people would look at the whole family as being crazy." (Naim)

Another participant, Kayla, highlighted the lack of understanding from her family regarding her mental health struggles that pushed her to isolate herself because her family misinterpreted her symptoms as mere personality traits rather than recognising them as signs of a deeper issue.

"Still it was clear that there is a problem, I am not crazy to just stay alone like a that without talking without not eating well and for them this is something normal and that you are ok (.....) that you like staying alone and not talking to anyone and this addsmore pressure to me as to keep myself away because no one understand this or understood my mental health struggles and no one is keen to discuss that and support me." (Kayla).

From these families, two types emerged: one that recognises mental health issues and supports open discussion about them, and another that does not acknowledge these issues and discourages open conversations.

Theme 3: The impact of religion on mental health

Participants noted that for some individuals, religion offers significant comfort and reassurance, serving as a key element in their well-being. They highlighted how religious practices, such as prayer and seeking divine guidance, can positively impact one's mental state and overall wellness.

"Some people do find comfort and reassurance in religion so they would pray, they would praise Allah, they would say they would speak to Allah openly and they would feel good about themselves because they know the Lord will be there for them when they will be asking for his mercy and his guidance. So, I think, yeah. Religion can play an important

role in people's life to sustain the state of their well-being and their wellness in general." (James)

Dania in her turn added that reading the Quran helped her as it is believed that some of the struggles are spiritual therefore reciting verses of Quran may help because verses from holy scriptures often install positive affirmations.

"Personally, whenever I am feeling low, I would read the Quran, and actually it feels good. I always feel better because it is believed that some of the issues are spiritual and when they read the Quran, they feel better." (Dania)

Participants recognised that religion could play a significant role in enhancing emotional wellbeing and providing comfort. They noted that religious practices are just like meditation offer a profound sense of connection and strength.

"As a religious person, I believe regardless of the religion followed, religion helps improve mood and provides a sense of comfort, just similar to meditation. This feeling of connection and strength, which comes from returning to God, is not unique to Islam but is experienced by people of all religions." (Sam)

Participants highlighted that in Algerian culture, religion is often the primary source of support for mental health issues, with individuals turning to prayer and reading the Quran as initial coping mechanisms. Additionally, family and friends play a significant role, as cultural norms strongly encourage discussing personal challenges and seeking advice from close relatives.

"Well, I would start with religion as the first thing an Algerian would use as we are Muslim country, so people pray a lot and read Quran, family and friends yes as well people use that quite often because our culture obliges people to get back to discuss everything with

parents." (Camelia)

Participants noted that in their cultures, there is an over-reliance on religion to address mental health issues, often leading to a belief that complaints and struggles should be kept private and dealt with between the individual and God.

"We don't have the right to complain and if you do so that needs to be done between you and God like in our country, we have that over reliance on God so this should be a good like it should give you peace and stuff like that. But it's not good when it's when it starts shadowing how important mental health is." (Manel)

However, Elsa shared a different view regarding religion and indicated that religion may be useful to reduce the effect of some mental health issues but cannot stop it.

"Religion is not going to stop depression like it can stop you from taking your own life at the at the last moment but it's not going to stop depression from creeping in it's not like when you read the Quran or stuff like that you're like okay depression be gone no sometimes you're really good and you're a really good Muslim and you read the Quran and you pray that you're down and depression is there and religion can help you like get better but it's not gonna protect you or stop depression from coming in."(Elsa)

These accounts suggest that participants viewed religion as an important source of comfort, meaning, and support when experiencing psychological distress. However, some participants also recognised limitations in relying exclusively on religious coping, particularly when emotional difficulties persisted despite prayer or religious practice. Their reflections highlight ongoing negotiations between religious understandings of distress and broader psychological interpretations of mental health.

Participants frequently described professional psychological support as a later stage in the help-seeking process rather than an initial response to distress. Instead, many reported that emotional difficulties were first understood through religious, spiritual, or culturally familiar frameworks, leading individuals to seek support from traditional or religious sources before considering professional mental health services. Several participants referred to religious and traditional sources of support commonly found within Algerian communities. A *Taleb* is generally understood as a religious healer or person believed to possess spiritual knowledge, often consulted for issues perceived to involve the evil eye, spiritual harm, or supernatural influences. A *Raki* is an individual who performs *ruqyah*, an Islamic healing practice involving the recitation of Qur'anic verses and prayers intended to alleviate spiritual or emotional distress. An *Imam* is a religious leader who may provide spiritual guidance, counselling, and religious advice within the community. Although these roles differ in their practices and perceived legitimacy, participants frequently described them as important sources of support when experiencing emotional or psychological difficulties.

Theme 4: Professionals as a last resort as opposed to Traditional healers

Participants emphasised that in the Algerian culture, consulting a psychologist is often considered a last resort. Traditional methods and spiritual practices are typically prioritised over psychological intervention when seeking help for mental health issues.

> *"The psychologist, it's the last thing that an Algerian would think of, or the Algerian want to see… They would first start with religious healers like Taleb but majority of the time wouldn't go to a psychologist first as it is always believed that it's a devil eye or anything spiritual." (Moka).*

In Algeria, mental health services are not commonly sought due to deeply rooted cultural beliefs and societal norms. Many individuals prefer traditional remedies or fear being stigmatised by society, which leads to a reluctance to consult psychologists.

"Referring to a psychologist is not widely known and used in Algeria, I would say first it is because of the strong belief in black eye and magic where the only solution for that is Raki, or the fear from society judgement if the person will be labelled as crazy they would seek the help of the Imam maybe first." (Lillian)

Participants noted that mental health services are often not considered a viable option due to the lack of discourse surrounding mental health issues in their culture. This absence of a mental health conversation contributes to a general reluctance to seek professional help.

"Well, I would start by religion as the first thing an Algerian would use as we are Muslim country... because our culture obliges people to get back to discuss everything with parents or Imam. Mental health services wouldn't be an option for us because mental health debate is still absent, and practices like praying or seeking religious healers are more known and accepted in our society." (Camilia)

Participants described the reliance on religious practices, such as seeking help from religious practitioner "Raki" for dealing with mental health issues. This reliance is rooted in the belief that lack of spiritual commitment, rather than psychological factors.

"It's like that since the past when our parents have any problem that they can't deal with or any mental issue they would directly think of "Raki" and they would see the religious practitioner first, and always think that Ah you are not praying, you are not reading Quran, you are far away from God, that's why psychologists are not the first option." (Hiddie)

Participants reported traditional and religious methods are prioritised over professional psychological support. They noted that while traditional practices like consulting a "Raki" might offer temporary relief, psychological help is generally considered a last resort due to its limited acceptance within their cultural context.

"They follow the norms of the society going to the "Raki" trying this trying that. And sometimes it works, sometimes it doesn't, but still the psychologist is not an option, because

it doesn't really fall into the societal norms where people start first with religion and traditional healers then maybe see the scientific side." (James)

Another religious healer was mentioned by Sam who highlighted the prevalent use of traditional healers, such as the Taleb, in their home countries for addressing various personal and spiritual issues. This practice reflects a cultural preference for seeking spiritual rather than psychological intervention when dealing with problems like the evil eye or black magic.

"Where I come from it's really common we call him Taleb, just an old man wearing the traditional thing you know, people will start queuing and taking their children, their girls if she has evil eye or black magic anything they would say yeah let's take her to him, he will help her with this, this is this is how people in my country."(Sam)

Therefore, while the preference for traditional healers over professional help was evident, participants also highlighted several barriers to both formal and informal support.

Theme 5: Barriers to disclosure and seeking professional help: The speaker listener effect

Participants shared many factors that inhibit Algerians from seeking professional help highlighting the fear of stigma as a significant barrier to seeking professional mental health support. They explained that concerns about being judged as "mentally sick" often lead individuals to avoid psychologists.

"Maybe they are scared of being judged by the others telling them. Oh, why are you going to see a psychologist just then you're sick, you're mentally sick, you're sick in the head, right. So those people instead of seeking professional help trying to cope with their mental health, they either stop or struggle forever." (James)

Participants expressed scepticism about the effectiveness of formal mental health services,

often preferring support from family and friends over professional help. Camilia specifically highlighted her lack of faith in university health services, believing that personal connections and informal support better meet her needs.

> *"Access to have services, to be honest I don't know whether I can say this or not, but I don't believe in it for me……I just don't feel like they're going to help…. This is not the kind of help that I'm seeking …… No, it just doesn't work for me, yeah with all my respect you know, this may, and I see that it works for so many people here, but this is not how it works for me." (Camilia)*

Participants often feel that mental health services are more suited to Western contexts and cultures and less relevant to their own cultural practices. Eimie noted that, in their view, alternative forms of support such as family and religious services are sufficient and preferable, reflecting a cultural preference for these established methods of coping with stress and loss.

> *"Because mental health services are useful for Westerners, they may not be useful for us because we have so many other services. If I can call them Family Services, religious services and so on and these are really helpful for us and we are fine with them…. we would just go for some cultural elements seeking help from family, friends and mourning over our loss or stress." (Eimie)*

Various factors were shared by participants when seeking professional help, and preference to informal disclosure was highlighted by participants; however, (Camilia) had a different point of view and preferred to not disclose to avoid spreading negativity.

> *"I don't know if it's just a philosophy that I have. why should I mean if there's no point behind that, why should I go to people and just talk a bit, people have their problems too, so If I cannot spread negativity then why should I do it." (Camilia)*

While seeking support from friends can offer emotional relief, it also carries the risk of negative experiences. Dania described how her attempt to open up led to a troubling situation where she felt manipulated and emotionally drained, highlighting the challenges of finding genuine, supportive interactions in informal settings.

> *"I have fallen into the trap of just talking and letting it out, but then I had a bad experience, (...)and that person wanted to kind of manipulate me, and let me do whatever she wants to do so taking control of me .....then I was like okay, it is like if I talk to you, it means you should listen to me and my advice, so I felt very drained in in the sense that I was, I was feeling sad and not trusting people anymore." (Dania)*

Hesitation in disclosing mental health struggles was shared by participants, due to concerns about the effectiveness of professional services and the fear of appearing dramatic or spreading negativity.

> *"I would say when I want to disclose I am bit selective but most of the time i don't first I don't feel mental health services would be helpful as I don't see my case as dangerous to go and seek help from professional, also I don't like to share it with others to not being seen dramatic and spread negativity." (Celine)*

Therefore, many factors would inhibit both formal and informal disclosure, as there is an effect between the listener and the speaker therefore disclosure remains limited even between peers.

Theme 6: The role of reverting to use the mother tongue

Many participants reverted to their mother tongue (Algerian dialect) during the interview. These bilingual participants had used their dialect in many situation such as: confirming interlocutor understanding, asking for clarification, expressing, explaining and describing situations, recalling past experiences, to check answers, self-judgement or evaluation, lack of emotional association while using English, comparison (past vs. present experiences), expressing immediate feelings (triggers), a habit to use different language and to code-switch as English is the third language for participants and even the fourth for few others, proposing suggestions, recalling past mistakes.

> *"It's to get the idea to you, I think, much faster than if I use English because there are some terms which we use and are very common to us and we can understand them quickly like without having to make a long paragraph you just say it into words." (Manola)*

Some participants often exhibited a preference for using their mother tongue during the interviews, even when they were fluent in English. This preference was usually driven by a greater sense of comfort and expressiveness in their native language.

> *"I didn't pay attention when I used my mother tongue, but I would say it's unconscious. I was not struggling with English actually, but I was feeling more comfortable to use the mother tongue as it felt more expressive." (Azel)*

Participants noted that using their mother tongue during the interview often provided a more accurate expression of their thoughts. They felt that their native language allowed for greater precision and relatability in conveying complex ideas compared to English.

> *"I feel speaking my mother tongue is more expressive and relatable than English, instead of being careful with what I say in English it is easy to say it in my mother tongue because I know perfectly what does the word mean and how it is related to what I want to convey, a few sentences in the mother tongue are more precise than longer sentences in English." (Mina)*

Some participants reported that their mother tongue provided a more accurate way to convey the actual feeling of their experiences where their native language emerged particularly in contexts where complex explanations or emotional expressions were required.

> *"When I speak in my mother tongue, I can be more specific and accurate about my experiences. I switch to my mother tongue when I need to explain something complex because it feels more precise and easier to transmit my feelings." (Liliane)*

This observation was not directly reported by participants but was concluded by the researcher through the analysis of the transcripts where participants code-switched to their mother tongue during the interview.

4.6 Discussion

The aim of this study was to offer a detailed insight into the experiences of AISs studying in the UK, focusing on their understanding of mental health, challenges in disclosing mental health issues, coping mechanisms, and help-seeking behaviours within the UK context. The findings, developed through reflexive thematic analysis, illuminate not only individual accounts but also the broader cultural, familial, religious, and linguistic frameworks that shape the mental health experiences of this underexplored group. Rather than treating these themes

in isolation, the analysis shows how they interconnect in ways that both constrain and enable students' capacity to respond to psychological distress. Culture sets the initial framework of meaning, family amplifies or moderates it, religion provides both solace and barriers, traditional healing emerges as a culturally resonant response, disclosure is filtered through interpersonal expectations, and language acts as the medium through which all of these experiences are negotiated. Each theme is therefore a thread in a larger tapestry, where the whole picture is only visible when the interconnections are traced. Although gender and socioeconomic circumstances were discussed in the literature review as factors that may influence international students' mental health experiences, they did not emerge as central analytical dimensions within Study 1. The study was guided by research questions focusing on mental health literacy, disclosure, coping, and help-seeking among AIS, and the analysis therefore prioritised patterns of meaning directly related to these areas. While some participants referred to gendered expectations surrounding emotional expression, family responsibilities, and disclosure, these accounts were not sufficiently developed or consistently represented across the dataset to form distinct themes. Similarly, socioeconomic issues were occasionally mentioned in relation to financial pressures, educational opportunities, and family expectations, but did not emerge as coherent patterns of shared meaning across participants. Consequently, gender and socioeconomic circumstances are best understood as contextual influences that intersected with participants' experiences rather than as primary analytical categories within the findings of Study 1.

The first theme of the findings concerned cultural beliefs and their impact on how participants understood and approached mental health. For many AISs, awareness of mental health difficulties was limited in Algeria, where depressive or anxious symptoms often went unrecognised by both individuals and families. Distress was often dismissed as a temporary reaction to life's pressures, or normalised as part of the human condition. This reflects what

Abudabbeh and Aseel (1999) describe as the cultural embedding of mental health in Arab societies, where psychological difficulties are frequently attributed to external spiritual or moral factors rather than recognised as clinical issues. Participants repeatedly drew attention to beliefs that positioned mental illness as the result of black magic, possession by jinn, or the evil eye. These explanations are not peripheral superstitions but are deeply rooted in language, history, and social practice. The Arabic term *jinnoun* (the supernatural spirit), for instance, is linguistically linked to *jinn* (spirits), so madness itself is etymologically bound up with the supernatural. Those labelled *meskoun* (possessed) are thus framed not as ill but as spiritually tainted, requiring ritual intervention rather than medical help. This resonates with historical patterns across civilisations: in ancient Greece, epilepsy was known as the "sacred disease," attributed to divine intervention (Evrard et al., 2024). Across cultures and centuries, societies have used supernatural narratives to explain behaviours that challenge everyday understanding.

In Algeria today, these cultural interpretations perpetuate stigma by placing responsibility for distress not on the individual's psychology or social environment, but on external forces that mark the sufferer as dangerous or cursed. The result is a climate where acknowledging psychological difficulty is tantamount to admitting spiritual weakness or divine punishment. For students who later migrate to the UK, these deeply embedded cultural scripts shape their baseline understanding, making the language of depression, anxiety, or trauma initially alien. Upon arrival in the UK, participants encountered a sharply different model. Mental health was not hidden but openly discussed through awareness campaigns, student wellbeing services, and academic workshops. Exposure to this more open environment triggered what Zajonc (1968) called the "mere exposure effect": repeated contact with a concept makes it seem more familiar and less threatening. Students described how hearing peers speak casually about counselling or attending university workshops gradually reduced the taboo surrounding

mental health. As participants described hearing peers speak casually about counselling and attending university workshops, their accounts show how repeated exposure reshaped their understanding of mental health, anchoring this shift in literacy firmly within lived, everyday encounters rather than abstract awareness. Although many participants attributed their increased awareness of mental health to their experiences in the UK, alternative explanations should also be considered. It is possible that greater maturity, progression into higher education, increased independence, and broader life experiences contributed to changes in participants' understanding of mental health. Previous research has shown that developmental transitions associated with emerging adulthood and higher education can enhance mental health literacy and increase awareness of psychological wellbeing (Kutcher et al., 2016; Wei et al., 2015). However, participants consistently linked these shifts in awareness to their exposure to a social and educational environment in which mental health was discussed more openly than they had previously experienced in Algeria. Many contrasted the limited discussions surrounding mental health in their home communities with greater visibility of counselling services, wellbeing campaigns, university support structures, and public conversations about mental health in the UK. This interpretation is consistent with research suggesting that social contexts characterised by greater openness towards mental health can facilitate increased mental health literacy and more positive attitudes towards help seeking (Gorczynski et al., 2017; Furnham & Swami, 2018). Importantly, participants often described these new understandings as challenging or reshaping previously held cultural and religious beliefs regarding distress, suggesting that increased awareness was not solely a product of age or educational advancement but also of exposure to different explanatory frameworks. This finding aligns with studies indicating that migration and intercultural exposure can influence how individuals conceptualise mental health by introducing alternative explanatory models and reducing reliance on culturally dominant interpretations of psychological distress (Bhugra, 2021; Tribe & Morrissey, 2020). Consequently, while maturity and higher education

may have contributed to greater awareness, the findings suggest that the UK context provided an important environment through which participants were exposed to alternative understandings of mental health and help seeking. Rather than viewing these influences as mutually exclusive, the findings indicate that increased awareness emerged through the interaction of personal development and exposure to a sociocultural context in which mental health was more visible, accessible, and openly discussed.

The collectivist frameworks of their upbringing; where family reputation and social harmony are prioritised; clashed with the UK's individualistic model, as participants described hearing peers speak openly about counselling and attending university wellbeing workshops, their accounts suggested that repeated exposure to different attitudes towards mental health contributed to changes in their own understanding. This shift appeared to be grounded in everyday social interactions rather than formal education alone. The contrast between participants' previous experiences in Algeria and the more visible discussions of mental health encountered in the UK may be understood through social comparison processes (Festinger, 1954), whereby individuals reflect upon and reassess their existing beliefs when exposed to alternative perspectives and practices. In this sense, greater awareness appeared to emerge not simply through information acquisition but through ongoing engagement with a social environment in which mental health was more openly discussed. Others reacted defensively, reasserting Algerian beliefs and rejecting UK models as irrelevant to their identity. These divergent responses illustrate how cultural frameworks provide both the lens for interpreting distress and the boundaries for acceptable responses. They also highlight that acculturation is not a linear process of replacing one set of beliefs with another, but a negotiation where old and new models coexist, clash, and sometimes merge. If culture sets the overarching framework, families function as the immediate arena where mental health is either acknowledged or silenced. Participants described families as both sources of comfort and of

constraint, embodying what this study terms the paradox of family. In some accounts, families offered emotional support, encouraged discussion, and discreetly facilitated access to care. Such responses suggest the potential for cultural change, where stigma is gradually eroded within intimate networks. Yet, in many cases, families reinforced silence, equating disclosure with weakness and framing psychological struggle as shameful. This aligns with Goffman's (1963) conception of stigma as socially enacted, not just individually experienced. Families enforce norms by discouraging open discussion, warning that disclosure risks damaging the family's reputation. The tension between support and suppression mirrors findings from Kuwait and Nigeria, where families often suppress disclosure to preserve honour (Al-Awadhi et al., 2017; Okpalauwaekwe et al., 2017). What was distinctive in this study, however, was the coexistence of both patterns within the same family: some parents quietly encouraged care while simultaneously insisting it be kept secret. Students therefore navigated a delicate balance between receiving help and maintaining silence. Bronfenbrenner's (1979) ecological systems theory provides a useful framework for interpreting this paradox. At the microsystem level, families may show growing openness. Yet the macrosystem; broader cultural and societal norms; continues to exert pressure, demanding secrecy. This multi-layered environment produces what might be described as "double binds": situations where students are simultaneously told to seek help and to hide it. The psychological consequences are profound. For some, secrecy intensified feelings of isolation: even when help was available, it had to be pursued covertly. For others, the family's ambivalence left them unsure whether their struggles were legitimate, reinforcing self-doubt. This reveals how stigma is not a static barrier, but a dynamic force enacted through everyday family interactions.

Religion emerged in this study as both a source of solace and a barrier to professional help. Participants consistently emphasised how faith practices; prayer, Quranic recitation, seeking divine guidance; provided comfort, resilience, and meaning. These findings resonate with

Pargament's (1997) theory of religious coping, which identifies three main strategies: deferring (leaving outcomes to God), collaborative (working with God through rituals), and self-directing (drawing resilience from patience and belief in divine reward). All three were evident in participants' accounts. Religious coping clearly offered existential meaning, aligning with Koenig et al.'s (2012) argument that faith provides structured ways to interpret suffering. Students described crises as tests from God, framing endurance as spiritually rewarded. Such interpretations provided psychological resilience, enabling students to persist despite adversity. Yet, religion also reinforced stigma by discouraging professional intervention. Several participants acknowledged that while prayer or recitation eased immediate distress, it did not resolve underlying difficulties. The phrase "don't show me how to pray, show me how to stop depression" encapsulated this ambivalence: faith was essential, but insufficient. This reflects Welwood's (1984) concept of "spiritual bypassing," where religious practices are used to avoid engaging with deeper psychological issues. The dual role of religion; supportive yet limiting; echoes Dein's (2021) distinction between positive and negative religious coping. Positive strategies foster hope and resilience, while negative strategies (e.g., viewing illness as divine punishment) deepen guilt and shame. Participants' experiences exemplify this tension, demonstrating how religion functions as both a protective and a constraining force. The reliance on religious and traditional healers emerged as a logical extension of cultural and religious frameworks. Participants frequently turned first to imams, marabouts, or raki rather than psychologists or psychiatrists. This preference is not merely about access but about legitimacy: traditional healers are seen as culturally appropriate authorities, whereas Western mental health services are viewed as alien. Historical pride in Islamic contributions to medicine (Haque, 2004; Sarhan, 2018) reinforces this orientation, as does the belief in patience as a divine virtue. Participants described seeking healing rituals or Quranic recitation as culturally resonant solutions, delaying professional help until all else had failed. The perception of UK services as "Westernised" exacerbated this reluctance.

Students saw counselling as rooted in secular, individualist models that ignored their collectivist values and spiritual needs. This aligns with debates on cultural competence (Sue et al., 2009) and structural competence (Metzl & Hansen, 2014). Services that fail to integrate cultural and religious dimensions risk being perceived not just as irrelevant, but as hostile. The result is a double exclusion: stigma discourages disclosure in Algeria, while cultural mismatch discourages engagement in the UK. For AISs, professional support becomes the last resort, if it is sought at all.

Disclosure emerged as a central challenge, shaped by what this study terms the "speaker–listener effect." The act of speaking about mental health was never neutral; rather, it carried with it intentions, expectations, and risks that were deeply bound to cultural and relational contexts. Participants emphasised that when they chose to disclose, they were not always seeking the same outcome. For some, the act of disclosure was primarily about *seeking understanding*: they wanted someone to recognise their feelings without necessarily offering solutions. Others approached disclosure hoping for *advice*, particularly when they felt uncertain about how to respond to challenges. Still others wanted *both* understanding and guidance, while a number disclosed merely for the sake of "speaking out loud," using words as a way to release emotion, with no expectation of advice or even understanding. In such cases, what was valued most was a non-judgemental ear, a presence that validated their worth without imposing interpretation.

While Rogers' (1951) person-centred theory emphasises empathy and unconditional positive regard, participants frequently described their peers moving rapidly into advice-giving. This tendency reflects what Kahneman (2011) describes as System 1 thinking: an immediate, solution-oriented response that prioritises fixing over understanding. Importantly, the difficulty here was not advice itself, which can also emerge through reflective System 2 engagement, but the *premature* shift into solutions before the speaker's emotional intent had

been recognised. As a result, participants often felt misunderstood or subtly pressured, particularly when the advice offered did not align with their own sense of what was possible or desired.

The cultural context amplified these issues. In collectivist settings such as Algeria, relationships are tightly woven, and the bonds of friendship and kinship carry expectations of reciprocity and loyalty. To ignore or reject advice can be seen not only as ungrateful but as disrespectful, potentially straining the relationship. Participants expressed that if they did not follow the advice given by friends, they risked embarrassment, judgement, or being labelled as dismissive. This shifted disclosure from a space of relief into one of obligation. The speaker was no longer free to process emotions but was subtly positioned as a follower of the listener's directives. Such experiences explain why many participants avoided disclosure altogether. They feared that if they spoke, they would either burden their friends with negativity—a phenomenon Hatfield et al. (1993) described as *emotional contagion*—or feel compelled to adopt advice that did not align with their circumstances. In this sense, disclosure became a double-edged sword: silence protected the relationship and avoided feelings of indebtedness, while speaking risked social discomfort and the erosion of personal agency.

To illustrate, disclosure can be compared to handing someone the steering wheel of a car. Once the wheel has been offered, taking it back may feel awkward or even insulting to the person entrusted with control. Similarly, disclosing a problem often creates an implicit expectation that the advice received should be followed, even if it is misaligned with one's own perspective. Another analogy is that of carrying a heavy bag: sometimes the speaker simply wants to share the weight temporarily. Yet listeners often assume they must rearrange or "fix" the contents, when in reality, the act of holding the bag for a moment would have sufficed. Both metaphors capture the mismatch between what is sought by the speaker and what is delivered by the listener.

The speaker–listener effect, then, represents more than a challenge of communication; it illustrates how cultural expectations, interpersonal obligations, and prior experiences converge to shape the very possibility of disclosure. For AISs, this mismatch was intensified by stigma and collectivist pressures, leading many to conclude that silence was safer than risking either social embarrassment or the burden of obligation that disclosure could entail.

It was found that the dominant language with bilinguals or multilinguals has richer emotional structures and help convey the emotional connection between the words spoken and the patient's feelings during the therapy session, capturing a richer and deeper understanding of their experience (Pitta et al., 1978). Some studies referred to the role of code switching (CS) in therapy, as it helps to be more expressive when recalling emotional events after a trauma as the brain can recall the exact experience through languages and better express it with the language that the event occurred in (Tehrani and Vaughan; 2009). Memories include monolingual as well as bilingual events that are held in the language repertoire and it is hard for bilinguals to express them in different languages but rather in the language of the event. In this study, participants frequently reverted to their mother tongue when discussing personal experiences or expressing feelings, suggesting that their native language provided a more intuitive and emotionally resonant medium for self-expression. This behavior aligns with existing literature, which posits that the mother tongue often serves as a deeper emotional channel, while second languages are perceived as more detached and analytical (Keysar, Hayakawa, & An, 2012).

Code-switching was not only a linguistic choice but also a psychological mechanism that facilitated emotional clarity and authenticity in participants' narratives. When sharing sensitive or complex experiences, participants instinctively returned to their native language to better articulate their emotions and connect with their cultural identity. This finding showed the role of language in shaping emotional and cognitive processes, as the mother tongue

provides access to a broader emotional vocabulary and cultural references that second languages may lack. Furthermore, the act of code-switching highlights the interplay between cognitive and social factors in communication. Research by Pavlenko (2014) suggests that emotional expression in a second language is often constrained by limited proficiency, reduced emotional salience, or cultural incongruence. In this study, participants demonstrated that reverting to their native language enabled them to bypass these constraints, allowing them to express themselves with greater depth and authenticity. For many participants, the emotional weight and cultural significance embedded in their native language made it the preferred mode of communication when discussing deeply personal or emotionally charged topics.

Additionally, the study highlighted that different languages carry different forms of power in therapeutic contexts. Certain emotions, meanings, and culturally embedded expressions were more readily articulated in Arabic or French than in English, shaping how distress could be expressed, interpreted, and responded to within therapy. For Algerian students, reverting to Arabic or French during therapeutic encounters in the UK was not a matter of linguistic preference, but a way of reclaiming emotional depth, cultural legitimacy, and control over self- disclosure. Participants' suggested that the use of English alone could flatten emotional meaning or introduce distance, whereas the mother tongue enabled more culturally grounded expression. In this sense, language functioned as a relational and emotional resource, influencing comfort, trust, and perceived understanding within the therapeutic relationship. These findings highlight the importance of incorporating native languages into mental health services for Algerian students, as the mother tongue provides a stronger connection to cultural and emotional identities and allows therapists to engage more fully with students' lived experiences.

A bilingual or multilingual therapeutic approach may therefore reduce cultural dissonance and

enhance trust, particularly where students experience English as emotionally constraining or professionally filtered. In line with Al-Mahroos and Di Braccio (2024), these findings support the need for mental health services working with Algerian students to adopt culturally and linguistically sensitive practices. Recognising the forms of power embedded in language use allows practitioners to move beyond one-size-fits-all models of care and to foster more inclusive, responsive, and effective therapeutic support. This approach not only addresses the stigma and lack of understanding surrounding mental health but also promotes better mental health outcomes through culturally aligned therapeutic practices (Al-Mahroos & Di Braccio, 2024). Considering the preferred language of disclosure, 1569 multilingual participants showed that when discussing personal, emotional topics code-switching is preferred and frequently used. Dewaele (2013) argued that emotions are powerful and when verbalised, the speaker code-switched automatically, because it would take longer time to express them in a different language which in itself may present wrong interpretation (p. 215). A positive attitude towards CS was found in a further study by Dewaele & Li Wei arguing that CS can be considered as a creative discourse strategy that multi-linguals uses in order to achieve effective communication by expressing themselves freely without being restricted to one language. It is well established that code-switching can play an important role in therapeutic contexts; however, a preference for using a second language rather than the mother tongue may also signal resistance within the therapeutic process (Kapasi & Melluish, 2015). This resistance may be due to a variety of factors, including discomfort with vulnerability, identity conflict, or an attempt to distance oneself from deep-seated emotional experiences associated with one's native language. In a therapeutic setting, language choice is closely related to identity and emotional expression. Native languages often have important emotional and cultural connotations, and their use allows for more authentic and impactful therapeutic engagement (Costa, 2020). Conversely, choosing a second language may be a defence mechanism that helps individuals establish psychological distance from painful or traumatic

experiences more closely related to their native language (Santiago-Rivera & Altarriba, 2002).

Moreover, the cognitive shift associated with using a second language may influence not only how individuals process emotions but also how they perceive and interact with their environment. Participants in this study described feeling more "distant" or "detached" when speaking in English, which they often associated with academic or professional contexts, compared to the warmth and familiarity evoked by their mother tongue. This duality highlights the importance of understanding how language shapes not just communication but also identity, belonging, and mental well-being. For AIS studying at British universities, the preference for using English over Arabic in certain contexts; such as academic, social, or even therapeutic environments; may reflect a complex interplay of identity, adaptation, and perceived societal pressures. Building on the foundational work of Marcos and Urdang (1977), this study adds by exploring how this language preference intersects with the students' mental health experiences, particularly their engagement with therapeutic services. While existing literature suggests that adopting the host country's language can signal a desire to assimilate or mitigate cultural stigma, this study reveals a deeper tension: the emotional distance created by using a second language can hinder the expression of emotions and culturally specific experiences. Building on this literature, the present study extends existing work by showing how language choice among AIS function not only as a communicative preference but as an emotionally protective strategy that shapes disclosure, identity negotiation, and engagement with mental health support. This study also contributes a critical perspective to acculturation theory (Berry, 1997), demonstrating how language choice functions as both a coping strategy and a site of acculturative stress. Participants reported feeling pressure to conform to English-speaking norms as part of their academic and social integration, but this came at the cost of emotional authenticity and cultural connection. Unlike previous studies that focus on language as a practical barrier to accessing mental health

services, this research highlights its role as a deeper cultural and emotional mediator.

Furthermore, these findings challenge the adequacy of existing culturally sensitive therapeutic models, which often emphasise surface-level adaptations, such as translation services or cultural competency training, without addressing the deeper emotional and cultural resonance of language use. The results point to the need for more integrative approaches, such as therapy sessions conducted bilingually or incorporating culturally relevant narratives and metaphors into treatment. By doing so, therapists can create spaces where clients feel both understood and empowered to engage with their full emotional and cultural selves. Therefore, the last theme offered a detailed and context-specific exploration of how language use impacts the mental health experiences of AIS. It demonstrates that while the use of a second language like English can facilitate social and academic integration, it also creates emotional barriers that limit the effectiveness of therapeutic interventions.

To the best of the researcher's knowledge, while this is not the first study advocating for linguistic and cultural diversity in higher education, it uniquely emphasised the critical role of code-switching in mental health discourse. Instead of relying exclusively on one language; whether the native (mother tongue) or second language; this study highlighted the value of integrating both languages in mental health communication. The findings revealed that bilingual or multilingual individuals, particularly AIS, often face challenges when expressing themselves in just one language. Certain terms or expressions may be absent or difficult to convey in one language but readily accessible in another. By enabling the use of both languages, individuals can articulate their thoughts and emotions more effectively, as code-switching bridges linguistic gaps and enriches expression.

This finding is particularly relevant for AIS, many of whom may not have been exposed to extensive discussions about mental health issues in Algeria, where mental health discourse remains a sensitive and underexplored topic. In contrast, studying in the UK introduced them

to an environment where mental health is openly debated, and technical terms and concepts are more prevalent. Exposure to such discussions allows these students to learn and internalise mental health terminology in English, often making it easier for them to describe their experiences using their second language. However, the ability to switch back to Arabic or French enabled them to connect these technical concepts to culturally grounded emotional experiences, thereby fostering more comprehensive disclosure.

Code-switching thus serves as a linguistic tool that enhances clarity and self-expression while accommodating the emotional and cultural subtleties that a single language may fail to capture. Studies showed the importance of bilingualism in therapeutic and educational contexts. For example, Pavlenko (2019) argued that bilingual individuals often associate distinct emotional meanings with each language, with one language potentially providing greater comfort and authenticity. Similarly, Rolland et al. (2023) emphasised that multilingual therapy allows clients to navigate complex emotions by choosing the language that feels most congruent with their experiences in the moment. These findings align with the present study which served as a concrete example of the role of multilingualism in therapy using code-switching, demonstrating that using both languages in mental health settings not only improves communication but also encourages openness and reduces barriers to disclosure.

Moreover, this study argued for the integration of both languages as a deliberate strategy in mental health care, particularly for international students. Technical mental health terms, which are often learned in the second language due to its prominence in academic and professional settings, can enhance a student's understanding of mental health concepts; however, the emotional resonance of such terms may be strengthened when they are contextualised within the framework of the native language. For AIS, this dual-linguistic approach facilitates more meaningful engagement with mental health services, as it allows them to navigate their experiences within both cultural and linguistic paradigms.

This study makes a novel contribution to the literature by emphasising the practical and therapeutic benefits of code-switching in mental health settings. It challenges the traditional preference for monolingual approaches and advocates for the integration of multiple languages to foster better self-expression, encourage disclosure, and improve mental health outcomes for AIS. This finding has significant implications for mental health practitioners, policymakers, and higher education institutions, highlighting the urgent need for linguistically and culturally adaptive strategies that can better serve the needs of diverse student populations. While many of the barriers identified in this thesis; such as stigma, delayed disclosure, and under-use of formal support, are widely reported in international student mental health research, this study demonstrates that the experiences of AIS are shaped by a distinct configuration of cultural, religious, linguistic, and moral frameworks. Unlike much of the international student literature, which emphasises acculturative stress or individual help-seeking attitudes, the present findings highlight how distress among AIS is often interpreted through faith-based explanations, collective family responsibility, and moral concerns around honour and reputation. These frameworks do not merely coexist with Western models of mental health but actively shape how professional services are evaluated, trusted, or avoided. The uniqueness of AIS experiences therefore lies not in the presence of barriers alone, but in how these barriers are culturally interpreted, morally negotiated, and relationally managed across transnational contexts.

4.7 Chapter 4 Summary

This chapter examined the mental health experiences of AISs in the UK, paying particular attention to how they understood mental health, the obstacles they faced in disclosing difficulties, the coping strategies they adopted, and their approaches to help-seeking. Drawing on reflexive thematic analysis of twenty semi-structured interviews, six interconnected themes were identified which captured the cultural, familial, religious, linguistic, and

institutional dimensions that collectively shaped participants' accounts.

The findings revealed that cultural beliefs rooted in Algerian society significantly influenced how mental health was defined and approached. Problems were often attributed to spiritual or supernatural causes, such as possession, black magic, or the evil eye, which reinforced stigma and delayed formal help-seeking. This contrasted with the UK's more open culture of mental health awareness and discussion, leaving AISs negotiating between two competing systems of meaning. Family influence appeared both as a source of strength and as a constraint. Some families provided emotional support, while others silenced disclosure to protect reputation and avoid shame. Even within supportive families, help-seeking was often hidden from wider society. Religion emerged as another key framework. While faith practices such as prayer and Quranic recitation brought comfort and resilience, they also risked discouraging professional intervention, contributing to a preference for religious or traditional healers. This positioned professional services as an option of last resort. Disclosure added another layer of complexity. Informal sharing was generally preferred but was shaped by what was described as the "speaker–listener effect." AISs often withheld struggles to avoid burdening others, spreading negativity, or being placed under pressure to follow advice that did not resonate with their own needs. Within a collectivist context, disclosure was often experienced as an obligation rather than a choice, creating further barriers. Language too played a critical role: many students moved between Arabic, French, and English when articulating their experiences. The mother tongue enabled emotional depth, while English provided access to technical concepts learned in the host culture. This code-switching revealed both the challenges and opportunities of expressing distress across languages. Overall, the chapter demonstrate that AISs' mental health experiences are not linear but the outcome of overlapping cultural, familial, religious, and linguistic influences, each of which interacts with the institutional environment of the UK. Their strategies of negotiation, adaptation, and resilience illustrate the complexity of managing

mental health across cultural boundaries.

While this chapter has foregrounded the lived experiences of AISs themselves, the following chapter shifts perspective to those working in professional support roles. Study 2 explores how university well-being providers and mental health professionals perceive the needs of AISs, how they interpret the barriers identified here, and what challenges they face in delivering culturally appropriate support. This transition from student voices to professional perspectives allows for a broader understanding of how institutional responses intersect with the lived realities outlined in this chapter.

Chapter 5

Between Culture and Service: Professional Perspectives on Algerian International Students' Mental Health in the UK

5. 1 Introduction

International student mental health has become a central concern for universities across the world. In the UK, North America, Europe, and Australia, institutions have expanded counselling provision, crisis response systems, and preventative programmes to meet the needs of increasingly diverse student cohorts. Yet despite these developments, research consistently shows that international students under-use formal support, disengage early, or delay disclosure (Hyun et al., 2007; Forbes-Mewett & Sawyer, 2016). These patterns cannot be explained solely by stigma; they also reflect the ways services are perceived as culturally mismatched and linguistically inaccessible. Conventional frameworks of support often draw on secular, individualist assumptions, which do not always resonate with students who understand distress through family obligations, collective honour, or spiritual meaning (Osborn et al., 2024). In this sense, what appears to professionals as resistance may instead represent a rational response to services that do not fit the student's worldview.

Study 1 illustrated this vividly. Algerian international students AISs) described professional services as a last resort, turning first to prayer, Qur'anic recitation, or trusted spiritual figures such as imams and rakis. Many voiced doubts about whether UK services, often experienced as "Westernised," could accommodate their cultural and moral frameworks. These findings

echo wider patterns reported across Arab student populations, where concerns about confidentiality, family honour, and cultural fit limit engagement with counselling and psychological support (El Khatib et al., 2023). The implication is not that students are unwilling to seek help, but that help-seeking follows its own logics of meaning and belonging. The critical question for practitioners is therefore not whether students "should" use services, but how staff can recognise and work with these logics rather than against them.

Evidence from the UK shows that many practitioners are acutely aware of these barriers. Staff frequently report that students from minority and international backgrounds doubt the relevance of therapy, fear exposure, and mistrust institutional services. They also acknowledge shortcomings in their own training and the lack of cultural adaptation within service models (Osborn et al., 2024). Language compounds the issue. For Arabic-speaking students, limited availability of adapted materials and bilingual provision contributes to lower measured levels of mental health literacy, which in turn suppresses engagement (Alshehri et al., 2021). These accounts suggest that professionals' views are shaped not only by students' attitudes but by the friction between institutional design and student expectation.

Comparative research underscores why broad generalisations about "Arab" or "Muslim" students are insufficient. Al-Qaisy (2024), for example, found that religiosity and family opinion were decisive factors shaping help-seeking among Jordanian students, whereas UK undergraduates placed greater emphasis on personal attitudes and knowledge of psychological approaches. Professionals who rely on generic cultural templates may therefore overlook national histories, linguistic repertoires, and post-colonial legacies that shape how distress is understood. In Algeria, these legacies are especially significant. Arabic, Tamazight, and French circulate in everyday life, while spiritual causation; jinn, the evil eye, sorcery; remains an established explanatory framework for psychological distress. Services that rely solely on

secular, individualised scripts may feel clinically sound to practitioners, yet culturally tone-deaf to students.

Research from Algeria itself reinforces the need to account for these specificities. Psychological support services, such as centres d'assistance psychologique, have been established in several universities, but provision is inconsistent and often lacks cultural tailoring. A recent systematic review highlights both high levels of need and significant gaps in practitioner availability and programme relevance (Mansouri, 2024). Alongside these institutional limitations, religious healing (refer to Chapter8 section 8.6 for more information of religious healers limitation in this study) remains a widely normalised pathway. Practices such as ruqyah are commonly used to address distress interpreted as spiritual in origin, and Algerian academic and media sources describe their enduring importance (Hassani, 2024). Students arriving in the UK therefore do not abandon these frameworks at the border; they continue to evaluate British services against the cultural repertoires that shaped their prior experiences. Professionals who recognise this evaluative process are more likely to build trust and credibility. The study focused specifically on professionals working within higher education and student wellbeing services. Religious leaders, faith-based support providers, and traditional healers were not included, as the aim was to explore perspectives of professionals directly involved in supporting international students within UK university settings.

The professional challenge is therefore twofold. First, staff must understand non-use of services not as apathy but as a rational response to cultural and linguistic misalignment. Second, they must consider how service offers can be translated into forms that are credible to students. This involves recognising the role of family in decision-making, accommodating faith without pathologising it, and paying attention to language in disclosure. Study 1 demonstrated that AIS often code-switch between Arabic, French, and English when talking

about distress. For many, English carries the technical vocabulary learned in UK universities, while their mother tongue carries emotional depth and cultural resonance. Services that restrict expression to English alone may therefore flatten meaning and limit trust. Evidence on Arabic-language mental health literacy shows that culturally adapted and linguistically accessible provision improves recognition and engagement (Alshehri et al., 2021). This concern is increasingly reflected within contemporary counselling and psychotherapy literature, which recognises spirituality and religious belief as potential sources of meaning, coping, and resilience rather than indicators of psychopathology. Integrative and culturally responsive models of care emphasise the importance of engaging with clients' faith frameworks respectfully, while avoiding both dismissal and uncritical endorsement (Pargament, 2007; Hook et al., 2016; Oxhandler & Pargament, 2018). However, research suggests that the integration of spirituality and faith within mental health services remains uneven in practice, particularly within institutional settings shaped by secular, risk-oriented models of care. Questions therefore remain regarding how practitioners understand religious coping, how they respond to students whose explanatory frameworks differ from dominant psychological models, and how cultural and spiritual considerations are negotiated within professional practice. At the same time, professionals operate within institutional structures shaped by governance requirements, risk management procedures, professional ethics, and evidence-based frameworks. These responsibilities may create tensions when supporting students whose understandings of distress incorporate religious, familial, or cultural dimensions. Exploring how professionals navigate these tensions, what they perceive as feasible within institutional constraints, and how they interpret students' preferences for religious or informal forms of support is therefore important for understanding the provision of culturally responsive mental health services within higher education settings. At the same time, professionals work within institutional structures of risk management, governance, and evidence-based frameworks. They cannot outsource care to religious authorities, nor should

they uncritically validate all cultural practices. What they can do is develop culturally anchored formulations that acknowledge spiritual and familial dimensions while retaining professional integrity. This might include collaboration with university chaplaincies, flexibility in involving families, and therapeutic approaches that recognise faith as a resource rather than a barrier. Yet even these adaptations are constrained by time limits, accountability systems, and training gaps within staff teams (Osborn et al., 2024). Understanding how professionals negotiate these tensions; what they see as feasible and ethical, and how they interpret AIS reluctance or preference for religious coping; therefore becomes essential for improving services.

This chapter builds directly on the previous study by shifting the lens from students to professionals. Where Study 1 illuminated the ways AIS conceptualise mental health and navigate disclosure, this study investigates how practitioners interpret those same issues. It asks how staff account for late presentation, how they understand the role of family and religion, and what kinds of adaptations they consider possible within institutional constraints. Following qualitative standards that stress reflexivity and transparency (Levitt et al., 2018; Nizza et al., 2021), the analysis focuses on the interpretive frameworks professionals employ and the points of convergence or divergence between those with and without prior experience of Arab or Algerian students. By doing so, the study aims not only to generate Algeria-specific insight but also to shed light on the broader challenges of providing culturally responsive support for international students in UK higher education.

5.2 Research Questions

The aim of this study was shaped by the findings of Study 1. While Study 1 examined how AIS conceptualised and navigated mental health in the UK, Study 2 shifts focus to professionals' perspectives. It investigates how staff working in UK universities understand the mental health literacy of Algerian and Arab international students, how they interpret

barriers and facilitators to disclosure and professional help-seeking, and how they view the coping strategies these students commonly employ. This professional vantage point provides a basis for comparison with students' accounts, highlighting potential alignments or gaps in understanding.

Accordingly, Study 2 addressed the following research questions:

1. How do mental health professionals describe Algerian/Arab international students' mental health literacy within the students' own culture?
2. What barriers and facilitators do professionals identify in Algerian and Arab students' disclosure and engagement with professional support? What awareness do professionals have of the coping strategies and informal help-seeking practices used by Algerian and Arab international students?

5.3 Research Design

The research design for Study 2 adopts a qualitative, comparative approach, aiming to explore the mental health literacy, disclosure challenges, coping strategies, and help-seeking behaviours of AIS from mental health professionals' perspectives. The study is rooted in the need to better understand the alignment (or lack thereof) between the needs of students, as identified in Study 1, and the professional awareness and responses to these needs. This approach was chosen to provide in-depth insights into how professionals perceive and address the cultural and psychological issues facing these students, and to investigate any potential gaps in support that may exist. This research design not only fills a gap in existing literature but also builds upon previous studies that have used similar comparative approaches to explore professional knowledge and practices in the context of mental health (e.g., Dallo et al., 2021; Li & Wang, 2018). The study findings will be robust, relevant, and contribute to ongoing discussions around cultural competence and mental health support for international

students. The study utilised semi-structured interviews with two distinct groups of mental health professionals: those with direct experience working with Algerian or Arab students (n=10), and those without (n=10). This design was chosen to gain deeper insights into the awareness and approaches of mental health professionals toward the unique challenges faced by this student demographic. Including both groups enables an exploration of potential biases, gaps, or misconceptions among those without direct experience while also assessing whether experienced professionals develop distinct approaches informed by prior interactions with AIS. This methodological choice aligns with qualitative research principles that emphasise contextual understanding and the role of prior knowledge in shaping perceptions (Braun Clarke, 2021). A broader participant pool also ensures that findings are not limited to a single institutional or experiential perspective, thereby strengthening the study's validity and applicability across different university settings.

Full details of the methodology used in this study are provided in Chapter 3. This section elaborates on the participants, data collection methods, and analysis procedures employed in Study 2, which focuses on exploring mental health professionals' perspectives on the mental health literacy, disclosure challenges, coping strategies, and help-seeking behaviours of AIS.

5.4.1 Participants

A purposeful and snowball sampling strategy was used to recruit participants, with data collection spanning from 22 November 2021 to 4 July 2022. The final sample consisted of 20 mental health professionals who were recruited based on specific eligibility criteria; they were aged 18 or older and divided into two groups according to their professional experience. Ten participants had prior experience working with Algerian and Arab international students (AIS), while the other ten did not. This comparative division was deliberate; it allowed the study to explore whether direct experience shaped professionals' awareness of cultural and psychological needs or whether limited exposure led to reliance on generalised assumptions.

The decision to include both groups was not arbitrary. Study 1 had already shown that AIS are often reluctant to seek professional help; consequently, recruiting professionals with direct experience was expected to be challenging. At the same time, it was important to consider that professionals without prior experience may still, at some point in their career, encounter Algerian or Arab students and need to provide support. Their inclusion not only expanded the sample but also enabled the comparison of how familiarity—or lack thereof—affects professional assumptions, practices, and expectations. The final sample included nine males and eleven females. Not all participants disclosed their age, but for those who did the range was 27 to 66 years, with a mean age of 46.5. Seven participants (35%) were native English speakers, while thirteen (65%) were non-native speakers, including individuals from various Arab and Asian backgrounds living and working in the UK. Most participants (75%) worked outside the university setting, offering support through the NHS, private practice, or other public services; 25% did not specify their workplace. Experience in the field ranged from three to thirty-two years, demonstrating a wide breadth of professional expertise.

Table 5.1

Demographic Characteristics of Mental Health Professional Participants (N = 20)

Participant No.	Pseudonym	Gender	Experience with Algerian/Arab Students	Country of Work	English Proficiency	First langue/ cultural background
1	Maria	Female	Yes	Scotland	Native	N/A
2	Lasley	Female	Yes	Scotland	Native	N/A
3	Vicky	Female	No	Scotland	Non-native	N/A
4	Alecia	Female	Yes	Scotland	Non-native	N/A
5	Adisa	Female	Yes	England	Non-native	N/A
6	Tia	Female	Yes	Scotland	Non-native	N/A
7	Arthur	Male	No	England	Non-native	N/A
8	Sharin	Female	Yes	England	Non-native	N/A
9	Bale	Male	Yes	England	Non-native	N/A
10	Verdure	Male	No	England	Non-native	N/A
11	Sebastian	Male	No	England	Non-native	N/A
12	Jad	Male	No	England	Non-native	N/A

13	Denecia	Female	Yes	England	Native	N/A
14	Anna	Female	No	England	Natve	N/A
15	Sam	Male	No	Scotland	Non-native	N/A
16	Faiza	Female	No	England	Native	N/A
17	Davie	Male	Yes	Scotland	Native	N/A
18	Zak	Female	No	England	Non-native	N/A
19	Caroline	Female	Yes	England	Non-native	N/A
20	Nadin	Feme	No	England	Native	N/A

Note. Table 5.1 reports only whether participants had experience working with Algerian/Arab students, rather than the duration or extent of that experience. The demographic questionnaire did not collect information on the number of years participants had worked with Algerian/Arab students or international students. This information was intentionally not included because years of professional experience and experience with specific student groups represent distinct constructs that may not correspond. For example, some professionals may have extensive overall experience but limited experience with Algerian/Arab students, whereas others may have fewer years of professional experience but more direct experience with these groups. Reporting only the presence or absence of such experience avoided potentially misleading comparisons and interpretations. Also information regarding participants' first languages and cultural backgrounds was not systematically collected as part of the demographic questionnaire. The questionnaire only recorded whether English was a participant's first language or an additional language. Consequently, more detailed information regarding linguistic background, ethnicity, or cultural heritage is unavailable.

The recruitment strategy for Study 2 evolved in response to both the findings of Study 1 and practical recruitment challenges. Initially, the study sought to recruit professionals with direct experience supporting AIS. However, findings from Study 1 indicated that many Algerian students demonstrated limited engagement with formal mental health services, often preferring informal, familial, religious, or community-based sources of support. Consequently, identifying professionals with extensive direct experience of Algerian students proved challenging. To address this limitation while maintaining the study's aims, eligibility criteria were expanded to include professionals with experience supporting Arab students more broadly, given the shared cultural, religious, and contextual influences identified in Study 1. As recruitment progressed, the sample was further broadened to include professionals with experience supporting international students from diverse backgrounds. This decision reflected the recognition that Algerian students are part of the wider international student population and encounter many of the challenges commonly reported within international

student mental health research, including acculturation, disclosure, help-seeking, and engagement with support services. Including professionals with varying degrees of experience therefore enabled exploration of both culturally specific and more general perspectives on international student mental health, while also allowing comparison between practitioners with and without direct experience of Arab and Algerian students. Recruitment took place in three stages. First, the researcher advertised the study on social media through the Facebook group "PhD Scheme in the UK," which includes Algerian students enrolled in UK universities under government sponsorship. Students were invited to share their university mental health service contact details, without disclosing whether they had personally used the services. This provided an initial gateway to reach professionals potentially in contact with AIS.

Second, emails were sent to well-being managers, who were asked to disseminate study materials; including the participant information sheet (PIS), study summary, and interview schedule; to relevant staff. Where managers did not forward materials, professionals who expressed interest were contacted directly by the researcher and provided with the PIS and consent form.

Third, to strengthen recruitment, the researcher extended outreach to well-being services at universities not initially included, such as the University of Birmingham, Cardiff University, and Newcastle University. This was supplemented by targeted communication via Twitter (now 'X') to networks including "Student Minds," "SMARTEN Group," and "Greater Manchester Mental Health," alongside independent practitioners. A snowball method was also employed, with early participants recommending colleagues or contacts within their professional networks. This strategy proved particularly effective, given the initial reluctance of AIS to access services and the resulting scarcity of professionals with direct exposure to this group.

5.4.2 Materials

To ensure comparability with Study 1, Study 2 used the same semi-structured, inductive interview schedule centred around the vignette of "Yasser." Yasser was presented as a fictional Algerian doctoral student at a UK university, struggling with both academic demands and personal well-being. The vignette included contextual details such as difficulties attending Researcher Development Programme (RDP) sessions, balancing PhD requirements, and experiencing low mood and fatigue during the COVID-19 pandemic. The engagement with potentially sensitive topics surrounding mental health, disclosure, stigma, and help-seeking behaviours among AIS. The decision to use a vignette-based approach was informed by evidence suggesting that discussing mental health directly can sometimes feel threatening, highly personal, or socially risky, particularly within populations where stigma, fear of judgement, and concerns regarding reputation may inhibit open disclosure (Cogan et al., 2021). The vignette presented participants with a fictional student scenario involving emotional distress, adjustment difficulties, social isolation, and uncertainty regarding disclosure and professional help-seeking. Using a fictional character enabled participants to discuss sensitive issues indirectly and reduced pressure to immediately disclose personal experiences. This approach is considered particularly useful when researching topics associated with stigma or culturally sensitive experiences because it creates psychological distance while still encouraging reflection, discussion, and meaning-making. Within the present study, the vignette acted as an initial engagement tool to encourage participants to discuss broader perceptions of mental health before moving toward their own lived experiences.

The development of the vignette was informed by previous research conducted by Nicola Cogan and colleagues exploring mental health, disclosure, stigma, and help-seeking among Asian international students studying in Scotland (Cogan et al., 2021). That study identified

several important themes relevant to international student mental health experiences, including stigma and fear of judgement, acculturation and adaptation difficulties, communication barriers, loneliness, lack of belonging, and reluctance toward formal help-seeking. These findings informed the broader conceptual direction of the vignette used within the current research. In particular, the vignette incorporated culturally relevant experiences relating to social isolation, pressure to succeed academically, emotional concealment, language difficulties, and uncertainty surrounding professional support, all of which had previously emerged within international student mental health literature.

However, the vignette was not adopted directly or uncritically from previous research. Instead, it was adapted specifically for the Algerian context to ensure cultural relevance and sensitivity. This adaptation was necessary because AIS differ from other international student groups in several important ways, including linguistic background, family expectations, religious coping practices, postcolonial histories, and understandings of mental health. Consequently, the wording, context, and themes included within the vignette were refined to reflect issues more likely to resonate with Algerian students, such as pressures surrounding family expectations, emotional silence, concerns about judgement, informal coping, and hesitation toward formal mental health services.

Prior to the main study, the vignette was informally piloted with Algerian students familiar with the UK higher education environment in order to assess clarity, realism, cultural appropriateness, and emotional sensitivity. Feedback from this process suggested that the scenario felt believable and relatable, particularly in relation to adjustment difficulties, loneliness, communication barriers, and concerns regarding disclosure. Minor revisions were subsequently made to simplify wording, improve cultural resonance, and avoid language that appeared overly clinical or detached from students' everyday experiences. Particular attention was given to ensuring that the vignette did not unintentionally pathologise normal adjustment difficulties or force participants into discussing mental health in rigidly medicalised terms.

The vignette also aligned with the critical-constructivist and reflexive orientation of the study. Rather than treating participant responses as objective reactions to a fixed stimulus, the vignette was understood as a conversational and interpretive tool through which participants could construct meanings around distress, stigma, coping, and help-seeking. Participants frequently moved between discussing the fictional student and reflecting on their own experiences, observations, or wider perceptions of Algerian student life. This fluid movement between hypothetical and personal discussion generated richer reflections while helping reduce the intensity that may accompany direct questioning around mental health difficulties. The inclusion of the vignette strengthened the methodological sensitivity of the research by supporting participant engagement with emotionally and culturally sensitive topics. Its use was informed by previous international student mental health research while also being adapted and refined specifically for the Algerian socio-cultural context. This design served two purposes. First, it created a relatable, concrete scenario for professionals who may not have worked directly with AIS, ensuring that all participants could engage meaningfully with the themes. Second, it encouraged reflection on both hypothetical and real-world cases, prompting professionals to consider not only their theoretical views but also their practical responses. The interview schedule contained 19 open-ended questions divided into three areas: mental health literacy; disclosure; and coping strategies/help-seeking. For example, one question asked: *"In your opinion, what are the barriers that hinder AIS from disclosing their mental health issues?"* These categories mirrored Study 1, enabling systematic comparison between student and professional perspectives. To prepare participants, the schedule was shared one hour before each interview. This allowed them time to reflect and reduced the likelihood of superficial answers. All interviews were conducted via Zoom, audio-recorded with consent, and later transcribed verbatim. All quotations are presented verbatim to preserve participants' original language, speech patterns, and meaning. Consequently, some quotations may contain grammatical irregularities, hesitations, repetitions, or non-standard phrasing

reflective of natural spoken language.

5.4.3 Procedure

The interview process was carefully structured to balance consistency with flexibility. Given the constraints of the COVID-19 pandemic and the dispersed locations of participants, all interviews were conducted remotely via Zoom. Each session lasted approximately 60 minutes. Participants were reminded in advance and provided with a personalised link to ensure accessibility. Before the interview began, the researcher gave a short briefing outlining the purpose of the study, the voluntary nature of participation, and ethical assurances, including confidentiality and the right to withdraw at any time. To reduce anxiety, only audio—not video—was recorded. Participants were reminded they could take breaks if needed. The interview schedule provided a guiding framework but was used flexibly. While all participants were asked about mental health literacy, disclosure, coping strategies, and help-seeking, the semi-structured format allowed for elaboration, follow-up questions, and exploration of unexpected insights. For example, when participants highlighted cultural differences in how AIS approached disclosure, the researcher probed further, asking how these shaped their professional practices. At the end of each interview, participants were thanked for their contributions and invited to add final reflections. This step ensured that participants could share insights not covered earlier and reinforced the collaborative ethos of the research.

5.4.4 Data Analysis

The interviews were analysed using comparative thematic analysis, following the reflexive model developed by Braun and Clarke (2006, 2019, 2021). This approach was chosen because it allows for a flexible yet systematic examination of patterns across qualitative data while

foregrounding the role of researcher reflexivity. Comparative thematic analysis was particularly appropriate for this study, given the design of including two groups of professionals; those with direct experience working with Algerian and Arab international students (AISs) and those without. This structure made it possible to compare perceptions and insights across groups, while still recognising shared understandings and divergences.

The analysis began with familiarisation; the researcher listened to each recording in full, read transcripts repeatedly, and noted early impressions. Initial codes were generated inductively, staying close to participants' words to avoid imposing preconceived categories. Codes were then collated into potential themes, with attention paid to how themes emerged differently between professionals with and without direct experience of AISs. This comparative stage was not about quantifying differences but about interpreting how prior experience shaped the ways participants constructed meaning around cultural barriers, stigma, and coping strategies.

Themes were reviewed iteratively; they were checked for coherence within each group and consistency across the full dataset. At this stage, the researcher actively reflected on how positionality, including shared cultural knowledge from Study 1 and personal familiarity with Algerian contexts, could shape interpretation. Reflexive notes and analytic memos were used throughout to make this process transparent. Themes were then refined, named, and defined in detail to capture both the semantic content of participants' accounts and the latent meanings underlying their talk.

Importantly, the comparative nature of this analysis allowed the research to address not only what professionals said but how their perspectives were influenced by whether they had prior experience of working with AISs. In this way, the analysis foregrounded cultural competence as both a resource and a potential gap in practice. This method aligns with wider calls for

qualitative research in psychology to emphasise context, reflexivity, and transparency (Levitt et al., 2018; Nizza et al., 2021).

5.4.5 Quality and Rigour

Ensuring quality and rigour in qualitative research requires more than procedural checklists; it involves sustained reflexivity, transparent reporting, and attention to trustworthiness throughout the research process (Yardley, 2000; Braun & Clarke, 2021). Several strategies were employed to enhance the quality of this study.

First, credibility was prioritised by adopting an inductive, reflexive approach to analysis. Rather than forcing data into pre-existing frameworks, themes were grounded in participants' accounts. To enhance credibility, prolonged engagement with the data was maintained, including repeated readings and reflexive memoing. The use of a vignette ensured that participants engaged with a shared scenario, providing comparability across interviews while still allowing individual reflections.

Second, dependability was addressed through clear documentation of analytic decisions. An audit trail was maintained, including coding notes, theme development records, and reflexive journals, ensuring that the analytic process was transparent and traceable. Regular reflexive discussions within the supervisory team supported this process, helping to surface assumptions and strengthen the interpretive depth of the analysis.

Third, transferability was considered by providing thick descriptions of the research context, participant characteristics, and the themes developed. Although qualitative research does not aim for statistical generalisation, detailed accounts enable readers to judge the applicability of findings to other settings, particularly where professionals work with culturally diverse student groups.

Finally, reflexivity was central. The researcher acknowledged the influence of prior knowledge from Study 1 and cultural familiarity with Algerian contexts. While this positionality offered valuable insight, it also carried risks of over-identification. Reflexive journaling was therefore used to examine moments of agreement, surprise, or discomfort, ensuring that interpretations remained grounded in participants' accounts rather than the researcher's expectations.

Taken together, these strategies align with contemporary standards of qualitative psychology, which emphasise that rigour is not about rigid adherence to protocols but about transparency, reflexivity, and a clear demonstration of how analytic claims are warranted (Levitt et al., 2018; Yardley, 2000; Braun & Clarke, 2021). By adopting these principles, this study aimed to generate findings that are both credible and meaningful, while contributing to ongoing debates about cultural competence in professional practice with international students.

5.5 The Findings

The analysis of the 20 interviews with professionals generated five overarching themes that capture how Algerian and Arab international students' (AISs) mental health literacy, disclosure practices, coping strategies, and help-seeking behaviours are understood from a professional standpoint. These themes represent interrelated areas of meaning rather than isolated categories; each theme reflects a layer of interpretation that professionals brought to their encounters with international students, shaped by their own training, cultural competence, and prior exposure.

The first theme, *Cultural Mirrors: Demons, Possession, and Madness in the Algerian/Arab Mental Health Context*, illustrates how many professionals understood the centrality of religious beliefs and spiritual explanations in shaping AISs' perceptions of mental health. Participants emphasised that conditions were often framed in terms of jinn, black magic, or

possession, leading to a preference for prioritising physical health and overlooking mental well-being.

The second theme, *Cultural Influences on Professionals' Perceptions of AISs' Mental Health*, highlights how practitioners' own cultural backgrounds and level of cultural competence shaped their interpretations of students' presentations. Professionals acknowledged that misunderstandings could arise when their own explanatory frameworks clashed with students' cultural framings, potentially leading to bias or misjudgement.

The third theme, *Types of Stigma through Cultural Complexities: Internal vs. External Stigma*, captures the dual pressures that students face. On one hand, societal stigma portrays mental illness as shameful, discouraging disclosure. On the other, self-stigma reinforces internalised shame, leaving students reluctant to articulate their distress even in safe spaces.

The fourth theme, *The Web of Barriers toward Disclosure and Seeking Professional Help among Algerian/Arab International Students*, draws attention to the interwoven challenges identified by professionals. These include fear of judgment from peers and family, language barriers that complicate help-seeking, and perceptions that UK services lack cultural understanding. Professionals described how these obstacles compound one another, producing a cumulative effect that limits students' engagement with formal support.

Finally, the fifth theme, *Isolation, Substance Use, and Reliance on Prayer and Spiritual Practices as Coping Mechanisms*, illustrates the range of strategies AISs employ to manage their mental health. Professionals described how students may withdraw socially, use substances as a form of escape, or turn to prayer and Qur'anic recitation for solace. Religious practices, while offering comfort, were seen as both a resource and a potential barrier when they delayed or replaced professional care.

To provide clarity and illustrate the structure of these findings, the table below summarises the master themes, sub-themes, and key insights.

Table 5.2

Themes Identified from Professionals' Perspectives

Master Theme	Sub-Themes	Key Findings
Cultural Mirrors: Demons, Possession, and Madness in the Algerian/Arab Mental Health Context	• Religious beliefs in mental illness; • Preference for physical over mental health; • Cultural framing of distress as spiritual	Professionals noted that mental health issues were often explained through possession, black magic, or demonic influence; physical health tended to be prioritised over psychological well-being.
Cultural Influences on Professionals' Perceptions of AISs' Mental Health	• Cultural sensitivity in practice; • Misunderstandings or biases due to cultural differences; • Influence of professionals' own cultural competence	Cultural differences influenced how practitioners perceived AISs; limited cultural competence risked bias or misinterpretation of distress.
Types of Stigma through Cultural Complexities: Internal vs. External Stigma	• Societal stigma; • Self-stigma and internalised shame	Stigma was seen to operate both externally (from peers, family, and society) and internally (self-judgement), discouraging disclosure.
The Web of Barriers toward Disclosure and Seeking Professional Help	• Fear of judgment from peers and family; • Language barriers; • Lack of cultural understanding in services	Professionals identified interconnected barriers; stigma, cultural expectations, and linguistic challenges

		collectively restricted engagement with formal services.
Isolation, Substance Use, and Reliance on Prayer and Spiritual Practices	• Social withdrawal and isolation; • Substance use as coping; • Prayer and spiritual practices as emotional support	Coping mechanisms included avoidance, substance use, and religious practices; prayer and Qur'anic recitation offered comfort but sometimes delayed professional intervention.

Note. Themes were developed inductively from semi-structured interviews with professionals; sub-themes capture recurring ideas within each master theme.

Theme 1: Cultural Mirrors: Demons, Possession, and Madness in the Algerian/Arab Mental Health Context from professional perspectives

When describing mental health understanding in Algerian/Arab countries, all participants acknowledged that mental health is not widely accepted or well understood within these cultures. The analysis did not reveal notable differences between the perspectives of professionals with prior experience working with Algerian/Arab students and those without, as both groups expressed similar views on the cultural perception of mental health. Adisa illustrated how cultural beliefs can significantly hinder awareness and understanding of mental health issues, she highlighted mental health issues are often linked to a lack of faith or viewed as a personal failure and accepted to be seen as demonic possession but not to acknowledge these issues as legitimate mental health challenges, which significantly impacts the understanding and acceptance of mental health in these cultures.

> *"I mean from a cultural perspective it's not understood, mental health issues are more linked to demonic procession and not a mental health difficulty." (Adisa)*

Tia added that, based on conversations with Arab international students and her own observations in the workplace, there are significant barriers in how these students perceive mental health. In their cultural context (students), mental health concerns are often viewed as a sign of weakness or something undesirable. This negative perception is linked to the terrifying notions of being possessed or cursed. Consequently, people tend to avoid acknowledging or addressing their mental health issues, choosing to ignore them.

> *"From conversations that I've had with international students and from where I work mental health issues are linked to being possessed and cursed which are frightening things, so people won't think of it and always ignore it." (Tia)*

Some participants mentioned that mental health is seen as a frightening concept because it is associated with being, cursed, or under the influence of "Jinn"

"Cultures have different understandings of mental health and in most cases, it is seen as something scary ... they think they're cursed, or they've got a Jinn... and this is easily related to some of the religion interpretations and the beliefs that people have has a big factor as well." (Anna)

Verdure admitted that he used to hold the same belief as Algerian/ Arab before being a professional where mental health is caused by black magic, being cursed and possessed. He highlighted the effect of religion on mental health treatment and shaping understanding describing that it is widely accepted to be cursed and possessed and not seen as mentally ill.

"They're very much driven by the religious factor, people are happy to believe that somebody has done black magic on them and unhappy to kind of accept that feeling mentally unwell ( )some people I have heard believe that it's a curse from the past deeds and that's why someone's suffering from mental health (…….)and in my own culture, again we do partly believe in black magic and until I went to mental health career, I seriously believe in it." (Verdure)

Together with Verdure, Sebastian highlighted a common belief in Eastern culture where people tend to be more spiritually oriented. When individuals experience emotional or psychological distress, they may interpret their feelings as being the result of spiritual attacks which can be described as feeling possessed. This perspective emphasises the significance of spiritual and supernatural elements in their understanding of mental and emotional well-being

"In the eastern culture, they say, people are more spiritual oriented, so you know when they feel like mentally unwell, they may feel they are under attack of some spiritual attacks and being possessed. "(Sebastian)

Vicky added another observation that reflects a common phenomenon where there's often confusion between the concepts of mental health and mental illness. When someone expresses

feelings of sadness or low mood and mentions being depressed, many people tend to immediately associate these emotions with a form of mental illness, often labelled as "crazy," "mad," or "insane." This confusion arises because some mental health conditions are erroneously linked to the belief in curses or possession. As a result, differentiating between everyday emotional struggles and actual mental illnesses becomes challenging.

> *"I believe in Algerian culture as well, people confuse between mental health and mental illness so when somebody says, I feel, low mood I feel depressed they automatically think something wrong with him mentally like being crazy, and mad insane (....) as some of mental illnesses are directly linked to being cursed or processed therefore people would never manage to make the differences and properly understand them*
> *."(Vicky)*

Lasley also noted that mental health understanding among Algerian/Arabs is often hindered by the stigma of madness. It is perceived as difficult to treat, live with, and even be around someone with a mental health condition. Mental health issues are sometimes associated with madness, creating a significant barrier to understanding.

> *"I think it's understood as it's difficult to treat it's difficult to live with somebody with a mental health condition is like mad, it is madness and a lack of understanding of how to treat them how to work with them how to be with them." (Lasley).*

Another observation about individuals experiencing depression or low moods is often met with criticism and judgment from friends and family in certain cultural contexts. Bale added that these negative reactions are tied to beliefs in curses, black magic, and the perception that experiencing such emotions signifies being spiritually distant from God. In such cultures, mental health struggles are sometimes attributed to supernatural or religious factors, leading to social stigmatisation rather than understanding and support. This further contributes to the

challenges individuals face when dealing with their mental health in such environments.

"Everybody feeling depression or low mood gets criticised by friends and family... it is linked to curses, black magic, and being far from God." (Bale)

Together with previous participants, Caroline argued that the lack of mental health understanding is due to consideration of mental health as a non-existing concept since it is linked to being possessed and cursed.

"You know in Africa, there are so many things that we don't even know because we don't have it, you understand, we don't name it; so you feel like it doesn't exist as a concept, you know that kind of when you come in here somebody like this antisocial if somebody antisocial in Africa it's not anything there is nothing wrong with it you get my point. So, the concept is not there but the practices and some beliefs show it is there, like mad, being cursed, or possessed. "(Caroline)

Furthermore, Arthur discussed that within Arab countries, physical health is prioritised to a greater extent than mental health. This prioritisation stems from a lack of understanding and awareness of mental health issues where people experiencing mental distress may express their condition through physical symptoms, such as body pain or headaches, as they struggle to comprehend the connection between mental and physical well-being.

"People express any mental distress in physical form because they don't understand mental health... they prioritise physical health over mental health ( ) Mental health is only recognised when they have severe mental problems or enduring mental problems and yet linked to curses, black magic, and being far from God. "(Arthur)

Together with Arthur, Bale noted that mental health concerns are typically only acknowledged when they reach a severe stage. In the early stages of mental health issues, there is often a lack

of recognition due to cultural beliefs and misconceptions related to curses, black magic, or distance from God.

"Mental health is only recognised in severe cases... they don't have it recognised in the early stage." (Bale)

Theme 2: Cultural Influences on Professionals' Perception of Algerian /Arab International Students' Mental Health

Professionals have acknowledged that their own cultural origins can shape their understanding of the challenges faced by international students, who often come from diverse cultural backgrounds and impacted students' mental health. Arthur acknowledged that his own cultural backgrounds influenced his understanding of international students' mental health challenges. He recognised that cultural differences could lead to variations in how distress is expressed, coping mechanisms are employed, and symptoms are interpreted within different cultures.

"You know we are all part of our upbringing and every culture has a different way, especially people almost don't always have the Western model of illness first of all, you know, disease and illness varies across each culture, how they see themselves so health behaviour itself vary in different cultures, more so in mental health, you know there's lots of religious component, you know people explain mental health in different forms in different ways, you know religion has big role in it."(Arthur)

According to professionals, cultural factors have a profound impact on their judgment and how they perceive mental health issues. Vicky conveyed the idea that cultural influences act like a filter through which people perceive and understand mental health. This cultural lens shapes her perspectives where she tends to interpret everything based on the values and beliefs instilled by her upbringings and cultural environment. She suggested that we are a product of the interplay between nature (inherent traits) and nurture (cultural upbringing)

" I'm going to see others mental health and everything in the lens of the culture that has taught me who we are, we are basically a part of nature versus nurture, so we are nurtured by the environment with certain variables that evolved in our own culture and that always has an impact on our judgment. (Vicky)

However, Bale shared different opinion regarding mental health understanding, where he said that being from a different culture of the international students put them in the ideal position to understanding different perspectives of mental health especially as professionals being internationals themselves.

"I'm in an advantage position because I am from different culture, so I can kind of understand instantly what are the possible reasons could be for someone experiencing problem and how it could be managed safely and adequately, so yeah I do understand how a different culture can influence their understanding around mental health problems and I am aware of the differences between my culture as a professional and the others culture." (Bale)

Additionally, Sharin shed light on experience at work, sharing that having experience within mental health helps professionals to understand others' mental health regardless the cultural differences.

"So, having had that experience with different backgrounds, with different cultures I'm able to understand what they mean by saying something so reading in between lines is quite easy and also having an open mind." (Sharin)

For some students, mental health struggles are interpreted through cultural and religious lenses. Verdure shared that he once believed in black magic as an explanation for mental health issues:

"We do partly believe in black magic and until I went to mental health career actually, I seriously believe it." (Verdure)

Participants in this study (professionals) indicated that cultural background can shape their understanding of international students' mental health experiences. While some professionals acknowledged that their own cultural background might influence their perceptions, others viewed cultural similarity to students as an advantage in building rapport and fostering trust with students. Additionally, professional experience emerged as a crucial factor that could enhance understanding and help bridge cultural differences, reducing the potential impact of personal biases on mental health comprehension.

Theme 3: Types of stigmas through cultural complexities: internal vs external stigma

In addition to madness, being cursed and possessed to avoid being seen weak, mental health stigma among Algerian/Arab international students is seen by professionals to be influenced by cultural complexities, societal attitudes, and personal struggles. Participants highlighted two key dimensions of stigma: internal stigma, driven by self-stigmatisation, and external stigma, shaped by societal attitudes. Internal stigma arises from a clash between cultural beliefs, societal norms, and personal values. Participants expressed how the fear of judgment by peers and family prevents students from acknowledging their mental health challenges. Faiza described this internal conflict, linking it to cultural expectations and norms that reinforce self-stigmatising attitudes:

"…. there's a perceived sense and self-stigmatising attitudes mental health which can create an embarrassment and fear of identifying with a mental illness or I
can't get help you know where sometimes i'm getting mental health issues, how would I get out of that. So it's our beliefs, our norms our values everything really. (Faiza)

Bale added that self-stigmatisation amplifies existing barriers, making it difficult for individuals to recognise or address their struggles.

> *"Sometimes you just don't want to admit it to yourself, like, you feel ashamed to even think you might have mental health issues. It's easier to just avoid it than to face it because of how you know people will see you—and even how you see yourself." (Bale)*

While cultural stigma operates externally, shaping societal attitudes and expectations, self-stigmatisation is an internalised process where individuals themselves come to believe in these cultural narratives, further deepening their reluctance to acknowledge their struggles as legitimate mental health concerns. The inclusion of participants' perspectives, like Zak's, illustrates this internal conflict—where individuals begin to attribute their distress to supernatural causes rather than recognising it as a mental health issue. This belief not only prevented individuals from seeking help but also led them to internalise these notions, creating a barrier to self-acknowledgment.

> *"People think if you're struggling, it must be because you've been cursed, or someone did black magic on you. And you start to believe it too, like, 'Maybe I'm cursed or weak especially for men. That makes it so hard to even think of it as mental health—you just feel stuck in that belief." (Zak)*

External stigma, on the other hand, stems from societal attitudes and stereotypes. Participants noted that mental health issues are often associated with madness, which perpetuates harmful misconceptions and discourages help-seeking. Bale emphasised that individuals experiencing mental health issues, such as depression, face criticism from their social circles, where this stigma is a barrier to early recognition and intervention for mental health problems.

"There is a big culture shock and stigma around mental health people feeling depression get criticised by friends and family as being mad or crazy therefore people won't even accept to be depressed or feel low." (Bale)

The stigma extends beyond those seeking help to include the professionals offering support. Sam shared the cultural barriers faced by international students when approaching counselling services, as mental health support is often perceived as something only for "crazy" individuals.

"There is a lot of stigmas around seeking professional help among international students, again, I can only speak from my behalf like there is cultural stigma about approaching counselling thinking that only people with issues or psychological conditions like being crazy go for counselling ... Also, I have to say that even in some culture they even consider professionals as crazy as there is a stigma toward their job as professionals. (Sam)

Alecia reinforced this view, adding that stigma impacts both the person seeking help and the professionals providing it. She highlighted how societal perceptions of psychologists as "mentally ill" raised the stigma around mental health issues.

It is also sad to say that generally people see a psychologist as a mentally ill person per see, like a crazy because he or she is already categorised within the crazy people category so, both are affected the person struggling and the psychologist themselves. So, society's way of dealing with such categories is very stigmatised. But I would also add that I think even psychologist back home don't look at people as normal people so it's both sides. (Alecia)

Theme 4: The web of barriers toward disclosure and seeking professional help among Algerian/Arab international students: professional insights

Professionals highlighted a complex network of interlinked barriers that hinder Algerian/Arab international students from seeking professional mental health support. These challenges

include a lack of awareness, language difficulties, reliance on family-based support systems, fear of judgment, cultural shame, and traditional beliefs about mental health. These factors combine to create significant obstacles to disclosure and engagement with mental health services.

A lack of understanding of how mental health systems operate in the host country emerged as a substantial barrier. Students unfamiliar with the structures and processes of mental health services may hesitate to seek help, assuming the system mirrors that of their home countries. This misconception often results in uncertainty and reluctance as Nadin explained:

> *Many international student are going to come here they might have would have gone through different scenario in their country and they might think that they might not be really aware of how mental health system works here and they might compare the system which is available in their country, and they may just think that you know it might be the same system here and they may just not willing to be to disclose it, I think that is one of the barriers, I think that would be one barriers, not knowing how the system works here that's one of the barrier. (Nadin)*

If aware where to seek help, students may struggle with language barriers. Participants shared that language differences can hinder students from disclosing and seeking professional help while in the U.K.

> *"I think it could be, because he didn't get the support when he tried before or it could be, because he wasn't understood when he first asked for help due to language barriers or the limited knowledge of how to express they struggles in a different language where people my fear misunderstands" (Sharin)*

In addition to language barriers, Arthur pointed out that some cultures may discourage women from talking to male therapists or doctors, creating discomfort for female students seeking

help. Additionally, age differences between the therapist or healthcare provider and the student can influence their willingness to disclose personal issues, as students may find it challenging to relate to someone much older or younger.

> *“Gender probably you know in some cultures women find it difficult to talk to men so that might you know gender is also different or age might be if the therapist or doctor is too young or too old for them and this can be considered as a barrier for them to seek help and disclose.” (Arthur)*

Tia shared her experience that in many Algerian/Arab cultures, family is seen as the primary source of emotional support, reducing the perceived need for external mental health services. Their therapeutic needs are often met within their family structures, making the idea of seeking help from external sources unfamiliar and even unnecessary.

> *"The students, I have worked with so many students including me when I first came, I didn't know what that company was (mental health service) about it's not within my construct because our support systems our family systems is therapeutic in its own way, so there was no need for external counselling." (Tia)*

However, Verdure highlighted the potential limitations of relying solely on family support, sharing a case where a family’s intervention exacerbated the student’s mental health condition:

> *"From I have seen a patient who was at university and he started struggling and disclosed to his family, so what his family did, they sought the help from local in this country who then virtually prescribing some medication they posted the medication across to him and he started using it which will be done from the symptoms is not treating symptoms which made it worse." (Verdure)*

Adisa explained that cultural expectations around honour and reputation were frequently identified as barriers. In many Algerian/Arab cultures, mental health struggles are perceived as a source of shame that could tarnish a family's reputation, particularly for men.

> *"It's kind of like a shame thing to the family ... so culture is us culture everything is dependent on that us thing you know and at times going to seek help is like putting your family's name into a bad reputation or something like that and it's just as simple as that is really huge." (Adisa)*

Faiza also highlighted the fear of acknowledging emotional struggles and the potential consequences of family members finding out:

> *"When they're feeling low no one ever mentioned those because they're scared of hearing about it and then they're scared if their family find out and what you can do about it." (Faiza)*

Deeply ingrained cultural beliefs about mental health, including associations with black magic and curses, can significantly delay or prevent seeking help. Verdure reflected on how such beliefs influenced his own family's response to mental health issues:

> *"In my own culture, again we do partly believe in black magic and until I went to mental health career actually I seriously believe it and then one of my family members had severe enduring mental health problems and he was always taken to temples to kind of be treated and we never understood why is behaving in a different way, compared to other people and then are always we were given reasons as like look, this is a curse from somebody." (Verdure)*

Sebastian also shared his belief in traditional treatment methods, despite their lack of scientific validation:

"I'm a Christian by background and you know, in the Eastern culture and I have seen this practices, and I actually believe in it you know, like casting out evil spirit ... unless scientifically proven we cannot do anything but I do see these things ion cultures and I also believe in it regardless being a professional, I must admit that in some cases this belief may affect the help seeking process by delaying it" (Sebastian)

Concerns about confidentiality and mistrust of professionals were common barriers. Verdure stressed the importance of ensuring confidentiality to alleviate these fears:

"Confidentiality is as much an important aspect, and sometimes when you face a mentally unwell person actually they are very much worried (...) about actually what if this person goes and says about my mental problems to someone around me or the university or to anybody yeah you know, so therefore professionals should be sure to kind of explain how they bound to confidentiality issues." (Verdure).

Arthur and Davie emphasized the difficulty of building trust with professionals from different cultural backgrounds, particularly when students are far from their families:

"Definitely trust depends on you know their previous experience, whether from that point of view, you know, there might not even see someone from outside their culture." (Arthur)

"Possibly the beliefs system they have been brought up with, trust issues these are you know, so when people are feeling low let's say they tempt to go to their families, but here their families are overseas, so they have to build relationships and trust with others and that's not always easy." (Davie)

This web of barriers; spanning awareness, language, cultural expectations, and trust—creates a challenging environment for Algerian/Arab international students seeking mental health support.

Theme 5: Isolation, Substance Use, and Reliance on Prayer and Spiritual Practices as Coping Mechanisms

Arab and AIS employ a range of coping strategies to adapt to the challenges of studying abroad. Professionals highlighted isolation as a significant behaviour, sometimes coupled with substance use to manage stress. However, isolation is often mitigated by seeking informal emotional support from family and friends, who play a central role in offering guidance and reassurance. For some students, the pressure of academic and cultural adaptation leads to social withdrawal and the use of substances as a coping mechanism. Faiza shared an example of a student struggling with academic expectations, who turned to cannabis and drugs. Unfortunately, this led to severe mental health issues, including psychosis:

> *"You know they may be withdrawn from the normal social group more isolating themselves I have come across one of the students who was doing a lot of studies here their parents from Dubai and having a lot of pressure with his studies what he did he ended up having a cannabis and drugs just for coping mechanism so that make him like you know, seeing things and hearing people's voices and hallucinating you know."* (Faiza)

Many students draw strength and solace from prayer and spiritual practices, using their faith as a source of resilience. Adisa highlighted how, in Algerian and Arab societies, religious healers often take precedence over psychologists:

> *"But society no I don't think so, the only thing that the majority would think of is religious practices, like praying or visiting the priest or Imam who will help, but not a psychologist."* (Adisa)

Similarly, Sam emphasised how cultural and religious traditions are deeply intertwined, with students relying on prayers, herbal remedies, and faith-based guidance to cope:

> *"Culture and religion intertwined in certain parts of the world, so people start to you know*

pray, seek solace in their religion and their holy scriptures, their books, their priests. You know, they drink herbal teas. Some take medicinal herbs, which can help… but sometimes not saying anything in itself is a way for them to cope with it, which is quite damaging in the long run." (Sam)

Arab and Algerian international students often rely on informal networks of family and friends to navigate the challenges of adapting to new cultural contexts. Prayer and spiritual practices provide a significant source of strength, while cultural explanations for mental health, such as beliefs in black magic, reflect a divergence from conventional scientific approaches. However, reliance on such coping mechanisms, particularly when paired with isolation or substance use, underscores the importance of culturally sensitive mental health support.

5.6 Discussion

This study set out to explore how mental health professionals perceive the mental health literacy, disclosure, and help-seeking behaviours of Algerian and Arab international students (AISs). The findings showed that cultural and religious beliefs, stigma, and language barriers strongly influence how these students approach mental health, shaping whether and how they disclose their difficulties and whether they turn to professional services. Importantly, the comparative design revealed no significant difference between the accounts of professionals with and without prior experience of working directly with AISs. While professionals occasionally provided more detailed illustrations, the overall patterns were remarkably similar, suggesting that the difficulties identified are structural and extend beyond individual expertise. What distinguishes AIS experiences, however, is not the existence of these barriers alone, but the specific cultural, religious, linguistic, and moral frameworks through which they are interpreted and negotiated. These frameworks shape how distress is understood, how

stigma is anticipated, and why certain forms of help remain inaccessible or mistrusted.

Professionals consistently emphasised that many AISs continue to understand psychological distress through cultural and religious frameworks. Conditions such as anxiety or depression were often described as linked to possession by jinn, the evil eye, or divine punishment. These interpretations are consistent with attribution theory, which demonstrates that when individuals attribute difficulties to external causes such as supernatural forces, they are less likely to view professional intervention as appropriate (Heider, 1958; Yang et al., 2020). External attributions also reinforce stigma and reduce help-seeking, as they shift responsibility away from treatable psychological factors and towards uncontrollable spiritual forces (Corrigan et al., 2016). The accounts given by professionals mirror broader findings across Arab contexts, where spiritual explanations remain widespread (Rassool, 2015; Merhej, 2019). Similar cultural attributions can be observed in South Asian communities in the UK, where mental illness is sometimes linked to black magic or divine punishment (Cinnirella & Loewenthal, 1999), and in China, where distress is explained in terms of imbalance and disharmony (Kleinman, 1980). These comparisons show that cultural attributions are not unique to Arab societies, but reflect broader worldviews that emphasise collective harmony, spirituality, or family honour over individualised psychological explanations. Another major feature of professional accounts was the tendency for AISs to prioritise physical health over mental health. Professionals described how students often presented distress in physical terms; complaining of headaches, fatigue, or stomach pain; rather than articulating psychological difficulties. This reflects the well-documented phenomenon of somatisation, whereby psychological distress is expressed through the body in order to avoid stigma (Kirmayer & Young, 1998; Al-Krenawi, 2022). Somatisation allows individuals to seek care without acknowledging socially stigmatised mental illness, but it also delays recognition of mental health needs until problems become severe. The Health Belief Model provides a useful

explanation here: people are more likely to seek care when they perceive an illness as severe, treatable, and legitimate (Becker, 1974). Physical symptoms are often recognised as legitimate, while psychological ones are trivialised, leaving mental health concerns marginalised. Similar patterns are documented among Indian and Chinese international students, who also present distress somatically as a culturally sanctioned way of accessing care (Jacob et al., 2019; Wong et al., 2021).

Stigma was described as the most pervasive obstacle, operating across multiple levels. Self-stigma emerged when students internalised negative cultural messages, feeling ashamed or guilty for experiencing distress, and believing that seeking help signalled weak faith or moral failure (Corrigan et al., 2014). Public stigma was evident in collectivist contexts where disclosure could damage family reputation, harm siblings' marriage prospects, or impact career opportunities (Dardas & Simmons, 2015). Professionals noted that students frequently remained silent not for individual reasons alone, but to protect family honour. Structural stigma also constrained engagement, as many services were described as Westernised, privileging therapeutic models that assume self-disclosure and individual autonomy. For students from cultures where family consultation and community values dominate, this mismatch eroded trust in services (Sue et al., 2009). An additional element identified was stigma directed at professionals themselves. In some Arab contexts, psychologists are perceived as ineffective or untrustworthy, while psychiatry is associated with coercion or confinement (Zolezzi et al., 2018). Several professionals reported that students or their families questioned whether "talking to a stranger" could provide meaningful help. This resonates with Link and Phelan's (2014) conceptualisation of stigma as a process involving labelling, stereotyping, and discrimination; here, stigma extended not only to the condition but also to the very professionals tasked with addressing it. Such compounded stigma; towards illness, disclosure, and treatment—creates a powerful cycle of silence and avoidance that

restricts opportunities for early intervention.

Gender norms further intersected with these cultural and structural barriers. Professionals consistently observed that male students were particularly reluctant to disclose difficulties, reflecting expectations of masculinity that privilege self-reliance and emotional control. Connell's (2005) theory of hegemonic masculinity provides an important framework here: cultural ideals of manhood that prioritise resilience and stoicism discourage men from seeking help. This aligns with Scambler's (2009) conceptual distinction between felt stigma; anticipation of judgement; and enacted stigma, which refers to direct experiences of discrimination. In this study, many men appeared to experience felt stigma particularly strongly, anticipating negative social consequences even in the absence of explicit judgement or rejection. This pattern is consistent with wider empirical research showing that Arab men are less likely than women to seek psychological support, often because help-seeking is perceived as a threat to masculinity or social standing (Hamdan-Mansour et al., 2018; Abo-Rass et al., 2023). Professionals' accounts therefore suggest that gendered expectations intensify existing cultural barriers, rendering silence a comparatively safer and more socially acceptable response for many men. Language was another critical barrier raised in the findings. Professionals reported that students often shifted between Arabic, French, and English when articulating their experiences. While English provided the vocabulary of psychology and diagnosis, Arabic and French carried deeper emotional resonance. This finding aligns with the Sapir-Whorf hypothesis, which suggests that language shapes thought and constrains expression (Whorf, 1956; Chen & Kim, 2020). Emotional disclosure tends to be richer and more nuanced in the mother tongue (Pavlenko, 2014), yet services that rely exclusively on English risk flattening meaning and underestimating distress. Research confirms that therapy conducted in one's native language fosters greater trust and disclosure (Diaz & Wong, 2022). For AISs, the inability to use familiar linguistic repertoires affect their

sense of safety and authenticity, leading to partial or delayed engagement with services.

The findings also emphasised the centrality of religious coping and traditional healing. Professionals noted that many AISs turned first to prayer, Qur'anic recitation, or imams, and only later; if at all; to professional care. This aligns with Pargament's (1997) model of religious coping, which highlights how spirituality can provide both resilience and meaning. However, professionals also recognised the risk of spiritual bypassing, where religious practices are used to avoid confronting psychological pain (Dein, 2021). While faith-based coping may provide short-term comfort, over-reliance can delay disclosure until crises emerge. This is consistent with studies across Muslim-majority contexts showing that while religious coping supports resilience, it may also act as a barrier to professional engagement (Mahmoud et al., 2021). Professionals suggested that integration of faith and therapy could be a way forward, though they cautioned against reinforcing stigma or discouraging evidence-based care. This finding resonates with contemporary counselling and psychotherapy literature, which increasingly recognises spirituality and religious belief as meaningful resources in coping and psychological adjustment rather than as markers of pathology (Pargament, 2007; Oxhandler & Pargament, 2018). Culturally responsive and integrative approaches emphasise the importance of engaging with clients' faith frameworks in ways that are respectful, reflexive, and non-reductive, avoiding both dismissal and uncritical endorsement (Hook et al., 2016). However, empirical work suggests that such integration remains uneven in practice, particularly within institutional contexts shaped by secular norms, risk management, and standardised models of care. The present findings extend this literature by illustrating how AIS experience the absence of faith-sensitive engagement not as professional neutrality, but as cultural and moral misrecognition, which in turn undermines trust and discourages disclosure. In this sense, accommodating faith emerges not as an optional cultural add-on, but as a relational condition for credible and effective support.

Coping strategies reported by professionals reflected both protective and harmful tendencies. On the adaptive side, prayer, family support, and cultural belonging were seen as providing resilience. On the maladaptive side, withdrawal and substance use emerged, particularly when students felt overwhelmed by the pressures of academic adjustment and cultural adaptation. Berry's acculturative stress theory (1997) offers a useful lens, highlighting how cultural dissonance and marginalisation produce psychological strain. Cases of cannabis use leading to psychosis were described by professionals, underscoring the risks of self-medication in the absence of accessible or trusted professional care. Similar findings have been documented among international students elsewhere, where maladaptive coping emerges when institutional support is limited (Smith & Khawaja, 2022).

Perhaps the most striking finding was the absence of significant difference between professionals with and without prior experience of working directly with AISs. Both groups identified the same barriers; cultural attribution, stigma, service mismatch, and coping strategies; although experienced practitioners sometimes offered more detailed examples. This convergence suggests that the barriers are not simply matters of individual expertise but are systemic and structural. The reflective practitioner model (Schön, 1983) helps explain this: professionals adapt by reflecting on prior knowledge and applying it to new contexts, even in the absence of direct experience. Schema theory (Bartlett, 1932) also suggests that professionals use existing cognitive frameworks to interpret unfamiliar groups. While this allows for understanding, it also risks generalisation, as professionals may rely on broad categories of "Arab" or "Muslim" rather than Algeria-specific histories and contexts.

This similarity in accounts raises a further issue about student perceptions. As shown in Study 1, many AISs expressed a preference for professionals who "understand Arabs," assuming that cultural familiarity guarantees competence. Yet if professionals without direct experience reach similar interpretations, this assumption may itself reflect distrust or stigma. Research

on perceived credibility shows that clients often judge competence based on perceived similarity rather than actual expertise (Sue et al., 1991). For AISs, this may mean avoiding professionals not because they lack skill, but because they are seen as culturally distant. This perception adds another barrier, reinforcing avoidance even when adequate help is available.

Taken together, these findings contribute to the literature in two important ways. First, they confirm and extend the insights of Study 1: the barriers described by AISs stigma, cultural attribution, linguistic constraints, and reliance on traditional coping; are also recognised by professionals. This convergence strengthens the argument that these barriers are structural, not merely individual misunderstandings. Second, the findings raise critical questions about the role of experience. While direct engagement may enrich professionals' examples, it did not fundamentally alter their understanding. This suggests that competence is shaped less by exposure to specific groups and more by broader professional training, reflective practice, and cultural humility (Hook et al., 2013). Cultural humility emphasises openness, self-reflection, and an ongoing willingness to learn, rather than mastery of specific cultural facts. The consistency in accounts supports this approach: what matters is not simply prior experience but the ability to engage students with sensitivity, flexibility, and respect.

In conclusion, this study demonstrates that AISs' reluctance to engage with mental health services is shaped by interconnected cultural, religious, linguistic, and systemic factors. Professionals, regardless of prior experience, recognised these barriers, but the similarity of their accounts suggests that structural change is needed to make services culturally responsive and linguistically accessible. The findings also challenge assumptions about the role of experience, showing that cultural humility and reflective practice may be as important as direct exposure in fostering competence. For AISs, who often perceive services as Westernised and distant, the challenge is not only to improve professional awareness but also to rebuild trust. Addressing stigma, strengthening cultural and linguistic adaptation, and

fostering dialogue between students and professionals are essential steps toward equitable mental health provision for Algerian and Arab international students in the UK.

5.7 Chapter Summary

This chapter examined the perspectives of mental health professionals on the challenges faced by Algerian and Arab international students (AISs) in relation to mental health literacy, disclosure, coping, and help-seeking. The findings showed that cultural and religious frameworks continue to shape how AISs conceptualise distress, often leading them to attribute problems to supernatural or spiritual causes, such as possession, the evil eye, or divine punishment. Such attributions reinforce stigma and delay professional intervention, echoing the accounts given by students themselves in Study 1.

Professionals also reported that AISs frequently prioritise physical health over mental health, expressing difficulties somatically rather than through psychological terms. While this allowsstudents to seek care without confronting stigma, it also postpones recognition of distress until problems become severe. Stigma remained the most pervasive obstacle across professional accounts, operating at multiple levels: self-stigma, where students internalise shame; public stigma, where disclosure risks damaging family reputation; and structural stigma, where services themselves are experienced as Westernised and mismatched with cultural values. Compounding this, some professionals described how psychologists and psychiatrists are themselves stigmatised in certain Arab contexts, reducing the credibility of services in the eyes of students and families.

Gender norms were also recognised as shaping disclosure. Male students were often seen as reluctant to seek help, constrained by expectations of self-reliance and emotional control. Theories of stigma and masculinity help explain why men, in particular, perceive disclosure as threatening to their honour and social standing. Language added another critical layer:

students often moved between Arabic, French, and English when expressing themselves, yet services that functioned exclusively in English risked misrepresenting or diluting their meaning. Professionals consistently emphasised that this linguistic barrier not only created misunderstanding but also undermined trust.

Coping strategies were described as a mix of protective and harmful practices. Prayer, Qur'anic recitation, and reliance on community provided resilience for some, while withdrawal and substance use were described as maladaptive strategies that exacerbated isolation or risked severe consequences. Professionals viewed religious coping as central, but also recognised its potential to delay professional engagement when students relied exclusively on spiritual practices to manage distress.

One of the most striking findings was the absence of significant difference between the accounts of professionals with and without prior experience of working directly with AISs. Both groups identified the same structural barriers and cultural frameworks, though those with experience sometimes provided more detailed examples. This convergence suggests that the barriers faced by AISs are systemic and not dependent on the individual expertise of professionals. It also raises questions about how students themselves perceive professional competence, as some may assume that only those with direct cultural familiarity are "qualified" to help, even when professionals without such exposure identify the same obstacles. The findings therefore highlight the need to move beyond assumptions about cultural mastery and instead emphasise cultural humility, reflective practice, and systemic adaptation of services.

Overall, this chapter has shown that AISs' reluctance to engage with mental health services reflects the interplay of cultural, religious, linguistic, and systemic factors. Professionals recognised these barriers regardless of prior experience, underscoring the importance of

adapting services to be linguistically accessible, culturally sensitive, and responsive to students' lived realities. These insights extend the findings of Study 1 by shifting the perspective from students to the professionals who support them, offering a more complete picture of the gaps between need and provision.

While Study 2 highlighted how professionals interpret and respond to AISs' mental health challenges, it also reinforced that these challenges are not confined to the period of study abroad. For many students, the return to Algeria after completing their education introduces new pressures and reactivates earlier dilemmas about disclosure, coping, and identity. Reintegration involves negotiating expectations of family, community, and labour markets while readjusting to systems of care that may be limited, stigmatised, or oriented around traditional healing practices.

Study 3 therefore turns to the voices of Algerian returnees themselves, focusing on how they make sense of their mental health after returning home from the UK. Whereas Study 1 explored students' struggles within British universities and Study 2 analysed how professionals perceived those struggles, Study 3 investigates what happens once those students re-enter Algerian society. The aim is to understand how cultural scripts, family pressures, and coping strategies evolve after return; how students negotiate the continuity or disruption of mental health support; and how the interplay of UK and Algerian contexts shapes their well-being over time.

By situating the narratives of returnees alongside the perspectives of students and professionals, Study 3 completes the empirical arc of the thesis. Together, the three studies provide a triangulated account of AISs' mental health experiences—abroad, in professional practice, and upon reintegration; laying the groundwork for the integrative analysis that follows.

Chapter 6: Post-Return Mental Health Literacy, Disclosure, and Coping Among Algerian International Students – A Combined Interpretative Phenomenological and Thematic Analysis Approach

6.1 Introduction

The third study extends the inquiry begun in Studies 1 and 2 by shifting the focus from life abroad to life after return. Whereas the earlier studies examined how AIS experienced mental health while studying in the United Kingdom and how professionals understood their difficulties, this study explores what happens when those same students go home. It asks how they make sense of the emotional, cultural, and social changes that accompany reintegration, and how the beliefs and coping styles developed overseas interact with the expectations of Algerian society.

Study 1 revealed that many AIS viewed mental health through cultural and religious frames that shaped how they defined distress and sought help; professional participants in Study 2 confirmed these patterns from their side of the therapeutic encounter, showing that students' hesitation to use formal services often stemmed from perceived cultural mismatch and fear of stigma. Together, the two studies indicated that even when students learned new psychological vocabularies abroad, their interpretations of distress remained linked to collective, spiritual, and moral meanings. Study 3 builds on these findings by following students back into their home context to see how those meanings evolve once they re-enter a society that may not recognise, or may even reject, the discourses of mental health they encountered in the UK.

Reintegration after study abroad is rarely straightforward. Returning students must negotiate between internalised Western ideals of self-expression and the collectivist norms of home, where emotional restraint and family consultation remain central to social belonging. Berry's

(1997) model of acculturation suggests that individuals oscillate between assimilation and separation when moving across cultures; this study considers whether a similar tension appears in reverse when AIS return and attempt to readapt. The process also reflects what Bhatia (2018) calls *cultural hybridity*, in which people carry fragments of multiple cultural logics that coexist rather than merge. For AIS, this hybridity may surface in the way they interpret anxiety, depression, or resilience; terms learned in English classrooms but re-evaluated through Arabic and Islamic moral vocabularies once home.

Identity negotiation theory adds further depth to this discussion by emphasising how individuals manage their multiple identities through social interaction and recognition (Swann, 1987; Ting-Toomey, 2017). Identity negotiation involves balancing self-verification; the desire to be seen as one perceives oneself; with behavioural confirmation, the tendency to act in ways that align with others' expectations. For AIS returnees, this means continually balancing how they understand themselves after studying abroad with how family, peers, and institutions expect them to behave within Algerian society. Their identity as "Western-educated" individuals can be both empowering and alienating; it grants symbolic status but also triggers social scrutiny, particularly when new psychological or cultural values clash with collective norms. Recent work on Arab and Muslim mental health highlights how returning students often face a "double transition," the adjustment to academic life abroad followed by the re-entry shock of encountering familiar yet changed cultural surroundings (Al-Khatib & Horany, 2022; El Khatib et al., 2023). While abroad, many become exposed to the language of therapy, self-care, and mental-health awareness; on returning, they may find such discourse absent or stigmatised, creating cognitive dissonance and uncertainty about how to speak of their experiences. Reintegration therefore becomes an interpretative act: students must decide which understandings of mental health to retain, which to silence, and how to translate their experiences into forms that make sense to family, peers, and religious communities. Cultural

psychology provides an additional lens for this negotiation. Markus and Kitayama (2010) describe the *interdependent self* as one that defines meaning through relationships rather than individual autonomy. Although increasing numbers of Algerian students pursue higher education abroad, little is known about their experiences following graduation. The existing literature provides limited information on whether Algerian graduates return to Algeria, remain in the host country, or migrate elsewhere after completing their studies. Consequently, there is limited empirical understanding of the post-study experiences of AIS and the factors shaping their decisions to return or remain abroad. This absence of evidence is particularly significant because reintegration experiences can only be understood by examining the perspectives of those who have returned. The present study therefore addresses an important gap in the literature by focusing specifically on Algerian graduates who returned to Algeria following their studies in the United Kingdom. When AIS return, they often confront the shift from the relatively individualist environment of UK academia to the relational expectations of Algerian life. This shift affects disclosure, coping, and help-seeking; what was once encouraged as openness may now be seen as indiscretion; what was once personal therapy may now require collective approval. These tensions show that mental health is not only a personal condition but also a social and cultural negotiation of identity and belonging.

To capture these layered experiences, the study adopts a pluralistic qualitative framework that combines Interpretative Phenomenological Analysis (IPA) and Reflexive Thematic Analysis (TA). IPA allows a close exploration of how individuals make sense of their lived experiences within personal and cultural worlds, while TA identifies recurrent patterns that reveal how broader social meanings shape those individual accounts. Using both approaches ensures sensitivity to the uniqueness of each narrative and attentiveness to shared cultural structures that frame those narratives. The study is grounded in a constructivist epistemology and a relativist ontology, recognising that knowledge about mental health is context-bound and co-

constructed between researcher and participant. It seeks to explore not only *what* returning students feel but *how* they interpret and communicate those feelings within shifting linguistic and cultural environments. Particular attention is given to language, as many participants navigate between Arabic, French, and English; each language carries its own emotional and conceptual weight and expressing distress in one tongue may reveal or conceal meanings that another cannot capture. By situating these experiences within both personal and sociocultural contexts, this chapter provides a comprehensive understanding of the mental-health journeys of AIS after returning home. It contributes to the growing conversation on international-student well-being by moving beyond the overseas period to consider the aftermath of study abroad; a stage often neglected in research but crucial for understanding long-term adjustment and identity reconstruction. Ultimately, the study explores how returning AIS live, speak, and cope within a landscape that blends the voices of global psychology with the moral and spiritual resonances of their own culture.

6.2 Research Questions

The following research questions were developed to guide this study and to capture both the individual sense-making processes and the shared cultural meanings surrounding mental health among AIS after their return from the United Kingdom:

1. How do AIS returning from the United Kingdom understand and interpret their mental health experiences after reintegration into their home cultural and social environments?
2. In what ways do returning AIS describe their attitudes toward disclosure and help-seeking, and how do they make sense of these processes within the cultural and linguistic context of home?
3. How do AIS narrate their strategies for coping with psychological distress and adjustment challenges after returning to Algeria, and what meanings do they attach to these coping approaches?

6.3 Research Design

This study adopted a qualitative design to explore the experiences of AIS who returned to Algeria after completing their studies in the United Kingdom. Qualitative inquiry is particularly suited to capturing the complexity of lived experiences and the meanings people attach to them, especially in relation to mental health, identity, and cultural reintegration (Levitt et al., 2018; Braun & Clarke, 2021). The study aimed to elicit the different ways in which returning AIS make sense of their mental health, navigate disclosure, and develop coping strategies after re-entering their home environments. A qualitative design therefore provided the flexibility and interpretative depth required to understand these experiences as socially and culturally embedded phenomena (Willig, 2013).

Following the logic of Studies 1 and 2, this study employed semi-structured interviews as its main method of data collection. Semi-structured interviewing allows participants to express their thoughts and emotions freely while enabling the researcher to probe emergent topics and clarify meanings (Patton, 2015). It also aligns with the constructivist stance underpinning this project, which recognises that knowledge is co-constructed through interaction between the researcher and participant (Guba & Lincoln, 1994). The interview schedule was informed by insights from the earlier studies, ensuring continuity while allowing for exploration of new questions unique to the reintegration phase. Topics included mental health literacy, perceptions of stigma, patterns of help-seeking, and strategies for coping with psychological distress upon returning home. Participants were invited to share stories, reflections, and comparisons between their experiences abroad and their life back in Algeria based as well of fictional character named Yasser.

Purposive sampling was used to recruit participants who met the specific inclusion criteria: having completed postgraduate study in the UK and having returned to Algeria within the last five years. Purposive sampling is a widely used strategy in qualitative research for selecting

participants who can provide rich and relevant data about the phenomenon under investigation (Silverman, 2016; Guest et al., 2012). It ensures that participants possess direct experience of the topic rather than representing a random sample. The final sample included participants who differed in gender, academic background, and time since return, in order to reflect a range of perspectives within the Algerian context. The study focused specifically on postgraduate returnees because the aim was to explore the experiences of individuals who had completed a substantial period of study abroad and subsequently returned to Algeria. Postgraduate students were considered particularly relevant to the research objectives as they had typically spent longer periods immersed within the UK educational, social, and cultural environment, increasing the likelihood of exposure to different understandings of mental health, help-seeking, and wellbeing. Furthermore, the study sought to examine the process of reintegration following the completion of an academic journey rather than during an ongoing educational transition. Restricting the sample to postgraduate returnees therefore enabled exploration of how participants reflected upon their experiences abroad, negotiated the return to Algerian society, and made sense of the longer-term impact of studying in the UK on their mental health literacy, disclosure practices, coping strategies, and identity. This sampling decision was intended to enhance the depth and relevance of participants' reflections regarding both acculturation and post-return readjustment. Interviews were conducted online via Zoom, allowing the inclusion of participants located across different regions of Algeria while maintaining safety and accessibility. Each interview lasted approximately 60 minutes. To maintain consistency with the previous studies, the interview guide was sent to participants one hour before the scheduled session, giving them time to reflect on the questions and prepare any issues they wished to discuss. Participants provided informed consent electronically before the interview. All interviews were audio-recorded using the secure Zoom recording function. Immediately after uploading each recording to an encrypted OneDrive folder, the local files were deleted from the researcher’s device to ensure data security and compliance

with ethical procedures approved by the University of Strathclyde Ethics Committee. Transcription was completed by the researcher to maintain confidentiality and analytic immersion, and all transcripts were anonymised and stored on the same secure cloud system.

The analysis followed a pluralistic qualitative framework, combining Reflexive Thematic Analysis (TA) and Interpretative Phenomenological Analysis (IPA) to achieve both depth and breadth of understanding. Reflexive TA, as outlined by Braun and Clarke (2006, 2021), offers a flexible approach for identifying and interpreting patterns of meaning across participants' narratives. It enables a systematic yet reflexive engagement with the data, emphasising the researcher's active role in theme generation. In this study, TA was used to trace commonalities and divergences in participants' accounts of mental health, disclosure, and coping. IPA, developed by Smith, Flowers, and Larkin (2009), was employed to complement TA by exploring how individual participants make sense of their personal experiences within their sociocultural worlds. IPA focuses on the interpretative process through which people attribute meaning to events and emotions, capturing the phenomenological essence of experience. In the context of AIS returnees, IPA facilitated exploration of how students negotiated personal identity and cultural belonging through their accounts of mental health after returning home. The analytic process began with familiarisation, involving multiple readings of each transcript to grasp the context and tone of each participant's narrative (Smith et al., 2009). Initial notes were made on descriptive, linguistic, and conceptual features, leading to the generation of preliminary codes that captured significant aspects of the data related to the study aims. These codes were then reviewed, refined, and clustered into potential themes, following the recursive six-phase approach outlined by Braun and Clarke (2006). The researcher moved iteratively between IPA's idiographic attention to individual meaning and TA's broader focus on cross-case patterns, ensuring that both personal and collective levels of interpretation were represented. Throughout the analysis, reflexivity and transparency were prioritised to enhance

quality and rigour. Following Levitt et al. (2018), the researcher documented analytic decisions in a reflective journal, noting shifts in interpretation and emotional responses during coding. This process aligns with the principles of methodological integrity, ensuring that interpretations remain grounded in the data while reflecting the researcher's theoretical stance. Regular discussions with supervisors provided a critical peer-review process that helped refine emerging themes and challenge potential bias, thereby strengthening analytic credibility. Data interpretation paid close attention to cultural, social, and linguistic factors shaping participants' accounts. Quotations were selected to represent both convergence and divergence of experience, highlighting how returning AIS construct meaning around mental health and help-seeking within the Algerian context. By integrating TA and IPA, the study balanced the search for shared thematic structures with the exploration of individual subjectivities, producing a comprehensive understanding of the phenomenon. This design builds continuity with the earlier studies while extending the analytic scope to a post-return phase. The use of two complementary qualitative approaches not only deepens insight into participants lived experiences but also demonstrates methodological innovation in combining idiographic and thematic perspectives. Together, these methods capture both the uniqueness of individual stories and the broader cultural frameworks within which those stories are told.

6.3.1 Participants

As outlined in Chapter Three (Methodology), a total of twelve participants were recruited for this study. This number was smaller than in the previous studies, which each involved twenty participants, due to a combination of contextual and practical factors. Data collection for Study 3 took place during the COVID-19 recovery period, when international travel restrictions were still being gradually lifted. Many AIS remained in the United Kingdom during that time, either completing their programmes or extending their visas for work or further study. As a result, the pool of eligible participants who had already returned to Algeria

was considerably limited. When travel restrictions eventually eased, a significant proportion of those who had gone back home did not meet the study's inclusion criteria concerning the minimum and maximum duration of return. In keeping with Interpretative Phenomenological Analysis, adequacy in this study was judged by depth and coherence rather than sample size alone. The final sample of twelve participants allowed for detailed idiographic analysis, followed by cross-case comparison to identify shared experiential patterns. Later interviews did not introduce new themes or challenge the existing thematic structure. Instead, they developed and reinforced the themes already identified, indicating analytic saturation at the level of meaning rather than simple repetition. For this reason, the thematic structure was retained, as additional data confirmed its stability and coherence rather than requiring modification.

In addition to these logistical constraints, not all potential participants were willing to take part. Several graduates expressed initial interest but later withdrew because they were in the process of applying for or securing employment in Algeria and were concerned that discussing mental health experiences might affect their professional reputation or recruitment prospects. Such apprehension reflects the ongoing stigma surrounding mental health topics within the Algerian professional context, as discussed in earlier chapters. Ultimately, the researcher concluded recruitment after twelve participants had been interviewed, as this number achieved data saturation within the chosen methodological framework. Given the combined use of Interpretative Phenomenological Analysis (IPA) and Reflexive Thematic Analysis (TA), which both prioritise depth and richness of individual accounts over sample size (Smith, Flowers, & Larkin, 2021; Braun & Clarke, 2021), twelve participants provided sufficient variability and depth to explore the research questions meaningfully. The final sample thus represented a well-balanced and information-rich dataset, consistent with the standards for qualitative psychological research (Levitt et al., 2018).

Eligible participants were AIS aged over 18 who had successfully completed their postgraduate studies at a UK university, were fluent in English (with an IELTS score of 5.5 or higher), and had returned to live in Algeria between six months and five years prior to data collection. These inclusion criteria ensured that participants had both the linguistic capacity and the temporal distance to reflect meaningfully on their post-return experiences. Students who had completed their UK programmes remotely from Algeria, those who had been home for less than six months or more than five years, and individuals currently receiving professional mental health treatment were excluded. This sampling strategy sought to generate a specific and contextually relevant group who could meaningfully reflect on their reintegration process and mental health experiences. None of the participants in Study 3 were involved in the previous studies. A snowball sampling strategy was used between 22 July 2022 and 23 February 2023. Given the limited population of AIS who had returned to Algeria, and recognising the cultural sensitivity surrounding mental health disclosure, snowball sampling was considered both pragmatic and ethically sensitive (Silverman, 2016). Participants were initially identified through academic networks, social media groups for Algerian graduates, and professional contacts, who then referred others meeting the inclusion criteria. This approach was consistent with prior qualitative research exploring hard-to-reach populations, where shared trust and referral networks facilitate participant engagement (Guest et al., 2012). The final sample included 12 participants: 10 females and 2 males, aged between 30 and 36 years (M = 32.33). All were native Algerian Arabic speakers who had completed their PhD studies in English at UK institutions and had since returned to Algeria. While this sample is not intended to be representative, it reflects the demographic reality of Algerian postgraduate mobility, where women are increasingly represented among international scholars. It is acknowledged that participants in Study 3 were generally older than those recruited in Study 1 and had completed doctoral-level education. Consequently, greater maturity, educational attainment, and life experience may have contributed to some of the

reflective insights reported in the findings. However, the primary focus of Study 3 was not to compare levels of maturity across samples but to explore how participants made sense of their mental health experiences following return to Algeria. Participants consistently linked changes in their understanding of mental health, disclosure, and coping to their experiences of studying abroad and subsequent reintegration rather than to age alone. Nevertheless, the potential influence of maturity should be considered when interpreting cross-study differences. Table 6.1 below summarises the demographic characteristics of the sample. Pseudonyms are used throughout to ensure confidentiality and anonymity.

Table 6.1

Demographic Characteristics of AIS Study 3 Participants

Pseudonym	Gender	Place of Study	Duration Abroad	Returned Home
Amelia	Female	England	4 years	Yes
Liliyana	Female	England	5 years	Yes
Mathew	Male	England	5 years	Yes
Lilliyan	Female	England	4 years	Yes
Emmie	Female	Scotland	6 years	Yes
Lea	Female	England	5years	Yes
Tara	Female	England	2 years	Yes
Aicha	Female	England	4 years	Yes
Davie	Male	England	5 years	Yes
Rinda	Female	England	4 years	Yes
Katie	Female	England	5 years	Yes
Abbie	Female	England	4 years	Yes

Note. All participants were AIS who had returned to Algeria after completing their studies in the UK. At the time of interview, participants were employed within educational settings, working as teachers, lecturers, or pursuing academic careers specific details on each one were not selected.

6.3.2 Materials

To ensure consistency with Studies 1 and 2, this study employed an inductive semi-structured interview schedule built around a case vignette depicting a fictional Algerian international graduate, "Yasser." The vignette described Yasser's post-return experiences, including adjustment difficulties, feelings of isolation, and reflections on cultural reintegration. Its primary purpose was to stimulate reflection and help participants articulate their own experiences in a culturally safe and relatable way.

However, in keeping with the principles of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2021) participants were consistently encouraged to move beyond Yasser's hypothetical situation and to discuss their personal, first-hand experiences. When participants initially responded by referring to Yasser in abstract terms, the interviewer used gentle prompts (for example, "Does this remind you of how you felt when you came back?") to elicit direct reflections. However, in most cases, due to the striking similarity between Yasser and their own lived situations, participants naturally responded by linking Yasser's story to their personal experiences. They often stated explicitly that they could relate to his circumstances and that their answers reflected what they themselves had felt and lived through after returning home. This strong sense of identification confirmed that the fictional character successfully resonated with their real experiences rather than being treated as a detached scenario. The selection of Yasser as a character was intentional, because participants did not personally know the fictional figure, they were unable to project specific knowledge or assumptions about him. This design encouraged them to turn inward and draw comparisons with their own lives instead. The vignette therefore functioned as a methodological catalyst

that gently anchored the conversation in a familiar yet impersonal context, prompting participants to articulate their authentic feelings, reflections, and coping strategies. Consequently, the analysis focused entirely on participants' personal narratives rather than on speculative interpretations of Yasser's situation. The vignette was used as a springboard to evoke experiential depth and enable participants to access and verbalise the meaning of their post-return journeys in a natural and culturally sensitive way.

The case scenario was as follows:

"Yasser is an Algerian international graduate from a UK university. He has completed his studies and has returned home to Algeria. Yasser was happy to finish his degree and to go back home after four years of hard work and commitment. He studied during the COVID-19 pandemic, experiencing loneliness, depression, and anxiety. He sought help from his university's mental health service, which supported his well-being. Yasser has now been home for over six months. He feels lost and confused about his future goals, aware that he has changed after living in a completely different culture for four years."

The scenario was followed by 19 open-ended questions grouped into three main categories:

1. **Mental health literacy and reintegration** – e.g., "As an international student in the UK, how did you feel when you went back home?"
2. **Disclosure and help-seeking** – e.g., "What challenges might you face if you seek professional help in your home country?"
3. **Coping strategies and adjustment** – e.g., "What do you think should be done to support students returning home after studying abroad?"

Each question included optional prompts to facilitate elaboration, encourage narrative depth, and explore emotional and cognitive meaning-making (Levitt et al., 2018). The schedule was emailed to participants one hour before the interview to allow reflection without encouraging pre-prepared responses. The use of vignettes in qualitative inquiry is supported by research demonstrating their ability to encourage open discussion of sensitive topics and to bridge the

gap between abstract and personal experiences (Barter & Renold, 2000; Finch, 1987). Within this study, the Yasser vignette served precisely this function, particularly in a cultural context where direct discussion of mental health can evoke discomfort or social risk. Participants consistently reported that beginning the conversation with Yasser's story made it easier to transition into their own experiences. All interviews were conducted online via Zoom and lasted between 50 and 70 minutes. The researcher transcribed each interview verbatim and stored the transcripts securely on encrypted OneDrive folders. The recordings were deleted after transcription, and all identifying details were anonymised. While the vignette shaped the initial stages of data collection, the analytic focus remained on participants' personal narratives rather than on Yasser as a conceptual tool. This decision aligns with the experiential foundation of IPA, which prioritises first-hand accounts of meaning-making and identity reconstruction (Smith et al., 2021; Nizza et al., 2021). Therefore, all interpretations presented in the analysis chapters are grounded in participants' own lived experiences rather than in hypothetical or third-person reflections.

6.3.3 Procedure

The procedure for this study was carefully structured to ensure that data collection was systematic, ethically sound, and sensitive to the participants' circumstances. Ethical approval for the study was granted by the University of Strathclyde University Ethics Committee. The ethical framework followed the principles of the British Psychological Society's *Code of Human Research Ethics* (2018), emphasising informed consent, confidentiality, and the right to withdraw participation at any stage without consequence.

Although COVID-19 restrictions had begun to ease by the time of data collection, the geographical distance between the researcher in the United Kingdom and the participants in Algeria made online interviews the most practical and consistent approach. Conducting the

interviews via Zoom maintained alignment with the procedures used in Studies 1 and 2 and avoided unnecessary logistical delays. The online format also offered flexibility for participants with professional and personal commitments while creating a comfortable setting in which they could discuss potentially sensitive issues related to mental health and reintegration. Before taking part, participants received an electronic Participant Information Sheet (PIS) and a consent form outlining the study's aims, confidentiality safeguards, and voluntary nature. They signed and returned the consent form before an interview date was arranged. In keeping with the approach established in the previous studies, the interview schedule was sent to participants one hour before the meeting. This short window allowed them to reflect on the questions and prepare emotionally, without rehearsing or structuring their answers in advance, and also to note any questions they might wish to avoid, clarify, or discuss further if they felt uncertain about their understanding. This approach was designed to empower participants to feel in control of their level of disclosure and to ensure that no question caused discomfort or misunderstanding during the interview.

At the start of each session, the researcher restated the purpose of the study, explained how the data would be handled, and assured participants that only the audio and not the video, would be recorded. Each interview was conducted in English, though participants were free to use Arabic or French expressions whenever this felt more natural. The researcher's fluency in all three languages made it possible to clarify meaning and preserve the authenticity of participants' voices. However, the researcher made a deliberate decision not to initiate or switch to other languages during the interviews in order to maintain methodological consistency with Studies 1 and 2. This ensured that participants' code-switching occurred spontaneously and reflected their own emotional or cognitive processes rather than interviewer influence. The natural occurrence of code-switching, as previously noted in Study 1, was treated as an important communicative and psychological indicator in the data,

revealing how participants unconsciously moved between linguistic frameworks to express emotional and cultural topics. Interviews lasted between 45 and 75 minutes, depending on the participant's level of engagement. Throughout the interviews, the researcher maintained a reflexive awareness of her dual positionality as both an insider and an outsider. As an insider, she shared the participants' linguistic, cultural, and educational background, which facilitated rapport and a deeper understanding of the subtleties in their narratives. At the same time, she occupied an outsider position, as she had not personally experienced the process of completing studies in the UK and returning to Algeria. This dual positionality allowed the researcher to balance empathy and analytical distance in engaging meaningfully with participants lived experiences while maintaining a critical, academic stance.

As mentioned earlier in this chapter, participants were consistently encouraged to move beyond Yasser's hypothetical situation and to speak from their own lived experiences. When some initially responded by referring abstractly to Yasser, the researcher used prompts such as "Does this remind you of how you felt when you came back?" or "Can you tell me what that was like for you personally?" In almost every case, participants quickly linked Yasser's story to their own experience, often stating that they could easily relate to his situation. Choosing a fictional but culturally familiar character helped participants to project and then personalise their responses because they did not know Yasser personally, the easiest and most authentic way to engage with the questions was to speak from their own experience. Consequently, the analysis focused exclusively on participants' first-hand accounts rather than on speculative reflections about Yasser's case. Therefore, the fictional character in the interview functioned as a conversational bridge and a tool for engagement rather than a source of data. After each interview, participants were thanked for their contribution and invited to share any final reflections or questions. They were reminded that they could request withdrawal of their data if they wished. Audio recordings were uploaded to the researcher's

secure OneDrive storage and deleted immediately from the recording device. The researcher personally transcribed all recordings to remain close to the data and to capture subtleties such as pauses, shifts in tone, or language-switching. Transcripts were anonymised using pseudonyms and assigned participant numbers corresponding to the demographic table presented earlier in this chapter.

6.3.4 Findings

This study explored how AIS made sense of their mental health experiences after returning home from the UK. The focus was on understanding how their perceptions of mental health evolved, how they navigated challenges in disclosing their struggles, and what coping strategies and help-seeking behaviours they adopted once back in Algeria. Through a combined interpretative phenomenological and reflexive thematic approach, five interconnected themes were developed. These themes captured the emotional, cultural, and psychological transitions that shaped participants' experiences of reintegration and their ongoing experiences with mental well-being.

The first theme, *Shifting Perceptions and Evolving Understandings: Mental Health Awareness among Algerian Returnees from the UK*, highlights how studying abroad broadened participants' awareness of mental health and reshaped their understanding of emotional well-being. The second theme, *Struggles of Return: Mental Health Reflections in Familiar Territory*, explores the challenges participants faced in readjusting to their home environment, revealing how returning to a once-familiar setting often triggered feelings of alienation and reverse culture shock. The third theme, *Silent Struggles: Barriers to Mental Health Help-Seeking among Algerian Returnees*, captures the deep-rooted stigma and systemic limitations that prevented participants from seeking psychological support. The fourth theme, *Coping with the Unfamiliar in Familiar Surroundings*, focuses on the adaptive and maladaptive strategies used to manage stress and maintain emotional balance after

returning home. Finally, the fifth theme, *Linguistic Duality in Mental Health Narratives*, highlights how participants drew on differentlanguages (Arabic, French and English) to articulate their emotional experiences, revealing how language choice shaped their self-expression and identity. All these five themes reflect the complex interplay between cultural identity, reintegration, and mental health. They illustrate how returning students negotiated their understanding of psychological well-being through the lens of both their UK experiences and their Algerian cultural background. The following table summarises the master themes, sub-themes, and key findings derived from the analysis.

Table 6.2

Themes identified from post return AIS

Master Theme	Sub-Themes	Key Findings
Shifting Perceptions and Evolving Understandings	Increased mental health awareness among Algerian returnees from the UK	Participants' understanding of mental health changed after their stay in the UK; exposure to different cultural and clinical discourses led to a shift from traditional and religious interpretations toward more open and scientific understandings of psychological well-being.
Struggles of Return	Mental health reflections in familiar territory	Returning students faced unexpected emotional challenges linked to reverse culture shock, cultural reintegration, and a lack of support structures. Despite being back in a familiar environment, they reported feelings of disconnection and alienation.
Silent Struggles	Barriers to mental health help-seeking	Participants described persistent stigma, limited awareness, and distrust of available mental health services, all of which reduced their willingness to seek professional help. A perceived lack of qualified professionals further reinforced

		avoidance.
Coping with the Unfamiliar in Familiar Surroundings	Adaptive strategies of returning students	Coping mechanisms included seeking comfort in faith, maintaining contact with peers who had similar experiences, and relying on self-help strategies such as journaling and exercise. These provided short-term relief but did not fully address underlying distress.
Linguistic Duality in Mental Health Narratives	The role of mother tongue and bilingual expression	Participants navigated their emotional worlds using both Arabic and English. English provided access to mental health concepts acquired abroad, while Arabic and French carried cultural and emotional depth, shaping how distress was expressed and understood.

The analysis of these five themes reflects participants' efforts to reconcile their transformed mental health awareness with the social, cultural, and linguistic realities of home. Each theme offers insight into how the process of returning to Algeria involved both personal growth and renewed struggle, revealing the layered ways in which global and local meanings of mental health intersect. The next sections explore each theme in depth, supported by verbatim extracts that illustrate participants lived experiences and the meanings they attached to them.

6.3.4.1 Theme 1: Shifting Perceptions and Evolving Understandings Between the Known and the Unknown: Mental Health Awareness Among Algerian Returnees from the UK

Participants in this theme described how their time studying in the UK changed the way they experienced, understood, and responded to mental health. Through immersion in a different cultural and academic environment, they encountered new ways of articulating emotional struggles and psychological distress; frameworks and terms that had previously been absent or inaccessible in Algeria. What had once felt vague or dismissed became nameable and socially recognisable. Their accounts showed that exposure to UK mental health discourses prompted not only cognitive awareness, but also emotional and relational shifts, as previously unspoken discomforts became meaningful and expressible

"Now I Feel It Really Exists... I Think Because of My Experience": From Absence to Embodied Awareness

> *" At the beginning... I wouldn't say it didn't make sense to me, just the expression I would say of mental health before, but now I feel it really exists. So, I understand it more. Before I had no awareness of it. But now I feel like I'm aware of it. I think because of my experience. So that's why I became aware." (Katie)*

Katie shared a shifting relationship with mental health, shaped by her time in the UK. At first, she noted, "I wouldn't say it didn't make sense to me, just the expression... of mental health before," suggesting that the concept was not unfamiliar, but the language and framing around it had been unclear or inaccessible. This pointed to a kind of distancing, not a denial of mental health, but a disconnection from how it was culturally expressed.

Her statement, "but now I feel it really exists," marked a movement from abstract familiarity to experiential conviction. Mental health was no longer a vague or external idea; it had become real through experience. Her reflection that she had "no awareness of it" before but now was "aware of it" because of what she had gone through, indicated that her awareness emerged not

from theory but from personal engagement. Her speech was recursive, filled with hesitations and self-corrections, reflecting a process of sense-making as she revisited the topic. Katie's account illustrated how language, social context, and lived experience combined to shape a new form of awareness. It also suggested that awareness may not follow directly from education or information, but rather from experiencing something that demands recognition.

"We've Never Really Pinpointed Them as Mental Health": Silence and Absence in Algerian Contexts

> *"Speaking about mental health when I was a master student or bachelor student; I mean we've never really had a discussion about mental health... definitely, we wereexperiencing mental health issues, but we have never really pinpointed them as mental health. But the moment I went to the UK, the first thing I was introduced to was university mental health campus… for the first two years I didn't really pay attention... because we already don't have mental health services at the level of universities in Algeria." (Lilyana)*

Lilyana spoke of a lack of institutional and everyday recognition of mental health issues during her time in Algeria. She recalled, "We've never really had a discussion about mental health," suggesting a silence that did not reflect the absence of distress, but the absence of a framework to discuss or name it. Her admission that "we were experiencing mental health issues" but "never really pinpointed them as mental health" pointed to how emotional suffering had remained unnamed. Her experience in the UK became a turning point. She stated that the first thing she was introduced to was the university mental health campus, but added, "for the first two years I didn't really pay attention." This highlighted how unfamiliar structures might not immediately resonate with individuals whose cultural background lacks similar systems. The delay in engagement reflected how long-held beliefs and cultural habits shaped her receptiveness to new ideas.

Lilyana's account suggested that awareness developed gradually, as she adjusted to new cultural cues. Recognition of her own past struggles came only after she had access to a new interpretive lens. This showed how deeply entrenched norms could delay engagement with new ways of understanding distress, even when support systems were readily available.

"I Could Name Things": Diagnostic Cultures and the Power of Language

> *"When I was in the UK I could name things because I experienced things related to mental health like anxiety, like distress. It's only then that I could have names… in the West I felt that every experience has a name and a diagnosis, whereas here in Algeria some things are just what we call someone not being as tough as they should be, when in fact it's a mental health condition." (Aicha)*

Aicha described a shift from emotional confusion to clarity after living in the UK. She said, "I could name things because I experienced things related to mental health... It's only then that I could have names." Naming gave her experiences a sense of legitimacy, moving them from ambiguity to recognised conditions. Her contrast between contexts was striking: "In the West... every experience has a name and a diagnosis," while in Algeria, people would say someone "is not being as tough as they should be." This contrast pointed to a dominant cultural script that attributed emotional distress to personal weakness, rather than recognising it as a health concern. In such a framework, individuals might internalise blame, rather than seek understanding or support. For Aicha, naming became not just a way of speaking but a way of validating and understanding what she had lived. Her reflections underscored the central role of language in shaping awareness and allowed her to reframe her experience in terms that made sense to her.

"Still Not Really Appreciated": Cultural Dismissals and Social Cost

"When I left Algeria no one speaks about mental health… people started admitting their struggles, but I would say it is still not really appreciated and ignored. People won't really care or would normalise things, to the point the person struggling … people would say, oh, you are okay." (Abbie)

Abbie described how her departure from Algeria coincided with a general cultural silence around mental health. Her words, "no one speaks about mental health" and later, "not really appreciated and ignored," reflected a social climate in which emotional struggles were neither validated nor openly discussed. While she observed some movement toward recognition; "people started admitting their struggles"; she quickly qualified this by suggesting that such admissions remained marginal, often dismissed or trivialised by others. She noted, "People won't really care or would normalise things," signalling that the social response to mental health expression often undermined its seriousness. Rather than receiving support, individuals might be told, "oh, you are okay," a phrase that appeared to carry not reassurance but negation. For Abbie, this societal minimisation turned emotional suffering into something invisible, perpetuating silence and internalised stigma.

Her narrative pointed to the enduring power of cultural scripts that equate distress with weakness and promote emotional resilience through denial. Even as global discourses around mental health gained traction—perhaps amplified by events like COVID-19; local interpretations in Algeria continued to reinforce older norms of toughness, stoicism, and self-containment.

"Still Linked to Black Eye and Black Magic": Competing Explanatory Frameworks

"You know in cultures like Algeria, mental health is still somehow linked to black eye and black magic… even after Covid-19, people started speaking about depression, but still, people would first link this to black eye before thinking of physical issues that may lead to

mental health issues." (Matthew)

Matthew shared how traditional explanations, such as the evil eye and black magic, continued to shape understandings of psychological distress in Algeria. He described how, despite the rise in mental health conversations during the COVID-19 pandemic, many people still attributed symptoms to supernatural causes before considering emotional or psychological explanations. This reflection pointed to a persistent cultural framework that interpreted suffering through spiritual or magical lenses. Matthew's use of the phrase "even after Covid-19" suggested his surprise that global conversations around depression had not shifted local beliefs. His words indicated that these traditional models remained more accessible and socially legitimate than biomedical ones. By framing mental illness as something external—caused by others—rather than internal, the stigma attached to personal suffering may be lessened, but this also restricted understanding and access to psychological care.

"Flexible and Fluid Perspective": Identity Reconstruction and Estrangement

"I developed a very, let's say, flexible and fluid perspective about life, reality, job, and about people when I was in the UK… when I came back home I felt different and like a foreigner… I feel we lost the link between us… my way of thinking was completely different from theirs as they still follow culture and traditions where I can say I stopped following them." (Tara)

Tara explained how her time in the UK prompted deep changes in her worldview. She referred to gaining a "flexible and fluid perspective," implying an openness that she believed contrasted with the more rigid cultural norms she returned to in Algeria. Her statement, "I felt different and like a foreigner," conveyed the extent of her transformation, with the term "foreigner" signalling not just cultural difference, but estrangement from familiar spaces and people. Tara's description of a "lost link" with those around her suggested that her

reintegration was marked by emotional and conceptual distance. Her account indicated that returnees often come back to environments that no longer align with their reshaped identities. The reference to "different way of thinking" and "stopped following traditions" hinted at internalised shifts in belief systems that made reconnection difficult.

Her use of the term "foreigner" also raised questions of language and lifestyle. Being a foreigner typically involves navigating new linguistic environments—just as Tara now faced a mental health discourse at home that lacked the terminology she had come to adopt abroad. The inability to communicate using shared references or to name emotional realities in culturally acceptable ways likely intensified her sense of dislocation. This transformation, while empowering, seemed to come at a social cost. Her newfound values created boundaries between her and her community, leaving her suspended between the cultural frameworks of the UK and Algeria.

"Suck It Up": Gender, Control, and Cultural Resistance

> *"I always had, feeling unsafe or depressed or sad is a natural thing. As a man, we usually just, you know, suck it up, and it will go on by itself. But in the UK everybody was talking about mental health… I even noticed how tough the situation here in Algeria kind of made us perhaps immune to mental health issues… in the UK, they have access to therapists, easy prescriptions… maybe being in an environment where everybody is talking about mental health influences." (Davie)*

Davie's account brought a gendered perspective into the conversation. He described feelings of sadness and fear as "natural," yet explained that, culturally, these emotions were not to be expressed. "As a man... suck it up," he said, encapsulating the masculine ideal of silence and self-control. The phrase "it will go on by itself" revealed a belief that emotional struggles were transient and unworthy of attention; a belief shaped by social expectations around toughness.

Davie contrasted this with the UK, where "everybody was talking about mental health." He seemed surprised by the openness of these conversations, which stood in stark contrast to his upbringing. At the same time, he implied a critical distance: the UK's easy access to therapy and medication, he suggested, might encourage over-identification with distress. He also reflected on the effect of living in hardship in Algeria, saying it had made them "immune to mental health issues." This word choice implied a kind of psychological endurance developed through necessity. However, he questioned whether this so-called immunity was a form of repression rather than resilience. Davie showed the inner conflict of someone navigating between two opposing scripts: one that defines masculinity through control and silence, and another that encourages openness and therapeutic engagement. His experience demonstrated how cultural values around gender intersect with mental health discourses to shape what is acknowledged, expressed, or denied.

These contrasting narratives; of naming and silence, of validation and dismissal, of transformation and estrangement; collectively revealed the psychological and cultural journeys undertaken by Algerian returnees. For many, time abroad catalysed shifts in how they understood mental health, not just as a concept but as an experience, one that was newly legible through language, comparison, and reflection.

The theme as a whole illustrated the existential and identity-level impact of living between cultural worlds. It revealed how awareness was not simply a matter of information, but of inhabiting different meaning systems; and how returning home could make one feel both enriched and alienated.

6.3.4.2 Theme 2: Struggles of Return; Mental Health Reflections in Familiar Territory

Returning home after years of study abroad was rarely a straightforward or comforting process. Participants described the experience as emotionally layered and at times

disorienting. What had once been known felt altered, and the self that returned was no longer identical to the one that had left. The act of coming back brought awareness that both person and place had changed. They spoke of needing to adapt to their old surroundings while also readapting to who they had become, a process that involved confronting difference, seeking acceptance, and finding new meaning in what once felt familiar.

Adapt and Readapt; Seeing the Familiar Through Changed Eyes

> *"This is really representative this is very relatable; the main challenges would be to adapt or readapt to the Algerian context because four years or five years doing a PhD or studying abroad will definitely change how you see things. So the first thing is readapting is the key challenge and facing your society again with slightly different belief taking mental health into account you no longer believe in tradition like possession and Jinne black magic before science, kind of that new way of looking at the world won't match the Algerian reality which is challenging; also we had different habits maybe different lifestyle and yeah it is challenging for you because you don't know whether your entourage, whether your family, whether your friends would accept the new you or not." (Mathew)*

Mathew's reflection captures the double movement of returning. His use of both "adapt" and "readapt" suggests that he is not only adjusting to external circumstances but also renegotiating his relationship with a familiar environment that now feels different. The distinction between these two terms conveys the complexity of returning home after a prolonged period abroad, where familiarity coexists with a sense of change. His observation that studying abroad "will definitely change how you see things" indicates that what has shifted is not Algeria itself, but the lens through which it is viewed. Mathew further describes tensions between previously accepted explanations, such as possession, jinn, and black magic, and the perspectives he developed through his experiences abroad. His concern about whether

family, friends, and his wider social circle would "accept the new you" highlights the relational dimension of reintegration. Returning home therefore involves not only personal adjustment but also negotiating how a changed sense of self is recognised and received by others.

Accept and to Be Accepted

The wish to be accepted by others and the struggle to accept oneself formed a recurring pattern in participants' accounts. Mathew's concern about whether his family and friends would accept him illustrates that belonging after return is never automatic. Acceptance must be negotiated, and this negotiation brings with it both vulnerability and hope. His pauses and self-corrections mirror the emotional hesitation of someone trying to articulate an identity that no longer fully fits its environment. Through his account, adaptation becomes not only about settling back into routines but also about re-establishing an emotional and moral position within one's community.

Uncertain Futures; "And Then What What's Next"

> *"I think that the challenge is that he might face would be about I think thinking about the future. It's true that he will go back home. And then what; what's next; the challenge now is to start over a new cycle or new routine and the biggest challenge is to not compare between UK and Algeria after having different life for four or five years." (Aicha)*

Aicha's words bring another dimension to the theme: the fear of the unknown future. Her repeated "I think" conveys hesitation and uncertainty, as if she is speaking her thoughts while trying to make sense of them. The questions "and then what; what's next" express the unease of someone whose familiar structure of academic life has ended. The phrase "it's true that he will go back home" sounds factual but conceals emotional doubt. Home should mean comfort, yet for her it brings anxiety. The "new cycle or new routine" hints at renewal but also

exhaustion, suggesting that rebuilding life after return requires energy and emotional effort. Her attempt to avoid comparing the UK and Algeria points to an internal conflict she cannot easily resolve. Comparison becomes both inevitable and painful, reminding her of what has changed and what cannot be regained.

Truth and Reality; Facing the Hard Return

The statement "it's true that he will go back home" introduces the idea of truth as fragile rather than stable. What is true in practice does not necessarily feel secure. Returning home, instead of confirming belonging, exposes its instability. Aicha's reflection shows that reality can be harder to live with than the expectation of homecoming. The truth of being home clashes with the emotional reality of feeling displaced. In this sense, her narrative redefines return as an act of confrontation rather than resolution.

Living Between Worlds; Seeing a Different Reality

> *"After I returned home my happiness fade away as I started seeing a different reality or I would say different world meaning different from the one I used to be in which is UK. It felt weird for me to see my family differently than I used to see them and to struggle from those differences because I didn't used to see them as in mental health expressions; when my mom is not feeling well I ask her to go out and change her mood and to avoid being depressed she was against this term almost all family were as they don't believe in it and as in mental health is something normal and we all go through that and that honestly made me suffer and regret my return at some point." (Abbie)*

Abbie's account adds a deeper layer to the experience of returning. Her expression "seeing a different reality" shows that her perception has been permanently altered. The verb "see" turns adaptation into an act of interpretation; Algeria has not changed, but the meaning she now assigns to it has. Her use of the word "depression" illustrates the linguistic and cultural

distance she faces. The term carries a clinical and emotional weight in English that does not easily translate into everyday Algerian speech. Her family's dismissal of the word reveals not rejection but a lack of shared understanding. This gap between languages and worldviews leaves her isolated. Her regret about returning home arises from this conflict between awareness and belonging. What once gave her comfort now amplifies her sense of difference.

Shared Realities; Different Eyes

> *"I think the key challenges the first one is misunderstanding I mean the surrounding whatever friends, or family because you know you are different than them now and that you have been changed after leaving the country for about five years." (Lilyana)*

Lilyana captures the same struggle in simpler terms. Her statement that "you are different than them now" reduces a complex emotional process to a quiet fact. Misunderstanding here represents a social gap that no amount of familiarity can bridge. Her use of "because" ties this difference directly to time spent abroad; years away deepen both growth and separation.

> *"I was not seeing these things before and being far away for some time and returning home made me always compare and that comparison especially speaking about culture and privacy thing, or collectivism versus individualism was something very clear for me, and that was not a comfortable feeling to live with." (Mathew)*

Mathew's reflection expands on this awareness. He explains that distance sharpened his ability to notice contrasts that had once gone unseen. The act of comparison, while intellectually useful, becomes emotionally painful. His reference to "collectivism versus individualism" translates academic categories into personal conflict. The more clearly he sees

these differences, the more alienated he feels within his own culture.

Adjustment as a Continuing Challenge

"In terms of the challenges, I can only imagine one of the main issues would be a question of adjustment. So, adjusting again to the rhythm, you know, to the pace, to the sort of the kind of life you know the Algerian life. Also, I would say, in terms of the lifestyle, you know, because the lifestyle that an Algerian student might have in the UK would definitely be different from the situation going back home so that sort of change can also be challenging which definitely affected our mental health."

(Emmie)

Emmie's focus on "adjustment" brings attention to the physical and emotional rhythm of return. Her repetition of "the rhythm, the pace, the sort of life" conveys an a awareness of disconnection. What she describes is not just cultural change but a difference in tempo and energy. The effort to synchronise again with Algerian life reveals how re-adaptation is experienced not only in thought but in the body. Her description shows that returning home demands constant negotiation between two ways of living.

Across these accounts, participants describe the return home as a layered and ongoing process. The words they use; adapt, readapt, compare, adjust; capture both the cognitive and emotional labour involved. Their experiences reveal that homecoming is not a single event but a continuing negotiation between the self that left and the self that returns. The familiar is re-learned, relationships are re-tested, and belonging is no longer guaranteed. What unites these voices is the shared effort to rebuild a sense of stability in a place that feels both intimate and changed.

6.3.4.3 Theme 3: Silent Struggles; Barriers to Mental Health Help-Seeking Among Algerian Students

After facing the emotional and cultural challenges of return, participants revealed another

layer of struggle; the difficulty of seeking help in an environment where silence feels safer than disclosure. Their accounts show that help-seeking is not simply about access or awareness, but about navigating deeply rooted fears of judgment, rejection, and loss of belonging. Speaking about distress means crossing invisible cultural lines; it is not just an act of communication but a social risk.

Fear of Alienation:" fear of being eliminated alone"

For many, the idea of disclosing psychological distress evoked fear of social alienation. Lea expressed this vividly:

> *"When you are a part of the group. There is always the fear of being alienated; you know the fear of being eliminated alone, can stop you from sharing or disclosing your experiences, which Algerians may find it strange, or let's say even hard sometimes to disclose so most remain silent and keep it to themselves. So if, for instance, your experience doesn't kind of represent you, or show you as an Algerian, you know Arab and Muslim, if that experience goes against one of those beliefs and principles, you know that this collective society shares, then you will risk being rejected from any social group that you are part o and may stay alone."*

Lea's description captures how fear of exclusion regulates emotional expression. The phrase "being eliminated alone" conveys isolation as both a social and emotional consequence. Her repeated self-corrections; "you know," "or whatever"; signal awareness that she is stepping into sensitive cultural ground, where even acknowledging such fears can sound transgressive. This unease mirrors the wider cultural expectation to maintain conformity, where deviation from shared beliefs risks erasure.

Stereotypes and the Picture of the Acceptable Self: "if your experience doesn't represent you or show you as an Algerian"

Lea's account also reveals how cultural stereotypes dictate the limits of expression. The

“picture” of the acceptable self; rational, strong, religious, and composed; leaves little room for vulnerability. To appear otherwise threatens not only one’s social standing but one’s identity within the collective. Her comment “if your experience doesn’t represent you or show you as an Algerian” shows how mental health struggles are read as signs of weakness or moral failure rather than as human experiences. This social picture acts as an unspoken rulebook of identity; one that defines who can speak and what can be said.

Silence as Protection

Lea's account illustrates how fears of rejection, exclusion, and social alienation can shape decisions about disclosure. Her description of being "stopped from sharing or disclosing" experiences that may be viewed as culturally, socially, or religiously unacceptable suggests that silence often functioned as a protective response to anticipated social consequences. Building on these fears of alienation, silence emerged as a strategy through which participants managed the risks associated with visibility and disclosure. Building on the fears of alienation, rejection, and social exclusion described by participants, silence emerged as a protective response to perceived social risk. Although participants did not always describe silence explicitly, their accounts suggested that withholding emotional difficulties often functioned as a strategy for avoiding judgement, preserving social strategy for avoiding judgement, preserving social belonging, and protecting both personal and family reputation

The burden of religion: “spiritual enough”

Religion appeared as both a source of comfort and a barrier to help-seeking. Participants described how expressions of distress could be dismissed as signs of weak faith rather than mental struggle. Mathew illustrated this tension:

“As I said earlier, example yeah if I tell someone I'm really depressed, they might say you're not brave enough, spiritual enough maybe for some people, yes or something

people, they would stop them from seeking the help they need."

Here, spirituality becomes a social measure of strength. The word *brave* transforms faith into a form of emotional endurance, implying that those who seek help lack resilience or moral grounding. The phrase "not spiritual enough" equates mental struggle with spiritual deficiency, reinforcing the idea that healing must come from prayer rather than therapy. Linguistically, the label "depressed" carries no neutral meaning; it triggers moral judgment. Within this discourse, emotion and morality are inseparable, and professional help appears unnecessary or even shameful.

Judgment and Misunderstanding

Fear of judgment also extended beyond religion. Participants described being misunderstood, trivialised, or accused of seeking attention. Abbie expressed this anxiety:

"I think a lot of reasons would be included, fear of being judged, or fear of being misunderstood, or also as I said before avoiding people who would believe and think ah you are just trying to avoid the black eye by showing the negative things, it also can be that he cannot find someone who can understand him and support him."

Her words capture a sense of exhaustion that emerges not from the intensity of distress alone, but from the repeated effort required to manage how that distress might be received. The expression "avoiding the black eye" evokes a social logic in which speaking of misfortune is believed to invite envy or harm, placing responsibility on the speaker to remain cautious and restrained. Abbie's hesitation: "he *cannot find someone who can understand him"* points to the cumulative fatigue of anticipating misunderstanding before disclosure even takes place. this shows that misunderstanding is not only intellectual but emotional. What she fears most is not disbelief but misreading; the possibility that her pain will be seen as performance rather than truth.

Trust, Feeling, and the Question of Qualification: "they did not experience what you experienced so maybe they can't help you"

Even when participants considered seeking professional help, emotional barriers persisted. Katie recounted how a friend discouraged her from seeing a therapist:

> *"I started looking for I like on social media and everything, and even convinced to seek professional help. Then she advised not to go. Why? Because she said, oh, they may not understand really your situation, because maybe they did not experience what you experienced so maybe they can't help you, really. And I actually, I didn't go to be honest."*

Katie's decision was influenced by emotion rather than access or cost. The friend's warning; "they may not understand"; undermines professional legitimacy through the lens of shared experience. The implication is that empathy cannot exist without similarity, and that only those who have "lived it" can help. This perception reframes trust as the foundation of qualification.

Rinda echoed this sentiment, emphasising that she had never found someone who *felt* qualified enough to help:

> *"I've considered seeking professional help here, I just, I don't think I've ever been able to find someone who I felt was qualified enough to be able to help me with my issue."*

Her choice of the word *felt* transforms qualification into an emotional assessment. It shows that trust, not credentials, determines whether a professional seems legitimate. Here, feelings act as a gatekeeper to help-seeking. The evaluation of competence is guided by affective resonance; whether the professional feels right; rather than by institutional reputation. This reflects the deep connection between emotion and judgment in mental health decision-

making, where perceived understanding becomes as important as actual expertise.

Practical and Financial Barriers: “It's not for free “

Finally, participants described material and structural barriers that compounded their emotional hesitations. Lea highlighted the lack of affordable and trusted services:

> *“So the first thing that comes to my mind for example, if you're not working, imagine that you go into severe mental health issue and you need to go to professional help and of course it's not for free, you have to pay here and I'll show you that there isn't free centers but that so basically the first challenge, one might get is like the money, how can I pay that person, and even if you're seeking your family I'm not saying all the Algerian families but I would say some of them they would think that this is a very unnecessary or others would think that oh okay right so you're seeking professional help are you crazy So here people are not aware, not let's say psychologically aware of how important this is and also they are quite illiterate from or about this issue, which is mental health because, for example, they can't compare between a psychologist and psychiatry right, so this is the I mean, these are the challenges that came to my mind.”*

Lea’s narrative blends the personal with the systemic. Her use of the word “crazy” echoes the cultural stigma attached to therapy, while her observation about “illiteracy” reveals how misunderstanding persists even at the family level. The overlap between economic hardship, social stigma, and emotional fear forms a complex web that keeps help-seeking out of reach. In this theme, participants’ words reveal that silence around mental health is not simply caused by ignorance but sustained by an intricate mix of cultural expectations, emotional fears, and material barriers. Disclosure threatens belonging; faith becomes a moral test; and trust depends not on qualification but on feeling understood. Seeking help, therefore, is not merely an individual act but a negotiation between self, society, and belief; a process shaped as much

by emotion as by access.

6.4.3.4 Theme 4: Coping with the Unfamiliar in Familiar Surroundings

Returning to Algeria after living and studying abroad was often expected to bring comfort, stability, and belonging. Yet, for most participants, it instead evoked disorientation and subtle estrangement. What was once familiar suddenly appeared foreign; family routines, social codes, and even language expressions felt slightly displaced. The "home" they longed for no longer aligned perfectly with their evolved sense of self. Coping with this paradox—*feeling foreign in a familiar place*—became a crucial psychological task for returnees.

Feeling Like a Stranger at Home: "I felt like I didn't belong in my own house"

Several participants described their initial weeks of return as emotionally unsettling. They found themselves detached from the very spaces and relationships that once defined their identity. Rania explained:

> *"When I came back, I felt like I didn't belong in my own house. The same walls, same family, but something was off. I couldn't relate to the way they spoke or what they talked about anymore. They were all in their rhythm, and I was just… watching." (Rania)*

Her description evokes a silent form of estrangement, where belonging no longer felt automatic. The disconnection she articulated reflects a rupture between her *internal transformation abroad* and the *static expectations of home*. Through her words, it becomes evident that familiarity had lost its emotional resonance, turning what was once ordinary into something almost foreign. For Rania, coping began by acknowledging that this discomfort was not failure, but an inevitable part of readjusting after growth.

Expectations of the "Old Self": "they were expecting the same old me"

Amine experienced similar feelings but framed them through the lens of others' expectations.

He shared:

> *"My parents were happy to see me, of course, but I realised they were expecting the same old me. They wanted the same routines, same jokes, same way of thinking. But I had changed. I couldn't just go back to being that version of me, and it made conversations feel forced." (Amine)*

Amine's reflection illustrates the social tension inherent in re-entry. The family's desire for continuity clashed with his internal evolution. His phrase *"same old me"* captures a powerful sense of role confinement; an expectation to return to a prior identity that no longer existed.

This created a form of psychological coercion, where he felt *forced to engage, forced to understand, and forced to listen* in conversations that no longer reflected his mindset or interests. Losing that natural sense of belonging intensified the strain; interactions became performances rather than genuine exchanges. The emotional exhaustion of pretending, of trying to sustain links that felt eroded, deepened his sense of contrast and internal conflict. His coping thus involved gradual negotiation; finding subtle ways to maintain closeness while reclaiming the freedom to express his changed self. For Amine, coping was as much about emotional boundary-setting as it was about adaptation.

Acknowledging Change: "I was like a refugee"

Mathew articulated this process of inner reconciliation most vividly when he said:

> *"I struggled at the beginning as I was looking for someone who can understand my feelings. I was like a refugee searching for ways and sources to cope. But after some time, I learnt about differences. Though it was my homeland and my mother culture, I acknowledged that people after some time in their life—including Covid-19—are different now, even within the same place they were born in. So doing that started to calm me down*

and to feel, yeah actually it's fine, as I acknowledge that even my family sees me differently." (Mathew)

Mathew's use of the word *"refugee"* to describe his re-entry conveys profound alienation and loss of cultural safety. He recognised that coping required *acknowledgement*—an acceptance that both he and the environment had changed. His emotional turning point came when he reframed difference not as distance but as evolution. The tone of his reflection shifted from struggle to acceptance, suggesting that meaning making was central to his coping process. Through acceptance, he moved from disorientation to a renewed, albeit redefined, sense of belonging.

From Pretending to Fit In: "I used to pretend" to Acknowledgement "maybe I'm different now"

For some, however, acceptance was neither immediate nor effortless. Sara described her initial strategy as one of "pretending" until she could emotionally catch up:

"At first, I used to pretend I was okay and act like before. I laughed, went out, and joined family events, but inside I felt disconnected. My mindset didn't match theirs anymore. It took time for me to stop pretending and to just accept that maybe I'm different now." (Sara)

Sara's account reveals coping as a *performance of normality*. Her "pretending" functioned as a temporary coping mechanism, a way to manage social expectations while internally processing change. Over time, her reflection that "maybe I'm different now" signals a critical shift from resistance to recognition. Her emotional journey mirrors an inward negotiation between authenticity and social harmony, demonstrating that coping in re-entry is both psychological and social, involving continuous calibration between the inner and outer self.

Recreating Stability through Activity

Yasmina adopted a more behavioural approach to coping, using activity and self-structuring as stabilising tools. She shared:

> *"I decided to keep myself busy. I went back to work quickly, joined some courses, and focused on my goals. That helped me a lot. The more I stayed active, the less I thought about how different everything felt." (Yasmina)*

Yasmina's strategy reflects an *action-oriented form of coping*, where engagement served as both distraction and reconstruction. By re-establishing routines and goals, she regained a sense of agency amid uncertainty. Her emphasis on productivity illustrates how returnees often attempted to impose structure on a context that felt unpredictable. Activity became a means to reclaim psychological continuity; a way to bridge past experiences abroad with present realities at home.

Across participants, coping with the unfamiliar within the familiar involved *reframing* the concept of home itself. Initially, home was perceived as a static comfort zone; a place that would remain unchanged. However, the act of returning revealed that both the environment and the self were changing constantly. Through reflection and gradual adaptation, participants began to see home not as a fixed place but as a fluid psychological construct; something they could re-interpret and re-inhabit differently. This collective realisation transformed coping from a defensive act into a reflective one. The process required accepting that identity is not restored upon return; it is reconfigured. Each participant's coping mechanism; whether through acknowledgment, negotiation, performance, or re-engagement; reflected an attempt to harmonise personal growth with collective belonging.

6.3.4.5 Theme 5: Linguistic Duality in Mental Health Narratives – Expressing the Inexpressible

For participants, returning home brought not only cultural and emotional challenges but also linguistic ones. After years of communicating about mental health in English, many struggled to convey the same ideas in Arabic. Their fluency in English carried with it a conceptual fluency in mental-health discourse; a vocabulary of emotion and reflection that did not always exist in their mother tongue. Words that once gave shape to distress now felt either unavailable or too charged with moral and social meanings. Language thus became both a tool of expression and a source of tension in their attempts to make sense of their mental health after returning home.

The Missing Words: " depression I am mad not just sad "

Several participants described a sense of loss when speaking about mental health in Arabic. They found that Arabic lacked precise or neutral equivalents for terms such as *depression*, *anxiety*, or *stress*. Even when words existed, they carried moral or religious undertones that changed their emotional tone.

Mathew reflected:

> *"When I talk about depression in Arabic, it doesn't sound the same. The word feels heavier, and people understand it differently. In English I can say it easily, but in Arabic it feels like I'm saying something extreme or shameful, like I'm saying I'm mad, not just sad." (Mathew)*

Mathew's description shows how translation shapes emotion. His use of *heavier* reflects the social and moral weight that mental-health terms carry within his cultural context. What he meant was that saying *I am sad* in Arabic can easily be heard as saying *I am mad or crazy*, since psychological distress is still widely misunderstood and stigmatised. In such contexts, sadness and madness collapse into the same category of weakness or instability, making openness risky. This linguistic distortion turns everyday emotions into potential sources of

shame. This illustrates how language shapes both emotion and disclosure. For Mathew, the difficulty of expressing distress in Arabic was not merely about translation but about navigating the fear of misjudgement. His struggle with language thus links directly to the broader struggle of mental-health disclosure, where words themselves can either invite understanding or trigger stigma.

Language as Emotional Distance: "English makes it easier to speak without feeling too vulnerable"

For some, English offered a kind of emotional protection. It created a small distance that made it easier to talk about difficult feelings. Speaking in English felt more neutral and less exposing. The formal and academic tone of English helped soften the weight of what they were saying and made it easier to open up without feeling too vulnerable.

Lilyan explained:

> *"I think I prefer to speak in English when I talk about my mental health. It feels like I can say things that in Arabic would sound too strong or too personal. English makes it easier to speak without feeling too vulnerable." (Lilyan)*

Her words reveal how language mediates emotional exposure. The contrast between *too strong* and *easier* reflects how emotional regulation is tied to linguistic choice. English gave her space to articulate distress without fear of judgment; Arabic, by contrast, brought intimacy that risked shame or misinterpretation. Choosing English thus became a coping mechanism; a way to preserve self-control; a means of protection and social identity while engaging with sensitive emotions.

The Struggle of Translation: "I can't find the right word I feel like I am translating myself"

Others found themselves caught between two linguistic worlds when trying to share experiences with family or friends.

Rinda explained:

> *"Sometimes I start explaining something I learned in the UK, like anxiety or burnout, but I stop halfway because I can't find the right word, or because I know they will not get it the same way. I feel like I am translating myself, not just the language." (Rinda)*

The phrase *translating myself* captures the psychological strain of bilingual existence. Each attempt to translate risks distorting lived experience, leaving her suspended between clarity and misunderstanding. Speaking becomes a negotiation of selfhood and recognition. Translation here is not linguistic but existential, each word carries the tension between being understood and remaining faithful to one's inner reality.

Emotional Authenticity and the Power of the Mother Tongue: "More expressive to use my dialect "

While some relied on English for protection, others found their mother tongue more emotionally authentic. Speaking in her dialect was experienced as more natural and less filtered than speaking in English. Amelia expressed:

> *"I would say I have done this for two major reasons; one is that it is more expressive to use my dialect, and second is that it is more direct to the point and doesn't need further explanation, unlike in English. I feel I need to be more careful to choose my words." (Amelia)*

Her reflection contrasts two emotional registers. In her dialect, expression feels spontaneous and embodied; in English, careful and filtered. The phrase *more direct to the point* suggests

that Arabic delivers emotional precision, while English demands self-monitoring. Language thus shapes not only communication but also how emotions are felt and embodied.

Lilyana echoed this instinctive attachment:

> *"I didn't really do that on purpose, but I felt the need to express my point of view in my dialect as I felt it's more expressive." (Lilyana)*

Her repetition of *felt* highlights the emotional rather than rational nature of her choice. Through her dialect, she reclaimed a felt truth, an emotional fluency grounded in cultural rhythm and shared understanding. Speaking in her dialect reconnected her to belonging and identity, bridging personal experience and collective meaning. Together, these accounts show that bilingual speakers continuously navigate identity through language. Choosing between Arabic and English becomes an act of self-positioning between emotional honesty and social acceptability, between individuality and communal belonging.

Language as Coping and Continuity: "think in English and explain in Arabic"

Despite these tensions, many participants saw bilingualism as a resource rather than a burden. Being able to move between two languages provided both emotional authenticity and cognitive distance. Davie described this adaptation:

> *"At first it was hard because I couldn't talk in the same way, but then I realised I can use both languages; I can think in English and explain in Arabic, and that helps me to make sense of what I feel. It's not perfect, but it works for me." (Davie)*

His phrase *it's not perfect, but it works* captures a pragmatic acceptance of imperfection. Flexibility itself became coping. Thinking in English while expressing in Arabic mirrors his dual belonging: his inner world shaped by two languages, neither replacing the other. His bilingual practice became a form of integration, turning linguistic tension into emotional

balance.

Across accounts, language emerged as both a mirror of identity and a means of survival. For some, English offered conceptual clarity and psychological distance; for others, Arabic restored intimacy and emotional truth. This duality illustrates that coping after return extends beyond emotion; it involves re-learning how to speak oneself into being. Through shifting linguistic choices, participants reconstructed belonging and continuity in ways that reflected their personal transformation and their cultural roots.

6.5 Discussion

The primary objective of this research was to delve into the experience of AISs' comprehension of mental health upon their return to their home country; the challenges they may encounter when attempting to disclose their mental health struggles and examine the various avenues through which these students seek help upon their return home while also exploring the coping mechanisms and strategies they employ.

This study showed that comparison was a key concept for participants to navigate knowledge and understanding to their experience. Comparisons serve as cognitive tools that humans employ to make sense of their surroundings and experiences (Kedia et al., 2014). This natural inclination to compare arises from our innate need to understand unfamiliar concepts or situations by relating them to familiar ones (Fiske & Taylor, 1991). When faced with two different things; one we have knowledge about and one we lack understanding of comparison helps us draw parallels, discern differences, and gain insights into both entities. This process allows us to contextualise new information within our existing knowledge framework, facilitating comprehension and informed decision-making (Fiske & Taylor, 1991). For example, when encountering a new product, people often compare it to similar products they are familiar with in terms of features, quality, and price to determine its value and utility;

however, in the context of this study, participants were comparing Algeria, their homeland, with the UK, where they had spent several years studying and living. This comparison between two familiar cultural contexts helped to reveal deeper insights into their adaptation, reintegration, and mental health awareness. When participants returned to their home country after an extended period abroad, they engaged in comparisons between the two cultures they have intimately experienced. This phenomenon can be termed "Dual Contextual Comparison". For Algerian students returning from the UK after five years of study, this comparison process is driven by their deep familiarity with both cultural contexts. Dual Contextual Comparison refers to the cognitive process of evaluating two well-known environments based on lived experiences. Unlike comparisons made between a known and an unknown entity, this involves evaluations informed by personal immersion in both contexts (Tajfel & Turner, 1986).

One primary reason for engaging in Dual Contextual Comparison is cognitive dissonance. Cognitive dissonance theory posits that individuals experience discomfort when holding conflicting cognitions and seek to resolve this by adjusting their beliefs or behaviours (Festinger, 1957). Upon returning to Algeria, students may find discrepancies between the mental health awareness and support they experienced in the UK and what they encounter at home. This dissonance prompts them to compare and contrast the two environments to reconcile their experiences and adjust their expectations accordingly. Another reason is the need to reaffirm one's identity and sense of belonging. Prolonged exposure to a different culture often leads to internalising certain aspects of that culture (Berry, 1997). Returning students compare their home culture with the host culture to navigate their dual identity and integrate the beneficial aspects of both. This process helps them maintain a coherent self-concept and reinforces their place within their home society while acknowledging the positive influences of their time abroad. Comparing familiar contexts allowed participants to evaluate

their personal growth by reflecting on how they adapted to the UK's cultural norms and mental health practices, where they understood the skills and perspectives they gained. This introspective comparison highlights their adaptability and the evolution of their mental health literacy, facilitating a smoother reintegration into Algerian society (Ward, Bochner, & Furnham, 2001). While participants reported significant shifts in how they understood mental health, identity, and social interaction following their time in the UK, they often perceived their social environment in Algeria as having changed less than they had expected. The findings showed a similar pattern among people in the study, with a first phase of happiness upon getting back home and then experiencing great difficulties that negatively impacted on their mental health. At first, there was a sense of excitement among everyone to see their families and the familiar faces. But the euphoria was short-lived as they slowly started to face different reality. Immediately after returning, the participants said that they had felt deeply disappointed, the frustration was that they saw everything at home remained the same in their absence (Minimum 4 years in UK). underwent significant shifts in how they understood mental health, identity, and social interaction. Exposure to different cultural norms, institutional practices, and discourses in the UK reshaped what they came to see as reasonable, acceptable, or possible in everyday life. These changes did not lead students to assume that Algerian society itself would transform rapidly. Rather, they recalibrated their expectations through their own personal and cognitive development. This realisation was in conflict with the expectations of growth and development they had been conditioned to hope for by their experiences in Britain. A major contributor was with the period they stayed in another country, participants had become distanced from friends and family back home. Since they lacked some local commitment and had long been away from home, returning students were often out of touch with new social, cultural or political changes occurring in Algeria. This difference may have affected their expectations since they inevitably compared life in the UK to the static state at home (Ward & Kennedy, 1999). Initially, students formed expectations about

their return home, influenced by their positive experiences abroad and their anticipation of changes in their home environment. For example, Algerian students expected societal progress, increased acceptance of new ideas, and personal growth. This phase of expectation-setting was crucial, as it shaped the students' perceptions and emotional readiness for their return (Oliver, 1980). Several participants described feeling that they had changed considerably during their time abroad, whereas family members, friends, and wider social networks appeared largely unchanged from their perspective. This perception was reflected in accounts of feeling like a "different person" upon return, struggling to reconnect with familiar social environments, and questioning whether others would accept the "new" version of themselves that had emerged through their experiences abroad. This realisation was particularly jarring when it clashed with their evolved perspectives, leading to a significant mismatch between expectations and reality (Ward & Kennedy, 1999). For instance, returning students found that mental health issues were still linked to superstitions such as the "black eye" or possession, rather than being understood through a scientific lens. In this sense, the distress described by returnees was less about unmet hopes for transformation at home, and more about the growing visibility of difference between the 'new self' they had become and the 'old home' they were returning to. Practices and interpretations that had once felt ordinary now appeared incongruent with their evolved understandings, creating a sense of emotional dissonance. The mismatch, therefore, emerged from asymmetrical change: personal transformation on the one hand, and contextual continuity on the other. This comparison between their expectations and their actual experiences led to disconfirmation, particularly when there was a significant mismatch.

The persistent mismatch between expectations and reality resulted in emotional distress and disappointment. Students often felt isolated and unsupported due to the cultural and societal gap between their experiences in the UK and those in Algeria. This gap contributed to a sense

of alienation, as their new coping mechanisms and lifestyle choices were not understood or accepted by their community (Berry, 1997). Consequently, this emotional distress manifested as anxiety, depression, and other mental health issues, exacerbated by the lack of understanding and support from the local community. Incorporating psychological theories such as Reverse Culture Shock and Acculturation Stress provides a useful framework for understanding the reintegration experiences of returnee students.

Reverse Culture Shock refers to the emotional and psychological adjustment difficulties faced when re-entering one's home culture after spending an extended period abroad. This phenomenon mirrors the initial culture shock encountered when first adapting to a foreign environment, where individuals struggle to adjust to new norms, customs, and social expectations (Ward, Bochner, & Furnham, 2020). On the other hand, Acculturation Stress; as defined by Berry (1997); describes the psychological strain resulting from the process of reconciling the new values, beliefs, and behaviours adopted abroad with those that prevail in the home culture. This stress arises as individuals attempt to navigate the complexities of their transformed identities, often facing tension between their experiences abroad and the expectations of their home society. Both theories offer key insights into the challenges faced by participants in this study, helping to explain the psychological and emotional difficulties involved in the process of reintegration.

After facing significant challenges upon their return, participants in the study attempted to seek help but encountered several barriers that impeded their efforts. These barriers can be understood through various theoretical lenses, offering deeper understanding. The barriers can be categorised into those affecting informal disclosure to family and friends, and those impacting formal disclosure to mental health professionals. A primary barrier to informal disclosure was the lack of understanding from those who had not experienced studying abroad. Participants feared being misunderstood due to their unique experiences and

perspectives gained while abroad, which differed significantly from those who had remained in Algeria. This fear of misunderstanding often deterred them from disclosing their struggles to family and friends (Ward & Kennedy, 1999). A subtle yet powerful distinction that emerged from participants' accounts is the thin line between being understood and being empathised with. Families and peers could often recognise that returnees had changed; acknowledging their new ways of thinking, speaking, or behaving; but this recognition rarely extended into emotional resonance. Participants described moments when relatives seemed to understand them; yet the connection felt hollow and understanding remained at a cognitive level, while empathy, which involves emotional atonement and shared feeling, was absent. This distinction has been widely acknowledged in recent psychological research, which differentiates between cognitive empathy (the ability to understand another's perspective) and affective empathy (the capacity to emotionally connect and share in another's experience) (Eklund et al., 2021; Zaki, 2014; Singer & Klimecki, 2014). In practice, the absence of affective empathy can leave individuals feeling recognised but not truly felt *with*. As several participants noted, being heard did not equate to being understood from the heart. They felt that their families could process their words but could not access the emotions beneath them; however, this disconnection was not always one-sided. In some cases, families reacted from the heart; showing genuine care, compassion, and sympathy; yet they still struggled to truly understand what the returnees were experiencing. Their sympathy was sincere but limited by a lack of shared experience or conceptual understanding of mental health. This reveals that emotional resonance without understanding can be as incomplete as understanding without empathy. Both dimensions; cognitive understanding and emotional connection; are necessary for meaningful support. This dual requirement is supported in relational and counselling literature, where effective empathy is understood to rely on both accurate comprehension and emotional atonement (Elliott et al., 2018; Mercer & Reynolds, 2002). When families empathised but could not conceptualise the reasons behind distress, participants felt cared for

but not validated; their emotions were acknowledged, but their experiences were not fully recognised. Conversely, when families understood logically but lacked warmth, participants felt acknowledged but not comforted. This pattern mirrors findings in recent studies on emotional support and validation, which emphasise that understanding without warmth risks detachment, while sympathy without insight risks misunderstanding (Decety & Cowell, 2015; Neumann et al., 2023). The challenge, therefore, lies in balancing both; the head that understands and the heart that feels. When individuals share painful experiences, they seek more than comprehension; they seek validation and emotional safety. Without this, disclosure risks deepening isolation rather than relieving it. As research on close relationships suggests, people experience greater intimacy and lower distress when their disclosures are met with perceived responsiveness; feeling understood, validated, and cared for (Laurenceau et al., 1998). In contrast, emotionally neutral or dismissive responses can heighten distress, as they signal understanding without acceptance (Jeon et al.,2024). This was also evident in this study where the act of expressing sadness in Arabic was easily misinterpreted as admitting madness or instability. The social meaning of words carried emotional weight that blocked empathy; listeners might intellectually recognise distress but respond defensively, avoiding emotional involvement. Such misinterpretation demonstrates how language and empathy intertwine; when words evoke stigma, they silence feeling. The thin line between understanding and empathy thus becomes a defining feature of the returnee experience. It explains why disclosure, even when attempted, often failed to bring relief. Understanding offers accuracy; empathy provides comfort. Without the latter, returnees felt emotionally exposed yet unsupported. This gap contributed to their sense of estrangement within familiar relationships; a phenomenon echoing what Zielinski et al. (2022) and Jeon et al. (2024) describe as the emotional cost of invalidation. In this study, empathy; or the lack of it; shaped the very conditions of coping. Where listeners crossed the line from understanding into empathy, conversations became healing spaces that fostered acceptance and belonging. Where empathy

was absent, interactions became forced, mechanical, and exhausting; leading to silence or withdrawal. Participants often said they felt *forced to talk*; *forced to listen*; or *forced to fit in*; illustrating that communication without emotional reciprocity can deepen alienation rather than bridge it. Recognising this distinction refines our understanding of reintegration. The participants' stories show that re-entry adaptation is not only cognitive but profoundly affective. Returning home required more than intellectual understanding from others; it demanded emotional re-attunement; a willingness to feel alongside the returnee rather than simply acknowledge their change. This aligns with recent findings that empathy is both motivated and context-sensitive, influenced by cultural norms and relational expectations (Zaki, 2014). In Algerian contexts where discussing emotions and mental health remains delicate, empathy may be consciously regulated; people may "choose not to feel too much" to preserve social harmony as found in study 1.

Additionally, participants expressed a fear of alienation and social rejection. Holding different beliefs and values, particularly around mental health, made them wary of being disregarded or ostracized by their community. The fear of being seen as deviating from societal and religious norms further discouraged them from sharing their mental health struggles (Sussman, 2002). Religion also played a significant role in the reluctance to seek informal help. Participants noted that disclosing mental health issues could be perceived as a sign of weak faith or insufficient religiosity. This stigma associated with mental health problems often led to silence, as individuals feared judgment from their religious community (Goffman, 1963). Despite being exposed to alternative views on mental health during their time abroad, these deeply ingrained religious beliefs about mental illness, particularly within the context of Islamic teachings, proved resistant to change. This suggests that, unlike other aspects of their worldview; such as social norms, educational expectations, or even attitudes toward cultural practices; the participants' views on mental health, shaped significantly by their

religious teachings, remained firmly entrenched. This phenomenon raises the question: why do religious views, especially those in Islamic contexts, remain so resistant to change even after exposure to differing perspectives during study abroad experiences? From a psychological standpoint, religion often functions as a core part of an individual's identity and coping mechanisms, making it resistant to alteration, even when confronted with conflicting viewpoints (Park, 2010). In Islam, mental health struggles are frequently framed within a religious narrative where suffering is seen as a test of faith or an opportunity for personal growth. This framing can create cognitive dissonance when mental health issues are seen through a medical or psychological lens. As discussed earlier in this chapter and in previous chapters (Study 1 and 2), according to Cognitive Dissonance Theory (Festinger, 1957), individuals experience psychological discomfort when confronted with information that challenges their deeply held beliefs. For many participants, reconciling the idea of mental health as a medical issue with religious views; where mental illness is perceived as a spiritual failing or moral weakness; created significant internal conflict. This dissonance often led them to minimise the importance of seeking professional mental health care, even after encountering alternative viewpoints abroad.

Furthermore, Social Identity Theory (Tajfel & Turner, 1986) provides additional insights into the persistence of religious beliefs about mental health. Religious identity is integral to group belonging, and in many religious communities, including Islamic ones, religious norms dictate how mental health issues are perceived and managed. The sense of social cohesion provided by religious groups is critical, and individuals who deviate from the group's norms (such as seeking help outside of the religious framework) risk being excluded or judged by the community. This reinforces silence and reluctance to disclose mental health issues, as participants feared being perceived as less devout or even as failing their faith. Islamic teachings on mental health are shaped by a complex interplay of spiritual and medical

understandings. In Islam, suffering, including mental suffering, is often interpreted as a test from Allah, which can lead individuals to view their mental health struggles as part of their spiritual journey (Ahmed, 2010). While Islam encourages seeking medical treatment, including for mental health, there is a prevailing belief that true healing comes from faith and prayer. The Qur'an mentions that God is the ultimate healer (Qur'an 26:80), and this religious perspective can create a barrier to seeking professional help, as individuals may prioritise prayer and religious rituals over evidence-based therapies or psychological support.

Recent studies support the notion that religious beliefs; especially in collectivist cultures continue to significantly influence mental health perceptions and treatment-seeking behaviour. For instance, Fadzil et al. (2020) found that Malaysian Muslims faced barriers to seeking mental health care due to concerns about stigmatisation and the belief that mental illness was a sign of weak faith. Similarly, Bhugra (2005) highlighted how religious beliefs about mental

health in South Asian communities often conflict with Western psychological models of mental illness, making it difficult for individuals to seek professional mental health services. These findings are particularly relevant to AIS returning home after studying abroad. While AISs may have been exposed to more Westernised approaches to mental health during their studies, the deeply ingrained religious and cultural perspectives they encounter upon returning to Algeria may create significant barriers to seeking help. Similar to the experiences of other collectivist cultures, AISs may feel that mental health issues are stigmatised within their religious communities, leading them to view such struggles as a sign of personal weakness or insufficient faith. This cultural and religious stigma hinder AISs from seeking professional help or disclosing mental health issues, despite the more open perspectives they may have encountered abroad.

From a sociological perspective, socialisation plays a crucial role in understanding why

religious views are so resistant to change. Socialisation within religious communities teaches individuals what is considered acceptable behaviour and belief, shaping their worldview from an early age. This socialisation is reinforced through family, community, and religious institutions, which provide individuals with a sense of identity and belonging. Religious beliefs about mental health are not only personal convictions but also collective norms within the community. In Islamic societies, mental health issues are often not openly discussed, and seeking help outside of religious frameworks can be viewed as an act of defiance against both family and community (Ebrahim et al., 2020). This collective reinforcement of religious norms creates a strong sense of continuity, making it difficult for individuals to integrate new perspectives into their existing belief system, even after encountering different cultural realities during their studies abroad. For AIS returning home, this socialisation process becomes particularly significant. During their time abroad, AISs have been exposed to Western mental health perspectives, that advocate for open discussions about mental health issues and encourage seeking professional help. However, upon returning to Algeria, they are confronted with the social and religious norms of their home community, which may view mental health struggles through a more traditional lens, emphasising religious explanations such as weak faith or punishment from God.

This creates a significant tension for AISs. On one hand, they may feel a newfound openness about mental health due to their experiences abroad, while on the other hand, they are still deeply influenced by the socialisation they received in Algeria, where religious beliefs regarding mental health are dominant. This cultural clash makes it difficult for AISs to fully integrate the perspectives they encountered abroad into their existing belief systems. The strong collective reinforcement of religious norms within their home country may act as a barrier, making it challenging for AISs to seek help or openly discuss their mental health struggles, despite the more accepting attitudes they may have encountered during their studies

in the UK. This illustrates the powerful role that socialisation plays in shaping individuals' ability to navigate and integrate new perspectives, particularly when these perspectives challenge deeply ingrained beliefs about mental health. When considering formal disclosure and seeking help from professionals, several additional barriers emerged. Participants questioned the qualifications and competence of local mental health professionals. Hearing about negative experiences from peers further discouraged them from seeking professional help, reinforcing their doubts about the efficacy of such services (Jorm, 2000). Financial constraints also posed a significant obstacle to formal disclosure. Many participants indicated that the cost of therapy was expensive, and this financial barrier was compounded by societal misconceptions about the necessity and value of professional mental health care, with some families equating it to being "crazy" (Corrigan, 2004). These barriers to both informal and formal disclosure can be linked to Health Belief Model (HBM), which suggests that individuals' decisions to seek health services are influenced by their perception of susceptibility, severity, benefits, and barriers (Rosenstock, 1974). In this case, the perceived barriers ranging from social stigma and financial cost to doubts about professional competence outweighed the perceived benefits, leading to a reluctance to seek help. In this study, participants struggled after returning home; however, they shared strategies they found beneficial for coping and reintegrating successfully. One effective strategy was sharing their experiences with fellow returnees who had similar international study experiences. This peer support helped them seek understanding without necessarily seeking advice, as described in the concept of social support theory (House, 1981). By connecting with others who had shared experiences, they could validate their own feelings and experiences, reducing feelings of isolation. Acceptance of their reality and the differences between themselves and their society was another crucial coping mechanism. By acknowledging and accepting their situation, students found inner peace and were better able to navigate cultural and societal differences. This aligns with the concept of mindfulness and acceptance-based approaches in psychology

(Hayes et al., 1999), which emphasised the importance of accepting one's experiences and emotions without judgment. Maintaining contact with people from their community after returning home was also significant. This allowed students to regain familiarity with local norms, values, and social dynamics, facilitating their reintegration process. These strategies; peer support, acceptance, and maintaining social connections; provided Algerian students with practical ways to cope with the challenges of reintegration into their home society after studying abroad. By employing these strategies, they were able to bridge the gap between their international experiences and their cultural roots, facilitating a smoother transition and adjustment. For some participants, acceptance of being "different" did not function as a straightforward or benign coping strategy. Rather than bringing relief, acceptance was experienced as inauthentic, requiring individuals to minimise or conceal aspects of themselves in order to maintain social harmony. In this sense, acceptance involved an emotional compromise, where outward adjustment occurred at the cost of inner congruence. This tension helps explain why acceptance was sometimes resisted during re-entry. From a person-centred perspective (Rogers, 1951; 1961), psychological wellbeing depends on congruence between lived experience and self-expression. When adaptation requires individuals to present a version of the self that aligns with external expectations rather than internal experience, it risks producing psychological incongruence. Within this framework, resistance to acceptance can be understood not as avoidance, but as an attempt to protect authenticity in contexts where the social environment no longer accommodates a changed self. Across participants strategies such as "pretending," self-monitoring, or selectively performing familiarity enabled social reconnection, but often involved suppressing internal shifts in identity, values, or emotional orientation. Acknowledging personal change therefore became emotionally complex: it offered recognition of growth, while simultaneously highlighting misalignment with familiar social worlds. Coping during re-entry was thus not merely about behavioural adaptation, but about managing the psychological cost of adjustment when authenticity and belonging came

into tension. Seen in this way, acceptance could be socially stabilising while remaining psychologically demanding. The distress associated with re-entry did not stem from change itself, but from the conditions under which that change had to be negotiated. Person-centred theory helps clarify why resistance to acceptance emerged as a meaningful response: it reflected an effort to preserve self-congruence in environments where social expectations implicitly required continuity rather than transformation.

One important contribution of this study is showing how language shapes the way returning students think and talk about mental health. Researchers such as Dewaele (2023) and Pavlenko (2021) explain that language does more than carry meaning; it influences how people feel and how they make sense of their emotions. In this study, bilingual returnees moved between Arabic and English not only to communicate but to manage the meanings attached to their mental health experiences. English and Arabic represented two different ways of thinking and feeling: English was often linked with openness, analysis, and reflection, while Arabic carried emotional, cultural, and spiritual weight. This movement between languages shows that talking about mental health after living abroad is never neutral. It is an act of balancing two worlds that hold different ideas about the self and suffering.

Scholars such as Wu and Thierry (2023) have shown that using a second language can make emotional disclosure feel safer because it gives distance from intense feelings. In the same way, Dewaele and Costa (2020) found that emotions may feel weaker when expressed in a second language. These ideas help explain why English, for many returnees, felt easier for discussing sensitive topics. It allowed them to describe distress more calmly and with less fear of judgment. Yet, Arabic remained tied to family, faith, and belonging, which made it both comforting and limiting. When certain English mental health terms had no clear Arabic equivalent, as Othman, Khalil, and Jaber (2023) describe, people found it difficult to explain what they were going through without sounding as if they were breaking social or religious

rules. Hassan, Al-Zubaidi, and Mansour (2024) reach a similar conclusion, noting that Arabic words about mental illness can carry moral or spiritual meanings that increase stigma. Still, bilingualism was not only a difficulty. Drawing on Grosjean's (2021) idea of complementary bilingualism, this study suggests that using both languages helped returnees cope with the gap between their two cultures. Switching between English and Arabic gave them control over how much emotion to show and how much to hold back. This flexibility helped them find a middle ground between honesty and protection. Language in this sense worked as a personal resource. It offered a way to speak about distress without losing connection to their community or to the personal insight gained abroad. The cultural meaning of language choice goes deeper than preference. In many Arab societies, mental illness is often spoken about through moral or religious terms. As Al-Adawi, Al-Zakwani, and Al-Harthy (2021) explain, distress is sometimes seen as a test of faith rather than a health condition. Speaking in English gave returnees another vocabulary; one that treated mental health as a normal human issue rather than a moral failing. But as Piller (2022) reminds us, every language carries social meanings. Choosing English might protect against stigma but can also create distance from family and friends who see it as foreign. This shows how returning students often face a difficult choice between being understood and staying connected. Language also reflects two different kinds of knowledge about the self. Western psychology encourages open discussion and individual responsibility, while Arabic traditions value social harmony and spiritual strength. Al-Krenawi and Graham (2021) point out that mental health understanding in Arab contexts cannot be separated from religion or community. For many returnees, trying to express Western psychological concepts in Arabic revealed the lack of shared vocabulary between these systems. Their experience suggests that reintegration involves finding new ways to express emotions that make sense in both languages.

Other studies support this idea. Dewaele (2023) and Fan, Pavlenko, and Bylund (2022) show

that bilingual people often shift between emotional identities when they change languages. What this study adds is evidence that such shifts continue during the process of coming home. Speaking English or Arabic did not simply change words; it changed how participants felt about themselves and how they related to others. For these reasons, coming home after studying abroad is not only cultural or psychological; it is also linguistic. The ability or inability to speak about distress in a socially acceptable way affects how supported or isolated people feel. Language choice becomes a way to negotiate belonging.

Furthermore, Participants expressed that the use of mother tongue allowed for a more direct and emotionally resonant expression of their thoughts and feelings, contrasting with the perceived need for careful word choice when using another language such as English. In psychology, code-switching is pivotal as it reflects cognitive flexibility and linguistic adaptability, both crucial for mental health and well-being (Green & Wei, 2014). In addition to that, code-switching within semantics delves into how alternating between languages influences the construction of meaning and its psychological implication (Muysken, 2000) which can be another reason that some people code-switch as this explain the feeling associated with the preferred language used without feeling the need for further explanation when share a point of view. And that is justified by scholars that language choice in mental health narratives is not merely a matter of communication but also a crucial aspect of identity negotiation and cultural expression (Smith, 2018; Li, 2020). Linguistic choices reflect individuals' comfort and familiarity in expressing complex emotions and experiences, which can significantly impact the authenticity and depth of their narratives (Smith; 2018). This study therefore extends existing knowledge by showing that language use after return can help or hinder mental health recovery. Reintegration is not complete until individuals regain the ability to talk about their emotions in a way that feels both truthful and culturally understood.

Going deeper with the findings of the study, facing challenges of re-integration after returning

home and trying to seek understanding and help in the familiar territory make the students seem like emotionally refugees. Unlike economic or political refugees who are forced to flee their homeland due to tangible threats, *emotional refugees* in this study refers to the students who find themselves estranged within their own country, caught between two conflicting cultural and psychological worlds. Their emotional and cognitive frameworks have shifted during their time abroad, making reintegration into their home society a source of distress rather than comfort.

One of the core aspects of emotional refugeedom is the sense of being a foreigner in a familiar place. Upon returning to Algeria, these students often find that the environment they once called home no longer feels like a place of psychological safety. Psychological safety here refers not to protection from physical harm, but to the perception that one can express thoughts, emotions, concerns, or vulnerabilities without fear of rejection, humiliation, or negative social consequences (Edmondson, 1999; Edmondson & Lei, 2014). Within the context of this study, psychological safety further encompasses the presence of empathic recognition, shared language, and moral permission to express distress. Where these elements were absent, students described heightened self-monitoring, selective disclosure, and emotional withdrawal as protective responses. Their perspectives on social norms, mental health, identity, and self-expression have evolved in ways that create cognitive dissonance with the dominant cultural expectations in Algeria. Upon returning to Algeria, many participants described a sense of estrangement from environments that were once familiar. Importantly, this estrangement did not reflect an absence of physical safety, nor a perception of direct threat. Rather, it reflected a loss of psychological containment and emotional recognition. Home no longer functioned as a space where distress could be easily understood, mirrored, or held with empathy. While they expect a seamless return to their previous roles within family and community structures, they instead encounter resistance, confusion, and a

pervasive feeling of misalignment. This feeling is exacerbated by the realisation that their own transformation has distanced them from the very people with whom they once shared a common worldview. The difficulty in articulating their changed perceptions to family and friends; who may lack exposure to the experiences that shaped them abroad, contributes to an ongoing sense of isolation, reinforcing their status as emotional refugees. In this sense, the loss experienced by returnees is better understood as a disruption of relational safety rather than a collapse of security. Psychological safety here refers not to protection from harm, but to the presence of empathic recognition, shared language, and moral permission to express distress. Where these elements were absent, students described heightened self-monitoring, selective disclosure, and emotional withdrawal as protective responses. Mental health awareness is a particularly salient area where this emotional displacement becomes apparent. Many Algerian students were introduced to open discussions on psychological well-being, therapy, and self-care during their time in the UK, where mental health discourse is normalised, and professional support is widely available. However, upon returning home, they found themselves in a society where mental health issues remain stigmatised, often dismissed as either signs of weakness or spiritual afflictions rather than legitimate psychological concerns. Their attempts to discuss mental health in the language they acquired abroad; both literally in terms of terminology and figuratively in terms of mindset; are frequently met with scepticism or outright rejection. This cultural and linguistic gap deepens their emotional exile, as they are left without adequate support structures to process their struggles. The lack of professional mental health resources and the general distrust in local practitioners further contribute to their sense of being stranded between two incompatible worlds; neither fully belonging to the culture they left nor being able to fully return to the one they re-entered.

Another dimension of emotional refugeedom is the erosion of trust in social relationships. The

returning students find that the interpersonal relationships they had before leaving no longer function in the same way. Conversations that once felt engaging now seem superficial, shared values that once provided a sense of community now appear rigid or limiting, and the emotional intimacy they built with people abroad does not translate into their home environment. Many experience a form of emotional withdrawal, hesitating to express their transformed identities for fear of judgment or alienation. This self-censorship creates a psychological burden, as they struggle to reconcile their internal realities with external expectations. In some cases, they may resort to compartmentalisation, presenting a version of themselves that conforms to societal norms while internally sustaining the identity they cultivated abroad. This dual existence, however, is mentally exhausting and can lead to feelings of inauthenticity and emotional fatigue.

The absence of adequate coping mechanisms and support networks further amplifies this struggle. One of the few ways these students find solace is through connecting with others who share similar experiences. Whether through online communities, informal peer support groups, or continued connections with friends abroad, these interactions provide a rare space where they can express their frustrations without fear of invalidation. The importance of these connections cannot be overstated, as they serve as emotional lifelines in the absence of broader cultural acceptance. The concept of *emotional refuge* thus extends beyond mere alienation; it also encompasses the active search for spaces where one can experience emotional safety and validation. These students are not only struggling to reintegrate but are also actively constructing new forms of belonging that exist outside the traditional frameworks of national or familial identity.

At the core of the emotional refugee experience lies a fundamental tension between personal transformation and the struggle for cultural reintegration. Although returnees physically return to their home country, their psychological and emotional experiences are often

irrevocably changed by their time abroad. This conflict exposes the limitations of traditional models of acculturation, which typically depict adaptation as a linear process. According to these models, migrants or returnees gradually adjust to the culture they move into or return to, through a step-by-step progression of assimilation or integration (Berry, 2006). However, this assumption of a fixed and predictable path does not fully capture the complexities of the emotional refugee's experience. Instead of following a straight or predictable path of adjustment, emotional refugees go through a non-linear and fragmented journey, where their sense of self keeps changing and being reshaped by the contrasts between what they knew before and what they learned abroad. Unlike migrants who may eventually blend into a new society, returnees often remain caught in-between; they live in what Marotta (2025) calls a liminal space, where complete assimilation is neither possible nor even wanted. They cannot simply return to who they were before leaving, yet they also cannot fully live by the perspectives and habits they developed while away. Their identity becomes something they keep negotiating, moving back and forth between their past and present selves. This constant movement creates cultural tension and uncertainty, as they try to bring together parts of two worlds that do not easily fit. As Mahmud (2023) points out, returning home is not just about going back but about finding a place again in light of all the changes that have already taken place within them. In contrast, a linear process of acculturation suggests that the individual gradually moves from one cultural context to another in a predictable, stepwise manner, often culminating in full adaptation or assimilation. For emotional refugees, however, this model falls short, as their experiences of transformation are uneven, non-sequential, and deeply intertwined with the complexities of both their previous and current cultural realities (Berry, 2006; Ward & Geeraert, 2016).

The implications of the emotional refugee phenomenon extend far beyond individual distress, raising crucial questions about the structural factors that shape international students'

experiences. Universities, policymakers, and mental health professionals must not only focus on the support systems available to students during their time abroad but also address the challenges they encounter upon returning home. The lack of adequate reintegration support compounds the difficulties faced by emotional refugees, forcing them to confront these struggles in isolation (Meleis et al., 2011). This gap in support highlights the need for institutions to reassess their approach to student well-being in the context of return migration. Therefore universities, policymakers, and mental health professionals need to consider not only the support systems available to students during their time abroad but also the challenges they face upon returning home. The current lack of reintegration support exacerbates the difficulties faced by AIS, leaving them to navigate their struggles in isolation. Addressing these issues requires both institutional and cultural shifts, including fostering awareness of reverse culture shock, expanding access to culturally competent mental health care, and creating platforms where returnees can share their experiences and find communal understanding.

Ultimately, AIS are considered in this study as emotional refugees caught in an existential paradox; returning to a home that no longer feels like home, seeking belonging in a place where they once felt secure but now feel estranged. Their struggles show the deep psychological and cultural complexities of returning migration, challenging simplistic narratives of homecoming as a relief. Instead, for these students, return is not an end but the beginning of a prolonged, often painful, process of self-reconciliation and emotional survival. Their journeys highlight the urgent need to rethink reintegration as an active, ongoing process rather than a passive phase of readjustment. By recognising their struggles as legitimate and providing spaces for them to articulate and navigate their emotional exile, we can begin to address the silent crisis of emotional refugeedom that many returning students endure in isolation. In conclusion, the findings from this study provide a deep and comprehensive

exploration into the mental health experiences of Algerian students returning home after completing their studies abroad.

6.5 Chapter Summary

This chapter has explored how returning to one's home country after studying abroad involves far more than physical relocation; it is an emotional and psychological process of relearning belonging. Drawing on the lived experiences of Algerian returnees, the discussion revealed that coming home required negotiating a transformed sense of self within an environment that often felt unchanged. What appeared familiar no longer carried the same meanings, and what was once stable now demanded reinterpretation. Participants' journeys showed that reintegration is not a return to the past but a continuation of personal change; a process of finding coherence between who they became abroad and who they are expected to be at home.

From an interpretative perspective, coping after returning involved reconstructing meaning through reflection, acceptance, and the creation of new connections. Familiarity was not comforting by default; it had to be earned through new forms of understanding. Participants' efforts to re-establish normality reflected ongoing attempts to align their internal transformations with external realities. This gradual alignment revealed coping as an act of adjustment rather than resistance; one that demanded patience, flexibility, and emotional honesty.

The study also examined the role of language in shaping these experiences, showing that linguistic duality deeply influenced how returnees expressed, concealed, or understood distress. Moving between Arabic and English was not simply a matter of translation but a process of navigating identity and emotional safety. English often provided distance and neutrality, while Arabic evoked intimacy and belonging. Yet neither language alone was sufficient; each carried both comfort and constraint. The act of choosing a language became

a way of choosing how much of the self to reveal and how much to protect. Through this, bilingualism emerged as both a challenge and a form of resilience, allowing returnees to balance the cultural and emotional contradictions of re-entry. Equally important was the tension between empathy and understanding within family and community relationships. Many returnees felt that loved ones cared deeply but could not fully comprehend their inner changes or the emotional language they had acquired abroad. The difference between being cared for and being understood often shaped whether reintegration felt healing or isolating. True support, as reflected in their experiences, required both; the emotional warmth of empathy and the cognitive clarity of understanding.

Taken together, the discussion in this chapter shows that reintegration after international study is best understood as an ongoing process of meaning-making rather than a fixed stage of return. It involves learning to live with contrasts, translating between worlds, and redefining home as a fluid psychological and cultural space. The findings presented here extend existing understandings of post-return adjustment by illustrating that belonging is not restored through return but recreated through reflection, language, and connection. In essence, coping in reentry was not about going back; it was about finding new ways to move forward; with both familiarity and difference now part of the same story.

Chapter 7: Integration Chapter

Revisiting the Stories, Reimagining Meanings: *Synthesising Insights into Mental health, Disclosure, and Coping among Algerina International Students in Transition*

7. 1 Introduction

This chapter builds directly on the empirical analyses presented in Chapters 4, 5, and 6, explaining how their findings were brought together to form one coherent interpretation of AISs mental-health experiences. The integration joins different perspectives gathered across time and place to understand how these students made sense of their emotional well-being, help-seeking, and coping before, during, and after their studies in the United Kingdom. Each study explored a different part of this journey. Study 1 examined how AIS in the UK understood mental health, stigma, and disclosure while living and studying abroad. Study 2 gathered the views of mental-health professionals, both those with and without experience of supporting Arab and Algerian students, to understand how these professionals interpreted the challenges that students described. Study 3 focused on AIS after their return home, focusing on how their experiences abroad shaped their reintegration, identity, and ongoing well-being in Algeria. Together, these studies offer a connected picture of how meanings around mental health change through migration, adaptation, and return. The purpose of this chapter is to combine these findings and show how they complement, differ from, and extend one another. The aim is not to repeat earlier results but to show how understanding develops across the three studies and what this reveals about the wider experience of Algerian students. Bringing the studies together makes it possible to see how beliefs and actions change as people move between cultures and how these shifts influence what they think mental health means and how they respond to it and cope. Consistent with this thesis's constructivist and relativist stance; that knowledge is created through interaction and shaped by setting, time, and relationship (Lincoln, Lynham, & Guba, 2018) ; the integration treats each study as a situated account

rather than a competing version of truth. From this perspective, differences between studies are not contradictions but signs of how experience takes different forms depending on who speaks, where they are, and what social expectations surround them.

In Study 1, students often explained their hesitation to seek help as a personal and moral decision. They worried that speaking openly might be seen as weakness or spiritual doubt. In Study 2, however, some professionals understood that hesitation as a silence and a sign of cultural resistance or lack of awareness of Western mental-health help. These explanations, though sympathetic, sometimes simplified students' experiences. Study 3 added another layer by showing that after going home, students had to rebuild a sense of belonging and self-confidence in societies where open discussion of mental distress remained uncommon. Their earlier exposure to counselling and self-expression now conflicted with expectations of reserve and endurance. Together, these accounts reveal how silence transforms across contexts; from a moral act of self-protection abroad to a social strategy of reintegration upon return; showing that meaning has evolved and changing rather than fixed. Without integration, such contrasts might appear inconsistent; through triangulation, however, they become interpretively coherent, revealing that each voice offers a partial truth grounded in its social standpoint. As Denzin (2012) explains, the goal of triangulation is not to reach a single truth but to bring several truths into conversation. Doing so allows a richer picture of lived experience to emerge, one that reflects both agreement and difference. The integration therefore uses three main approaches: thematic synthesis, interpretive triangulation, and cross-study analysis. Thematic synthesis (Thomas & Harden, 2008) provided a way to connect related ideas and build broader themes that run across all studies. Interpretive triangulation (Flick, 2018; Denzin, 2017) made it possible to recognise how meanings shift between students and professionals without forcing them into one explanation. Cross-study analysis (Miles, Huberman, & Saldaña, 2020) then allowed systematic comparison across contexts,

showing where ideas such as stigma, faith, and coping remained constant and where they changed. Two additional strategies supported this work. Integrative diagramming helped visualise how ideas developed from one study to the next, while reflexive commentary kept the researcher's position visible and transparent (Finlay, 2002; Berger, 2015). Reflexivity was treated as part of the method itself, ensuring that the analysis remained self-aware and ethically grounded.

Following Sandelowski, Voils, and Barroso (2006), special care was taken to avoid reducing the findings to general statements: The intention was to keep participants' voices clear while linking them to broader interpretations relating to experiences of being in the UK, professionals' perspectives, and experiences following return to Algeria. This chapter therefore moves from description toward explanation, showing how meanings are shaped and reshaped through study abroad, professional encounters, and homecoming. Therefore, the integration chapter is not a restatement of the three studies, but a new interpretation built from them. It shows that Algerian students' approaches to mental health cannot be explained only culture and tradition or individual psychology, instead, these approaches are ongoing negotiations between belief, context, and relationship. By joining the studies together, the chapter provides a fuller and more grounded understanding of what it means for AIS to face and make sense of mental-health challenges across changing worlds.

7.2 Method of Integration

To connect the three studies in a clear and meaningful way, the integration followed a structured but flexible approach built mainly on three strategies: thematic synthesis, interpretive triangulation, and cross-study comparison. Two further techniques, integrative diagramming and reflexive commentary, were used to support and clarify the process. Each step was guided by the same constructivist position that informed the whole thesis, which views knowledge as produced through experience, interpretation, and social context rather

than discovered as a single objective truth. The first stage of integration focused on identifying conceptual overlaps across the three studies through thematic synthesis.

7.2.1 Thematic synthesis

Thematic synthesis (Thomas & Harden, 2008) was used as the main analytical tool to bring the findings together. This involved reading and rereading the final themes from all three studies, identifying where ideas overlapped, and creating new categories that captured the meaning shared across them. For example, the idea of silence first appeared in Study 1, where students described not speaking about their struggles because they feared judgment or shame. In Study 2, professionals noticed the same silence but interpreted it as uncertainty or lack of awareness about therapy. When Study 3 was added, silence appeared again, this time as an inner form of control; students kept quiet to protect their sense of belonging after returning home. Through synthesis, these different expressions of silence were drawn together into a broader understanding: silence as both a protective and limiting strategy, shaped by culture and experience. Another example came from the theme of coping. Across the three studies, coping moved from self-isolation and prayer (Study 1) to professionals' recognition of culturally shaped coping (Study 2) and finally to selective adaptation of coping practices after returning home (Study 3). Linking these patterns through thematic synthesis allowed the researcher to see coping not as a fixed behaviour but as an evolving skill that shifts according to social context and personal change. The second stage moved from connection to interpretation, using triangulation to explore how perspectives interacted or diverged.

7.2.2. Interpretive triangulation

Interpretive triangulation (Flick, 2018; Denzin, 2017) helped to compare how different groups made sense of similar experiences without forcing them into one explanation. Instead of looking for agreement, the aim was to understand what each group revealed that the others could not. For instance, when students in Study 1 said they preferred to speak to an imam

rather than a counsellor, their decision reflected faith, comfort, and cultural familiarity. Professionals in Study 2, however, often viewed this choice as avoidance of modern treatment. Triangulation made it possible to hold both views together and explore the gap between them. This difference itself became an important finding, showing how meanings around help-seeking depend on who is interpreting the act and from what position.

Triangulation was also used to explore gendered experiences. In Study 1, male students described suppressing emotions to protect their reputation, while Study 2 showed that professionals often interpreted this as simple resistance. Study 3 indicated that such difficulties in expressing emotion frequently persisted after return, as expectations around strength and emotional control remained intact. Looking across these accounts showed that silence among men was not merely resistance but part of an ongoing negotiation between identity, culture, and masculinity that continued after migration. The final stage involved systematically comparing the studies across time and context to trace thematic transformations.

7.2.3 Cross-study comparison

Cross-study comparison (Miles, Huberman, & Saldaña, 2020) provided a way to move step-by-step between the studies, tracing both development and contrast. The integration first compared students' personal narratives in Study 1 with professionals' accounts in Study 2 to see where interpretations met or diverged. Then, findings from Study 3 were added to show how perspectives changed once students returned home. This comparison helped to identify how time and place influenced the same themes.

For example, stigma appeared across all studies but carried different weight. In Study 1, stigma was felt through fear of family judgment; in Study 2, it was discussed as a social barrier that professionals tried to reduce through awareness; in Study 3, it became internalised, with

returnees describing self-stigma and regret for not fitting the social norm. Comparing these shifts showed that stigma does not disappear but changes form depending on the stage of the student's journey. Similarly, language moved from being a barrier in Study 1, to a recognised cultural factor in Study 2, and finally to a tool for reflection in Study 3, where participants switched between Arabic, French, and English to express emotions. This comparison illustrated how language develops from a technical difficulty to a medium of identity expression.

Supporting techniques

Two supporting methods added clarity to this process. Integrative diagramming was used to map how ideas progressed from one study to the next. Diagrams visually displayed links between themes such as faith, stigma, and coping, showing where they overlapped and where new meanings appeared. Reflexive commentary was maintained throughout, with the researcher noting her position as both insider and outsider; an Algerian researcher educated in the UK but analysing experiences of returnees. Reflexivity ensured that interpretation remained sensitive to culture while still grounded in academic rigour (Finlay, 2002; Berger, 2015). Following the guidance of Levitt et al. (2018), Yardley (2000), Nizza et al. (2021), and Smith, Flowers, and Larkin (2021), the integration was carried out systematically and with transparency. Each decision was recorded, including how codes were combined and why certain interpretations were chosen. Rather than aiming for one unified theory, the synthesis preserved the differences that gave each study its strength. This reflects the warning by Sandelowski, Voils, and Barroso (2006) that integration must deepen, not dilute, understanding. Reflexivity therefore acted not only as a methodological safeguard but also as an ethical commitment, ensuring that interpretations acknowledged both the researcher's insider position and the participants' vulnerability within culturally sensitive discussions of mental health.

7.2.4 Step-by-Step Strategy for Cross-Study Mapping

To ensure transparency and analytic rigour, the integration followed a structured, iterative six-step procedure that combined the three analytic strategies described above; thematic synthesis, interpretive triangulation, and cross-study comparison; together with the supportive techniques of integrative diagramming and reflexive commentary. These steps translated the individual thematic findings into a coherent comparative framework.

This six-step procedure was adapted from recognised qualitative synthesis frameworks (Thomas & Harden, 2008; Braun & Clarke, 2021; Flick, 2018; Miles, Huberman, & Saldaña, 2020) and tailored to the present thesis's constructivist design. It does not claim to be a novel analytic method but rather a context-specific adaptation that integrates well-established techniques into one transparent and reflexive process. Adaptation was necessary because the three empirical studies varied in both methodology and participant composition: Study 1 used reflexive thematic analysis with Algerian students in the UK; Study 2 used comparative thematic analysis with mental-health professionals; and Study 3 employed interpretative phenomenological analysis with returning students in Algeria. Given these methodological and contextual differences, a conventional meta-analysis or aggregative synthesis was inappropriate. The adapted procedure therefore operationalised a constructivist logic of meaning-making across contexts, allowing comparison of conceptual development without collapsing cultural or temporal variation. Each step embodies the principles of transparency, reflexivity, and epistemological coherence. the following explains the steps followed for this cross analysis:

Step 1: Re-familiarisation with thematic frameworks

Each study's final themes and subthemes were revisited, along with exemplar quotations and analytic memos, to re-enter the analytic context of each dataset.

Step 2: Extraction of interpretive codes

Within each theme, key analytic ideas; the interpretive codes that captured meaning; were identified and recorded with their provenance (Study 1/2/3 and participant group) to preserve context.

Step 3: Identification of conceptual resonances

Codes were compared across studies to detect similarities or contrasts in *meaning* rather than wording. Divergent or discrepant cases were retained to ensure that variation was represented rather than normalised.

Step 4: Grouping into higher-order conceptual categories

Related codes were clustered into broader conceptual categories (e.g., stigma, faith, coping, language). Each category was defined and linked to its evidential base through an audit trail, supported by integrative diagramming to visualise relationships.

Step 5: Mapping temporal and contextual movement

Using matrix displays and diagrammatic mapping, each category was traced across the three studies to identify emergence (where it first appeared), convergence (where understandings overlapped or stabilised), and divergence (where meanings shifted by setting or time). This mapping produced the comparative matrix presented later in Table 7.1.

Step 6: Reflexive validation

Interpretive links and category boundaries were reviewed through reflexive note-taking and supervisory dialogue to ensure analytic integrity. Reflexive commentary documented how the researcher's positionality, assumptions, and interpretive decisions influenced the synthesis.

7.2.4.1 Illustrative Example of the Process

The examples presented below are intended to demonstrate how the six-step integration strategy was applied in practice. They are provided as methodological illustrations of the analytic process rather than as a full presentation of findings. More detailed interpretation and discussion of the conceptual categories identified through the synthesis are presented in the subsequent sections of this chapter. To demonstrate how the six-step integration strategy was applied in practice, two conceptual examples are presented here: *mental-health literacy and understanding* and *stigma.* These examples were selected not because they represent the only outcomes of the synthesis, but because they most clearly illustrate how the analytic steps unfolded in tracing meaning across different contexts. The full comparative scope; including all conceptual categories derived from shared interpretive codes; is summarised in Table 7.1. The two examples below therefore serve as representative illustrations of the process rather than exhaustive accounts.

The first example focuses on mental-health literacy and understanding, a recurrent theme that captured how participants developed, negotiated, and redefined their awareness of psychological concepts across settings. During Steps 2 and 3, several interpretive codes; such as "limited vocabulary," "learning Western ideas," and "difficulty translating emotions"; were identified across the three studies. In Study 1, Algerian students in the United Kingdom described gaining initial awareness of mental health through exposure to Western counselling and psychological terminology. However, they also emphasised the challenge of articulating feelings in English or finding equivalent expressions for cultural idioms of distress. In Study 2, professionals observed the same linguistic and conceptual gaps but frequently interpreted them as indicators of low literacy, rather than as issues of cultural translation or differing frameworks of meaning. Upon returning to Algeria (Study 3), participants reported that this awareness became a source of inner conflict; the psychological concepts learned abroad now

coexisted uneasily with traditional explanations that attributed distress to social or spiritual causes. Following Steps 4 and 5 of the integration process, these codes were synthesised into the broader conceptual category Mental-Health Literacy and Cultural Learning. This category was then mapped as *emergent* during exposure abroad, *convergent* in shared recognition of language as a mediator of meaning, and *divergent* after reintegration, where traditional frameworks regained prominence and triggered identity dissonance. This example demonstrates how the procedure captured both the development of understanding and the renegotiation of meaning through time and cultural transition.

The second illustration focuses on the recurring theme of stigma and silence, which demonstrates how the same behaviour can carry very different meanings across social and cultural contexts. The interpretive code "keeping problems to oneself" appeared in all three datasets but evolved in significance over time. In Study 1, students in the United Kingdom described remaining silent about their struggles as a form of self-protection; a way to maintain dignity, avoid stigma, and prevent burdening others or spreading negativity. In Study 2, mental-health professionals viewed this same silence through a different lens, interpreting it as avoidance of therapy or a cultural resistance to discussing personal distress in Western settings. However, in Study 3, when students had returned to Algeria, silence was reinterpreted as a sign of moral strength and emotional control, because of the lack of understanding from others, making speech seem pointless or even risky. Through Steps 4 and 5 of the integration process, these distinct meanings were brought together under the higher-order category Stigma and Silence. The concept was mapped as emergent in the UK, where silence first appeared as a coping response to unfamiliar stigma; convergent across both students and professionals, who recognised its emotional and cultural function; and divergent after reintegration, when silence took on a renewed moral and social weight. This example demonstrates how the six-step integration strategy made it possible to trace both continuity

and transformation in meaning by showing that what might appear as a single behaviour actually reflects complex negotiations between culture, morality, and identity across different contexts. Therefore; these two illustrations show that the six-step integration strategy was not a mechanical procedure but a reflexive and interpretive process. It allowed the researcher to follow how meanings evolved across time, culture, and social position, transforming the original thematic findings into higher-order conceptual insights. While only two examples are discussed in detail here, the full comparative synthesis; represented in Table 7.1; captures the wider range of conceptual categories that collectively illuminate the shifting construction of mental-health understanding, stigma, coping, faith, and identity among Algerian students within UK and upon their return to Algeria.

7.2.4.2 Validation and Theoretical Coherence

This integration process draws its strength from established qualitative-synthesis traditions but has been carefully adapted to suit the particular design and aims of the present thesis. Bringing together three studies conducted in different contexts required an analytic approach that was both systematic and flexible. Rather than inventing a new method, the researcher drew on existing approaches and shaped them to fit the specific needs of this multi-study project. Techniques such as code extraction (Thomas & Harden, 2008), thematic abstraction (Braun & Clarke, 2021), interpretive triangulation (Flick, 2018), and matrix mapping (Miles, Huberman, & Saldaña, 2020) were combined into a single transparent and reflexive framework. Each offered a distinctive lens in a way one for structuring data, another for interpretation, and another for comparison all allowing patterns to be traced across time and context while preserving each dataset's individuality.

The intention was not to produce a rigid formula but to establish an analytic pathway that respected the complexity of each study while still enabling meaningful dialogue between them. The resulting integration process is grounded in the constructivist position that

knowledge is contextually produced and shaped by relationships and interpretation. This procedure therefore accommodates multiple perspectives and settings while maintaining conceptual coherence. In doing so, it transforms methodological diversity into an interpretive conversation rather than a contradiction, demonstrating how the three studies collectively contribute to a more nuanced and layered understanding of Algerian students' experiences of mental health. By integrating multiple perspectives without collapsing their contextual differences, the synthesis produces a conceptual map that visualises relationships among ideas rather than re-stating empirical themes. This approach allows for nuanced comparison across time, culture, and standpoint, while remaining faithful to the interpretive and relativist foundations of the thesis. It thus meets qualitative standards of trustworthiness and theoretical coherence, ensuring that the integration reflects both methodological discipline and epistemological integrity.

7.3 Cross-Study Conceptual Mapping and Comparative Synthesis

Following the step-by-step strategy detailed in Section 7.2.4, the findings from the three studies were mapped through iterative comparison of interpretive codes and higher-order categories. The aim was not to reproduce the original themes verbatim but to visualise how key ideas evolved and interacted across contexts and participant groups. Because each dataset had its own structure; six themes in Study 1 and five in Studies 2 and 3; a direct one-to-one alignment was neither feasible nor epistemologically appropriate. Instead, comparison focused on conceptual resonance, tracing where ideas overlapped, expanded, or shifted in meaning. The resulting conceptual mapping identifies areas of emergence (new awareness), convergence (shared or stabilised understanding), and divergence (contextual or temporal shifts). This synthesis provides an overview of conceptual movement across the three phases of the students' journeys.

Table 7.1

Cross-Study Conceptual Mapping and Comparative Synthesis

Conceptual Category	Study 1 (Students in the UK)	Study 2 (Professionals)	Study 3 (Returnees in Algeria)	Cross-Study Synthesis — Emergence, Convergence & Divergence
Mental Health Literacy	Exposure to Western counselling and psychological language fostered initial awareness of mental health yet limited emotional vocabulary.	Professionals identified language barriers and noted that limited mental-health literacy was often linked to spiritual explanations such as black magic, eye.	Returning home, students faced tension between their new understanding of mental health and the traditional views that dominated their environment, creating confusion and identity dissonance.	**Emergent:** literacy as cultural learning. **Convergent:** Mental health literacy is influenced by exposure to different explanatory frameworks and cultural contexts **Divergent:** regression following reintegration. Inner conflict between Western awareness and traditional frameworks upon return.
Stigma	Fear of social judgment and shame; avoidance of disclosure to preserve respectability.	Professionals identify cultural and institutional stigma, compounded by limited representation and cultural competence in services.	After returning home, awareness gained abroad heightened sensitivity to stigma. Students recognised mental-health struggles more clearly but felt renewed tension as traditional and faith-based views framed distress	**Emergent:** stigma as both social and moral regulation. **Convergent:** awareness of stigma persists across contexts. **Divergent:** post-return, awareness intensifies rather than resolves stigma,

			as weakness or moral failure. This clash created reverse culture shock and inner conflict.	producing reverse culture shock and deeper self-recognition of distress.
Disclosure	Students disclosed selectively, turning first to family, close friends, or traditional healers, with professional help considered a last resort.	Professionals viewed avoidance of formal disclosure as fear of being misunderstood and as a belief that therapy suits Western people more than others from different cultures.	After returning home, disclosure was confined to peers who had shared the experience of studying abroad, as these conversations provided understanding rather than sympathy. Family remained emotionally supportive but unable to relate, and professionals were often avoided due to perceived lack of cultural understanding.	**Emergent:** disclosure as a culturally and morally negotiated act. **Convergent:** emotional risk and fear of misjudgement persist across settings. **Divergent:** post-return, disclosure becomes selective sharing for mutual understanding rather than help-seeking, reinforcing re-moralised silence.
Language and Expression	Students frequently code-switched between Arabic, French, and English. English provided new terms to describe emotions but often felt detached from lived experience.	Professionals viewed language differences as barriers to therapeutic rapport and emotional understanding, noting that psychological concepts did not always translate across languages.	Students' linguistic coping becomes dual and reflective; English remains tied to introspection and analytical thought (learned abroad), while Arabic regains emotional resonance. The coexistence of languages becomes part of identity and	**Emergent:** awareness of emotional expression through multiple languages. **Convergent:** language functions as a mediator of meaning and connection. **Divergent:** after return, languages acquire distinct emotional roles, reversing

			coping, not just communication.	preference and deepening identity duality.
Coping and Help-Seeking	Students managed distress mainly through prayer, private reflection, and emotional support from trusted peers. Professional help was considered only when personal strategies failed.	Professionals observed that students relied on familiar informal networks and self-directed strategies rather than institutional services, interpreting this as culturally grounded resilience as well as limited trust.	After returning home, coping combined reflective practices learned abroad with faith-based and family-oriented approaches. Awareness of mental health increased, but limited resources and social barriers encouraged continued self-reliance.	**Emergent:** adaptive hybrid coping. **Convergent:** Reliance on informal, and culturally familiar sources of support **Divergent:** reduced help-seeking post-return.
Faith and Spirituality	Faith provides comfort and moral framing; sometimes linked to self-blame.	Faith recognised as both therapeutic asset and treatment barrier.	Religion reasserts moral authority; distress viewed as weakness of belief.	**Emergent:** spirituality as dual-edged resource. **Convergent:** faith central to meaning making. **Divergent:** re-moralisation of distress post-return.
Reintegration and Identity	Focused on adapting to life abroad rather than reintegration; identity	Professionals observed that many students struggled with cultural adaptation while in the UK,	Students described feeling divided between two worlds, missing aspects of their UK life	**Emergent:** early signs of identity tension during adaptation abroad.

negotiation centred on belonging in the UK and balancing cultures.	and anticipated that readjusting later could be emotionally challenging.	while struggling to meet social expectations in Algeria.	**Convergent:** adaptation and identity as an ongoing process of negotiation. **Divergent:** renewed identity tensions at home.

Note. This table does not reproduce the exact empirical themes or subthemes from each study. It presents higher-order conceptual categories derived from interpretive comparison across datasets. Each category integrates related codes and meanings to show how ideas evolved between contexts. The mapping was guided by conceptual resonance, temporal sequencing, and theoretical significance rather than identical thematic labelling.

7.4 Interpretive Integration and Cross-Study Insights

The cross-study synthesis presented in Table 7.1 shows how the findings from the three empirical studies were brought into dialogue through the interpretation of shared codes, rather than by repeating or aligning their original themes. Each study explored a different dimension of Algerian students' mental-health experiences and involved distinct participant groups, which makes a strict theme-to-theme comparison both unfeasible and contrary to the epistemological commitments of this thesis (Levitt et al., 2018). Because the studies were grounded in a critical-constructivist epistemology where meaning is relational, contextual, and co-constructed; themes cannot be treated as interchangeable analytic units. Instead, they reflect the specific meaning-making processes of each group: students describing their lived experiences abroad, professionals interpreting Algerian students' needs within institutional systems, and returnees reconstructing their stories within Algerian cultural and moral frameworks. Forcing these different perspectives into direct thematic alignment would obscure important differences and wrongly imply that they carry equal interpretive weight. Accordingly, the integration revisited each dataset to trace recurring meanings, tensions, and developments across time, context, and perspective. The categories summarised in Table 7.1

therefore represent higher-order insights conceptual understandings that became visible only when the studies were examined together (Braun & Clarke, 2021; Flick, 2018). Practically, the integration involved returning to each dataset and re-reading the full thematic and IPA analyses while keeping the overarching research questions in view. The research examined where codes, interpretive comments, and theme titles spoke to similar underlying processes, even when they appeared in different forms or at different stages of participants' journeys. Cross-study matrices and analytic memos were used to map these connections, noting where meanings converged, diverged, or developed over time (Flick, 2018; Miles et al., 2014). This process was abductive rather than mechanical: rather than forcing categories to match, the researcher moved back and forth between data and interpretation, gradually refining a set of integrative concepts that could hold together the complexity of the three studies. In this sense, Table 7.1 is the outcome of an iterative, reflexive process of interpretive integration rather than a simple aggregation of results. Bringing these findings together did not produce one neat or unified story. Instead, it revealed a set of interconnected narratives showing how students' awareness, beliefs, and sense of identity shift and develop as they transition abroad and then return home. This integrative reading echoes constructivist positions that view knowledge as relational and shaped through social interaction (Lincoln et al., 2018; Schwandt, 2014).

This interpretive approach aligns with Denzin's (2017) idea of interpretive triangulation, which views differing viewpoints as complementary rather than conflicting. Differences between the studies were therefore treated as opportunities to see the phenomenon from new angles. Each dataset illuminated a particular piece of the broader picture; mental-health literacy, belonging, disclosure, and help-seeking—yet each did so from a different vantage point. One example of this cumulative process is the evolution of mental-health literacy across the three studies. Awareness of psychological concepts initially emerged while students were abroad, expanded through exposure to Western counselling language, and then became a

source of tension upon their return to Algeria, where more traditional explanations regained relevance. This reflects what Berry (2006) and Ryder et al. (2011) describe as acculturative negotiation, in which individuals continually re-evaluate their beliefs as they move across cultural frames. This fluidity highlights that understanding mental health is not a fixed achievement but an ongoing, context-shaped process. Consistent with work in cross-cultural psychology (Bhatia, 2020; Bhugra, 2021), the findings suggest that Algerian students' mental health cannot be understood solely through Western diagnostic models, nor through cultural explanations in isolation. Instead, the integration points to a shared space of meaning where personal experience, faith, language, and morality intersect in shaping how individuals interpret and respond to mental distress. This resonates with intersectional and constructivist approaches that emphasise how structural, cultural, and personal factors interact to shape lived experience (Crenshaw, 1991; Morrow, 2007). By treating differences as interpretive openings rather than contradictions, the synthesis transforms methodological diversity into a coherent understanding of how meaning-making unfolds across changing worlds. Ultimately, this integrative reading reflects the thesis's commitment to epistemological pluralism and the view that multiple forms of knowledge can coexist and collectively deepen understanding (Yardley, 2000; Guba & Lincoln, 2005). Rather than seeking one singular interpretation, the synthesis invites reflection on how transitions, faith, and linguistic identity intertwine to shape students' mental-health narratives. These cross-study insights form the conceptual bridge to the following discussion chapter, where they are explored through broader theoretical lenses such as acculturation, intersectionality, and critical constructivism.

7.4.1 The Cross- Cutting Theme of Power

Power emerged as the most fitting cross-cutting concept not because it was imposed a priori, but because it consistently appeared across all three studies as an implicit organiser of experience. When re-examining the integrated codes and themes, the researcher found that

questions about who is believed, which explanations are taken seriously, and what can safely be said recurred in different guises across students, professionals, and returnees. These patterns did not cluster neatly around a single content area such as stigma, literacy, or belonging; instead, they pointed towards a deeper structuring force that shaped how all of these were lived and negotiated. Across the three studies, the integrative analysis revealed that "*power"* was a central and connecting element shaping how understanding, communication, and coping were experienced in different contexts. Here, power does not mean domination, but the subtle influences that decide what can be spoken, who/ what is believed, and which explanations are accepted. It moves through relationships, beliefs, languages, and institutions, at once limiting and enabling how people make sense of mental health; and how they act upon that understanding in their choices to communicate, disclose, and cope.

7.4.1.1 Power in Study 1: Students in the United Kingdom

For Algerian students studying in the UK, power appeared at several linked levels. On a personal level was the power of understanding and this includes the effort to interpret emotional distress using new Western psychological vocabularies while still drawing on familiar cultural and spiritual beliefs. Exposure to British counselling language gave access to new ways of describing feelings, yet these often conflicted with long-held views. Students referred to black magic, the evil eye, or spirit possession, revealing another form of cultural power that framed how suffering was explained and addressed. Alongside this operated the power of family and community expectations, which encouraged silence and restraint, because family was of two types: give support, or add pressure. Disclosure was shaped by the wish to maintain dignity, while coping was guided through prayer, endurance, or visits to traditional religious healers. Within this spiritual field, the power of religion appeared in several layers: the moral authority of the Qur'an, prayers, the influence of imams and healers, and the inner belief that faith could both comfort and correct behaviour. A further layer was

the power of relationships seen in the balance between *speaker* and *listener*. Students often wanted understanding rather than advice, yet when responses felt critical or moralising, they withdrew. The listener's reaction be it supportive or dismissive, shifted the emotional weight of the exchange, showing how communication itself carried authority. Furthermore; language itself carried influence. Students moved between Arabic, French, and English, each language offering different emotional possibilities. English opened a door to new ideas but often felt emotionally detached; Arabic was intimate yet morally charged. This power of language and code-switching determined what could safely be shared and with whom.

7.4.1.2 Power in Study 2: Professionals' Perspectives

Among professionals, power operated through both institutional structures and personal awareness. Practitioners worked within systems shaped by Western psychological frameworks, assessment practices, and policy expectations that carried their own institutional authority. These structures sometimes conflicted with the culturally grounded understandings of Algerian and Arab students, yet professionals' responses revealed a complex balance between formal knowledge, cultural positioning, and individual reflexivity. Two overlapping forms of influence emerged from the analysis, both marked by the subtle presence of power. The first was experiential authority, rooted in familiarity with the lived realities of international and Arab students. Professionals varied in how they engaged with Algerian and Arab students, but this variation did not map neatly onto levels of prior experience with these groups. Rathert than experience alone determining cultural sensitivity, what mattered was how professionals approached difference in practice. Some professionals; regardless of the length or specificity of their experience, demonstrated relational competence by recognising the impact of family pressures, religious interpretations, and linguistic barriers, adapting their communication accordingly by checking understanding, slowing their pace, or validating spiritual explanations rather than dismissing them. The authority exercised in these encounters

stemmed not from institutional rank or specialist expertise, but from relational engagement grounded in empathy and trust. Through this, power became a shared process rather than a top-down exercise: students felt safer to disclose, and professionals acted as cultural mediators rather than distant experts. The second, more implicit form was knowledge-based authority, shaped by the dominance of Western psychological discourse. This form of power was not confined to professionals with limited cultural experience; instead, it reflected how professional frameworks themselves define what counts as legitimate distress, appropriate emotional expression, or effective coping. When students used religious or spiritual language, speaking about black magic, the evil eye, or divine testing some practitioners initially interpreted such expressions as avoidance or lack of insight. However, several professionals, including those trained within Western clinical models, demonstrated reflexivity by acknowledging that their assumptions were culturally bounded and that meaning could not be imposed unilaterally from one framework. In this way, power was not purely restrictive but could also be used reflexively to adapt, question, and open dialogue.

Beyond institutional and experiential authority, the analysis also revealed the power of the professionals' own cultural backgrounds. Culture shaped not only how they viewed students but also how they made sense of distress itself. Two tendencies were visible. Some professionals approached students through the lens of their own cultural values and norms interpreting behaviour, emotion, and help-seeking according to what their own societies considered "appropriate." This often coloured their empathy and understanding, producing subtle biases in how they perceived silence, faith, or family influence. Others, however, came from cultural or religious backgrounds similar to the students and therefore shared some of the same beliefs about mental health. In these cases, their interpretations often blended professional knowledge with personal faith, leading them to view distress through a more spiritual or moral lens. Both patterns demonstrate that professional interpretation is never

neutral; it is filtered through the power of culture itself, which frames what is seen, what is believed, and what is valued. Seen in this way, the distinction between experiential, knowledge-based, and cultural authority is not about categorising professionals into fixed groups but about revealing how different forms of power intersect in practice. Whether through direct experience, clinical training, or personal belief systems, professionals used their authority to interpret, mediate, and sometimes challenge dominant definitions of mental health. Power here defined not only what professionals believed but also how they communicated empathy, engaged across cultural and linguistic divides, and influenced whether students perceived help as shared understanding or as a negotiation of difference.

7.4.1.3 Power in Study 3: Returnees to Algeria

After returning home, participants faced a new configuration of influence shaped by cultural comparison, memory, and belonging. The power of comparison became central: the psychological and linguistic awareness developed during their time in the UK met the enduring authority of traditional interpretations, producing a constant negotiation between two systems of meaning. Many participants described feeling caught between what they had learned abroad where mental health was discussed more openly, and what awaited them at home, where distress was often explained through spiritual or moral terms. This friction marked the power of cultural dissonance, as the "new self," more self-reflective and emotionally articulate, encountered social expectations that prized modesty, discretion, and endurance. The power of identity also emerged as a defining thread. Having acquired new cultural reference points, returnees often felt detached from familiar spaces and relationships. They spoke of losing spontaneity in their own language and gestures, sensing that they no longer entirely belonged to either world. The power of absence which is the time spent abroad, deepened this division: participants had internalised new ways of thinking and speaking yet found that their social environments no longer validated these perspectives. What had once

felt empowering abroad now created discomfort and misalignment at home. This sense of displacement was not purely emotional but epistemic it affected how they recognised, named, and acted upon psychological distress. At the centre of these tensions lay the power of culture itself, which determines what is seen, what is believed, and what is valued. After returning, many students realised that the social and moral frameworks surrounding them had remained largely unchanged. What was *seen* as legitimate distress or acceptable emotion still followed collective rather than personal norms. What was *believed* often clashed with the awareness and knowledge acquired abroad: professional counselling or open dialogue were still viewed as unnecessary or even inappropriate when faith or endurance were expected. Yet, what was *valued* began to shift internally. Participants continued to respect and practise their religious traditions, but they also learned to value reflection, dialogue, and scientific understanding. This dual valuation created an inner negotiation between faith and knowledge—a reconciliation of two systems that often seemed incompatible yet were both deeply meaningful.

Language again became a field where power was both visible and felt. For many, bilingual or trilingual fluency offered a richer emotional vocabulary but also created tension. Using Arabic often reattached distress to moral or religious meanings invoking sin, weakness, or divine testing, while English or French allowed more neutral or self-analytical descriptions. Switching between languages was not a random act but a deliberate strategy: a way to manage closeness and distance, sincerity and safety. This power of linguistic duality allowed participants to navigate conversations in ways that balanced authenticity with self-protection. Yet it also revealed how deeply language governs the expression of emotion, serving both as a bridge and as a boundary between internal experience and social expectation. Coping and disclosure reflected similar negotiations of power. The power of shared experience became a central resource: returnees preferred to confide in peers who had also studied abroad, seeking

understanding rather than sympathy. These exchanges carried an implicit equality where peers could validate feelings without moralising them. In contrast, the power of mistrust shaped interactions with local institutions. Many returnees felt that professionals in Algeria lacked the cultural or experiential understanding to interpret their struggles, fearing that openness would lead to judgment or dismissal.

7.4.2 Power as the Structure of Understanding

Across all three studies, power can be seen as the underlying structure through which meaning, belief, and action are organised. It determines what can be known, who is authorised to speak, and which explanations are granted legitimacy. It shapes the relationships between students and professionals, between faith and psychology, and between language and emotion. Within the constructivist position guiding this thesis, these forces are not viewed as external constraints but as relational one co-created through interaction. People reproduce these systems through habit and social expectation, but they also reshape them through everyday acts of communication, interpretation, and coping.

Power determines, for instance, how language becomes a medium of inclusion or exclusion. In Study 1, English opened access to psychological concepts but also imposed distance from emotional immediacy; some students could name anxiety but not always *feel* it in words that resonated with their lived experience. In Study 3, Arabic and French reintroduced emotional depth but also reattached distress to moral judgment. These linguistic movements illustrate how power operates through vocabulary itself: languages carry cultural assumptions about emotion, selfhood, and morality, meaning that every act of speech reproduces a social order of what is sayable and unsayable. Linguistic codes like idioms, metaphors, become tools through which power is both enacted and negotiated. Similarly, power structures the relationship between belief and evidence. Within religious and cultural frameworks, faith offers not only comfort but also an authoritative system of explanation. For many participants,

mental distress was initially interpreted through the vocabulary of sin, spiritual weakness, or supernatural interference. Yet through exposure to Western models, these same individuals encountered new epistemic frameworks; psychology, counselling, self-awareness; that positioned distress as natural, treatable, and socially acceptable. Returning home, they found these frameworks in tension. This clash reveals that knowledge is not neutral; it is stratified by cultural legitimacy. The words of an imam, a mother, or a counsellor each hold different social power, and the credibility of each depends on where and by whom it is spoken. Power also influences the relational structure of communication. Disclosure is never a purely personal decision; it is a social act conditioned by the listener's position and the speaker's perceived vulnerability. When students disclose distress, they enter a field of negotiation where understanding depends on recognition; being heard in a way that validates, rather than redefines, their experience. The speaker–listener effect found across the studies highlights this constant negotiation: a friend's empathy can be empowering, while a dismissive response can reinforce silence. Even silence carries meaning it can be an act of self-preservation within unequal structures of power. In linguistic terms, silence operates as a form of pragmatic resistance: a refusal to participate in a discourse that might distort or delegitimise one's experience. From a broader sociocultural perspective, power determines what knowledge survives across contexts. In the UK, students learned to talk about emotions through the discourse of counselling, self-care, and openness. Upon returning home, those same discourses lost authority against the moral language of patience, faith, and collective reputation. Yet, rather than replacing one system with another, participants constantly blended and reinterpreted them. Power here acts as a mediating structure not simply suppressing one worldview but forcing an active reconfiguration between multiple sources of meaning. This ongoing reinterpretation is where cultural learning, identity formation, and agency converge. Seen through the constructivist lens guiding this thesis, disclosure is never a purely personal decision; it is shaped by the relational nature of communication itself by who listens, who

responds, and how understanding is exchanged. This means that power is not only hierarchical but also relational. It flows through interaction, habit, and belief, shaping the very categories by which people understand themselves and others. As these patterns began to accumulate across the three studies, it became increasingly clear that the forces shaping Algerian students' mental health understanding were not operating at the same level of visibility. Some influences appeared explicitly in participants' narratives, while others worked quietly beneath the surface, structuring interpretation and behaviour without always being named. This distinction between the visible and the implicit emerged inductively through the analytic process. During cross-study synthesis, repeated contrasts in power became evident: the power of language at one moment, the authority of religion at another; the moral weight of family reputation; the epistemic legitimacy of professional discourse; and the silent pressure of stigma that shaped when, how, and to whom distress could be expressed. These forces were not isolated. They interacted, overlapped, and at times contradicted one another, forming a multi-layered system that students navigated as they moved between the UK and Algeria. Drawing on relational accounts of power (Foucault, 1978; Bourdieu, 1991), this analysis understands power as not only hierarchical but also relational. Power does not reside solely in formal authority or institutional position; rather, it circulates through interaction, habit, and belief, shaping the categories through which individuals come to understand themselves and others. As patterns accumulated across the three studies, it became increasingly clear that the forces shaping Algerian students' understandings of mental health did not operate at the same level of visibility. Some influences appeared explicitly in participants' narratives, while others operated more quietly beneath the surface, structuring interpretation and behaviour without always being named. This distinction between visible and implicit forms of power emerged inductively through the analytic process. During cross-study synthesis, recurring contrasts in power became evident: the power of language in one context; the authority of religion in another; the moral weight of family reputation; the epistemic legitimacy of professional

discourse; and the silent pressure of stigma shaping when, how, and to whom distress could be expressed. These forces were not isolated. They interacted, overlapped, and at times contradicted one another, forming a layered system that students navigated as they moved between the UK and Algeria. Recognising this layered quality required an interpretive shift in the analysis; from viewing power as a set of discrete influences to understanding it as a structural arrangement that organises meaning itself, consistent with accounts of symbolic power that operate most effectively when taken for granted (Bourdieu, 1991). It was from this analytical realisation that the visual model was developed: not to simplify complexity, but to represent how some dimensions of power are readily visible in discourse and behaviour, while others remain embedded within deeper cultural, linguistic, relational, and spiritual logics that guide experience less overtly. The purpose of the model is therefore to render visible the stratified nature of power and the ways in which these layers collectively shape understanding, disclosure, and coping across contexts

7.4.2.1 The Deep Structures of Power Model

As the analysis progressed, it became necessary to find a conceptual form that could capture the layered and often invisible processes shaping how participants constructed meaning. What emerged across the three studies was not a simple or linear pattern. It resembled a structure with depth. Some influences were spoken about directly, while others such as stigma, faith, family reputation and cultural expectations worked more quietly, shaping experience without being named. In psychology, the movement between what is visible and what is hidden is often explained through depth models and layered frameworks. Schema theory, for example, shows how internal cognitive structures organise experience at different levels of awareness (Bartlett, 1932; Piaget, 1952). Structuralist traditions make similar claims about the hidden rules that shape meaning within cultures (Lévi-Strauss, 1963). Ecological approaches in developmental psychology also illustrate how internal and external forces interact across

nested layers of context (Bronfenbrenner, 1979). Scholars frequently rely on visual metaphors to make these layers easier to understand. Bronfenbrenner's ecological model, for instance, maps invisible social influences into clear concentric systems. Cognitive psychologists and psychoanalytic theorists have also used iceberg-like structures to illustrate how implicit beliefs or unconscious processes sit beneath conscious awareness (Freud, 1915). Following this tradition, the researcher began to see the emerging pattern as a stratified system. The forces that shaped understanding and disclosure most strongly were often the ones beneath the surface of awareness. This realisation created the basis for imagining the visual model in the form of an iceberg. The visible tip reflects the behaviours and expressions that can be observed. The larger, submerged part represents the deeper cultural, linguistic, relational and spiritual influences that quietly organise meaning-making.

Following this tradition, the researcher began to see the emerging pattern as a stratified system. The forces that shaped understanding and disclosure most strongly were often the ones operating beneath the surface of awareness. This analytic realisation formed the basis for imagining the visual model in the form of an iceberg. The visible tip reflects the behaviours and expressions that can be observed, while the larger submerged part represents the deeper cultural, linguistic, relational and spiritual forces that quietly organise meaning-making. These include: Family Power, Stigma Power, Religious Power, Cultural Interpretations, Coping Power, Language Power, Professional Culture, Western–Home Cultural Tension and the Speaker–Listener Effect, all of which are represented in the following diagram.

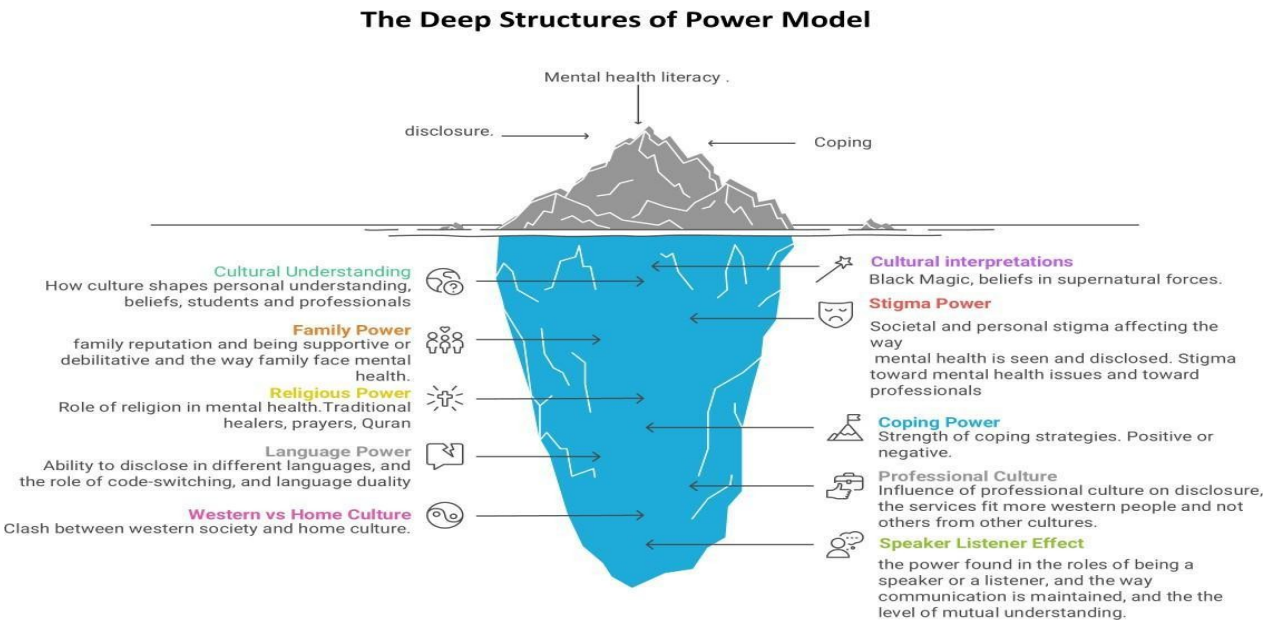

Figure 7.1 . The Deep Structures of Power Model.
A visual representation illustrating the visible dimensions of mental health literacy, coping, disclosure

7.5 Visual Integrative Models

The purpose of this section is to bring together the interpretive work developed across the three studies by presenting it in a series of visual conceptual models. While the preceding sections examined how students understood mental health through language, belief, cultural expectations, and their encounters with institutional systems, written text alone cannot fully convey the relationships and shifts that occur across these different contexts. For this reason, visual representations are used here not as decorative additions, but as analytic tools that deepen the reader's understanding of how meaning is shaped, re-shaped, and carried across time and place.

The use of visual models in qualitative research has long been encouraged for their capacity to display relationships that remain difficult to hold in mind when reading narrative text. Miles and Huberman (1994) notably argued that diagrams make it possible to "see" links and transitions that would otherwise remain implicit or obscured when working with dense qualitative material. Radnofsky (1996) similarly maintained that visual representation can

convey how meaning is formed or reconstructed, especially when the material is layered, situated, and shaped by the interaction of multiple cultural worlds. More recent contributions from Pain (2012) and Chandler, Anstey, and Ross (2015) emphasised that such visual approaches make tacit forms of understanding more available to the researcher and the reader, helping audiences to grasp processes that evolve across contexts. In keeping with this thesis, the visual models presented here accompany and clarify the written analysis rather than replace it.

The diagrams map how Algerian students' understanding of mental health develops as they move across different cultural, linguistic, and institutional worlds. The first figure traces this movement from the early stages of Study 1, where students were exposed to Western psychological vocabulary for the first time and began experimenting with English terms that sometimes clarified their feelings but also created emotional distance. The progression then moves into Study 2, where the "web of barriers" identified by professionals becomes central: misunderstandings about how the UK mental-health system works, language difficulties that limited expression, cultural shame around disclosure, gendered expectations that shaped who students felt able to talk to, and mistrust linked to fears about confidentiality. These barriers interacted with the institutional logic of British wellbeing services, meaning that professionals' interpretations could either support students' confidence or amplify their hesitation. The final part of the sequence reflects Study 3, where the return to Algeria reactivated familiar moral expectations, linguistic preferences, faith-based explanations, and traditional understandings of distress. Many students found that the vocabulary and reflective habits they had acquired abroad now sat alongside, and sometimes clashed with, the cultural authority of family, religion, and local meaning systems. By presenting these shifts visually, the diagrams make it easier for the reader to follow how students assembled their understanding across time. They show, for instance, how a student might move from learning

how to name anxiety in English, to feeling unsure whether a British counsellor could understand culturally grounded experiences, to later struggling with the moral language of "weakness" when speaking about distress back home. Visualising these transitions helps demonstrate that understanding did not develop in a straight line; instead, it was shaped through encounters with new concepts, institutional barriers, and the reassertion of cultural norms. This layered movement is at the heart of meaning-making across the three studies, and the diagrams therefore provide a clear and coherent way of illustrating how these changes unfolded.

Illustrating these movements visually reinforces one of the chapter's central arguments: understanding does not "settle" in any fixed form. Rather, it changes through negotiation, re-evaluation, and the conditions under which people feel permitted to express or silence their distress. This position is consistent with constructivist approaches in qualitative inquiry, which hold that knowledge is shaped through relationships, contexts, and the social conditions in which people communicate (Lincoln & Guba, 2000; Schwandt, 2014). It also aligns with work in cross-cultural psychology showing that ideas about distress, identity, and coping are fluid and become reorganised through cultural transition, whether that transition involves leaving home, navigating life abroad, or returning after extended absence (Bhatia, 2020; Bhugra & Minas, 2021).

Within this framework, the visual models serve two main functions. First, they offer the reader a structured overview of how the three studies relate to one another, showing where understanding carries forward, where it changes, and where it encounters resistance. For example, reading Study 1 and Study 3 side by side reveals how the same students who once struggled to name their emotions in English later struggled to express those same emotions in Arabic, now complicated by moral expectations and family-based interpretations. Second, the diagrams make visible the recurring influences like language, faith, stigma, identity, and

institutional authority that shape students' responses across settings. These influences appear in different forms in each study, yet they consistently determine what students can say, what they hold back, and how they interpret their own experiences. Furthermore, the diagrams support the overall argument of the thesis: that meaning-making is not simply an individual act, but a situated and relational process shaped by cultural expectations, linguistic resources, institutional practices, and the forms of authority that make particular interpretations possible.

7.5.1 The Transnational Chain of Meaning-Making

The following visual model illustrates how students' understanding of mental health developed across the different stages represented in Studies 1, 2 and 3. Unlike the Deep Structures of Power Model, which focuses on the forces that shape meaning beneath the surface, this model highlights movement across time and place. It captures how understanding does not remain fixed within any single context but travels with students as they shift between the UK and Algeria, encountering new concepts, negotiating unfamiliar expectations and later reinterpreting these ideas upon returning home. This approach aligns with calls in qualitative scholarship to map movement and change across moments of transition rather than treating understanding as a static outcome (Chamberlain et al., 2011).

In Study 1, students first engaged with Western psychological vocabulary and began using English words to describe their internal states after having limited vocabulary around mental health. For some, this new vocabulary offered clarity and a sense of legitimacy. Being able to say "anxiety," "stress," or "panic attack" in English created space to articulate experiences that previously lacked precise labels in Arabic or French. For others, however, English introduced emotional distance. Expressing distress in a language learned later in life sometimes felt detached from the affective reality of their emotions. Yet, it also allowed them to speak without

triggering shame or moral judgment, particularly when discussing topics that felt culturally sensitive. This initial stage therefore involved an early form of meaning-making: students experimented with new concepts, compared them with familiar cultural understandings, and began to carry these partial interpretations forward.

This movement continued into Study 2, where students encountered UK wellbeing and mental-health professionals. Here, meaning-making was shaped not only by language but by the institutional culture of British mental-health services. Students described uncertainty about how these services worked, fears around confidentiality and a sense of mismatch between their expectations and the expectations of professionals. In this stage, meaning became negotiated through misunderstandings, cultural hesitation, and the implicit moral frameworks embedded within institutional practice. The "web of barriers" identified by professionals operated alongside students' own uncertainties. These included linguistic difficulties, gendered expectations, family-related concerns about disclosure, and broader cultural messages about the appropriateness of seeking help. As students moved through this setting, their understanding of mental health expanded but also became more complex. They learned new ideas about wellbeing and coping, yet remained cautious and selective about the concepts they accepted or rejected. This middle point in the chain therefore reflects a period of negotiation, where meaning was co-constructed with professionals in ways that sometimes aided understanding and at other times reinforced hesitation.

The final stage, represented by Study 3, shows what happens when students carry these accumulated forms of understanding back into their home context. Upon returning to Algeria, many described feeling caught between two interpretive worlds. The psychological language and reflective habits they had acquired abroad remained with them, but these now sat alongside powerful cultural norms that framed distress through morality, faith, social reputation and

collective expectations. In this setting, students revisited the concepts they had learned in the UK but filtered them through familiar linguistic and cultural frameworks. Arabic and French offered emotional closeness, yet they also carried moral weight. Describing distress in Arabic often triggered associations with weakness, sin, or family shame. At the same time, psychological ideas learned abroad were not entirely abandoned. Many students blended these frameworks, drawing on English psychological terms to conceptualise their experiences privately, while turning to culturally grounded explanations in conversations with family and community members. Meaning-making in this final stage thus involved a process of reattachment and reinterpretation, in which students attempted to reconcile their expanded understanding with the moral and cultural expectations of home.

The Transnational Chain of Meaning-Making model visually represents this movement. It follows the student's journey as meanings are formed, questioned, reshaped and blended across contexts. Across all three stages, the model highlights the recurring conceptual codes that continue to influence meaning-making: language expressions, religion and faith, stigma and cultural expectations, and growing self-understanding. These elements appear throughout the chart because they are not tied to one moment; they travel with students and re-emerge in new forms across contexts. The model therefore shows meaning-making as a chain of connected shifts shaped by movement between people, places and languages, rather than as a fixed set of ideas carried consistently from one setting to another.

Transnational Chain of Meaning Making

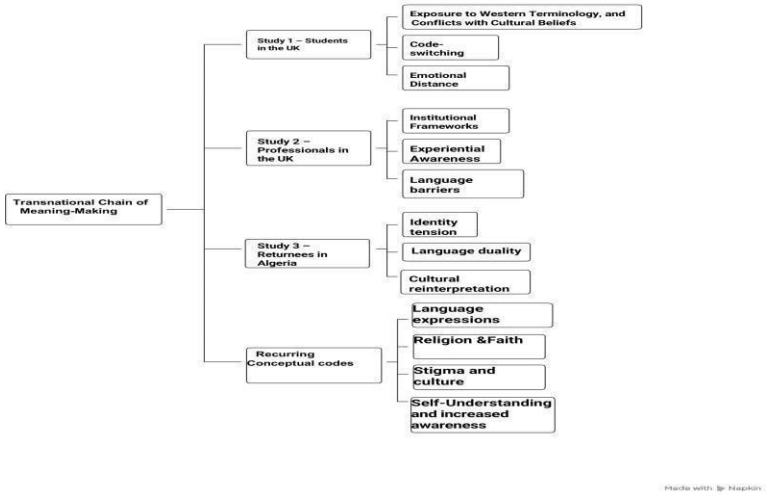

Figure 7.2. The Transnational Chain of Meaning-Making.
A sequential visual representation of how students' understanding of mental health shifts across Study 1 (initial exposure to psychological vocabulary), Study 2 (encounters with UK wellbeing professionals), and Study 3 (reinterpretation and reattachment to cultural norms after returning to Algeria).

7.5.2 The Web of Barriers and Supports

The second visual model focuses on the network of influences that shaped students' encounters with UK wellbeing and mental-health services. While the first model traces understanding across time, this diagram highlights the complexity of the environment students entered when attempting to seek help in the UK. It draws from findings in Study 2, where professionals described a range of factors that enabled or constrained communication, trust and emotional expression. These influences rarely operated in isolation. Instead, they formed a web of interconnected pressures and possibilities that shaped students' willingness to approach services, their confidence when speaking about distress, and their perception of whether

support was culturally safe. At the centre of this model is the student who enters UK wellbeing

systems with a mixture of curiosity, need and uncertainty. Surrounding this central point are several interlinked nodes, each representing a barrier or support identified across the interviews with professionals. One of the most prominent barriers was language. Both students and practitioners noted that emotional nuance is difficult to convey in English when it is not the speaker's first language. This led some students to avoid naming their experiences or to simplify complex feelings, which sometimes caused professionals to underestimate the depth of distress. However, language could also serve as a support. For some, English provided enough emotional distance to speak about sensitive topics without feeling exposed or judged, especially when discussing issues that felt morally charged in Arabic or French.

Another major node in the web was cultural shame around disclosure. Many students feared that talking openly about distress might be interpreted as weakness or disrespect within their cultural background. These fears were reinforced by concerns about confidentiality. Professionals explained that some students feared information would reach family members, academic departments or community networks. In these cases, even small misunderstandings about how UK systems protect privacy cast doubt on whether services were safe to use. Gender norms also played a significant role. Professionals noted that female students were often more willing to speak about distress but also more concerned about being judged by male listeners, while male students sometimes avoided discussing emotional pain altogether due to cultural expectations around strength and self-control. These gendered expectations interacted closely with family dynamics, where some students felt pressure to maintain an image of competence abroad, especially when their study opportunities were financially supported by family members. In contrast, certain nodes in the network functioned as supports. Empathy and cultural awareness from professionals helped build trust and allowed students to feel seen and understood. When practitioners demonstrated sensitivity to cultural norms or knowledge of the sociocultural pressures Algerian and Arab students face, students

were more willing to disclose and reflect on their experiences. Practical supports, such as appointment flexibility or reassurance about confidentiality, also helped students feel more secure. By mapping these connections visually, the Web of Barriers and Supports model highlights how students' decisions to seek help were shaped by a combination of constraints and facilitators rather than by individual choice alone. It shows how linguistic difficulties, cultural shame, gendered norms, fears about confidentiality and institutional expectations formed a dense environment of influences, each pulling students toward or away from disclosure. The model therefore illustrates why interactions with UK services were complex and why the same student could feel encouraged in one moment and hesitant in another. The barriers and support mechanisms represented in Figure 7.3 were derived from the cross-study synthesis of all three empirical studies. Several barriers, including stigma, fear of judgement, disclosure concerns, and reliance on informal support, were evident across multiple datasets, while others were more strongly associated with specific stages of the student journey. Study 1 contributed insights from AIS studying in the UK, Study 2 contributed professionals' perspectives on barriers and support needs, and Study 3 contributed returnees' reflections on reintegration and post-return experiences. The figure therefore represents an integrated synthesis rather than a direct reproduction of findings from any single study.

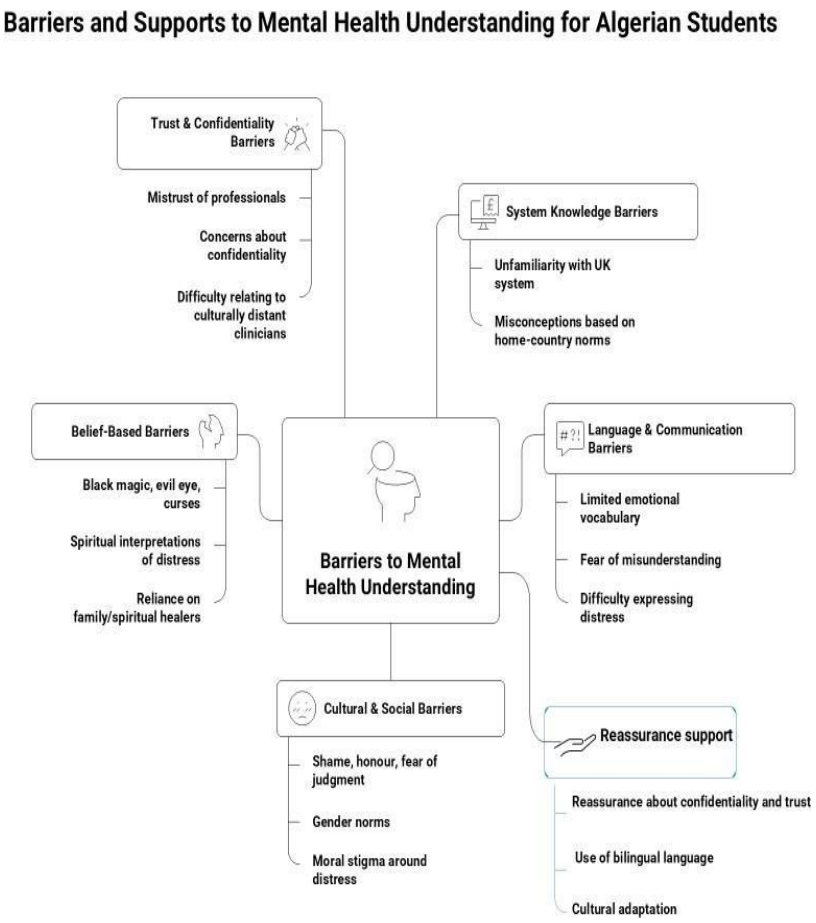

Figure7.3. The Web of Barriers and Supports

A network diagram illustrating the interconnected barriers and supports influencing students' engagement with UK wellbeing services, including language, cultural shame, gender norms, confidentiality concerns, family expectations, professional misunderstandings and empathetic or culturally aware practitioner responses. The apparent imbalance between barrier and support categories is intentional and reflects the relative emphasis of the findings across the three studies. Participants and professionals consistently described a broad range of interconnected barriers influencing mental health understanding, disclosure, help-seeking, and engagement with support services, including cultural stigma, language difficulties, trust concerns, limited system knowledge, and belief-based explanations of distress. In contrast, support mechanisms were discussed less frequently and tended to operate as facilitating conditions rather than distinct sources of support. For example, reassurance regarding confidentiality and trust, the use of bilingual communication, and culturally responsive adaptation were often described as factors that reduced barriers rather than independent support systems. The figure therefore reflects the greater complexity and differentiation of barriers within the data while acknowledging the presence of support mechanisms that may facilitate engagement and understanding.

7.5.3 The Reintegration Triangle

The third visual model examines the process of reintegration explored in Study 3. While the previous models focus on movement across contexts and the barriers encountered in UK systems, this diagram centres on what happens when students return to Algeria and attempt to reconcile competing frameworks of meaning. Reintegration was not simply a matter of returning to familiar cultural territory. Instead, participants described a tension between the psychological concepts they had learned abroad, the moral and social expectations embedded within Algerian cultural norms and the religious or traditional explanations that shaped family and community interpretations of distress. The Reintegration Triangle positions the student at the intersection of three powerful forces that shape how they make sense of mental health upon returning home. The first corner represents the psychological knowledge and reflective habits gained in the UK. Students learned to name emotions, identify patterns of stress and use concepts such as self-care, boundary-setting or anxiety. These ideas often remained meaningful to them, even if they struggled to express or justify them in their home environment. The second corner represents Algerian cultural norms and moral expectations. Upon returning home, students described re-encountering beliefs about emotional strength, endurance, modesty and the importance of maintaining family reputation. In this context, open emotional expression could be judged as unnecessary or inappropriate, and psychological distress was frequently understood through moral categories such as weakness, ingratitude or failure to cope. This cultural positioning sometimes conflicted with the reflective practices students had adopted abroad, creating a sense of internal conflict around how to talk about distress and how to interpret it. The third corner represents religious and traditional explanatory systems. Many students returned to environments where faith-based interpretations of distress held significant authority. Experiences such as fear, sadness or insomnia were often explained through spiritual imbalance, envy or supernatural forces. For some students, these explanations offered comfort and a sense of belonging. For others, they

clashed with the psychological vocabulary they had learned abroad, leading to further uncertainty about how to make sense of their emotional experiences. The centre of the triangle represents the student navigating these three frameworks simultaneously. Reintegration involved selecting, blending and sometimes resisting particular explanations. Students drew privately on psychological concepts when reflecting on their internal states, yet often adopted culturally familiar explanations when speaking to family or community members. This tension did not represent confusion but rather a negotiated attempt to maintain social harmony while preserving personal meaning. The Reintegration Triangle therefore illustrates how returning students must balance competing interpretations and how reintegration involves an ongoing process of reconciling psychological, cultural and religious frameworks. It highlights the complexity of meaning-making within transnational lives and shows why understanding cannot be reduced to any one perspective. Figure 7.4. The Reintegration Triangle A triangular model depicting the three main forces shaping meaning-making after return: psychological knowledge acquired in the UK, Algerian cultural norms and moral expectations, and religious or traditional explanatory systems. The centre reflects the student's negotiated meaning-making across these competing frameworks. While the findings suggested that Algerian cultural norms and religious/traditional explanatory systems were often closely intertwined and mutually reinforcing, the purpose of the Reintegration Triangle was not to represent the relative strength of relationships between components. Rather, the model was developed to illustrate the three principal systems of meaning that participants negotiated during reintegration. The triangular structure therefore represents interaction, tension, and ongoing negotiation between these influences rather than equal proximity or equal weighting. Psychological knowledge acquired during study abroad frequently operated as an alternative interpretative framework that participants attempted to reconcile with existing cultural and religious understandings. The model was therefore retained because its purpose was to illustrate this process of negotiation rather than the degree

of overlap between components.

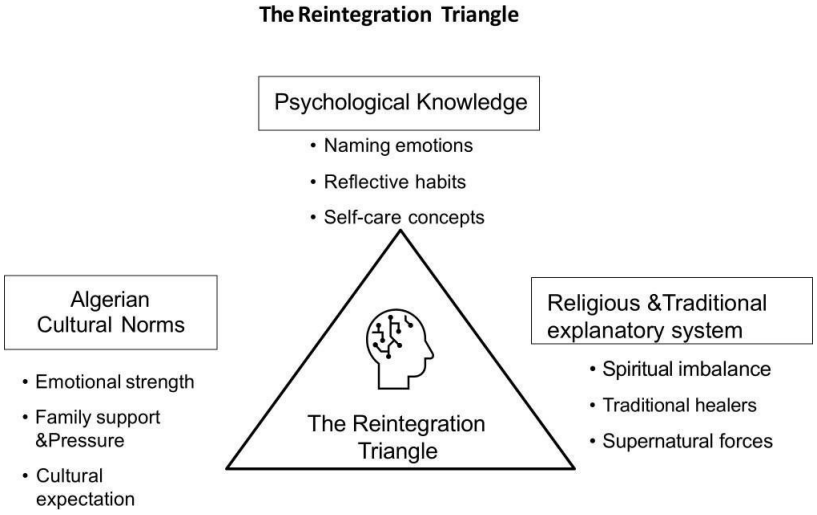

Figure 7.4 The Reintegration Triangle

Note. A triangular model depicting the three main forces shaping meaning-making after return: psychological knowledge acquired in the UK, Algerian cultural norms and moral expectations, and religious or traditional explanatory systems. The centre reflects the student's negotiated meaning-making across these competing frameworks. The Reintegration Triangle is an original conceptual model developed from the cross-study synthesis and is not directly adapted from an existing theory or framework. The model is intended to represent the three principal influences shaping participants' reintegration experiences.

7.5.4 The Triadic Model of Disclosure

While the previous three models visualise movement, barriers, and reintegration, the Triadic Model of Disclosure captures a different dimension of meaning-making. It focuses on the relational and interactional processes that shape whether, how, and to whom students disclose distress. The model highlights that disclosure is not an individual decision but a negotiated exchange between the speaker, the listener, and the cultural–institutional context in which the interaction occurs. The final visual model presented in this chapter examines one of the most consistent relationships across the three studies: the relational nature of disclosure. While previous models explained how understanding shifts across contexts and how different cultural and institutional forces shape meaning-making, disclosure emerged as a process that

could not be explained solely by internal states or cultural scripts. Instead, it was repeatedly shaped by the interaction between three elements: the speaker, the listener, and the broader context in which communication took place. This pattern appeared in the narratives of students in the UK, in professionals' accounts of their interactions with Algerian and Arab students, and again in the experiences of returnees navigating emotional conversations in Algeria. The Triadic Model of Disclosure captures this relation by showing disclosure not as an individual act, but as a relational negotiation that depends on the interplay of vulnerability, interpretive authority and contextual norms.

The first point of the triad is the "speaker", whose willingness and ability to disclose is shaped by several internal and culturally mediated factors. Participants across the studies described experiencing vulnerability when considering whether to speak about distress, particularly when discussing experiences that carried moral risk, such as loneliness, depression, anxiety or academic failure. Students often evaluated their own readiness to disclose, questioning whether they had the emotional capacity or the right words to express what they felt. In many cases, fear of judgement served as the most immediate barrier. This fear was not imagined; it reflected broader cultural scripts surrounding emotional expression, responsibility and family reputation.

For some, speaking openly risked being labelled weak or ungrateful. For others, the issue was not weakness but the moral weight attached to certain types of distress, which made disclosure feel risky in both interpersonal and cultural terms. While others avoid disclosure to avoid spreading negativity and being controlled by the speaker when receiving some advice. The model therefore places the speaker's vulnerability and readiness at the forefront, recognising that disclosure begins long before words are spoken.

The second point of the triad is the "listener", whose position holds significant interpretive

authority. In the interviews with professionals, students and returnees, it became clear that the listener's response was often more influential than the content of the speaker's disclosure. A listener who was empathetic, culturally sensitive and willing to engage without judgement could create a space in which students felt understood, even when discussing difficult or culturally sensitive topics. Conversely, even subtle signs of misunderstanding or invalidation could close down the possibility of further disclosure. Students described moments when they felt their experiences were "translated" into a Western psychological framework in ways that ignored cultural or religious dimensions therefore they stepped back from disclosing. Others noted that professionals sometimes interpreted silence or hesitation as a lack of engagement, rather than as signs of fear, shame or cultural caution. The role of cultural competence among listeners was therefore critical; it shaped whether disclosure became a moment of recognition or a moment of distancing. Trust was not automatic but had to be earned through the listener's stance, language, and willingness to accommodate the speaker's cultural world.

The third point of the triad is the "context", which includes moral expectations, cultural norms, institutional rules and the power of stigma. Across the three studies, disclosure was not simply shaped by who was speaking or who was listening, but by the environment in which the interaction occurred. In UK wellbeing services, the institutional structure itself communicated expectations about openness, autonomy and emotional clarity. Students often struggled to meet these expectations because they came from cultural contexts where privacy, endurance and modesty were valued more highly than verbal expression. In Algeria, the context shifted, but the pressures remained. Family expectations, religious interpretations and the continuing presence of stigma created an environment in which disclosure could have significant social consequences. In some cases, students adopted dual strategies: using psychological language privately to understand their emotions, while publicly framing distress in culturally accepted terms. In some cases, students adopted dual strategies: using

psychological language privately to make sense of their emotions, while publicly reframing distress in terms that were culturally acceptable. One student described an incident in which she told her mother that she felt depressed. Rather than receiving acknowledgement, her mother firmly rejected the term and instructed her not to say such things again. The mother insisted that feeling "depressed" meant she was questioning God's protection and that true believers should avoid speaking in this way. She encouraged her daughter to pray, read the Qur'an, and reassure the family by saying she was fine. In response, the student learned to avoid psychological vocabulary at home and instead used softer expressions, such as "I am tired" or "I need a moment" which would not provoke moral judgement or spiritual correction.

This same participant also illustrated how contextual pressures shaped disclosure when she attempted to seek help from professionals in the UK. While completing the intake form for student mental-health services, she hesitated when asked to indicate her religion. She later explained that the question triggered two conflicting interpretations: one part of her believed that her faith should be a sufficient source of strength and that relying on professional help might signal a lack of trust in God; the other part worried that her religious identity might influence how professionals perceived her or limit the kind of support she would receive. These competing thoughts led her to pause, reconsider, and eventually withdraw from the appointment.

At the centre of the Triadic Model of Disclosure is the communicative event itself: the moment where speaker, listener and context converge. Disclosure is not predictable; it fluctuates depending on the speaker's readiness, the listener's stance and the cultural or institutional environment. A student may disclose partially, test the listener's reaction or withdraw if the interaction feels unsafe. This flexibility does not reflect lack of clarity but shows how disclosure operates as a relational negotiation shaped by power, expectation and emotional need. The model illustrates why the same student may speak openly in some contexts but

remain silent in others, and why disclosure cannot be interpreted as a simple indicator of distress or wellbeing.

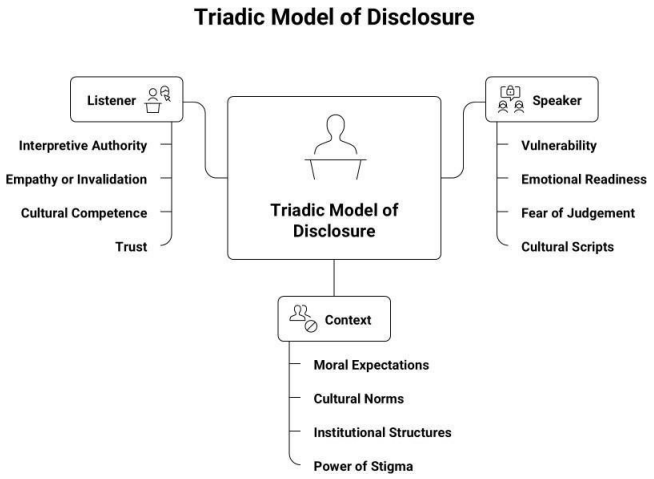

Figure 7.5. The Triadic Model of Disclosure
A three-part model illustrating how disclosure emerges through the interaction between the speaker, the listener and the contextual forces that shape communication, including cultural norms, moral expectations and institutional structures.

7.6 Chapter Summary

This chapter brought together the findings of all three studies and showed how they connect to one another. Each study offered a different angle on how Algerian students understand and talk about mental health, but it is only when the studies are placed side by side that the deeper patterns become visible. The chapter showed that understanding does not stay the same across contexts. Instead, it shifts as students move between languages, beliefs, families, and institutional systems in the UK and Algeria.

The chapter first explained how power shapes what students can say, how they describe their feelings, and which explanations feel acceptable or unsafe. Power appeared through language, religion, family expectations, stigma, and the authority of professionals. These forces influenced how students judged their own distress and how they communicated it to others.

The analysis made clear that meaning-making is not simply personal. It grows out of the social and cultural worlds students live in. The Deep Structures of Power Model captured this by showing that what we see on the surface such as coping, silence, or disclosure; is supported by deeper forces that are not always spoken about openly. These deeper layers include cultural norms, moral expectations, linguistic choices, religious beliefs, and ideas about reputation. The iceberg model helped visualise this hidden structure and showed why students' expressions often carry meanings that are not visible at first sight.

The chapter then introduced a series of visual models to guide the reader through the process of meaning-making across the three studies. The Transnational Chain of Meaning-Making showed how students' ideas change as they move from Algeria to the UK and then return home. The Web of Barriers and Supports showed the mixed environment students encountered when seeking help in the UK, where trust, language, cultural shame, confidentiality concerns, and professional awareness all shaped whether they spoke or stayed silent. The Reintegration Triangle illustrated the challenge students faced after returning to Algeria, when psychological ideas learned abroad met cultural and religious norms at home. The Triadic Model of Disclosure explained how speaking about distress depends on three parts: the speaker, the listener, and the context in which the conversation happens. This model helped show why students often kept their psychological interpretations private while using safer cultural language in public. Together, these visual models and the written analysis showed that understanding mental health is a process that changes across time and place. Students did not simply "learn" psychological concepts in the UK. They adapted them, questioned them, combined them with cultural and religious beliefs, and changed them again when returning home. These shifts reveal how meaning-making works in transnational lives, where ideas must constantly be adjusted to fit different social expectations.

This chapter has therefore set the foundation for the next step of the thesis. The following

Discussion Chapter will take these integrated findings and place them in conversation with existing theories. It will show how the findings support, challenge, or extend current ideas in acculturation, cultural psychology, mental-health literacy, and qualitative research. It will also explain the contribution this thesis makes to understanding mental health in transnational and culturally complex settings.

Chapter 8

Discussion: Interpreting Distress and Wellbeing in Transnational Algerian International Students Journeys

8.1 Introduction

As outlined in Chapter 1, the overarching aim of this thesis was to explore how AIS experience, understand, and navigate mental health across transnational contexts, particularly as they move between study in the United Kingdom and return to Algeria. This aim was addressed through three interrelated research questions examining: (1) how Algerian international students perceive and make sense of their mental health across different cultural settings; (2) the challenges and barriers they encounter in disclosing distress and seeking professional support in both the UK and Algeria; and (3) how UK mental health professionals understand and respond to the needs of Algerian and Arab international students, and the implications of these responses for support provision.

Building on the Integration Chapter (Chapter 7) , which mapped patterns of convergence and divergence across contexts, the present chapter moves beyond description to offer an interpretive account of why these patterns emerged and how they were shaped by cultural norms, institutional practices, and power relations. In doing so, the chapter addresses a central concern running across the thesis: that mental health is not experienced as a fixed or universal phenomenon, but is continually reinterpreted as students move between cultural, linguistic, and moral worlds. Specifically, the discussion examines how students' understandings of distress shifted across UK and Algerian contexts; how disclosure and help-seeking were negotiated in relation to stigma, language, and institutional expectations; and how professional frameworks sometimes aligned with, or diverged from, students' own meaning-making processes. By integrating student, professional, and returnee perspectives, the chapter demonstrates how

mental health experiences are co-constructed as students navigate life between the UK and Algeria.

Across the data, students did not describe distress as a purely internal or individual phenomenon. Instead, emotional difficulties were closely linked to family expectations, religious beliefs, shame, language, and pressures to appear resilient within different social settings. These meanings shifted as students moved between the UK and Algeria, supporting long-standing arguments that mental health cannot be separated from the cultural and social worlds in which people live. For example, Kirmayer (2018) argues that emotional experience is shaped by the cultural frameworks available for interpreting suffering, while Kleinman (2020) emphasises the moral dimensions through which distress is understood and responded to in everyday life. More recent work by Malafouris and Röhricht (2024) extends this perspective by highlighting the role of material environments and embodied interaction in the emergence of distress. Considered together, these approaches resonate closely with the students' accounts in this study, which portrayed mental health not as a stable medical category, but as a contextually shaped process that shifted across countries.

Early work on acculturation tended to classify migrants into fixed patterns of adjustment, most notably Berry's fourfold model of assimilation, separation, integration, and marginalisation. Subsequent research, however, has challenged such typologies, conceptualising cultural belonging as fluid, relational, and context-dependent (Schwartz et al., 2010; Ward & Geeraert, 2016). This perspective aligns closely with this study, which revealed ongoing negotiation rather than stable adaptation. Students continually adjusted how distress was framed, which language felt safer to use, and how much vulnerability could be expressed across different contexts. These micro-level adjustments constituted the everyday work of addressing mental health across borders.

Intersectionality provided a critical lens for understanding variation in how students related to distress and disclosure. Gender, religion, language, socioeconomic background, and migration status did not operate independently; rather, they intersected to shape what students felt permitted to express and how they interpreted both their own emotions and the responses of others. While Crenshaw's (1991) work remains foundational, more recent scholarship emphasises that intersectionality also shapes interpretive frameworks—defining what "someone like me" is allowed to feel, say, or endure. Related work on literacy as a human practice further highlights how meaning-making is guided by shared cultural narratives about identity and emotional appropriateness (Understanding Literacy as Human Practice, 2022). In this study, students drew on such narratives when interpreting distress as weakness, moral failure, divine testing, or acceptable vulnerability. Intersectionality, understood in this way, illuminates how silence, caution, and selective disclosure emerged through converging gendered expectations, religious teachings, linguistic norms, and cultural stories.

Psychological and cognitive research also helps explain why many students struggled to recognise or articulate their distress. Cognitive models suggest that emotional recognition depends on the conceptual frameworks and vocabularies individuals possess (Beck & Haigh, 2014), while work on mentalisation and metacognition highlights the social and cultural conditions that make certain emotional labels usable or risky (Allen et al., 2008; Fonagy et al., 2019). These tensions were evident in participants' narratives. Some students described recognising that they were "not okay" yet lacking culturally acceptable language through which their distress could be understood by others. In such cases, distress was misinterpreted as a personality trait or moral disposition rather than an emotional experience. This suggests that identifying distress requires not only personal insight, but also linguistic and cultural environments that allow emotional experiences to be named and recognised.

Decisions about disclosure were similarly shaped by anticipated judgement. Students did not simply choose whether to speak or remain silent; they evaluated the moral, relational, and institutional risks surrounding disclosure. Early stress-appraisal models framed such decisions as individual assessments of threat and safety (Folkman & Lazarus, 1985), whereas more recent research highlights the role of culture, power, and social positioning in shaping these evaluations (Biggs et al., 2017). Many students described weighing the potential consequences of disclosure, including fear of moral judgement, damage to family reputation, or misunderstanding by professionals. Repeated experiences of dismissal or misrecognition often led students to conclude that silence was safer than seeking help, a pattern consistent with contemporary accounts of learned helplessness (Maier & Seligman, 2016; Zulkosky et al., 2022). Silence, in this sense, functioned as a protective response rather than an absence of need.

Coping practices added a further layer to this analysis. Coping was not experienced as a simple choice between adaptive or maladaptive strategies, but as a culturally negotiated response shaped by what felt acceptable, protective, or shameful. While some psychological models treat coping strategies as universal, others argue that coping can only be understood within the cultural worlds that give behaviours their meaning (Kim et al., 2020). From this perspective, strategies such as withdrawal may be interpreted as avoidance in Western contexts, but as maturity or self-control in others. Ungar (2021) further suggests that coping often involves protecting identity and relationships rather than maximising psychological efficiency. Students' accounts in this study align with this view, demonstrating how coping practices were chosen in relation to cultural expectations and anticipated social consequences.

These analyses reinforce the central argument of this chapter: for AIS, experiences of distress, disclosure, and coping are best understood not as functions of individual knowledge or willingness, but as context-dependent and relational practices

shaped by power, language, and moral recognition across transnational settings. The visual models developed in this thesis; the iceberg model, the transnational chain, the web of barriers and supports, and the reintegration triangle, illustrate how meanings shift through movement between contexts rather than settling into a single stable form. This chapter therefore establishes an interpretive foundation for understanding why students' mental health experiences unfolded as they did, and what these patterns reveal about mental health within global higher education contexts.

8.2 Revisiting the Conceptual Foundations

This section revisited the main philosophical and theoretical lenses that informed the interpretation of findings across the three studies. The aim was not to repeat the Methodology Chapter, but to clarify how a set of linked frameworks helped make sense of AIS mental health experiences across Algeria and the UK. The discussion was grounded in a critical-constructivist epistemology, supported by acculturation and re-acculturation theory, emic/etic positioning and intersectionality. Together, these lenses allowed the analysis to move beyond individual explanations and to situate students' narratives within wider cultural, historical and institutional contexts (Berger and Luckmann, 1966; Charmaz, 2014; Schwandt, 2000).

Rather than treating these frameworks as separate, the thesis used them in combination. Critical constructivism provided the philosophical base for viewing mental health as socially and culturally produced. Acculturation and re-acculturation theories helped interpret how students adjusted to and then returned from the UK. Emic/etic positioning guided how insider and outsider perspectives were held together in the research. Intersectionality drew attention to the way gender, religion, language and social position shaped access to support and the moral terms in which distress was understood. The following subsections summarise how each of these frameworks contributed to the interpretation.

8.2.1 Critical-Constructivist Epistemology in Mental Health Research

At the heart of this thesis is a simple but unsettling question: What if mental health is not something we discover, but something we create? A critical-constructivist epistemology encouraged the study to start from that position. Instead of treating distress, diagnosis or recovery as fixed concepts waiting to be identified, this perspective suggested that these ideas are shaped by the cultural worlds people inhabit. What counts as "illness," "depression" or "strength" is not universal; it is negotiated through religion, family expectations, social history and the power of institutions (Berger & Luckmann, 1966; Schwandt, 2000).

This starting point immediately placed the research in tension with much of the global mental-health literature. Western diagnostic categories are often presented as if they were neutral descriptors that travel easily between nations and contexts (Kirmayer & Gómez-Carrillo, 2019; Summerfield, 2012). This thesis; however, refused that assumption. Students in this study did not talk about panic attacks or depressive episodes. Instead, many described mental health issues as being tested by God, overwhelmed by shame, burdened by family duty, or spiritually out of balance. A deficit model would interpret these accounts as gaps in literacy or misunderstanding. Constructivism takes these explanations seriously, it reads them as interrelated, culturally grounded ways of making sense of suffering and ways that have their own emotional logic and moral history (Fernando, 2010; Harper & Speed, 2014). Taking this into account, AIS were not struggling to "recognise" Western mental-health concepts. They were moving back and forth between two different knowledge systems. One was shaped by faith, moral obligation and social reputation. The other was shaped by UK academic discourse, clinical guidelines and the language of psychology. Their stories echoed recent work showing that contemporary Algerians are navigating a moment of psychosocial transition, where religious and biomedical concepts increasingly sit side by side and sometimes collide (Laoudj, 2024). The critical element of this epistemology also kept

questions of power in constant view . Rather than guiding the empirical research itself, these questions shaped *how* the thesis interpreted what students said and which meanings were foregrounded. Critical constructivism encouraged the study to look beyond the surface of participants' accounts and ask: Which explanations of distress are treated as legitimate, and which are quietly dismissed? Whose understandings of suffering travel across borders as authoritative knowledge, and whose are reduced to superstition or cultural misunderstanding? These are not the research questions of this thesis; rather, they are the analytical questions that positioned the study within wider debates on knowledge and inequality. They clarified why the thesis approached students' religious, moral and cultural framings of distress not as errors but as meaningful, socially situated interpretations.

For instance, in Study 1, students were not rejecting clinicians after negative encounters; most had never reached a psychologist in the first place. Instead, they turned first to the immediate moral world around them be it family, close friends, elders, or to religious figures such as Imams or Rakis. Distress was understood through ideas of envy, the evil eye, spiritual imbalance, or distance from God. Help was sought through Qur'anic recitation, prayer, ritual reassurance, and conversations that restored moral meaning and spiritual stability. Within this world, psychological services did not appear as the natural or obvious next step. They felt distant, culturally thin, and less equipped to speak to the spiritual, relational and moral dimensions of suffering that students valued. The issue, therefore, was not resistance to help but a fundamental mismatch between the cultural frames that made sense to students and the biomedical categories that structured formal services. Critical constructivism helped keep this mismatch visible, showing how Western psychiatric models risked narrowing thick, culturally rooted accounts of distress into categories that felt incomplete or irrelevant.

Additionally, this epistemological stance did not leave the researcher untouched and not involved, working as an Algerian insider-outsider created a particular kind of interpretive connection. Sharing language and cultural codes made it possible to hear the softness behind a participant saying, "I was actually suffering," or to understand the social weight contained in a single word like Mahboul (Crazy). It made space for humour, hesitation and unspoken meaning to enter the analysis. But this position also carried responsibility. It demanded ongoing reflexivity, an awareness of how the researcher's own upbringing, faith, memories and academic training shaped what was heard and what was amplified (Finlay, 2002; Charmaz, 2014). This thesis therefore does not present itself as neutral. Instead, it frames the analysis as a dialogue: between participants' voices, the researcher's positionality, and the broader debates on knowledge, power and cultural meaning in mental-health research.

8.2.2 Acculturation and Re-Acculturation

Acculturation theory provided a useful, though imperfect, lens for understanding how AIS navigated cultural transitions. Early models in the literature, particularly Berry's fourfold framework, sorted migrants into fixed categories of integration, assimilation, separation and marginalisation (Berry, 1997). These typologies suggested that individuals could be neatly placed into one pattern of adaptation. More recent work has challenged this view and described acculturation as a flexible, situation-dependent process that changes over time (Schwartz et al., 2010; Ward and Geeraert, 2016).

The findings of this thesis aligned more strongly with these newer perspectives. In Study 1, students did not simply integrate or separate. They shifted between ways of belonging as they moved through the UK academic system, social networks and religious communities. They chose when to use English or Arabic, when to rely on psychological language or spiritual idioms, and when to keep distress hidden. These choices reflected not fixed acculturation "types" but continuous negotiation.

Study 3 highlighted an area where classic acculturation models were especially limited: return to the home country. Many returnees described experiences closer to what Adler (1981) called a transitional or re-entry crisis rather than straightforward reintegration. After internalising aspects of UK mental-health discourse and daily life, they found that their transformed perspectives did not fit easily back into Algerian expectations. Some were viewed as "too Western," while at the same time feeling no longer fully at ease in British settings either. This double sense of not-fitting illustrated how acculturation and re-acculturation involved emotional dislocation as much as behavioural adaptation (Kuo, 2014; Tummala-Narra, 2021). Across all three studies, the thesis therefore treated acculturation not as an individual trait but as a socially embedded negotiation, shaped by religious norms, linguistic access and institutional structures. The framework was stretched and critiqued rather than adopted uncritically, and it was used to support a more context-sensitive account of movement across cultures.

8.2.3 Emic/Etic Positioning and Multi-Voiced Triangulation

The emic/etic distinction, originally developed by Pike (1967), has remained an influential framework in cross-cultural and qualitative research for understanding phenomena from both insider and outsider perspectives. An emic perspective refers to the interpretation of experiences from within a particular cultural group, focusing on meanings, values, beliefs, and practices that are significant to members of that culture. In contrast, an etic perspective involves examining experiences from an external analytical standpoint, enabling comparison across cultural contexts and the application of broader theoretical frameworks (Morris et al., 1999; Berry, 2013). Contemporary cross-cultural researchers continue to emphasise the importance of integrating emic and etic approaches to achieve culturally sensitive yet theoretically informed interpretations of human behaviour and experience (Berry, 2013; Cheon et al., 2020). The use of both perspectives in this study enabled the exploration of how

mental health was understood by participants themselves while also situating these understandings within wider psychological, cultural, and theoretical contexts. The emic/etic distinction, first developed by Pike (1967), helped the study work with both insider and outsider perspectives. In this project, emic and etic were not abstract categories but lived positions held by three groups: the AIS participants, the UK professionals and the researcher. Each group brought its own way of understanding mental health and its own language for describing distress.

In Study 1, emic perspectives were especially visible as students slipped naturally into Algerian Arabic and French terms such as *mahboul* (mad) or *hchouma* (shame) when describing sensitive experiences. These terms carried cultural and moral weight that could not be captured by direct translation. Shared language and cultural background between participants and the researcher allowed these meanings to be explored with depth and care (Al-Issa, 2015; El Khatib, 2019).

Study 2 introduced a second layer. Some professionals with similar cultural backgrounds drew on their own emic understandings when working with students, while others approached AIS from a more distant, etic position. Professionals unfamiliar with Algerian or Arab contexts often relied on generalised models of "international student stress," which sometimes missed the cultural and religious meanings students attached to distress. This showed that emic alignment alone did not guarantee cultural competence; it had to be accompanied by reflexivity and sensitivity to power.

Study 3 highlighted the tension between internal and external language. Many returnees had developed a mental-health vocabulary in English during their stay in the UK. Once home, they struggled to find equivalents in Arabic or French that would be understood or accepted by family and community members. This created a gap between inner experience and outer

expression and contributed to feelings of dislocation (Tummala-Narra, 2021). Across the three studies, emic/etic positioning was treated as relational and shifting rather than fixed. Triangulating between students' accounts, professionals' viewpoints and the researcher's reflections strengthened the analysis by revealing not only points of agreement but also sites of misunderstanding and power imbalance (Denzin, 1978; Bradbury-Jones et al., 2014). Rather than collapsing these perspectives into a single story, the study used them to show how meanings were negotiated across different positions.

8.2.4 Intersectionality and Structural Constraints on Disclosure

Intersectionality offered a further analytic tool for understanding how identities, social expectations and structural conditions shaped AIS mental health experiences. Following Crenshaw's (1989) and Collins's (2019) framing, the thesis approached gender, religion, language, class and migration status as *interacting dimensions* rather than discrete variables. This made visible why students in superficially similar situations experienced different degrees of emotional safety or risk when considering disclosure.

Across the three studies, intersecting identities shaped not only *who* felt able to speak, but *when*, *how*, and *to whom*. In Study 1, both male and female participants linked disclosure to moral and relational expectations. Men often felt that expressing distress conflicted with cultural ideals of self-control and strength, whereas women worried about how disclosure might affect reputation, marriage prospects or broader family honour. For many, distress was interpreted through spiritual or moral frameworks—possession, envy, divine testing or distance from God—which oriented help-seeking towards religious healers such as rakis or imams and away from formal mental-health provision. When services failed to recognise these culturally embedded explanatory models, students felt misunderstood or morally judged (Al-Krenawi & Graham, 2011; Weatherhead & Daiches, 2010).

Study 2 demonstrated how professionals' own social positions and epistemic frameworks shaped their interpretations of AIS distress. Practitioners with cultural familiarity tended to validate spiritual or moral explanations as one component of a broader care pathway, whereas others interpreted such beliefs as signs of denial, non-compliance or resistance. Intersectionality helped illuminate how these interpretive gaps, combined with institutional norms of neutrality and Westernised models of care, could either reinforce stigma or create openings for culturally resonant support. It also highlighted the asymmetry of interpretive power: professionals' understandings carried institutional authority, whereas students' meanings were often treated as secondary or culturally "other."

In Study 3, intersectional pressures reconfigured once again. Language, gender and re-entry moral expectations intersected to produce new barriers to disclosure. Returnees who had developed confidence in articulating mental-health experiences in English frequently felt unable to translate these meanings into Arabic or French, where vocabulary was limited and meanings carried heavier moral weight. The absence of shared emotional language at home, combined with renewed expectations around faith, modesty and family responsibility, made disclosure feel precarious. Many participants opted for silence or partial disclosure as a way to protect their dignity, avoid burdening relatives, and prevent misinterpretation.

Taken together, these patterns demonstrate that disclosure cannot be understood as an individual choice or psychological trait. It emerges from the interplay of intersecting identities, cultural expectations, linguistic resources and institutional structures. Intersectionality therefore complements the constructivist, acculturation and emic/etic lenses by showing how emotional expression is embedded in shifting systems of belief and power (Bentall et al., 2022; Zahir, 2020). It clarifies why students' emotional lives and help-seeking behaviours changed across contexts, and why greater awareness did not straightforwardly lead to disclosure in any of the three studies.

In combination, critical constructivism, acculturation and re-acculturation theory, emic/etic positioning and intersectionality provided a coherent interpretive framework for this thesis. Constructivism offered the philosophical grounding for treating mental health as culturally produced rather than universally fixed. Acculturation and re-acculturation theories situated students' experiences within the dynamics of movement, adaptation and return. Emic/etic positioning allowed students' and professionals' perspectives to be placed in dialogue without collapsing differences. Intersectionality brought into view the structural and identity-based constraints that shaped emotional expression and access to care. Together, these frameworks ensured that the thesis remained anchored in AISs' lived realities while also contributing to broader debates in cross-cultural mental health.

8.3 Interpreting Distress and Emotional Meaning-Making Across the Three Studies

This section develops a cross-study interpretation of how AISs understood, articulated, and managed psychological distress across study abroad, encounters with mental health professionals, and reintegration. Rather than conceptualising distress as a stable, internal psychological state, the discussion aligns with contemporary cultural and critical mental health scholarship that frames emotional experience as socially produced, morally evaluated, and relationally negotiated (Kirmayer et al., 2017; White et al., 2017; Mills, 2014). Through the three studies, distress was not simply felt but actively interpreted, assessed, and strategically managed in relation to anticipated judgement, social consequences, and the likelihood of recognition. This position, however, stands in tension with dominant biomedical and cognitive-behavioural models that continue to frame distress primarily as an individual phenomenon rooted in symptoms, dysfunction, or maladaptive cognitions (Harvey et al., 2017). From these perspectives, barriers to disclosure are often attributed to deficits in awareness, stigma, or help-seeking attitudes. While such explanations remain influential in policy and service design, the findings of this thesis suggest that they are insufficient for

understanding AISs' experiences. Participants across all three studies frequently demonstrated high levels of psychological insight, yet continued to regulate disclosure carefully. This indicates that non-disclosure was not simply a failure of knowledge, but a response to social and moral conditions that made emotional expression risky.

While foundational theorists such as Kleinman (1988), Hochschild (1979), and Lutz (1988) originally articulated the cultural and moral structuring of emotion, this thesis does not rely on These works as its primary evidential base. Rather, they serve as conceptual anchors that continue to shape contemporary debates. Recent scholarship has extended and empirically substantiated these insights, showing how emotional expression is governed by socially learned norms, power relations, and relational expectations across diverse contexts (Thoits, 2016; Mesquita et al., 2017; Kirmayer & Gómez-Carrillo, 2019). It is within this contemporary literature that the present findings are situated, while also pushing beyond it by examining emotional meaning-making across *transnational trajectories* rather than within a single cultural setting.

Across all three studies, participants' accounts indicated that emotional expression was conditional rather than spontaneous. This finding supports relational and sociocultural models of emotion, which emphasise that individuals learn when, where, and with whom emotions may be expressed safely (Campos et al., 2018; Ford & Gross, 2019). However, it also challenges strands of mental health literacy research that continue to conceptualise disclosure as the natural outcome of increased awareness or reduced stigma (Jorm, 2012; Gulliver et al., 2019). In contrast to these linear models, the present findings suggest that disclosure functioned less as an act of openness and more as an emotional risk assessment, shaped by anticipated moral judgement, power asymmetries, and relational history. This aligns with relational disclosure frameworks (Fox & Earnshaw, 2018; Quinn et al., 2014), but extends them by demonstrating how such risk assessments shift across migration, institutional

encounters, and return. The first analytic focus concerns how distress was framed as a moral and relational phenomenon, rather than a purely psychological one. In line with recent cross-cultural mental health research, participants interpreted suffering through narratives of endurance, spiritual meaning-making, personal responsibility, or obligation to others (Kohrt et al., 2018; Kirmayer & Gómez-Carrillo, 2019). However, some scholars have argued that moral framings of distress may obscure psychological need or delay access to care (Summerfield, 2013; Mills, 2014).

While this critique holds weight in contexts where moral explanations are imposed coercively or used to delegitimise psychological suffering, the present findings complicate this position by showing how AISs actively navigated multiple interpretive frameworks simultaneously. Participants did not simply replace psychological understandings with moral or spiritual explanations, nor did they treat these frameworks as mutually exclusive. Instead, they often held them in parallel, moving between them depending on context, audience, and perceived risk. For example, across Studies 1 and 3, many participants described learning to recognise their distress through psychological language while studying in the UK. Exposure to UK mental health discourse enabled students to name experiences as anxiety, depression, or stress, often for the first time. Several participants spoke about realising that what they had previously experienced "had a name" or was something others also talked about openly. This comparison with UK norms made distress more visible and intelligible to them at a personal level; however, when students returned to Algeria, this psychological understanding did not translate straightforwardly into open disclosure. Participants described becoming more careful about how, or whether, they spoke about distress at home. While they still understood their experiences in psychological terms internally, they often avoided using such language with family members or wider social networks. Instead, distress was reframed in more socially acceptable ways, or not spoken about at all and only shared with those who have been through

the same experience. This shift was driven not by loss of awareness, but by an acute awareness of how psychological language might be judged, misunderstood, or morally reinterpreted in the home context.

In this way, the experience of studying in the UK introduced a point of comparison rather than a permanent transformation. Students learned alternative ways of understanding distress, but reintegration required recalibrating disclosure in line with familiar moral and relational expectations. The result was not confusion between cultural and psychological frameworks, but a selective and strategic use of them. Psychological meanings were often retained privately, while moral or spiritual explanations were mobilised publicly to preserve dignity, protect relationships, and avoid unwanted scrutiny.

This illustrates how cultural and clinical explanations of distress did not replace one another but operated side by side, with their use shaped by context and perceived risk. It is precisely this comparative process; between what could be said in the UK and what could be said at home; that helps explain why students returned to more cautious disclosure practices upon reintegration. Participants often reported that while psychological language helped them make sense of their internal states privately or in English-speaking contexts, moral or spiritual framings were more socially intelligible within family and community settings. As a result, students did not abandon psychological understandings upon return to Algeria; rather, they strategically downplayed or translated them into culturally acceptable language. The tension, therefore, lay not in knowing what distress was, but in deciding which interpretation could be safely voiced without risking judgement, misunderstanding, or moral sanction. Importantly, this tension also emerged in professional encounters. Some professionals interpreted spiritual or moral explanations as resistance to psychological insight, assuming that such framings obstructed engagement with care. However, participants' accounts suggest the opposite: moral and spiritual narratives often coexisted with psychological awareness, but were

mobilised selectively to preserve dignity or relational harmony. The difficulty arose when institutional settings failed to recognise this layered meaning-making, treating cultural explanations as incompatible with clinical ones. This misrecognition contributed to withdrawal and partial disclosure, not because students rejected psychological models, but because they were unable to reconcile them publicly with dominant moral expectations.

These findings therefore expose the limits of binary distinctions between "cultural" and "clinical" explanations of distress. Rather than operating as alternatives, these frameworks functioned as overlapping interpretive resources that students navigated dynamically. Distress was neither purely cultural nor purely psychological, but situated at the intersection of emotional experience, moral evaluation, and social consequence. It is precisely this intersection that renders disclosure complex and context-dependent, laying the groundwork for understanding emotional expression as conditional rather than straightforward.

Building on this, the discussion develops the concept of emotional conditionality and the social learning of feeling, examining how repeated encounters across cultural and institutional contexts taught AISs which emotions could be expressed, which required translation, and which were best left unsaid. Drawing on contemporary theories of emotional socialisation and regulation, emotional regulation emerged not as an individual coping style but as a socially patterned practice shaped by relational histories and power asymmetries (Campos et al., 2018; Ford & Gross, 2019). This supports scholarship that emphasises the social learning of emotion, yet challenges approaches that frame emotional regulation primarily as an internal skill to be taught or corrected. Participants did not lack regulatory capacity; rather, they demonstrated sophisticated regulation attuned to context, audience, and consequence. Within this process, sympathy functioned as a critical mediating mechanism. Some clinical traditions argue that professional neutrality is essential to ethical care, guarding against emotional over-involvement and bias (Hall et al., 2016). However, participants' accounts suggest that

emotional neutrality was often experienced not as safety, but as distance. Consistent with recognition-based and relational models of care (Honneth, 2018; Renedo et al., 2018), understanding that was not accompanied by visible sympathy was interpreted as lack of care or concern. In contrast, sympathetic recognition reduced the perceived cost of vulnerability and enabled tentative disclosure. In this study, sympathy did not appear to compromise professionalism; instead, its absence often undermined trust, especially for individuals accustomed to regulating emotional expression in response to moral and social scrutiny.

Language constituted a further layer shaping emotional meaning-making. Recent psycholinguistic and sociolinguistic research highlights how multilingual individuals use language strategically to manage emotional proximity and moral meaning (Pavlenko, 2017; Ożańska-Ponikwia, 2020; Dewaele & Costa, 2013). However, some service-oriented literature continues to treat multilingual expression as a barrier to accurate assessment or a source of misunderstanding (Flores, 2014). The present findings complicate this deficit framing. AISs' code-switching practices functioned not as confusion, but as epistemic work allowing them to preserve emotional accuracy while navigating institutional intelligibility. Where such practices were misrecognised as avoidance or incoherence, participants experienced epistemic injustice, with their ways of knowing and expressing distress discounted (Kidd et al., 2016). This suggests that linguistic competence alone is insufficient; epistemological openness is equally necessary. Finally, the section attends to silence, partial disclosure, and hesitation as meaningful outcomes of these intersecting processes. While silence is often interpreted in clinical and policy discourse as avoidance or disengagement, recent critical scholarship has reframed silence as a form of agency shaped by power and moral risk (Medina, 2013; Kirmayer et al., 2017). The present findings support this reframing. Across the three studies, silence functioned as a way of preserving dignity, sustaining relationships, and protecting the self in contexts where recognition was uncertain or

potentially harmful. Rather than indicating lack of insight, silence reflected participants' acute awareness of the social consequences of speech.

Understanding AISs' distress, disclosure, and coping requires moving beyond individualised and universal frameworks. By placing competing biomedical, literacy-based, relational, and cultural perspectives in dialogue, this analysis conceptualises emotional meaning-making as a changing process embedded in moral frameworks, relational conditions, linguistic repertoires, and power relations. In this way, the study contributes a transnational extension of relational and cultural approaches to mental health, highlighting how distress is continuously reinterpreted across movement, institutional engagement, and reintegration.

8.4 Cross-Study Synthesis: Shifting Meanings Across Contexts

Building on the analysis of emotional meaning-making in the previous section, this section synthesises how AISs' understandings of distress, disclosure, and coping shifted across the three studies. While some strands of international student mental health research continue to imply a progressive relationship between awareness, openness, and help-seeking, more recent scholarship has questioned this assumption, highlighting the uneven and context-dependent nature of disclosure (Forbes-Mewett & Sawyer, 2019; O'Reilly et al., 2023). The present findings align with this latter position, showing that AISs' emotional meanings did not unfold along a linear trajectory from awareness to openness, but were repeatedly recalibrated in response to context, audience, and power. Across transition to UK, professionals, and return, emotional meanings were not simply carried forward but continually renegotiated. This challenges models that treat mental health literacy as a cumulative resource that travels unchanged across settings. Instead, the three studies demonstrate that awareness and literacy were activated, constrained, or silenced depending on whether students perceived their understandings to be intelligible, legitimate, and safe within particular social and institutional environments. In this sense, the findings extend recent critiques of universalist mental health

frameworks by showing how emotional knowledge is shaped not only by culture, but by shifting relations of recognition and authority across transnational contexts.

The divergence between awareness and disclosure can be understood by distinguishing between internal recognition of distress and its public articulation. Across the three studies, encompassing AISs' experiences in the UK, professionals' perspectives on student mental health, and students' experiences following their return to Algeria, emotional meanings were not simply carried forward but continually renegotiated. This challenges models that treat mental health literacy as a cumulative resource that travels unchanged across settings. Instead, the three studies demonstrate that awareness and literacy were activated, constrained, or silenced depending on whether students perceived their understandings to be intelligible, legitimate, and safe within particular social and institutional environments. In this sense, the findings extend recent critiques of universalist mental health frameworks by showing how emotional knowledge is shaped not only by culture, but also by shifting relations of recognition and authority across transnational contexts. This supports research suggesting that international students often develop increased emotional and psychological awareness during study abroad (Sawir et al., 2020; Worsley et al., 2022). However, the present findings complicate interpretations that equate such awareness with readiness to disclose. Translating understanding into speech required not only cognitive clarity but confidence that distress would be interpreted sympathetically, without moral judgement or social cost. Where recognition was uncertain, awareness remained internalised rather than expressed.

Importantly, psychological language acquired in one context did not retain the same legitimacy or safety in another. While some scholars argue that exposure to Western mental health discourse equips students with transferable tools for self-expression, others caution that such tools may lose authority outside the contexts in which they are learned (O'Reilly et al., 2023). The present findings support this cautionary position. As students entered institutional

settings or returned home, they reassessed whether particular vocabularies would be intelligible or sanctioned. In professional contexts, psychological explanations risked being interpreted as exaggeration or instability; in family and community contexts, they could be read as weakness, moral failure, or distance from faith. Moral and spiritual framings, while often more socially legible, carried different implications for responsibility and endurance. Students therefore selectively activated or suppressed aspects of their understanding, not due to lack of insight, but in response to unequal epistemic authority. Mental health literacy thus emerged not as a stable possession, but as a situated practice shaped by context, audience, and power.

8.4.1 From Awareness to Conditional Disclosure

Across the three studies, increased awareness of mental health did not translate into a straightforward increase in disclosure. In Study 1, exposure to UK academic environments, peers, and wellbeing services enabled many AISs to recognise distress using psychological language. Participants described learning to name experiences as anxiety, stress, or emotional exhaustion through psychoeducational workshops, informal conversations, and online discourse. This aligns with research suggesting that study abroad can expand students' emotional vocabularies and interpretive frameworks (Sawir et al., 2020; Worsley et al., 2022). However, scholars diverge on what such awareness enables. While some mental health literacy models assume that naming distress reduces barriers to help-seeking, others argue that awareness may coexist with silence where disclosure carries moral or relational risk (Gulliver et al., 2019). The present findings support the latter view. Several participants described understanding their distress psychologically while choosing silence to avoid appearing weak, ungrateful, or incapable. Awareness did not dissolve moral considerations; instead, it sharpened students' assessment of what could safely be disclosed.

Study 2 further illustrates this process. When engaging with mental health professionals,

students described becoming more selective about disclosure, often simplifying their experiences or avoiding culturally specific explanations. Participants spoke about omitting religious or moral interpretations of distress to avoid misunderstanding, or emphasising academic stress rather than emotional vulnerability. This aligns with recent studies showing that disclosure among culturally diverse students is shaped less by need than by anticipated professional response (Byrom et al., 2020; Watsford et al., 2021). At the same time, the findings extend this literature by showing that such selectivity is not a failure of trust, but a learned response to prior experiences of misrecognition. By Study 3, following return to Algeria, disclosure became even more tightly regulated. While psychological understandings acquired in the UK were retained internally, participants described heightened caution in expressing distress publicly. Familiar moral expectations, family responsibilities, and stigma surrounding mental illness reasserted themselves. Students reported reverting to silence, partial disclosure, or culturally acceptable explanations such as tiredness or faith-related struggle. This pattern challenges assumptions that increased literacy leads to sustained openness across contexts. Instead, disclosure emerged not as a developmental endpoint, but as a conditional practice continually reshaped by social and moral context.

8.4.2 Institutional Encounters and the Limits of Recognition

Institutional encounters played a central role in shaping how emotional meanings were validated or constrained. Study 2 highlighted a recurring gap between professional intention and students' lived experiences of recognition. While many professionals demonstrated cultural sensitivity at a cognitive level, participants frequently described feeling that their distress was only partially understood. Emotional neutrality, reliance on standardised assessment tools, and limited engagement with moral or spiritual frameworks often resulted in students feeling heard but not recognised. This finding speaks directly to debates within cultural psychiatry and psychology. While some approaches emphasise procedural cultural

competence, others argue that recognition requires relational attunement rather than knowledge alone (Renedo et al., 2018; Metzl & Hansen, 2019). The present study supports the latter position. When students' ways of understanding distress did not align with institutional expectations; particularly when framed through faith, family obligation, or moral responsibility participants narrowed disclosure rather than withdrawing awareness. Silence, simplification, or strategic framing functioned as ways of navigating institutional power rather than indicators of disengagement. Therefore, comparisons across contexts further reinforced this pattern. Across Studies 1 and 3, participants contrasted professional encounters in the UK with anticipated or actual encounters in Algeria. In the UK, misrecognition was linked to cultural and linguistic gaps; in Algeria, it was associated with stigma, moral judgement, and limited trust in services. These comparisons support recent findings that recognition, rather than access alone, is central to sustained engagement with mental health services among international populations (O'Reilly et al., 2023; Worsley et al., 2022).

8.4.3 Reintegration and Epistemic Dissonance

Reintegration emerged not as a return to familiarity but as a site of epistemic dissonance. Study 3 illustrated how returning students navigated tension between psychological frameworks acquired abroad and moral or spiritual frameworks dominant at home. Some scholarship frames return as an opportunity for integration of new knowledge; others note that it can intensify identity conflict (Cairns, 2021). The present findings align with the latter perspective. Rather than replacing one system with another, participants held multiple frameworks simultaneously, often describing an internal understanding that could not be expressed publicly. This dissonance was experienced both cognitively and relationally. Participants described difficulty translating psychological concepts into socially acceptable language, leading to frustration, emotional withdrawal, or renewed silence. Recent work on reverse acculturation similarly highlights how return can re-activate earlier constraints rather

than resolve them (Abdulazeez et al., 2025). In this study the reintegration reactivated earlier lessons about emotional restraint. Rather than signaling regression, this reflected heightened awareness of social consequence. Emotional conditionality intensified because students now possessed more knowledge but fewer safe spaces to articulate it. This challenges assumptions that international education produces linear personal transformation, instead highlighting the circular and negotiated nature of emotional meaning-making across transnational lives.

8.4.4 Continuities and Transformations Across the Three Studies

Despite contextual differences, several continuities cut across the three studies. Emotional expression consistently involved assessments of risk, recognition, and consequence. Moral frameworks remained salient throughout, even as their specific content shifted. Silence and partial disclosure persisted as meaningful practices rather than residual barriers, supporting scholarship that frames non-disclosure as relationally situated rather than deficient. At the same time, important transformations occurred. Exposure to alternative frameworks expanded students' interpretive repertoires, even when these could not be enacted openly. Comparison across contexts sharpened awareness of difference, making emotional regulation more deliberate rather than less. These findings align with transnational mental health research that conceptualises coping not as adaptation to a single cultural setting, but as ongoing negotiation across multiple moral and epistemic systems (Kirmayer et al., 2021; O'Reilly et al., 2023). These continuities and transformations disrupt linear narratives of progress, acculturation, or assimilation. Rather than moving towards a single endpoint, AISs developed increasingly nuanced strategies for navigating emotional life across transnational spaces, adapting expression without relinquishing understanding.

8.5 Theoretical Contributions of the Thesis

This thesis makes several interrelated theoretical contributions to cross-cultural and international student mental health research by reframing distress, disclosure, and coping as

processes of socially situated meaning-making rather than individual psychological states. Drawing on three qualitative studies conducted across movement, institutional encounter, and reintegration, the analysis extends existing relational and cultural approaches by foregrounding how emotional understanding is shaped by conditionality, power, and recognition within transnational contexts.

8.5.1 Distress as Meaning-Making Rather Than Symptom Expression

A first major theoretical contribution of this thesis lies in its reframing of psychological distress as a process of meaning-making rather than as the mere presence or articulation of symptoms. Much contemporary mental health research, particularly within biomedical and literacy-based traditions, conceptualises distress as an internal psychological condition that becomes visible through symptom recognition and verbal reporting (Reavley et al., 2020; Jorm, 2022). Within this framing, understanding distress is largely a matter of identifying, labelling, and responding to symptoms in accordance with established diagnostic or psychoeducational frameworks.

More recent cultural and critical scholarship has begun to challenge this position by emphasising that distress is shaped by social context, cultural interpretation, and moral evaluation (Kirmayer et al., 2018; White et al., 2017). From this perspective, emotions are not simply experienced and reported, but interpreted through shared narratives that give them meaning. However, much of this work remains situated within single cultural or national contexts, offering limited insight into how meanings shift across transnational trajectories. The present findings extend this literature by demonstrating that distress among AIS was actively interpreted through moral, cultural, and relational frameworks that varied across movement, institutional encounter, and return. Across the three studies, students' emotional experiences were shaped not only by what they felt, but by what those feelings signified about

responsibility, endurance, faith, dignity, and social positioning. Distress was evaluated in relation to moral questions such as whether suffering reflected weakness, spiritual testing, failure of resilience, or duty towards others. Importantly, these meanings were not fixed. In Study 1, distress was often reframed through exposure to UK mental health discourse, enabling students to interpret emotional strain as stress, anxiety, or burnout. In Study 2, institutional encounters further reshaped meaning, as professional frameworks privileged certain explanations over others. In Study 3, upon reintegration, earlier moral and spiritual interpretations regained salience, not because emotions changed, but because the frameworks through which they were understood shifted. This demonstrates that distress cannot be treated as a stable psychological object travelling unchanged across contexts.

8.5.2 Emotional Conditionality and the Social Learning of Feeling

A second key theoretical contribution is the introduction of emotional conditionality as an analytic concept for understanding why increased awareness of mental health does not necessarily lead to disclosure or help-seeking. Dominant psychological and educational approaches often assume that emotional regulation and expression are individual capacities that can be strengthened through psychoeducation, skills training, or stigma reduction (Ford & Gross, 2019; Gulliver et al., 2019). Within these models, difficulties with disclosure are frequently attributed to deficits in emotional competence or confidence. Other scholars have begun to question this assumption, arguing that emotional expression is shaped by socialisation, cultural norms, and power relations rather than individual skill alone (Campos et al., 2018; Mesquita et al., 2017). However, this work has rarely examined how emotional regulation is recalibrated across transnational movement or return. The findings of this thesis extend and refine these perspectives by showing that emotions themselves were not conditional: across all three studies, participants consistently recognised their distress internally. What became conditional was the *expression* and *legitimacy* of emotion. Through

repeated social experiences, participants learned when emotional expression was safe, when it was morally risky, and when it should be contained. Emotional regulation therefore functioned not as an internal deficit, but as a socially learned practice shaped by anticipated judgement and relational consequence.

Across the three studies, participants demonstrated highly attuned emotional regulation grounded in long-standing cultural scripts, gendered expectations, religious interpretations, and institutional power. Emotional expression was carefully calibrated in relation to context, audience, and potential outcome. In Study 1, students described experimenting with greater openness in the UK while remaining cautious about over-disclosure. In Study 2, emotional expression was further shaped by professional norms and institutional authority. In Study 3, reintegration prompted a renewed alignment with familiar moral frameworks, leading to selective restraint rather than emotional regression. By tracing emotional conditionality across movement, institutional encounter, and return, this thesis extends emotion socialisation theories by demonstrating that feeling rules are not static but dynamically reactivated and recalibrated in response to social risk. Emotional conditionality thus emerges as an adaptive, meaning-driven process that complicates deficit-based interpretations of silence and non-disclosure. Rather than reflecting lack of emotional awareness, restraint often reflected deep emotional knowledge combined with sensitivity to context and consequence.

8.5.3 Understanding, Sympathy, and Power in Disclosure Processes

A third theoretical contribution lies in distinguishing between understanding and feeling understood, and in demonstrating how this distinction is structured by power. Much mental health literature assumes that increasing mental health knowledge among professionals and institutions will improve disclosure and engagement (Jorm, 2022; Worsley et al., 2022). Within this assumption, understanding is treated primarily as a cognitive achievement: the ability to recognise distress accurately and respond appropriately. More recent relational and

recognition-based scholarship complicates this view by emphasising that care depends not only on knowledge, but on how understanding is communicated (Renedo et al., 2018; O'Reilly et al., 2023). However, the role of sympathy in mediating disclosure remains under-theorised, particularly in cross-cultural and international contexts. The present findings demonstrate that participants' willingness to disclose distress depended not only on whether others understood mental health conceptually, but on whether that understanding was accompanied by visible sympathy. Understanding without sympathy; frequently encountered in professional and institutional settings was often experienced as emotionally insufficient. Participants described feeling that their distress was acknowledged in principle but contained relationally, leading them to conclude that it did not genuinely matter. These challenges assumptions embedded in some professional models that emotional neutrality safeguards ethical practice (Hall et al., 2016). While neutrality may protect boundaries, participants' accounts suggest that it can also reinforce hierarchical relationships in which distress is recognised but emotionally distanced. For students whose emotional expression had long been socially conditional, sympathy functioned as a signal of safety, reducing the perceived cost of vulnerability. Its absence reinforced silence as a protective response. By foregrounding sympathy as a communicative practice rather than an optional interpersonal quality, this thesis extends mental health literacy frameworks beyond knowledge acquisition. It shows that literacy alone cannot facilitate disclosure when it is decoupled from relational recognition. Understanding, sympathy, and power therefore operate as interdependent forces shaping whether emotional knowledge can be voiced, received, and sustained.

8.5.4 Silence as a Contextual and Protective Response

A further theoretical contribution of this thesis lies in its reconceptualisation of silence as a contextual and protective response rather than a deficit, barrier, or failure of engagement. Within much of the contemporary mental health literature, non-disclosure continues to be

interpreted primarily through deficit-based frameworks. Some scholars conceptualise silence as evidence of internalised stigma, limited mental health literacy, or avoidance of help-seeking (Gulliver et al., 2019; Reavley et al., 2020). Within this perspective, disclosure is implicitly positioned as the desirable endpoint of mental health awareness, and silence as a problem to be overcome through education or stigma reduction. Studies focusing on culturally diverse and international populations increasingly note that non-disclosure may reflect concerns about trust, cultural misalignment, or anticipated misunderstanding rather than lack of insight (Byrom et al., 2020; O'Reilly et al., 2023; Watsford et al., 2021). From this viewpoint, silence is not necessarily a marker of disengagement, but may signal a careful assessment of relational and institutional safety. However, even within this emerging literature, silence is often framed as a temporary obstacle on the path toward disclosure, rather than as a meaningful practice in its own right.

The present findings extend and complicate these positions. Across the three studies, participants consistently demonstrated the capacity to recognise and interpret their distress internally, often drawing on psychological frameworks acquired through study abroad, peer interaction, or prior encounters with mental health discourse. Silence did not arise from lack of awareness or conceptual understanding. Instead, it emerged at the point where internal recognition encountered external conditions perceived as morally risky, relationally unsafe, or epistemically misaligned. In this sense, silence functioned not as absence, but as containment.

In Study 1, participants described remaining silent in academic and peer contexts despite increased exposure to mental health awareness initiatives in UK universities. While some scholars argue that such initiatives should naturally reduce non-disclosure by normalising distress (Sawir et al., 2020; Worsley et al., 2022), the present findings suggest a more complex process. Students often assessed disclosure against concerns about appearing weak, incapable,

or undeserving of opportunity. Silence reflected an evaluation of consequence rather than a rejection of mental health knowledge. This challenges models that treat disclosure as a direct outcome of awareness and supports critiques that emphasise the moral and relational dimensions of speaking about distress (Byrom et al., 2020). Study 2 further complicates deficit-based interpretations by showing how silence is shaped within institutional encounters. While some clinical and educational frameworks assume that access to services and culturally informed practice will reduce non-disclosure (Metzl & Hansen, 2019), participants' accounts revealed that emotional neutrality, standardised assessment practices, and limited engagement with moral or spiritual meaning-making often constrained expression. In these contexts, silence and selective disclosure functioned as responses to partial recognition. Rather than withdrawing from care, students adjusted their narratives to fit what they believed institutions could safely receive. This finding aligns with emerging critiques of procedural approaches to cultural competence, which argue that recognition without relational attunement may inadvertently reinforce power asymmetries (Renedo et al., 2018; O'Reilly et al., 2023).

The protective function of silence became most visible in Study 3, during reintegration. Returnee participants described recalibrating their emotional expression as familiar moral frameworks regained authority. Some reintegration research frames such patterns as regression or difficulty readjusting (Cairns, 2021). However, the present findings suggest a different interpretation. Psychological understandings acquired abroad were retained internally, but public expression was selectively muted in response to stigma, moral judgement, and concerns about family reputation. Silence was associated with dignity, faith, maturity, and self-respect, while overt disclosure risked social sanction. This pattern demonstrates that silence can coexist with high levels of emotional insight and reflective understanding, challenging assumptions that reintegration difficulties stem from diminished awareness.

By conceptualising silence as contextual and protective, this thesis advances recent calls to move beyond binary distinctions between disclosure and suppression (Kirmayer et al., 2021; O'Reilly et al., 2023). It shows that silence can serve as a means of preserving coherence between internal meaning-making and external expectation, particularly in environments where emotional expression remains morally charged or epistemically unsafe. Importantly, this reframing does not romanticise silence or deny its potential psychological costs. Rather, it situates silence within the broader processes of emotional conditionality, recognition, and power that shape when speaking becomes possible, safe, and worthwhile. In doing so, the thesis contributes a more nuanced theoretical account of non-disclosure that neither pathologises silence nor treats disclosure as universally desirable. Instead, it positions silence as an intelligible response within transnational lives marked by shifting moral orders, unequal institutional authority, and culturally contingent modes of recognition. This perspective invites mental health research and practice to attend less to whether individuals speak, and more to the conditions under which speech becomes meaningful. It is important to note that the conceptualisation of silence developed in this thesis was derived primarily from participants' accounts of non-disclosure and selective disclosure rather than from a formal linguistic or discourse analysis of interview interactions. Although moments of hesitation, pauses, and careful wording were occasionally observed during interviews, these features were not systematically analysed as communicative data. The interpretation of silence presented here therefore refers principally to the meanings participants attached to withholding, limiting, or managing emotional disclosure within different social and cultural contexts.

8.6 Limitations and Directions for Further Research and Policy Development

As with all qualitative and contextually grounded research, the contributions of this thesis are shaped by its scope, epistemological commitments, and methodological choices. Rather than

representing shortcomings, these limitations reflect deliberate analytic decisions aligned with the study's critical constructivist and intersectional framework. At the same time, the findings generate important directions for further research and policy development that extend beyond what a single thesis can reasonably address.

A first consideration concerns the cultural, linguistic, and religious specificity of the study. This research focused on AIS and returnees, drawing primarily on Arabic, French, and English linguistic repertoires, and on Islamic moral frameworks as they were lived and interpreted by participants. Some feedback has raised the question of whether mental health services can realistically engage with all religions and languages, and whether such expectations are pragmatic. The findings of this thesis do not suggest that institutions should attempt exhaustive representation of every religious or linguistic tradition. Rather, the data indicate that distress becomes intelligible and support becomes effective when services are capable of recognising and engaging with meaning making processes that matter to the populations they serve. This points not toward total coverage, but toward responsive and situated models of care. In this sense, the contribution of the thesis lies in demonstrating why a one size fits all approach to cultural competence is insufficient, and why flexibility, dialogue, and relational responsiveness are more realistic goals than encyclopaedic knowledge.

Importantly, the findings suggest that meaningful engagement with religious and linguistic diversity does not require professionals to be experts in theology or multilingualism. Instead, it requires institutional conditions that allow for co interpretation of distress, respectful curiosity, and referral pathways that acknowledge non biomedical forms of support when these are important to students. Existing examples of such approaches can already be found in related sectors, including community mental health, refugee services, and trauma informed care, where cultural mediators, peer supporters, and faith informed partnerships are used to bridge gaps between lived experience and formal services. Future policy development in

higher education could draw on these models rather than attempting to replicate all forms of cultural knowledge internally.

A second scope boundary relates to the absence of religious healers and spiritual leaders, particularly Imams, as direct participants in the research. Participants across all three studies frequently described consulting Imams or other religious figures before or alongside professional mental health services. Their exclusion from the present research does not undermine the findings, but it does point toward an important direction for future inquiry. Including religious leaders would allow further examination of how religious interpretations of distress are constructed, contested, or reinterpreted within religious institutions themselves. Such research could clarify the extent to which explanations such as possession, divine testing, or moral weakness are rooted in religious doctrine or in culturally transmitted understandings of religion. From a policy perspective, this direction is particularly significant. The findings suggest that collaboration between mental health professionals and religious leaders may be more effective than attempting to replace spiritual frameworks with biomedical ones. Further research could explore models of cooperative engagement, training, or referral that respect religious authority while reducing stigma and misinformation. This would not require mental health services to adopt religious roles, but to acknowledge existing pathways of trust and influence within communities.

A further boundary concerns the temporal design of the study. While the research captured experiences across study abroad, institutional encounter, and reintegration, it did not follow the same individuals longitudinally over time. The findings nevertheless indicate that mental health literacy, emotional expression, and disclosure practices are not static, but recalibrated across contexts. Future longitudinal research could deepen understanding of how these processes unfold, stabilise, or shift over longer periods, particularly during key transitions such as graduation, prolonged return, or entry into employment. In addition, although the

thesis engaged deeply with cultural, linguistic, and epistemic dimensions, it did not systematically disaggregate experiences by gender, class, or region within Algeria. Participants' accounts indicate that these factors intersect with moral expectations, stigma, and access to support. Further intersectional research would strengthen understanding of how vulnerability and protection are unevenly distributed within Algerian student populations, and how institutional responses might better reflect this variation.

A specific limitation of focusing on the professional sample and did not include religious or traditional healers, such as imams, *ruqyah* practitioners, *raqi*, or other community figures who may be consulted in relation to emotional or psychological distress. The study instead focused on professionals with and without prior experience of supporting Algerian or Arab international students. This sampling decision enabled comparison between professional perspectives shaped by direct cultural experience and those developed without such experience; however, it limited the range of explanatory and support systems represented in the study. Religious and traditional healers may play an important role in how some Algerian and Muslim individuals understand and respond to distress, particularly where difficulties are interpreted through spiritual concepts such as the evil eye, *jinn*, religious testing, or perceived weakness of faith. Their inclusion could therefore have provided further insight into the relationship between spiritual explanations, community-based support, psychological understandings, and formal help-seeking. It may also have clarified whether religious support operates alongside professional mental health care, provides an alternative to it, or contributes to delays in accessing clinical services in particular circumstances. Nevertheless, identifying religious healers who could speak specifically about Algerian international students in the United Kingdom would have been difficult. Muslim religious leaders and healers in the UK represent diverse national, linguistic, cultural, theological, and denominational backgrounds. A religious practitioner's familiarity with Muslim communities generally would not

necessarily indicate knowledge of Algerian cultural meanings, Algerian Arabic or French expressions, family structures, migration histories, or the specific circumstances of Algerian students. Interpretations may also vary according to theological orientation, religious training, healing tradition, and views concerning the relationship between spiritual distress and psychological or psychiatric care. Including a small and internally diverse group of healers could therefore have risked presenting individual religious interpretations as representative of Algerian or Muslim perspectives more broadly.

There were also conceptual and methodological reasons for maintaining a more clearly defined professional sample. Study 2 sought to examine how individuals working within or alongside formal support systems understood the mental health experiences and service needs of Algerian and Arab international students. Religious and traditional healers may operate according to different epistemological, therapeutic, and institutional frameworks. Their understandings cannot be assessed appropriately solely against biomedical or psychological standards, nor should religious interpretations automatically be regarded as equivalent to clinical assessment. Combining these groups within one sample could therefore have reduced conceptual clarity and made meaningful comparison difficult without a separate research design addressing their distinctive roles, practices, training, accountability, and relationships with formal services. The absence of religious and traditional healers means that Study 2 primarily represents perspectives associated with professional and institutional support and does not fully capture the broader network through which Algerian students may seek help. The findings should consequently not be interpreted as representing all culturally or religiously available forms of support. Future research could address this limitation through a separate study involving Algerian or North African imams, religious counsellors, traditional healers, community leaders, mental health professionals, and service users. Such research could examine areas of agreement and tension between spiritual and psychological

explanations, referral practices between religious and clinical services, and the conditions under which religious support complements or discourages professional help-seeking.

These limitations suggest that the contribution of this thesis lies not in offering a universal model of international student mental health, but in demonstrating why such universality is neither feasible nor desirable. The findings support a shift toward context responsive, dialogical, and relational approaches to care that recognise limits as starting points for collaboration rather than failures of inclusion. By identifying how meaning, recognition, and power shape emotional expression, this research provides a foundation upon which future studies and policies can build more realistic and ethically grounded forms of support.

8.7 Chapter Conclusion

This chapter has synthesised findings from three interconnected qualitative studies to interpret AISs' mental health experiences across the United Kingdom and Algeria. Grounded in a critical constructivist and intersectional epistemology, the discussion reframed distress, disclosure, and coping as culturally mediated and relationally situated processes rather than as individual psychological deficits.

The analysis demonstrated that increased awareness of mental health did not automatically lead to disclosure or help seeking. Instead, emotional expression was shaped by conditionality, moral evaluation, linguistic intelligibility, and the presence or absence of sympathetic recognition. Silence, code switching, and selective disclosure emerged not as failures of literacy, but as meaningful responses to environments where emotional expression carried social and moral consequences. By placing students' accounts alongside those of mental health professionals, the chapter highlighted how institutional practices can unintentionally reproduce misrecognition, particularly when emotional neutrality, standardisation, or limited cultural engagement constrain relational trust. The chapter also showed how reintegration

intensified epistemic tension, as psychological understandings acquired abroad encountered moral and spiritual frameworks at home, leaving many returnees navigating internal clarity alongside external restraint. Overall, the discussion argued for a more dialogical and context responsive approach to international student mental health. One that recognises affective expression, religious idioms, multilingual practices, and silence as legitimate forms of emotional knowledge. In doing so, this chapter laid the groundwork for the final chapter of the thesis, which will draw together the study's overall contributions, implications, and recommendations for research, policy, and practice.

Chapter 9

General Conclusion and Recommendations

9.1 Introduction

This chapter brings together the findings, interpretations, and theoretical contributions of the thesis. Drawing on three interconnected qualitative studies, the research examined how AISs understood psychological distress, negotiated disclosure, and managed wellbeing across study abroad in the United Kingdom, encounters with mental health professionals, and reintegration into Algerian contexts. Rather than treating mental health as a universal or purely clinical phenomenon, the thesis adopted a critical-constructivist and intersectional approach to explore how emotional experience is shaped by culture, language, morality, and power across transnational trajectories. The purpose of this chapter is fourfold. First, it provides a concise synthesis of the key findings across the three studies. Second, it summarises the central theoretical contributions of the thesis. Third, it outlines practical recommendations for policy, practice, and higher education that follow directly from the findings. Finally, it offers closing reflections on the significance of the research and its contribution to international student mental health scholarship.

9.2 Summary of Key Findings Across the Three Studies

Across the three studies, a consistent pattern emerged: AISs did not lack awareness of psychological distress, nor were they uniformly resistant to support. Instead, distress, disclosure, and coping were shaped by socially situated meaning-making processes that varied across context, audience, and perceived consequence. Study 1 demonstrated that exposure to UK academic and social environments expanded students' mental health awareness and emotional vocabulary. Participants learned to recognise experiences such as anxiety, stress,

and emotional exhaustion through peer discourse, institutional messaging, and wellbeing initiatives. However, this increased awareness did not translate straightforwardly into disclosure or formal help-seeking. While this finding may partly reflect the study's sampling criteria, the exclusion of students experiencing severe mental health difficulties or currently receiving professional treatment was an intentional ethical decision. The study was not designed as a clinical investigation, and the researcher was not positioned as a qualified mental health practitioner able to provide therapeutic intervention if significant distress arose during interviews. Excluding participants currently experiencing severe difficulties therefore reduced the risk of harm and ensured that the research remained within its ethical and methodological scope. At the same time, this exclusion should not be understood as invalidating the finding that increased awareness did not necessarily lead to disclosure or formal help-seeking. Existing research indicates that stigma, shame, fear of judgement, and cultural expectations can discourage disclosure and delay professional help-seeking, particularly within Arab, Muslim, and culturally minoritised communities (Ciftci et al., 2013; Al-Krenawi, 2022; Elshamy et al., 2023; Fekih-Romdhane et al., 2023). In the Algerian context, professional support may also be approached as a last resort, with individuals often turning first to family, religious coping, or informal support. Therefore, the absence of participants currently receiving treatment does not necessarily mean that the relationship between awareness, disclosure, and help-seeking was artificially produced by the sample. Rather, it reflects a broader cultural and ethical context in which distress may be recognised privately while still being withheld socially or professionally. Nevertheless, this remains an important limitation. Future research could include AIS who have previously accessed counselling or mental health services after completing treatment or reaching a more stable stage of recovery. Such research could provide valuable insight into how students retrospectively evaluate professional support and whether increased awareness translated into help-seeking under different circumstances. Emotional expression remained shaped by moral concerns related to strength, gratitude, faith,

and family responsibility. Study 2 revealed how these meanings were further negotiated within institutional encounters. Although many mental health professionals demonstrated cultural awareness and goodwill, students often experienced partial recognition. Emotional neutrality, standardised practices, and limited engagement with moral or spiritual frameworks led students to narrow or regulate disclosure. Silence and selective expression functioned as strategies for navigating institutional power rather than indicators of disengagement. Study 3 highlighted the complexities of reintegration following return to Algeria. Psychological understandings acquired abroad were retained internally, but public expression of distress became more constrained as familiar moral, religious, and social expectations regained authority. Participants described heightened caution around disclosure, not as a loss of insight, but as a recalibration of expression in response to renewed stigma and relational risk. Reintegration therefore intensified epistemic tension rather than resolving it.

Therefore, the findings showed that emotional expression among AISs was conditional rather than spontaneous. Disclosure depended not only on awareness, but on the availability of recognition, sympathetic response, and culturally intelligible meaning.

9.3Overall Theoretical Contributions

This thesis makes four interrelated theoretical contributions to international student mental health research. These contributions move beyond deficit-based and universal models in several concrete ways. First, rather than treating distress as evidence of individual vulnerability, lack of resilience, or insufficient mental health literacy, the analysis suggests that many AIS participants demonstrated considerable emotional awareness and interpretive capacity. Participants were often able to recognise, reflect upon, and make sense of their emotional experiences using a range of psychological, cultural, religious, and social frameworks. What constrained disclosure was not necessarily ignorance or denial, but socially learned assessments of moral risk, relational consequence, and epistemic safety. This

repositions silence, hesitation, and selective disclosure not as failures to engage, but as intelligible responses to environments in which emotional expression carried social or institutional costs.

Second, universal models often assume that mental health knowledge functions as a stable resource that, once acquired, travels unchanged across contexts. In contrast, this thesis shows that knowledge was continually recalibrated as students moved between cultural, institutional, and national settings. Psychological concepts acquired in the UK did not lose relevance upon return to Algeria, but their public expression became constrained by renewed moral expectations, stigma, and concerns about misrecognition. Mental health literacy therefore emerged not as a fixed competence, but as a context-dependent practice shaped by power and legitimacy.

Third, deficit-based frameworks typically locate barriers to help-seeking within individuals or cultures, framing non-disclosure as resistance, stigma internalisation, or maladaptive coping. By contrast, this thesis locates the conditions of disclosure within relational and institutional structures. Professional neutrality, standardised practices, and culturally narrow modes of recognition were shown to shape whether students felt emotionally received, even in settings where services were formally accessible. In doing so, the analysis shifts explanatory weight away from individual or cultural shortcomings and toward the social organisation of care.

Finally, grounding the analysis in lived experience across study abroad, institutional encounter, and reintegration enables a transnational account of mental health that resists universal developmental narratives. Rather than depicting international education as a linear trajectory toward openness or psychological integration, the findings reveal cycles of expansion, constraint, comparison, and recalibration. Emotional meaning-making unfolded

across movement and return, producing neither assimilation nor regression, but ongoing negotiation. It is through this attention to lived experience across contexts that the thesis offers a relational and transnational alternative to universalist mental health models.

9.4Implications and Recommendations

The findings of this thesis have clear implications for mental health policy, professional practice, and higher education pedagogy. Crucially, these implications do not call for the exhaustive representation of all cultural, linguistic, or religious traditions. Rather, they point to the need for systems that are relationally flexible, epistemically reflexive, and responsive to how distress is understood and expressed across contexts. The recommendations offered here are therefore grounded in what the data reveal about conditions of recognition, rather than in abstract ideals of cultural coverage.

9.4.1 Policy Implications

At the policy level, this research calls for a shift away from universal, biomedical assumptions that treat international student mental health primarily as an issue of individual vulnerability or service uptake. Across the three studies, AISs demonstrated awareness of distress and familiarity with mental health concepts, yet their willingness to engage with services depended on whether these services could recognise distress in culturally and morally intelligible ways. Policy frameworks that prioritise access without attending to recognition risk reproducing exclusion under the guise of inclusion. Rather than attempting to accommodate all religions or languages within formal policy, institutions should prioritise *procedural openness*. This includes flexible assessment protocols, referral pathways that allow movement between psychological, pastoral, and community-based support, and policies that legitimise collaboration with faith-informed or culturally embedded resources where appropriate. Such an approach recognises that students may move between explanatory frameworks without requiring institutions to become experts in each one. Cross-national

coordination between host and home institutions is particularly important. The findings from Study 3 show that reintegration is a critical yet under-supported phase, during which psychological understandings acquired abroad may lose public legitimacy. Policy mechanisms that support continuity of care; such as information sharing, transitional guidance, or reintegration-focused wellbeing initiatives could mitigate epistemic dissonance and reduce isolation upon return. Importantly, these recommendations do not assume that policy can resolve cultural tension. Rather, they aim to create conditions in which students are not required to abandon meaningful frameworks of understanding in order to access support.

9.4.2 Implications for Professional Practice

For mental health practitioners and university support staff, the findings underscore that disclosure is shaped as much by relational safety as by awareness. Across the studies, participants did not describe uncertainty about whether they were distressed, but uncertainty about how their distress would be received. This has direct implications for professional interaction. Training programmes should therefore move beyond static models of cultural competence and towards relational and reflexive practice. Practitioners need support in recognising silence, hesitation, and code-switching as meaningful communicative acts rather than as resistance or disengagement. Emotional neutrality, while ethically motivated, should be applied reflexively rather than assumed to be universally reassuring. For students whose emotional expression has long been socially conditioned, neutrality may signal distance rather than safety.

The findings also point to the value of intermediary roles, such as cultural mediators, peer supporters, or liaison staff, who can help bridge epistemic gaps without requiring clinicians to master all cultural or religious frameworks. These roles already exist in some health and refugee-support sectors and offer a pragmatic model for higher education settings. Overall,

professional practice informed by this research would prioritise *how* understanding is communicated, not only *what* is understood.

9.4.3 Pedagogical Implications

Within higher education, this thesis challenges narrow conceptions of mental health literacy as the acquisition of biomedical knowledge. The findings suggest that literacy functions as a cultural and narrative competence, shaped by language, morality, and context. Pedagogical approaches that focus solely on symptom recognition risk overlooking how students make sense of distress within their own interpretive worlds. Universities should therefore integrate reflexive mental health education into induction, advising, and support structures. Such initiatives should invite students to articulate their own understandings of wellbeing and coping, rather than positioning Western psychological frameworks as the default or endpoint. This does not require replacing clinical models, but situating them alongside other forms of meaning-making. Pedagogy should also attend to language. Allowing multilingual expression in reflective or support-oriented contexts can enhance emotional articulation and recognition, particularly during periods of transition. Finally, reintegration should be recognised as an educational as well as psychological process. Students returning home may require structured spaces to reflect on epistemic change, identity negotiation, and the reconfiguration of emotional expression.

9.5 Final Reflections

This thesis has demonstrated that understanding international student mental health requires attention not only to services, knowledge, or attitudes, but to the conditions under which emotional meaning can be expressed, recognised, or withheld. By foregrounding emotional conditionality, recognition, language, and power, the research offers a relational account of distress that is grounded in lived experience across transnational contexts. Rather than portraying AISs as reluctant or deficient help-seekers, the findings show that silence, restraint,

and selective disclosure often reflect sophisticated responses to morally and relationally complex environments. Emotional expression was shaped not by lack of insight, but by careful assessments of consequence, legitimacy, and safety. In this sense, non-disclosure emerges not as absence, but as strategy. Additionally, professional, and returnee perspectives, the thesis highlights how institutional practices, linguistic norms, and moral expectations interact to shape mental health experience across movement and return. It also shows how international education does not produce linear psychological transformation, but ongoing negotiation between multiple systems of meaning.

In recognising the sociocultural and epistemic plurality of distress, this research contributes to broader efforts to de-centre universalist mental health models within globalised higher education. It calls for approaches that do not simply seek to increase disclosure, but that attend to the relational and structural conditions under which speaking becomes possible, safe, and worthwhile. In doing so, the thesis advances a more ethical, inclusive, and context-sensitive framework for understanding and supporting international student wellbeing.

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Appendices

Ethics: 64/27/05/2020/A

Appendix A: Participant Information Sheet

Study 1

This appendix presents the informed consent form used in the study. Participants confirmed that they had read and understood the Participant Information Sheet, were aware of their right to withdraw, and consented to participation and audio recording.

Participant Information Sheet

Name of department: School of Psychological Sciences and Health Title of the study: Understanding mental health, disclosure and help seeking behaviour of Algerian international students

Introduction

You are being invited to take part in a research study. Before deciding to participate, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. This study is conducted by Nesrine Boussaoui, a PhD student, supervised by Dr Steve Kelly and Dr Nicola Cogan.

What is the purpose of this research?

Psychological distress among higher education students has been shown to sometimes be higher among international students; however, little is known about the Algerian international students experience in the UK universities, and very little is known about the potential unique aspects of Algerian culture as it applies to acculturation of students and their mental health and wellbeing as international students. This study aims to explore Algerian international students' experience in Scottish universities by understanding their experience and understanding of mental wellbeing, ideas about seeking help for such issues, and possible coping strategies.

Do you have to take part?

No, you do not have to take part in this research.

Your participation is voluntary and entirely confidential. Even if you accept to take part in the study, you are still able to withdraw from the study at any time, and you are not required to provide a reason. To ensure confidentiality, the interview data will be anonymised immediately upon finishing the interview and all quotes(extract from the interviews) that are going to be used in reports/publications will be reviewed by the researchers to make sure that no personally identifiable information is included. It will not be possible to remove such anonymised data from the study.

What will you do in the project?

If you are willing to participate in the project, please write your name on the consent from and email it back to the researcher. They will then contact you to finalise a date and time for the interview. One day before the interview, they will email you a short questionnaire to complete which will be screened by a therapeutically trained member of the research study. This is to ensure that you are not experiencing issues which may be exacerbated by discussion in the actual interview. This questionnaire will be destroyed immediately once it has been seen by the researcher undertaking the screening. If this measure shows anything which may indicate any issue, the researcher will get in contact with you to discuss what this might mean for you.

You are going to attend an online/ telephone interview with the researcher Nesrine Boussaoui. The interview will not take more than 60 minutes, and if it does, you will be asked to take a break of 10 minutes. You will be asked open-ended questions about a fictional character's mental health and coping strategies, in addition to your knowledge about mental health and the way it is expressed in your home country. You will receive the case scenario one hour before the interview.

Please try to find somewhere in your home if you are still self-quarantined or any private space to participate in the interview. Please remember that you are not obliged to answer all the questions and that you can skip questions that you consider sensitive or stop the interview at any time without providing a reason.

Zoom video call will be used to conduct the interview online. This is a secure platform which features end-to-end encryption of data, requires a password to enter the interview session, and the ability to lock the session once the interview has begun to ensure that no other person can join the interview.

Who is eligible to take part?

You are able to take part in this study if you are: (1) aged over 18 years old; (2) a full time Algerian international student; (3) studying at a Scottish university; (4) have been living in the UK for at least three months; (5) reasonably fluent in English (5.5 or above on IELTS as required by the universities the participants are enrolled in); (6) able to provide informed consent to your participation in the study.

You are not eligible for this study if you are experiencing a severe and/or enduring mental health problem or are under medical treatment for a mental health illness.

What are the potential risks to you in taking part?

Although participants may not currently be experiencing any mental health issues, consideration of the topic may raise issues or concerns for yourself or others. You may stop the interview or withdraw

from the study at any time without having to give a reason and if you would like to speak to someone about any concerns or issues, your University's wellbeing service will be a point of contact, as well as contacting your medical service (e.g. local g.p. or University medical service). You will also be provided with a list of national mental health helplines for immediate or future reference.

What information is being collected in the project?

This researcher will be collecting qualitative data for the purpose of understandings the distinctive experiences of Algerian international students' mental health, disclosure and help seeking strategies at Scottish universities. The data collected are going to be first audio recorded and then transcribed.

Who will have access to the information?

The data will not be shared with anyone other than the three researchers named on the form. (Nesrine Boussaoui, Steve Kelly, Nicola Cogan)

Where will the information be stored and how long will it be kept for?

All interviews will be recorded on either the telephone used to make the call or the computer used for online meeting. These will be uploaded to OneDrive (a secure and encrypted storage service provided by the University of Strathclyde) and deleted from local devices. The researcher will transcribe the recordings to electronic documents stored on OneDrive. These data will be kept securely on OneDrive for five years following the end of the interviews after which time they will be deleted. If you would like to receive a summary of the full results of the study, please email Nesrine Boussaoui.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants

What happens next?

If you are happy to be involved in this project, you will be invited to attend a one to one online/telephone interview with the researcher. Please email Nesrine Boussaoui (details below) with a signed (name written on document) copy of the consent from to arrange a time and date for the interview or to ask any questions you may have. If you want to receive a brief copy of the results after the investigation is completed, you may inform the researcher and a summary will be sent to your contact details. If you decided not to be involved in the project, we would like to thank you for your interest and time in reading the information.

Researcher contact details:

Miss Nesrine Boussaoui PhD

researcher

School of Psychological Sciences and Health University

of Strathclyde Glasgow

Email: nesrine.boussaoui@strath.ac.uk

Tel: (+44) 07840819082

Chief Investigator details:

Dr Steve Kelly

Department: School of Psychological Sciences and Health

Telephone: 0141 548 4880

E-mail: steve.kelly@strath.ac.uk

Address: Room 5.95, School of Psychological Sciences and Health, University of Strathclyde, Graham Hills Building, 40 George Street, Glasgow G1 1QE

Co-investigator

Dr Nicola Cogan

Department: School of Psychological Sciences and Health Telephone:

0141 548 2580

E-mail: nicola.cogan@strath.ac.uk

Address: Room 6.79, School of Psychological Sciences and Health, University of Strathclyde, Graham Hills Building, 40 George Street, Glasgow G1 1QE

This research was granted ethical approval by the School Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Dr Susan Rasmussen
Chair of The School of Psychological Sciences and Health Ethics
Committee School of Psychological Sciences and Health University of
Strathclyde
Graham Hills Building
40 George Street, Glasgow, G1 1QE Telephone:
0141 548 2575
Email: hass-psh-ethics@strath.ac.uk

Consent Form

Name of department: School of Psychological Sciences and Health

Title of the study: Understanding mental health, disclosure and help seeking behaviour of Algerian international students

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.
- I consent to being audio recorded as part of the project

Please type your name in below to indicate agreement with the above statements and email this from to Nesrine Boussaoui nesrine.boussaoui@strath.ac.uk

Type name here:

Study 2

Participant Information Sheet

Name of department: School of Psychological Sciences and Health
Title of the study: Understanding mental health, disclosure and help seeking behaviour of Algerian/ Arab international students in UK universities

Introduction

My name is Nesrine Boussaoui and I am PhD researcher at the University of Strathclyde. The study involves developing a greater understanding of mental health awareness and barriers to seeking help for psychological difficulty in Algerian and Arab students. My supervisors are Dr Steve Kelly and Dr Nicola Cogan.

What is the purpose of this research?

Psychological distress among higher education students has been shown to be higher among international students in general. All students including Algerian/Arab students may have specific difficulty in adapting to an unfamiliar environment which does not contain similar traditional therapies and understandings of mental health.

The aim of this study is to learn from university mental health providers and professionals of any differences that may exist between Algerian/ Arab international students in terms of mental health understanding, disclosure, and help seeking behaviours as it applies to acculturation of students and their mental health and wellbeing

Do you have to take part?

No, you do not have to take part in this research.
Your participation is voluntary and entirely confidential. Even if you accept to take part in the study, you are still able to withdraw from it at any time, and you are not required to provide a reason. To ensure confidentiality, the interview data will be anonymised immediately after finishing the interview and all quotes (extracts from

the interviews) that may be used in reports/publications will be reviewed by the researchers to make sure that no personally identifiable information is included. It will not be possible to remove such anonymised data from the study.

What will you do in the project?

You will be invited to attend an online interview with the researcher, Nesrine Boussaoui. The interview should not take more than 60 minutes, but if it does, you will be offered a break. You may also take breaks during the interview whenever you wish. You will be asked open-ended questions about a fictional character's mental health and coping strategies, and about your knowledge and experience concerning mental health and the ways it is viewed and expressed in different countries/ cultures. You will receive Consent PIS form / summary of the interview schedule through your manager; however, by confirming your consent to take part in this study, both the interview schedule + the demographic survey will be shared with you one hour before the interview to give time to consider how you wish to answer the questions or to prepare any questions before we start the interview.

Zoom video call will be used to conduct the interview online. You may choose to have the video component switched on or off. This is a secure platform which features end-to-end encryption of data, requires a password to enter the interview session, and the ability to lock the session once the interview has begun to ensure that no other person can join the interview.

Who is eligible to take part?

You have been invited because you are: 1) Employed as a university well-being provider, 2) experienced with students' mental health, 3) experienced professionals with Algerian/ Arab students' mental health.

You are not eligible for this study if you have no experience with Algerian/ Arab students' mental health and well-being.

What are the potential risks to you in taking part?

Discussions of previous experiences may in some cases be distressing. You are reminded that you have the right to end the interview or withdraw from the study at any moment without giving a reason. It may also be beneficial to contact your line manager or to use your clinical supervision process if available to address any concerns that occur as a result of your responses or reflections on your answers to the questions discussed.

What information is being collected in the project?

This researcher will be collecting qualitative data for the purpose of understandings the distinctive experiences of Algerian/ Arab international
students' mental health, disclosure and help seeking strategies at UK universities. The data collected are going to be first audio recorded and then transcribed.

Who will have access to the information?

The data will not be shared with anyone other than the three researchers named on the form. (Nesrine Boussaoui, Steve Kelly, Nicola Cogan)

Where will the information be stored and how long will it be kept for?

All interviews will be recorded on zoom with the help of a backup handheld recorder (Olympus handheld device with no wireless internet connection used to record interviews), that will be placed next to the laptop to be used to cover any technical issue that may happen during recording the interview via the laptop. These recordings will be uploaded to OneDrive (a secure and encrypted storage service provided by the University of Strathclyde) and all recordings will be deleted from local devices (computer and the backup recorder). The researcher will transcribe the recordings to electronic documents stored on OneDrive and delete the recordings and only keep the transcripts. These data will be kept securely on OneDrive for five years following the end of the interviews after which time they will be deleted. If you would like to receive a summary of the full results of the study, please email Nesrine Boussaoui.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

Please also read our Privacy Notice for Research Participants

What happens next?

If you are happy to be involved in this project, you will be invited to attend a one to one online interview with the researcher (in case of any issue with this, a telephone interview may be used as an alternative). Please email Nesrine Boussaoui (details below) with a signed (name written on document) copy of the consent form to arrange a time and date for the interview or to ask any questions you may have. If you want to receive a brief copy of the results after the investigation is completed, you may inform the researcher and a summary will be sent to your contact details. If you decide not to be involved in the project, I would like to thank you for your interest and time in reading the information.

Researcher contact details:

Miss Nesrine Boussaoui

PhD researcher

Graduate School

Lord Hope Building

University of Strathclyde Glasgow Email:

nesrine.boussaoui@strath.ac.uk

Chief Investigator details:

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Co-investigator

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E-mail: nicola.cogan@strath.ac.uk

This research was granted ethical approval by the School of Psychological Sciences and Health Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Dr Susan Rasmussen
Chair of The School of Psychological Sciences and Health Ethics Committee School of Psychological Sciences and Health
University of Strathclyde
Graham Hills Building
40 George Street, Glasgow, G1 1QE
Email: hass-psh-ethics@strath.ac.uk

Consent Form

Name of department: School of Psychological Sciences and Health

Title of the study: Understanding mental health, disclosure and help seeking behaviour of Algerian/ Arab international students

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I am aware of the Privacy Notice for Research Participants
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.
- I consent to being audio/ video recorded as part of the project

Please type your name in below to indicate agreement with the above statements and email this form to Nesrine Boussaoui nesrine.boussaoui@strath.ac.uk

Type name here:

Study 3

Participant Information Sheet

Name of department: School of Psychological Sciences and Health

Title of the study: Understanding mental health, disclosure and help seeking behaviour of post graduate Algerian international students going back home.

Introduction

I would like to invite you to take part in a research project. Before you decide to do so, it is important to you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. This study is being conducted by Nesrinr Boussaoui PhD researcher, supervised by Dr. Steve Kelly (steve.kelly@strath.ac.uk); and Dr. Nicola Cogan (nicola.cogan@strath.ac.uk), from the School of Psychological Sciences and Health at the University of Strathclyde.

What is the purpose of this research?

Previous research has shown that psychological distress is common among Higher Education (HE) students, but little research has examined mental health or help-seeking knowledge and experiences among Algerian international students in UK universities. This research project is a continuation of two previous research projects that examined these factors in Algerian students in the UK and wellbeing professionals at UK Higher Education institutions. It explores concerns of Algeria international students in terms of disclosing mental health, issues in and seeking help for mental health when back in their home country after finishing studies.

Do you have to take part?

No, you do not have to take part in this research.

Your participation is voluntary and entirely confidential. Even if you accept to take part in the study, you are still able to withdraw from the study at any time, and you are not required to provide a reason. To ensure confidentiality, the interview data will be anonymised and no personal information that could identify an individual will be published. It will not be possible to remove such anonymised data from the study.

What will you do in the project?

If you decide that you would like to participate, you will be asked to sign a consent form (type /write your name) and send it back to the researcher. You will first be invited for CORE-10 Screening Measure interview (Clinical outcomes routine evaluation) to make sure that you are not suffering from any psychological problems one hour before the study interview. This won't last more than 10 or 15 minutes.

One of the therapeutically trained investigators(Steve Kelly & Nicola Cogan) will screen your answers to the CORE-10 and decide whether you are exhibiting any sign of mental distress or not and able to participate in the interview or not. If the CORE-10 shows any scores which may be of concern, this will be discussed directly with the you, either by SK or NC.

If you don't show any level of distress, then you will directly receive the interview schedule and the demographic questionnaire of the study one hour before the interview, then will be interviewed by the researcher BN; however, if you show any level of distress you will be immediately followed up by

either SK or NC and they may help if support is needed and provide where that support maybe found.

The interview will last approximately 50 minutes. You will be interviewed about a hypothetical character and your understanding to the scenario as well as about mental health literacy, difficulties to disclosure and coping strategies that are adapted and learnt in UK universities and how you think they could be used in your home country.

Why have you been invited to take part?

You are being invited to take part in this study because:

You are: 1) aged over 18 years; 2) an Algerian international student, finished with international study and has returned home; 3) a student of a UK university 4) returned stay period of 6 months and maximum of 5 years.

You are not eligible for this study if you are: 1) an Algerian international students who studied remotely from your home country; 2) an Algerian international students who is resident again in Algeria for less than 6 months or more than 5 years; 3) currently under mental health care/receiving treatment for mental health.

What are the potential risks to you in taking part?

Although participants may not currently be experiencing any mental health issues, consideration of the topic may raise issues or concerns for yourself or others. You may stop the interview or you may choose not to answer any question during the interview or even withdrawing from the study at any time without having to give a reason and if you would like to speak to someone about any concerns or issues, you will be reminded to seek help from your GP or call **34342 and 43** to find mental health support.

What information is being collected in the project?

This researcher will be collecting qualitative data (responses to hypothetical scenario, some demographic data, your mental health understanding, difficulties for help seeking behaviour and coping strategies) for the purpose of exploring the concerns of Algeria international students experience after finishing their studies and going back home.

Who will have access to the information?

The data will not be shared with anyone other than the three researchers named on the form.
(Nesrine Boussaoui, Steve Kelly, Nicola Cogan)

Where will the information be stored and how long will it be kept for?

All interviews will be recorded on zoom with the help of a backup handheld recorder (Olympus handheld device with no wireless internet connection used to record interviews), that will be placed next to the laptop to be used to cover any technical issue that may happen during recording the interview via the laptop. These recordings will be uploaded to OneDrive (a secure and encrypted storage service provided by the University of Strathclyde) and all recordings will be deleted from local devices (computer and the backup recorder). The researcher will transcribe the recordings to electronic documents stored on OneDrive and delete the recordings and only keep the transcripts.

These data will be kept securely on OneDrive for five years following the end of the interviews after which time they will be deleted.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

All personal data will be processed in accordance with data protection legislation. Please read our Privacy Notice for Research Participants for more information about your rights under the legislation. *[provide paper copy if PIS is provided in paper format. Remove if you are not collecting any personal data – i.e. only collecting anonymous data with no consent form]*

What happens next?

If you are happy to be involved in this project, you will be asked to first sign the PIS form and send it back to the researcher, and arrange the suitable time for you to do the interview with the researcher.

Then you be invited to take part in the interview that will approximately last for 50 to 60 minutes and to be interviewed about your understanding about mental health, and disclosure to help seeking, and coping strategies that are adapted and learnt in UK universities.

Please email Nesrine Boussaoui (details below) with a signed (type/ write your name) copy of the consent from to arrange a time and date for the screening interview or to ask any questions you may have. If you want to receive a brief copy of the results after the investigation is completed, you may inform the researcher and a summary will be sent to your contact details. If you decided not to be involved in the project, we would like to thank you for your interest and time in reading the information.

Researcher contact details:

Miss Nesrine Boussaoui

PhD researcher Graduate

school

Lord hope building

University of Strathclyde Glasgow Email:

nesrine.boussaoui@strath.ac.uk Tel:

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Chief Investigator details:

Dr Steve Kelly

Department: School of Psychological Sciences and Health E-

mail: steve.kelly@strath.ac.uk

Co-investigator

Dr Nicola Cogan

Department: School of Psychological Sciences and Health E-

mail: nicola.cogan@strath.ac.uk

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Dr Deidre Harrington

Chair of The School of Psychological Sciences and Health Ethics

Committee School of Psychological Sciences and Health University of

Strathclyde

Graham Hills Building

40 George Street, Glasgow, G1 1QE Telephone:

0141 548 2575

Email: hass-psh-ethics@strath.ac.uk

Consent Form for

Name of department: School of Psychological Sciences and HealthTitle of the study:
Understanding adjustment and difficulties and impact of acculturation, on Algerian/ Arab international postgraduate students mental health

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.

- I confirm that I have read and understood Privacy Notice for Research Participants and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long). ▪ I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences. ▪ I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data: ▪ I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.

I consent to being audio and/or video recorded as part of the project

(PRINT NAME)	
Signature of Participant:	Date:

Appendix B: Semi-Structured Interview Schedule

Study 1

This appendix presents the semi-structured interview schedule used during data collection. Interviews were guided by a fictional case scenario ("Yasser") to facilitate discussion of mental health literacy, disclosure, coping strategies, help-seeking behaviour, and cultural influences, while reducing pressure for personal self-disclosure. Prompts were used flexibly to support depth and participant-led exploration.

Interview schedule

The following is a fictional scenario that I would like to share with you

Mental health literacy

Please take your time reading this and you are welcome to ask for any clarification.

Case scenario: Yasser is an Algerian international student studying at Strathclyde University. He has just started his journey as a PhD researcher and he found it hard to keep on track with the sessions of The Researcher Development Programme (**RDP**) that requires credits to get a certificate, and to work in parallel on his PhD project. He has been working hard, and struggling because he always finds himself thinking about different things at the same time, such as food, rent, study, family. But, what has been harder for him is the covid-19 period. Consequently, he has been experiencing restless nights. Therefore, he started feeling low, more worried, and noticed a decrease of his energy during his day and withdrawing from some daily activities like eating and practicing some sports.

Q) From your understanding of the scenario, what are the key challenges that Yasser is experiencing?

Q) Can you tell what type of issues may Yasser be suffering from?

Prompts

- Physical
- Mental health and emotional
- Causes
- Recovery

Q) If you were in Yasser's position, can you give me some example of how would you think you might feel/behave?

Q) As an international student, do you think that your home culture has any influence on your understanding of mental health?

Prompt: If yes – how might it influence your understanding?

Q) Do you think your cultural background has influenced how you have felt or behaved in coming to a new country, particularly with respect to living in a different culture?

If yes – can you provide one or more examples of situations where your cultural background has had such an influence.

Mental health disclosure

Q) Referring back to Yasser's situation, in your opinion, what should Yasser do?

Q) Do you think that if Yasser talks about his issue, he will overcome his

distress Prompts:

- Family and/or friends
- Religion and faith
- Student support services
- Psychotherapy/ medication / health care professionals
- Social media

Q) If Yasser was living in Algeria, what types of issues would he experience?

Q) If you were in Yasser's situation, how would you like to describe your difficulties?

Q) If you were in Yasser's situation, would you want to talk to anyone about these issues or share them with anyone?

If yes, ask: who might this person be? Is there anyone else that you would talk to? Are there some people you definitely wouldn't want to talk to?

If no, ask: can you share one or more reasons why you would not wan tto talk to someone.

Coping strategies and help seeking behaviour

Coping strategies are ways in which people cope with both usual and unusual circumstances in their life, so as to maintain a state of wellbeing.

Q) In Yasser's case, if he decided to use coping strategies, what coping strategies might he consider using to help his well-being? Instead of what would coping strategies mean to him?

Q) why do you think Yasser would choose these specific strategies? Are there strategies he definitely would not choose?

Prompts

- Being aware of his health needs (mental and physical)
- Developing social network
- The ability to express his emotions
- Self-Directed Journaling (keeping diaries)
- Access to health services
- Get support from his surroundings

Q) If Yasser was living in Algeria, what solutions would be available to help him overcome the difficulties he is experiencing?

Prompts

- Your own point of view
- Others point of view

Q) If Yasser did not use any coping strategies, what might his reasons be?

Q) What do you think are the barriers that hinder people from your society or culture to seek help for mental health issues?

Q) Have cultural barriers ever felt like they've stopped you from seeking

help? If yes: can you share one or more examples?

Q) With reference to your home country, what do people do/use in order to help with their mental health? Instead of How people manage to maintain their mental health?

Q) Is there anything that should be done differently in order to help international students to seek help while at University? (

Q) Do you have any further suggestions as to what might be beneficial for students to help them cope in the host country?

Thank you kindly for your precious time to take part in this interview, as your participation is

highly appreciated. The information we have discussed will remain confidential and it will be anonymised.

Study 2

Understanding adjustment and difficulties and impact of acculturation, on Algerian/ Arab international postgraduate students mental health

The following is a fictional scenario that I would like to share with you
Mental health literacy
Please take your time reading this and you are welcome to ask for any clarification.

Case scenario: Yasser is an Algerian international student studying at Strathclyde University. He has just started his journey as a PhD researcher and he found it hard to keep on track with the sessions of The Researcher Development Programme (RDP) that requires credits to get a certificate, and to work in parallel on his PhD project. He has been working hard and struggling because he always finds himself thinking about different things at the same time, such as food, rent, study, family. But what has been harder for him is the covid-19 period. Consequently, he has been experiencing restless nights. He started feeling low, more worried, and noticed a decrease in energy during his day He began to withdraw from some daily activities such as eating and practicing some sports.

Q) From your understanding of the scenario, what are the key challenges that Yasser is experiencing?

Q) Can you tell what type of issues may Yasser be suffering from?

Q) Do you think that international students' home culture has any influence on their understanding of mental health?

Prompt: If yes- how?

Q) In your opinion (with respect to cultures), how do you think mental health is understood and treated in different cultures?

Q) Is there anything specific that you can tell about Arabs' culture towards mental health understanding?

If yes _ Is there anything specific about Algerian that you might come across?

Q) As an outsider specialist, do you think that your own culture has any influence on understanding others mental health with respect to their culture?

Q) Is there anything that you use or follow that helps you to understand mental health in different cultures?

Q) In your opinion, what are the things that might hinder mental health understanding?

Mental health disclosure

Q) Referring back to Yasser's situation, in your opinion, what should Yasser do?

Q) As a professional, who you might think are the different people that Yasser might disclose to?

Q) what might his reason be for not disclosing?

Q) In your opinion, what are the barriers that hinder international students to disclose, and seek professional help?

Q) How do you think we should behave with someone with different culture to help them share their experiences and accept to disclose?

Q) What are the diverse ways that international students use to describe their difficulties?

Coping strategies and help seeking behaviour

Coping strategies are ways in which people cope with both usual and unusual circumstances in their life, to maintain a state of wellbeing.

Q) In Yasser's case, if he decided to use coping strategies, what coping strategies might he consider using to help his well-being?

Q) What coping strategies do you think that he definitely would not choose?

Q) Some students prefer to keep using old coping strategies while a different country. To what extent might this help their mental health?

Q) Have cultural barriers ever felt like they've at some point stopped some students from seeking professional help?

If yes: can you share one or more examples?

Q) With reference to culture, what do Arabs do/use in order to help with their mental health?

Q) what about Algerians if you may add?

Q) Is there anything that should be done differently in order to help international students to seek help while at university?

Q) Do you have any further suggestions as to what might be beneficial for students to help them cope in the host country?

Thank you kindly for your precious time to take part in this interview, as your participation is highly appreciated. The information we have discussed will remain confidential and it will be anonymised.

Study 3

derstanding mental health, disclosure and help seeking behaviour of post graduate Algerian international students going back home

This Interview starts with a fictional character (Algerian international student named "Yasser" studying in one of the UK universities who suffers from some issues)

The questions used in this interview are divided into three parts. The first part is about mental health literacy to learn how international students understand mental health. The second part is about: mental health disclosure, to be aware of the barriers and the difficulties that international students may have to disclose their issues. The third part is about coping strategies and help seeking behaviour.

Interview schedule

The following is a fictional scenario that I would like to share with you.

Please take your time reading this and you are welcome to ask for any clarification.

Case scenario: Yasser is an Algerian international student graduated from Strathclyde University in UK. He has finished his journey as a PhD researcher and he is planning to go back home (Algeria). On the one hand Yasser is happy by finishing his degree and going back home after 4 years of hard work and commitment and anxious on the other hand, as he knows he will face some difficulties.

During Covid-19 Yasser suffered from some mental distress issues, such as loneliness, depression and anxiety where he sought help from university mental health service that helped him to maintain his mental well-being.

Yasser started asking previous laureates who went back home, about their situation and the difficulties they faced and how they managed to solve them. He got to know about the reversal cultural shock, and post study depression. Therefore he started feeling more worried, and his anxiety got worse with the stress. Now he is feeling lost, and confused about his future goals because he is aware that he has been changed and that family, friends, and neighbours may find it difficult to comprehend the changes he has been through and may expect him to be the same person who left 4 years ago. He is finding it hard to balance fulfilling old roles and breaking in new ones.

Mental health literacy

Q) From your understanding of the case scenario, what are the key challenges that Yasser is experiencing or would face when he goes back home?

Q) In your opinion, how would you imagine Yasser's mental health after going back home?

Q) If you were in his position can you tell of how you think you may feel and behave?

Q) As an international student here in the UK, studying here for more than two years, how did you feel when you went back home for a visit?

Q) As an international student, and after being away from your home culture for some years now, do you think that the host country's cultures has influenced your understanding to mental health?

- If yes, can you provide an example where the new culture influenced your understudying to mental health?
- If no, can you give some reason?

Mental health disclosure

Q) Do you think that if Yasser speaks about these issues after going back home, he will overcome his distress?

- If yes, would you please tell to whom?
- If no, would you please justify your answer?

Q) If Yasser refuses to disclose and share his experience, what might his reason be?

Q) If you were in his position, after going back home, would you share your challenges, and seek professional help?

If no, would you please tell the reason behind that?

Q) What are the challenges that you may face when you seek professional help in your home country?

Q) In Yasser's case, he sought the help of professional in UK, do you think it would be beneficial for him if he continues to seek professional help even when he go back home?

Q) In your opinion, in case of going back home, what would be preferred by you formal professional help, or informal one?

Prompts:

- Family and/or friends
- Religion
- Medicines

Coping strategies and help seeking behaviour

- Coping strategies are ways in which people cope with both usual and unusual circumstances in their life, so as to maintain a state of wellbeing.

Q) In Yasser's case, if he decided to use coping strategies, what coping strategies might he consider using to help his well-being before and after going back home?

Q) In your opinion, if Yasser remain using the coping strategies that he learned and adopted from UK culture, and apply them in Algeria, to what extent would that be beneficial to help his mental health?

Q) Do you think that cultural barriers back home would stop him from seeking professional help again?

Q) In your opinion how would Yasser manage the cultural barriers and cope again?

Q) What do you think should be done in order to help students cope with the reversal cultural shock after going back home?

Q) do you think that all Algerian/ Arabs students would behave (cope) the same way when they get back home?

Q) Do you have any further suggestions to what might be beneficial for students to consider before going back home to readjust with their culture?

Thank you kindly for your precious time to take part in this interview, as your participation is highly appreciated. The information we have discussed will remain confidential and it will be anonymised.

Appendix C: Mental Health and Counselling Support Resources

Study 1

This appendix lists national mental health and counselling support organisations provided to participants following the interview. These resources were supplied to ensure that participants had access to appropriate support during or after participation if neede

A list of Mental Health & Counselling Support Organisations and services

Thank you for participating in this research study. The topic concerned Algerian students' understanding of mental health and help-seeking behaviour. Although you may not have any current wellbeing issues, you or anyone you know may find the following information helpful for future wellbeing. In addition to accessing mental health and wellbeing services via your medical practice/g.p. or via your University's counselling or wellbeing service, the following national organisations offer free help and advice on a range of issues. There may also be services or charities available in your local area which may also be useful and may be found on a web search.

Name	Details
Action on Depression	Offers a range of services to help people affected by depression in Scotland, including phone and email support as well as courses and self-help support groups. Helpline : 0800 4 70 80 90 or 0808 802 2020 24hrs a day.
Scottish Association for Mental Health	Provides help, information and support for people with mental health problems. Work includes community based support services and an information service which can be accessed by phone, 0800 917 34 66, or email, info@samh.org.uk. Website : https://www.samh.org.uk/
NHS24	Health Information and self care advice. Helpline : 111 open 24hrs a day Website : http://www.nhs24.scot/

	Penumbra	Penumbra is an innovative Scottish mental health charity, working to improve mental wellbeing across the nation. We work to PROMOTE mental health and wellbeing for all, PREVENT mental ill health for people who are 'at risk' and to SUPPORT people with mental health problems. Helpline : 0131 475 2380 Website : http://www.penumbra.org.uk/

	Anxiety UK	Support and help for those diagnosed with, or who suspect that they have an anxiety disorder. Also, help dealing with specific phobias. Helpline : 08444 775 774 Mon-Fri 9.30am-5.30pm Website : https://www.anxietyuk.org.uk/
	Samaritans	24/7 emotional support by phone or email for anyone in the UK or Ireland. Website : https://www.samaritans.org/about-samaritans.aspx Tel 116 123.
	No Panic	Helping people who suffer from panic attacks, phobias, obsessive compulsive disorders and other related anxiety disorders including whose who are trying to give up tranquillisers. Helpline : 0800 138 8889 Open daily 10am – 10pm Website : https://www.nopanic.org.uk/

Study 3

tanding mental health, disclosure and help seeking behaviour of post graduate Algerian international students going back home

This appendix lists national mental health and counselling support organisations provided to participants following the interview. These resources were supplied to ensure that participants had access to appropriate support during or after participation if neede

A list of Mental Health & Counselling Support Organisations and services

Thank you for participating in this research study. The topic concerned understanding mental health, disclosure and help seeking behaviour of post graduate Algerian international students going back home. Although you may not have any current wellbeing issues, you or anyone you know may find the following information helpful for future wellbeing. In addition to accessing mental health and wellbeing services via your medical practice/g.p. or via your

nearest hospital service, the following international/national organisations offer free help and advice on a range of issues. There may also be services or charities available in your local area which may also be useful and may be found on social media or web.

Name	Details
Befrienders World wide	An online volunteer action to prevent suicide all over the world, the website can be used with many languages including Arabic or French as these are the official languages used in Algeria. https://www.befrienders.org/
DabaDoc	The DabaDoc is a website that contains a list of doctors (psychologist, psychiatrist) from all over Algeria who can offer online/non-online help for your issues. https://www.dabadoc.com/dz/psy chologue
Les Page Maghreb	Les Page Maghreb is an online website that you can use to select any psychologist near you or any type of help needed by just adding your area and the type of help needed. https://www.lespagesmaghreb.com/
SGSA : Clinique de gestion de stress et d'anxiété	Is a clinic that helps for depression and anxiety in Algeria that contains 50 beds where you can go and stay to receive the needed help, you can call: 023 53 13 8020 https://www.cgsa-hy dra.com/
Med.tn Premier R	Med.tn is another platform that you can use to search for a doctor or any kind of help that you can just select via online. https://www.med.tn/

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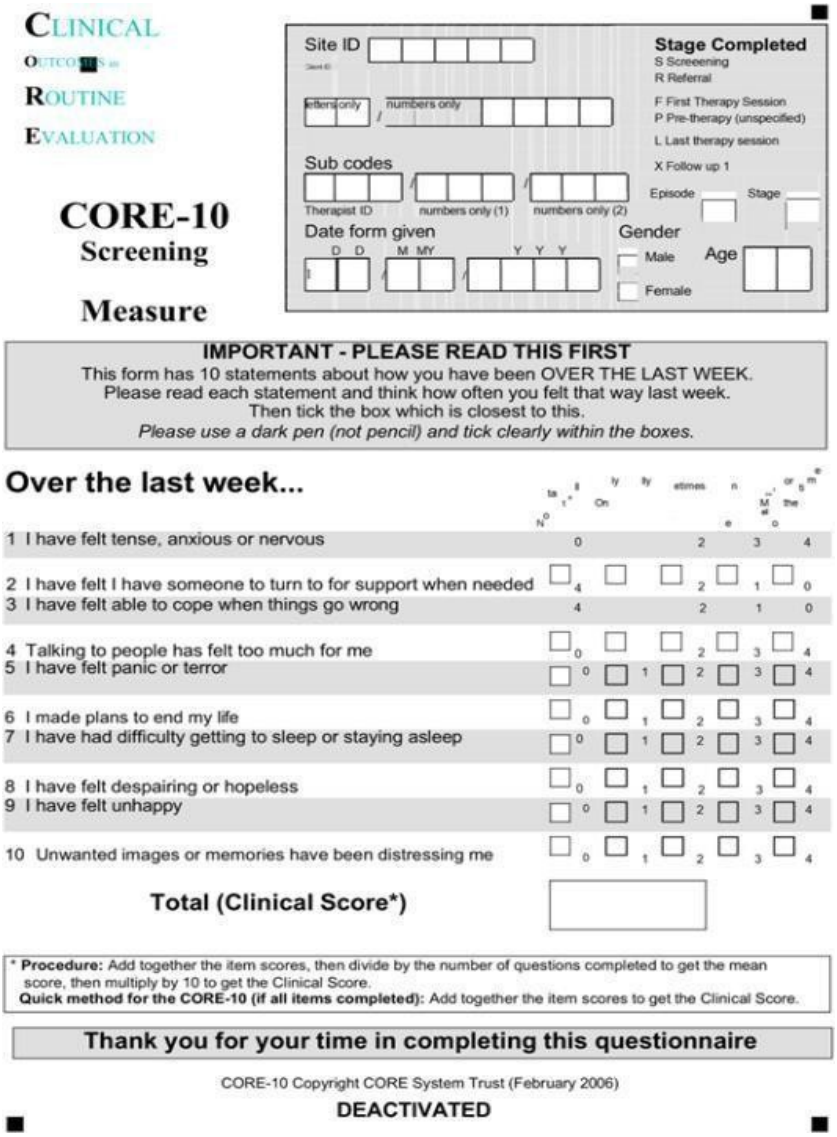
Appendix D: Core –10 Screening



CLINICAL OUTCOMES IN ROUTINE EVALUATION

CORE-10 Screening Measure

Site ID

Stage Completed
S Screeening
R Referral
F First Therapy Session
P Pre-therapy (unspecified)
L Last therapy session
X Follow up 1

letters only / numbers only

Sub codes

Therapist ID / numbers only (1) / numbers only (2)

Episode Stage

Date form given D D M MY Y Y Y

Gender Male Female

Age

IMPORTANT - PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week...

	Not at all	Only occasionally	Sometimes	Often	Most or all the time
1 I have felt tense, anxious or nervous	0	1	2	3	4
2 I have felt I have someone to turn to for support when needed	4	3	2	1	0
3 I have felt able to cope when things go wrong	4	3	2	1	0
4 Talking to people has felt too much for me	0	1	2	3	4
5 I have felt panic or terror	0	1	2	3	4
6 I made plans to end my life	0	1	2	3	4
7 I have had difficulty getting to sleep or staying asleep	0	1	2	3	4
8 I have felt despairing or hopeless	0	1	2	3	4
9 I have felt unhappy	0	1	2	3	4
10 Unwanted images or memories have been distressing me	0	1	2	3	4

Total (Clinical Score*)

* **Procedure:** Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.
Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

Thank you for your time in completing this questionnaire

CORE-10 Copyright CORE System Trust (February 2006)

DEACTIVATED

Appendix F: Adverts

Study 1 Advert

Dear colleagues.
I am conducting online interviews as a part of my PhD project. The aim here is to increase our understanding of Algerians International Students mental health and well-being in Scottish universities.
Your participation will help to capture the experience of Algerian international students by assisting in understanding their mental health disclosure and help seeking behaviour. As Algerian international students you are in an ideal position to provide me with valuable insights. The interview will not take more than 60 minutes, and it will only be audio recorded. Your answers will remain confidential. The only condition would be that you are a student in one of the UK universities.

Please make sure that you have the following characteristics:
you are: (1) aged over 18 years old; (2) a full time Algerian international student; (3) studying at UK universities; (4) living in the UK for at least three months; (5) reasonably fluent in English (5.5 or above on IELTS as required by the universities the participants are enrolled in); (6) able to provide informed consent to your participation in the study.
You are not eligible for this study if you are experiencing a severe and/or enduring mental health problem or receiving treatment for a mental health illness. (E.g. severe and/or enduring mental illness such as psychosis or bipolar disorder)

Your help would be highly appreciated.
For more information about participation, please don't hesitate to contact me.

Thanks!
Nesrine Boussaoui

Study 2 Advert

Understand mental health disclosure and help seeking behaviours of international students from professional perspective

My name is Nesrine Boussaoui PhD researcher at Strathclyde University. I am conducting online interviews as a part of my PhD project. The aim here is to increase our understanding of international Students mental health and well-being in UK universities. For the sake of completing my first study that was on Algerian international students' mental health and well-being, I need to conduct interviews to better understand mental health disclosure and help seeking behaviours of international students from professional perspective and learn more about Algerian/ Arab international students' culture as it applies to acculturation of students and their mental health and wellbeing, from the perspective of wellbeing providers and will be discussed in relation to the students' views collected as part of the first study.
I wonder if your service might have people who would be interested in taking part in my study preferably those experienced with Algerian or Arab international students' mental health; however, all professionals experienced with international students' mental health and well-being are also welcomed and needed in this project.
I would be very grateful if you think it is appropriate for you to help me spread my study among your service or to put me into contact with people who might help me by taking part in my interview.
If you need more details about my project or have any question please email me at: (nesrine.boussaoui@strath.ac.uk), or you can email my supervisors at: Dr. Steve Kelly: (steve.kelly@strath.ac.uk). Dr. Nicola Cogan: (Nicola.cogan@strath.ac.uk)

Thank you kindly for taking time for reading this, your time and help are highly

appreciated. Nesrine Boussaoui

Study 3 Advert

University of Strathclyde
Humanities & Social Sciences

UNDERSTANDING MENTAL HEALTH, DISCLOSURE AND HELP SEEKING BEHAVIOUR OF POST GRADUATE ALGERIAN INTERNATIONAL STUDENTS GOING BACK HOME

Aim of investigation:

The aim of this project is to explore the concerns of Algeria/Arab international students experience in terms of their mental health, issues in disclosing mental health problems and in seeking help for mental health within UK universities, and learn how Algerian/ Arab international students will apply the understanding they are having around mental health from UK to their countries, and identify the difficulties that they may face by and the way they will cope and seek help in order to readjust

Method: Online interview

Are you in your final year of your studies, or have finished it!!!
Please take part in our research

Inclusion criteria:

- Aged over 18 years
- Algerian/ Arab international students finished with international study and has returned home
- A student of a UK university
- Returned stay period of 6 months and maximum of 5 years.

Exclusion criteria:

- Algerian International students who studied remotely from your home country,
- Algerian/ Arab international students who is resident again in Algeria for less than 6 months or more than 5 years
- Currently under mental health care/receiving treatment for mental health.

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