“Loved and not judged” `
How African/Caribbean’s with a diagnosis of Schizophrenia experience the therapeutic relationship in Psychological therapy: An interpretive Phenomenological Analysis

A thesis submitted in partial fulfilment of the Doctorate in Counselling Psychology at London Metropolitan University

by

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Declaration

I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated.

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Acknowledgement

I would firstly like to thank God for giving me the strength and perseverance to get through this course. Secondly, I acknowledge the support from my research supervisor, Dr Catherine Athanasiadou-Lewis and appreciate her encouragement, input and feedback throughout my journey of completing this thesis. I must say a very special thankyou to my Daughter Elyse who has been very patient and understanding over the past few years and has stayed strong despite the sacrifices and challenges. I would also like to thank my husband for his encouragement and belief in me and my parents for their support and understanding over the years. Also, my colleagues/friends on the course you were a big source of strength. Finally, a big thank you goes to the participants who kindly took part in this study. This thesis could obviously not have been completed without you and I really appreciate the time you took to partake.

Contents

Abstract

Rationale: There is a strong amount of evidence that suggests that the therapeutic relationship is an important aspect of psychological therapy and important in terms of positive outcomes and a significant contributor towards change and valued above any one technique. However, there is limited amount of qualitative research that has focused on how individuals with a diagnosis of Schizophrenia experience the therapeutic relationship. African/Caribbean's are more likely than white and other ethnic groups to be diagnosed with Schizophrenia and tend to have poorer therapeutic outcomes. Yet very few studies that have examined the experiences of this group, in psychological therapy. *Aim*: This thesis aimed to address this gap by exploring how African - Caribbean individuals with a diagnosis of Schizophrenia, experience the therapeutic relationship in psychological therapy. *Method*: Semi-structured interviews were conducted with five participants. Transcripts were analysed using Interpretative Phenomenological Analysis. *Findings:* Three superordinate themes emerged; Never Condemned (Love without Judgement); A chance to be heard (Fear vs Freedom); Separation from the therapeutic relationship. A description of these superordinate themes and the nine related subordinate themes are discussed. The finding indicate that the therapeutic environment enabled the establishment of a strong therapeutic relationship. Implications for clinical practice are discussed.

Reflexivity

The relationship between subjectivity and reflexivity is fundamental to the counselling psychology research process (Kasket, 2013). Reflexivity can be defined as the conscious revelation of the beliefs and values held by the researchers in the choosing of research methodology and generation of knowledge production (Shacklock & Smyth 1998). Willig (2001) states that the qualitative researcher must examine and consider how their own views and positioning in relation to the phenomena under investigation has influenced and shaped the research process and findings. I acknowledge that I'm not a neutral observer and that my individual subjectivity, personal experiences, thoughts and feeling, will be implicated in the research process. However, as (Willig, 2001) recommends above, my aim is to reflect on these preconceptions throughout the process of this research and be transparent about them by keeping a reflective journal.

Willig (2001) highlights that there are two types of reflexivity, personal reflexivity and epistemological reflexivity. Personal reflexivity involves reflecting upon how our own experiences, values, beliefs, interests, political commitments, social identities and how wider aims have influenced and shaped the research. Epistemological reflexivity allows us to think about how the research question defined and limited what can be found. Also, how the study's design and chosen method of analysis, constructed the data and findings.

Personal Reflexivity

I acknowledge that my past experiences and background has shaped my current interest into wanting to explore this topic area. I first encountered working with this group during my social work training when I was placed in a forensic residential setting with male service users with Psychosis. The men at the unit were predominantly from African-Caribbean backgrounds between the ages of Eighteen to Sixty - Five. I found this setting very interesting and really wanted to work with this client group in an NHS setting. I requested another placement within a community mental health team, working with adults with severe and enduring mental health problems.

I found working in this setting very challenging, but extremely rewarding. I felt even the small changes I contributed to the individuals I worked with, such as encouraging and helping clients to build stronger support networks, helping with housing issues, or just engaging in conversations surrounding their problems, seemed to make a big difference. One thing that really stood out, was the relationships that I was able to establish with the clients. It was this experience that sparked my interest in wanting to pursue a career in psychology.

I also spent some time volunteering for a mental health hospital with BME service users with Psychosis as a befriender. During this time, I was also able to build meaningful relationships with this client group and gain insight from a BME perspective. I can see how being within this setting, influenced my interest in wanting to explore my topic area, due to some of the experiences that were shared by individuals on the wards. A common theme that I found among this group during my time as a volunteer, was a need to be recognised as a person beyond their diagnosis and feeling failed by the mental health system.

Furthermore, during my training as a counselling psychologist, I had the opportunity to work with this client within an NHS setting, providing psychological therapy. Within this context, building a strong therapeutic relationship was integral to my practice. I recognise that being in such placement setting, may have influenced my research choice and that choosing the placement in the first instance, was a conscious decision, as I had an idea about the research I wanted to pursue. I also acknowledge my preconceptions

and biases and how they were shaped from my clinical experiences with this group, which has led me to believe that this client group can build good therapeutic relationships, despite the challenges involved. Moreover, as part of my doctorate training, I had to engage in psychological therapy and did so for four years, which allowed me to discover first-hand, the importance of the therapeutic relationship and the need for a therapist to possess certain qualities.

I recognise that being a BME myself, allowed participants to possibly experience a sense of familiarity, which can allow for a closer entry into the experiences of participants. However, I also acknowledge the limitations and potential disadvantages of this sense of familiarity and how this may have led to participants omitting aspects of their experiences based on the assumption that I already share or understand due to my own personal characteristics and cultural background. I acknowledge that this assumption of familiarity may have impacted upon the research process.

Epistemological Reflexivity

I believe we are always in relation to others and that it is not possible to get out of ourselves and observe others and the world objectively. Biases and distortions can be viewed as the norm and something that should be acknowledged and embraced. As Finlay (2002) highlights, subjectivity and intersubjectivity are an opportunity, not a problem and I view an individual's subjectivity as an opportunity for me to gain access to their individual lived experience. I'm uncomfortable with putting people into boxes and categories and believe that everyone is unique and that all experiences should be valued.

I embrace the view that there is more than one way of knowing, as people are diverse and feel that counselling psychology has a duty to challenge diagnostic categories. I hold the position that an individual's social context and interpersonal relations can be a highly influential source in their unhappiness and adopt a critical realist epistemology. I recognise that my epistemological position would have influenced my decision to explore this topic area and to even ask this research question to begin with. I will endeavour to adopt a position that is critical, reflective, reflexive and transparent, throughout this research process

CHAPTER 1: INTRODUCTION AND CRITICAL LITERATURE REVIEW

Introduction

The dominant ideas and reading around Schizophrenia today are bio-medical perspectives (Boyle, 2002). There are accounts of psychotherapy and counselling, but contribution from counselling psychology is sparse within this area of research and practice (Larsson, Loewenthal & Brooks (2012). Counselling psychology's value base is embedded within a Humanistic framework and at the heart of the profession is the value placed upon therapeutic relationship (Woolfe, 1996; Health and Care Professions Council (2015). The therapeutic relationship is fundamental to the progress and outcome of therapy and the therapist plays an integral part in that relationship (Lewis & Bor, 1998; Orlinsky, Grawe & Parks, 1994; Lambert & Barley, 2001). Sensitivity, self - awareness, warmth and a non-judgemental attitude are advocated as essential characteristics for helpers (Barker, 2001; Watkins, 2001).

While there maybe challenges in the relational process, research suggests that this is no different for individuals with Schizophrenia and that the therapeutic relationship is viewed as the most important aspect of psychiatric care (Johansson & Eklund, 2003; Hewitt & Coffey, 2005; NICE Guidelines (2014). The dominance of the medical model and conceptualisation of Schizophrenia as being a biological disorder, has led to an exclusion of the necessity of the therapeutic relationship and denied the possibility that psychotherapy can be beneficial to serious mental health problems (Repper, 2002). As a result, the approach of psychotherapy for individuals with a diagnosis of Schizophrenia is focused on treating symptoms, as oppose to adopting a more person-based approach that considers the nature of people's problems (Barker & Jackson 1996).

The concept of schizophrenia has been a contentious subject in both psychiatry and psychology. Since Schizophrenia's original classification of Dementia Praecox by Kraeplin (1896) there has been controversy with regards to its nature and a lack of consensus concerning its aetiology (Read, Mosher & Bentall, 2004). The World Health Organisation (2017) classifies schizophrenia as a severe mental disorder characterised by significant disruptions in thinking, perception, language and sense of self. Positive symptoms refer to psychotic experiences such voice hearing and delusions, whereas negative symptoms are associated with disruptions to behaviours and emotions, such as

reduced feelings of pleasure. It has been debated whether Schizophrenia should be classified as a distinct mental illness at all and that the concept should be abandoned altogether (Bental, Jackson & Pilgrim, 1988; Boyle, 2002). While the term "Schizophrenia" is used throughout this paper it must be acknowledged that a critical position has been taken and the term is merely viewed as a social construct to describe a complex phenomenon. Dominant discourses privilege certain versions of social reality and this has implications for certain groups in society (Hare-Mustin & Marecek, 1997; Coyle 2006).

Boyle (2002) argues that symptoms of Schizophrenia should be viewed from a phenomenological perspective and delusions and paranoia should be viewed as a phenomenon, rather than as a single symptom model. It has been argued that the medicalisation of distress and the use of diagnostic labels places the source of distress firmly within the individual, which may neglect the individual's social context and interpersonal relations as a source of dysfunction or unhappiness (Hare - Mustin & Mareck, 1997). Counselling psychology has a societal duty to challenge psychiatric categories and diagnosis (Golsworthy 2004). Rather than pathologizing difficulties and distress the counselling psychologist proposes an interactive alternative, that embraces the subjective and phenomenological experiences of clients, which seeks to understand their constructions of reality (Strawbridge & Woolfe, 2006).

BME Experiences and Mental Health

There is little research that focuses on schizophrenia and the therapeutic relationship from a counselling psychology perspective in general, let alone more specific populations such as African - Caribbean groups. In this paper, the term African - Caribbean will be used to describe people with African ancestry who migrated from the Caribbean isles, African groups, second generation Black British and some forms of mixed-race parentage. Black and Minority Ethnic (BME) is a term used to describe and group together cultural and ethnic minorities in the United Kingdom. While this is done as an attempt to represent minority groups, the term can also neglect the variation of all the individuals it represents (Richardson & Fulton, 2010).

The literature indicates that African-Caribbean people have significantly raised incident rates of Schizophrenia in comparison to their white counterparts (Fearon, Kirkbride & Morgan, 2006). Various reasons have been proposed in the literature from migration effects, social exclusion, unemployment, lack of social support and racism (McKenzie & Bhui, 2007). People from black and minority ethnic communities are more likely to have poorer health outcomes and experience less satisfaction with mental health service provision than the White population (Raleigh et al, 2007; Department of Health, 2005). It is thought that a Lack of understanding among staff concerning cultural based issues, stereotypical beliefs, language barriers and institutional racism have all been suggested in the literature as reasons why black people experience less appropriate intervention and satisfaction (McKenzie & Bhui, 2007; Singh, 2007).

Poor engagement and mistrust of services lead to delays in help seeking and therefore BME communities are more likely to meet services at crisis stage, resulting in more coercive measures and involuntary detention under the Mental Health Act, reinforcing the "circles of fear" (Keating & Robertson, 2004; (Bhui, McKenzie, & Gill, 2004). BME groups are less likely to access therapy and when they do are more likely to drop out (Arnow et al. 2007; Wierzbicki & Pekarik, 1993) and have unsatisfactory outcomes (Cochrane & Sashidharan, 1996) and a lower working alliance than the white population (Walling, Suvak, Howard, Taft & Murphy, 2012). This group are also less likely to be offered psychological therapy and medication is often the most common form of treatment (Fernando, 2005). The National Service Framework for mental health: Delivering Race Equality (2005) aimed to address these inequalities in accessing services and aimed to promote well-being and improve services.

The aim of the next chapter is to review the literature on the therapeutic relationship and its significance in relation to Schizophrenia in general and then focus on literature in relation to BME groups, then narrowing the focus to African - Caribbean's with a diagnosis of Schizophrenia and the therapeutic relationship, with the intention of highlighting this gap in the literature. The conception and aetiology of Schizophrenia will be briefly discussed below.

Theoretical conceptualisations of Schizophrenia

Biomedical Overview

There has been controversy surrounding the aetiology of Schizophrenia and the biomedical claim of the 'brains' of individuals diagnosed with Schizophrenia as being different from the general population due to there being a genetic predisposition to the condition (Kendler & Diehl,1995; Olin & Mednick, 1996). It has also been postulated that one of the causes for Schizophrenia is an imbalance of chemicals of the brain, particularly dopamine which has substantiated the pharmacological maintenance of the condition (Read, Mosher & Bentall,2004). A major problem is that the biomedical model fails to acknowledge the adverse psychological and social factors as being a cause of individual distress in Schizophrenia, despite the wealth of evidence that shows this client group are often exposed to earlier traumatic events, such as sexual abuse and social disadvantage (Falloon, 2000; Bentall, Wickham, Shevlin & Varese, 2012; Allen, Balfour & Marmot, 2014).

Genetic predisposition for Schizophrenia has been justified through adoption, twin and genetic linkage studies. However, many of these studies have been found to be quite problematic, with contrary evidence overlooked and discarded, lack of diagnostic consistency, issues controlling for nature versus nurture and lack of blindness of the researcher towards the zygosity of twins. The diagnostic criteria utilised in these studies were so general that the meaning of concordance between twins who met it, was undermined. Studies of twins separated at birth did not account for the influence of pre-natal experience or allow for the likelihood that monozygotic and dizygotic twins would have different experiences and would be reacted to differently by their environments based on similar and dissimilar appearances. This suggests that environmental factors may play a crucial role in why monozygotic twins would act similarly, not only genetics (Boyle, 2012).

Moreover, Eco-epidemiological schools of thought postulate that Schizophrenia may develop from the complex interaction of the psyche, environment and genetic predisposition, proclaiming that environmental factors may change gene expression, increasing susceptibility to psychosis. Predominant environmental factors related with

the onset of schizophrenia include, belonging to a visible immigrant group that experiences discrimination, being part of an ethnic group that is socially fragmented, unemployment, living in a neighbourhood with low levels of social capital and urbanization (Kirkbride & Jones, 2011).

Biopsychosocial Model/Vulnerability Stress Model Overview

The Biopsychosocial model aims to unify the biological causes with the psychological and social causes that potentially lead to Schizophrenia, by considering the complex interaction of all three domains (Gilbert, 1995). While on the other hand, the vulnerability stress model relates environmental stressors, physical or interpersonal deprivations to the innate predisposition of individuals developing Schizophrenia (Jones & Fernyhough 2007). Kiesler (1999) argues that biopsychosocial models are often poorly taught, poorly formulated and rarely adopted, mainly due to the dominance of the biomedical conceptualisation of Schizophrenia. Furthermore, Boyle (2002) argues that that the stress vulnerability model underplays the environment, by making it look as if the "stress" element of the model consists of "everyday stresses" that most us would be able to manage but would overwhelm someone who was "vulnerable". Such view neglects the context and meaning of individual lived experience and further "pathologizes" individuals with a diagnosis of Schizophrenia, therefore maintaining the primacy of biology.

Psychological /Psychodynamic Overview

Psychoanalytic perspectives view Schizophrenia as difficulties in living, mainly due to personal and social relationships, as a result of earlier unsatisfactory interpersonal experiences (Sullivan, 1974). Attachment theory may provide some further insight into how these fundamental primary relationships, maybe implicated in the formation of the symptoms of Schizophrenia. The main function that attachment serves is to enable the infant to gain a sense of security and to help regulate their emotional state (Davies,2011). As we process information around us from the external world, this forms unconscious assumptions about self and others, helping us to make sense of our own internal world (Diener & Monroe, 2011). When an individual does not experience a

secure attachment during their early years, this may lead to deficits in emotional regulation and feelings of uncertainty and anxiety.

Additionally, the capacity to mentalise, operationalised as reflective function, emerges within the context of secure attachment (Fonagy, Gergely, Jurist, & Target, 2002; Meins, Fernyhough, Russell, & Clark-Carter, 1998). Mentalisation can be explained as the ability of the individual to understand and infer the mental states of both themselves and others and the impact of mental states on one's cognitions, affective state and behaviour. Negative interpersonal experiences during childhood and adolescence reduce an individual's opportunities to develop mentalisation skills, subsequently compromising their understanding of mental states.

Moreover, within each of us is a set of intricate "feedback loops" which play into one another based on past experiences; actions and perceptions often generate consequences that end up 'confirming' the view of the world from which those consequences originated" (Wachtel, 2011, p.66). Hence, this pattern of anxiety, fear, distrust and insecurity that was formed as a child, maybe perpetuated and repeated continuously. Attachment develops overtime and these internal feedback loops are formed based on recurring interactions and the relationships we have with the people in our lives (Allen, 2001). For individuals who have developed insecure attachment styles, the assumptions attached to their internal working models are blighted by distrust concerning the intentions and motives of others. This leads to a more negative self - representation and difficulties engaging intimately with others, resulting in weariness and suspicion (Diener & Monroe, 2011). Without a consistent "love object," interactions become unpredictable, chaotic and frightening (Allen, 2001) which results in attachment trauma. These characteristics of distrust and fear are features that are present with people with Schizophrenia spectrum disorders.

Karon (2003) asserts that while the symptoms of schizophrenia may appear erratic and unclear, if one takes time to listen carefully to the person, the disorder will begin to make psychological sense within the context of that individuals life experience. Distortions of individuals with Schizophrenia, can be viewed as attempts to deal with their problems symbolically, allowing the unconscious to be expressed and therefore Schizophrenia can be seen as an interpersonal disorder. It is thought that even though

people with Schizophrenia may be withdrawing into themselves, it is argued that this internal world in which they retreat, is still one of object relations (Post,1982). It is this withdrawal, that allows them to create within themselves a relationship between oneself and another person. From an object relations perspective, it has been suggested that the reason for this disengagement, is that a person with Schizophrenia longs both for connection and understanding of the fundamental parts of themselves, but also fears this at the same time. The fear is that if one becomes to connected with another, that their love will engulf and destroy the object of their affections and therefore withdrawal can be conceived as a protective measure (Post,1982).

Such view acknowledges developmental causes in Schizophrenia and is compatible with literature relating to early trauma (Varese et al, 2010; Shannon et al, 2011; Bonoldi,2013). It is the role of the therapist to decipher the problems that have been hidden in the psychotic symptoms. Atwood (2012) contrasts this model of conceptualisation with the biomedical model which "pigeonholes clients into discrete mental disorders," rather than treating the "complex life issues" that are the root of many psychotic disorders. Moreover, humanistic models emphasise fostering the growth of the whole person. Breggin (1997) argues that the empathetic humanistic psychology model maybe the most powerful for healing human distress. Such approach takes into consideration the context of experience, in relation to distress. Boyle (2002) asserts that the belief of Schizophrenia as a "brain disorder" has implications for research and interventions. Considering that the prevalent conceptualisation of Schizophrenia is underpinned and dominated by the biomedical model, this will have implications for the psychological approaches which are adopted in practice.

The next section will discuss the Antipsychiatry movement and how it challenged dominant psychiatry discourses, diagnosis and labelling.

Antipsychiatry movement

The anti-psychiatry movement which began in 1960's saw the rise of prominent psychiatrist's, R.D Laing, Thomas Szasz, and David Cooper, who rejected the illness model of mental illness, all holding in common dissatisfactory beliefs in the psychiatric orthodoxy, with the desire to challenge it. Laing (1969) formulated his views on

schizophrenia accordingly and rejected the idea that schizophrenia was a failure of human adaption, on the contrary, he regarded it as a successful attempt not to adapt to what he referred to pseudo-social realities. He regarded madness as a product of a grapple between the repressive society and the individual who is seeking to escape its repression.

Szasz (1960) described mental illness as a metaphorical illness, arguing that the mind is not an organ or part of the body, and therefore cannot be diseased in the same sense as the body can. Szasz was not denying that humans have difficulties but preferred to refer to them as problems in living, rather than attributing them to psychiatric labels. He took the view that any psychiatric diagnosis is a licence for coercion and the exercise of psychiatrist power. Kennedy (1980) went further and argued in broad agreement with Szasz, stating that the psychiatrist acts as a thought policeman and that psychiatric diagnosis is a political weapon aimed to constrain civil liberties. For individuals who are labelled with schizophrenia, the implications of this can be very oppressive in terms of the sense of shame and powerlessness it brings. For individuals from a BME background, there are further areas of complexity due to how racism can be implicated in diagnosis.

Furthermore, the following section will discuss the impact of racial discrimination on the mental health of African/Caribbean's and racial bias and the implications this may have on the diagnosis of Schizophrenia.

Racism and discrimination among BME groups and Schizophrenia

Racism induced stress

Berzoff, Flanagan and Hertz (2008) ague that there is an inescapable relationship between a person and their society and that this concept is fundamental to the understanding of race and Racism. Racial discrimination directed towards those from African/Caribbean decent is grounded in Britain's history of slavery colonialism and continues to influence modern British culture, pervading every aspect of British society. Systemic barriers to the upward mobility of African/Caribbean persist and social

statistics relating to key social policy areas demonstrate major inequalities between African /Caribbean and whites, in the labour market, education, healthcare services and criminal justice system (Commission for Racial Equality 2009).

Well renowned earlier activists such as Frantz Fanon (1965) and Cecil Sumner worked hard to confront the Eurocentrism and racial biases within psychiatry/psychology, around decolonisation and the psychopathology of colonisation. Such figures highlighted the damaging effects of racism on black people, especially when they internalise the societal norms of white superiority and black inferiority. McKenzie (2011) uses the term "cultural schizophrenia" to describe a type of paranoid defence system that occurs when black people targeted by racism become aware of how systemised the oppression is and behaviours are adopted to help manage this psychic pain. Pierce (1970) who developed the concept of "microaggression", demonstrates how even the smallest occurrences of racial discrimination can have a significant impact on black mental health. Grier and Cobbs (1968) developed the term "cultural paranoia", to explain an adaptive device, or way of being that black people adopt, which invokes suspicion and hypervigilance in response to a hostile and racist environment.

It has been postulated that an individual's minority status represents an intrinsic stressor, and that racism acts as a chronic stressor, which may precipitate psychiatric disorders (Hammack, 2003 and Bhugra and Jones, 2001). It has widely been acknowledged in the literature that African/Caribbean people in the UK are diagnosed with Schizophrenia at much higher rate than anywhere else in the world (Cochrane and Sashidharan,1996). It has been argued that there has been a preoccupation with biological explanations and whilst some effort has been made to address sociological factors such as social disadvantage, unemployment, and paternal separation, there has been little focus on how racialised experiences, could contribute to incident rate of schizophrenia.

Cultural factors and diagnosis

Similarly, to other public institutions, it has been argued that racism lies at the core of the theoretical and conceptual foundations of psychiatry (Timini, 2005; Fernando 2017; Sashidharan and Jones 2001). It has been suggested that the evidence regarding the

black incidence rate of Schizophrenia highlights factors of social alienation and racism experienced by black people and misdiagnosis by white British Psychiatrists (Hickling 2005). Metzl, (2011) argues that psychiatric diagnosis and treatment depend heavily on the historical and political context. He postulates that before the civil rights era, that is was mainly middle class white men receiving a diagnosis of schizophrenia and how this changed during the civil rights era, as black people were predominantly given this diagnosis, especially those who were poor and perceived as angry.

He further goes on to criticise the cultural competency approach in practice, which heavily focuses on the individual and argues that psychiatrists need to develop what he calls 'structural competency' – i.e. competence in understanding the way systems work and the influence that social context has on the process of diagnosis. It is this way that negative stereotypes and racial biases around African/Caribbean people can be effectively deconstructed. It could therefore be argued that mental health classifications are not objective but derive from white European culture and is therefore inappropriate for labelling the experiences of non-European people. Racial and ethnic differences in expression are often disregarded and pathologized, which may contribute towards misdiagnosis.

Impact of Adverse care pathways

Furthermore, African/Caribbean people are more likely to follow adverse care pathways into the psychiatric services, which result in compulsory admission, or entry through the criminal justice system (Fernando, 2005). They are less likely to be referred by their GP, and often have more untreated symptoms, due to the delays with coming in contact with services, although some of this may due to fear around accessing services (Keating & Robertson, 2004). This again demonstrates how both perceived and systemic racism interact to cause delays in treatment and how poor and coercive experiences for African/Caribbean groups impacts upon them developing trusting working relationships with clinicians and mental health professionals.

Historical Overview//Theoretical conceptions of the therapeutic relationship and psychological therapy

The concept of the therapeutic relationship was present in the asylum era and influential in later developments of therapeutic movement in the 19th Century (O'Brien 2001). Freud was the first to consider the importance of the therapeutic relationship and in the early 1900's used the term to explain the relationship between "healer "and "patient", what he described as positive transference, this being the necessary component for successful treatment outcomes. Empirical research on the therapeutic relationship emerged in the 1970's where early models were still rooted in psychodynamic theory (Howgego, Yellowlees, Owen, Meldrum & Dark 2003). Rogers (1957) Humanistic therapeutic movement which was fundamentally based upon the therapeutic relationship and developed as a reaction against behaviourism and psychoanalysis (Howgego, et al 2003).

Greenson (1965) suggested the idea that the relationship is fundamental, enabling client change and made the distinction between the working alliance (task focused) and the therapeutic alliance (personal bond). Luborsky (1976) and Bordin (1979) extended the concept so that it could be relevant to other types of theory. The former described two phases of the relationship. The early stage of the relationship is characterised by the clients' belief in the ability of the therapist to provide help and ensuring a secure environment for the client, this later maturing into a mutual relationship of working on the tasks of therapy. The therapeutic relationship has been broadly defined as the collaborative and affective bond between therapist and client (Martin, Garske & Davis, 2000). The therapeutic relationship has been described as a perquisite for effective client and therapist interaction and a moderate determinate of patient outcomes (Martin, Garske & Davis, 2000).

Psychodynamic Overview of therapeutic relationship

Psychodynamic perspectives derive from Freudian views of unconscious processes and positive transference. Freud postulated a need for psychoanalyst to establish an effective transference before the full work of psychoanalyst could begin. Obscurity on the part of the therapist in Freud's view was necessary for transference to be projected (Carew, 2009). "Unconscious conflicts which a person may encounter in everyday life, may emerge in the therapeutic relationship itself (Howgego, Yellowlees & Owen, 2003). More contemporary approaches have challenged and abandoned the notion of the therapist being a "blank slate" (Sherby, 2005). Guntrip (1969) advocated the importance of developing a genuine and "real" relationship alongside the transference relationship with the client, which requires authenticity on the part of the therapist. Relational approaches to psychoanalysis (Jacobs,1991; Greenberg, 1999; Aron,1996 see the interaction between client and therapist as an important aspect of therapy. Orbach (2007) further highlights that the analyst is not a static figure onto whom the client projects their transference, but an active part of the therapeutic dyad who brings his or her subjectivity to the therapeutic relationship.

Many authors have described the client and therapist relationship as an attachment relationship (Bowlby, 1988; Pistole, 1989; Epstein, 1995; Parish, 1999; Parish & Eagle, 2003; Daniel, 2006; Collins, 2007). The therapeutic relationship is thought to hold many features that activate the client's ingrained attachment behaviours and expectations (Bowlby,1988). Like attachment behaviours initiated by infants during times of stress,
people are more likely to seek therapy when faced with challenging situations that they cannot manage alone. It is in this context that therapists provide the primary function of attachment, which is security, comfort and safety. The therapeutic relationship can be viewed as the therapist serving as an attachment figure, providing a secure base (Bowlby,1988).

Humanistic Overview

The humanistic, or person-centred approach derives from the work of Carl Rogers. The essential conditions that encourage therapeutic change are empathetic understanding, unconditional positive regard and congruence (Rogers,1957). The relationship fosters conditions for growth and change through the therapeutic use of self (Watkins,2001). The only way for the therapist to be able to demonstrate unconditional positive regard to the client, would be if the therapist first experiences unconditional positive regard towards themselves. Empathy can be viewed as a process in which the therapist aims to 'stay with' the client and enter their phenomenological world. An important aspect of therapy involves the therapist adopting the clients frame of reference, as if it were their own and putting aside their own personal experiences.

CBT Overview

Beck conceptualised the CBT relationship as a working alliance characterised by collaboration and a focused goal orientated relationship, where therapist and client have an agreement on the direction of therapy. Contrary to Roger's (1957), the therapeutic relationship is necessary but not sufficient for a good therapeutic outcome (Beck, Rush, Emery & Shaw, 1979). Based on a model of collaborative empiricism, therapist and client work together to test validity of client's beliefs and assumptions to facilitate positive change.

Traditional CBT approaches have been criticised for being too mechanistic and overlooking important aspects of the relationship (Mahoney's (1991). Overholser and Silverman (1998) highlight the importance of the therapist creating an atmosphere of openness and trust and to establish hope in the client, regarding his or her capacity for change. They further advocate that this can be achieved by the therapist paying close attention to the core conditions as outlined by Roger's. Relational approaches to CBT recognise how therapeutic relationships can be used to identify and highlight interpersonal schemas and early attachments problems, such as lack of compassion and validation and acknowledge that the relationship can be a vehicle for change (Safran & Muran, 2000; Gilbert and Irons, 2005; Boucher, 2010). Relational approaches are more congruent with the values which underpin counselling psychology.

Counselling Psychology Values/Therapeutic relationship

Counselling psychology has a value base that is grounded in the primacy of the therapeutic relationship. What makes the profession distinct from other psychological professions, is that it is embedded within a set of core values and ethics (Wolfe, 1996; Walsh & Frankland, 2009). It embraces a democratic non-hierarchical therapeutic relationship. Counselling psychology is committed to prioritising the subjective experiences of clients and there is an appreciation of the individual as a unique being and therefore a phenomenological approach is embraced, to enable access into the world of the client. There is an emphasis on facilitating growth and the actualisation of potential and empowerment, rather than treating pathology (Woolfe,1996). Such approach is essential when working with oppressed and marginalised client groups, which can be applied to African/Caribbean's with Schizophrenia.

Counselling psychology is situated within a clash of culture, with the medical model on the one hand and the Division of Counselling Psychology's guidelines of practice, which highlights the importance of embracing the fundamental values of the profession (Golsworthy, 2004). The medicalisation of distress and the use of diagnostic labels and categories place the source of distress firmly within the individual, neglecting the social context and interpersonal relationships as sources of unhappiness and dysfunction (Hare – Mustin & Mareck, 1997). Parker (1997) argues that counselling and psychotherapy can to some extent provide settings for the deconstruction of psychopathology. This becomes more complexed with African/Caribbean's as it has been argued that such diagnostic tools are incompatible with non – European's, due to cultural differences in expression which has serious implications for diagnosis with this group. (Hickling, 2005). Moller (2011) has argues that Counselling Psychology in the UK needs to a adopt a position that focuses on diversity and multiculturalism.

Kagan, Tindall and Robinson (2010) argue that counselling psychology should move away from an individualist focus and embrace social and cultural explanations of distress and broader psychological interventions. It has been argued that social justice is one of the five main values endorsed by community psychology, and that "without an even distribution of social goods, other basic values, needs, and rights cannot be fulfilled (Prilleltensky & Nelson, 1997. Therefore, it is imperative that counselling

psychology as a profession work towards challenging societal and institutional oppression towards marginalised groups, such as African/Caribbean groups with a diagnosis of Schizophrenia.

Moreover, William & Irving (1996) advocate that counselling psychology has a conflicted conceptual framework which is rooted in both a logical empiricist framework and a phenomenological one. This places counselling psychology between two different epistemological positions. Dealing with complexity and engaging with difference and conflicting world views, adopting a multi - perspectival approach is compatible with the core values of the discipline, such as embracing diversity.

Pluralism and Valuing Difference

A pluralistic viewpoint embraces that a multiplicity of different theories and models of psychological distress change can be 'true' and that trying to reduce these into one unified model is unnecessary (Cooper, 2007). Working pluralistically with clients allows for creativity and enables an exchange which values the individuality of the client (Stiles, Honos-Webb, & Surko, 1998). Pluralism in counselling and psychotherapy also acknowledges the increasing degree of cultural diversity in both therapist and client and the essentiality of advancing therapeutic practice that welcomes an array of world views and beliefs concerning change (Pedersen, 1994). Such approach is essential when working with BME groups, as it may help with understanding how culture may impact upon the therapeutic encounter. Cooper (2009) paper uses Levina's (1969) concept of 'welcoming the other' as being closely aligned with the values of counselling psychology and being the very essence of our practice.

The following section will attempt to critically explore research and literature in relation to psychological therapy for Schizophrenia.

Psychological therapy interventions and Schizophrenia

Psychodynamic Therapy and Schizophrenia

Fenton (2001) highlights two theoretical traditions in the history of psychotherapy for Schizophrenia the "investigative trend", which grew from the psychoanalytic and "Sullivanian" traditions which emphasises the alleviation of emotional difficulties and symptoms. The "supportive" tradition of psychotherapy for Schizophrenia where treatment is more pragmatic and symptom focused and grounded in the medical model, an approach which has been favoured by biologically and pharmacologically oriented clinicians. It could be argued that more contemporary psychological approaches towards Schizophrenia lean more towards the "supportive" approach, where the aim of treatment is to target symptoms. Psychoanalysts such as (Fromm-Reichmann, 1954; Searles, 1965; Knight, 1946) postulated that meaningful intimate bonds with individuals with Schizophrenia emerged in therapy and advocated that these bonds could form the basis of a movement towards health. There was a focus of therapy providing a corrective emotional experience, privileging the experiential quality of the therapeutic relationship over the interpretive emphasis of more traditional therapy. The authors developed a plethora of anecdotal reports, suggesting that individuals with Schizophrenia could use psychoanalytic therapy to understand their lives and develop richer and more meaningful experiences of themselves in daily life.

Sullivan redefined psychiatry as the science of interpersonal living. He described Schizophrenia as a human process, promoting the view that humans are more alike than different, and that psychotherapy ought to be a project of working together to understand our common humanity from an empathetic stance, rather than an objectifying and pathologizing perspective (Evans, 1996). Sullivan held the view, that if a child's needs weren't met by parents and society, that they would be satisfied by the child in a covert manner, which can grow to be split off (dissociation); which Sullivan believed was only in response to the untenable situation in which "the bad mother cannot be avoided nor can the good mother be called"(Evans, 1996, p. 89). Sullivan characterised this splitting off as a 'not me' experience. He believed that the cumulative effect of enduring many 'not me' experiences during childhood, contributed to what is described by psychiatry as schizophrenia. Dissociation is employed when motivations

and experiences are so anxiety-ridden that they need to be excluded from any awareness of the self and experienced as 'not-me'.

Frieda Fromm-Reichmann had a similar view to Sullivan and believed that all human beings exist within a relational framework, making transference possible and that psychosis, rather than an arbitrary brain impairment, was a type of communication. She believed that people with schizophrenia were extremely sensitive to the therapist's internal processes, both conscious and unconscious (Cohen,2010). She postulated that even those living with Catatonia were able to identify and hear everything outside of themselves, despite not being able to react externally. Karon (2003) similarly believes that people with Schizophrenia are constantly trying to solve their problems but are afraid to deal with these issues directly and instead use symbols as a way of communicating their internal reality. She further argues that it is only when the manifesting symptoms, or symbols and the triggering event from the past are reconnected in one's conscious mind, that healing can take place. The fundamental aspect of therapeutic work with people diagnosed with schizophrenia, is based around the sympathetic understanding and skilful management of the relationship, rather than in the intellectual comprehension or technical exactness of the therapist (Cohen, 2010). Such an approach emphasises the healing element of the relationship between therapist and client.

Earlier pertinent psychodynamic case studies claimed success in treating individuals diagnosed with Schizophrenia, although were criticised due to a lack of empirical evidence to support these claims and the use of case reports (Rosenbaum & Harder, 2007). Moreover, the move towards a more biological conceptualisation of Schizophrenia as a "brain disorder," meant that the aetiology of Schizophrenia from a psychodynamic perspective, where emphasis was placed on difficult earlier relationships and resolving conflicts, became incompatible with the contemporary views and aetiologies of Schizophrenia (Lysaker, Glynn, Wilkniss & Silverstein 2010). Since then there has been a resumption of interest in psychotherapy for Schizophrenia which has taken several forms. Cognitive Behavioural Therapy (CBT) originally designed to target depression, has steadily widened its scope to address Schizophrenia and psychotic disorders (Rector & Beck, 2002). Cognitive Behavioural approaches view the cause of distress in individuals diagnosed with Schizophrenia as being due to cognitive

distortions, as the assumption is that information is processed in a way that does not match with reality.

Various controlled studies have shown that CBT can reduce dysfunctional cognitions, leading to reductions in positive and negative symptoms, including in samples during early stages of illness and for individual's resistant to medication (Drury, Birchwood & Cochrane 2000; Senksy, Turkington & Kingdon 2000; Gumley**,** O'Grady, McNay, 2003). Studies have also reported reduced distress, auditory hallucinations and coping strategies in the CBT group and effects were maintained months after treatment (Wykes, Parr & Landau, 1999). Furthermore, a study by Tarrier et al (1998) provided intensive CBT to individuals with chronic Schizophrenia, which focused on teaching patient's methods of coping with their symptoms and teaching strategies to reduce relapse. Improvement was found in the CBT group, but not in the routine care or counselling group. There have been more recent CBT procedures that have been adapted and associated with improvements in vocational function (Lysaker, Davis, Bryson & Bell (2009).

CBT and Schizophrenia

There has been some concern around the long-term success of CBT treatment. Durham, (2009) found that CBT did not improve relapse rates or reduce the number of days spent in hospital, Twelve or Twenty - Four months after treatment. Garety et al, (2008) also had similar findings and concluded that standard CBT for psychosis should only be reserved for individuals who have very distressing positive symptoms, which are unresponsive to medication. While there is a substantial amount of evidence that demonstrates CBT's efficacy in being able to treat individuals diagnosed with Schizophrenia, it could be argued that an overemphasis on CBT, has led to an exclusion of other possible methods and approaches.

The shift towards evidence-based practice has led to an increased focus on measurable outcomes of interventions and a culture of where only "scientific" evidence appears to prove effectiveness (Coleman & Jenkins, 1998). Roth and Parry (1997) point out that randomised controlled trial's (RCT's), measure outcome rather than process and efficacy rather than effectiveness. They dispute that the same methods that are used to

evaluate the effectiveness of drug treatments, cannot be used for studying psychological treatments and argue that practice that is truly skilled is eclectic and cannot be standardised. They further advocate that the skilled practitioner adapts techniques to maintain the integrity of the treatment and relationship, which further decreases the possibility of achieving a measurable standard approach. Outcome studies are incompatible with psychotherapy research as standardised treatments are employed based on psychiatric diagnosis, rather than individualised assessment (Persons 1991). Issues have also been raised surrounding investigator alliance being predictive of outcome (Luborsky et al 1999; Paley & Shapiro, 2002).

It has been argued that the conceptualisation of Schizophrenia as a biological disorder has disregarded the importance of the therapeutic relationship and rejected the possibility that serious mental illness could be amendable by psychotherapy (Repper,2002). The lack of controlled evidence to support the use of the therapeutic relationship with individuals with Schizophrenia, is conceived as proof of its lack of efficacy. A major disadvantage of this is that approaches and techniques such as CBT which are more easily definable, will be over emphasised over other possible methods and techniques (Gournay & Sandford 1998; Trenchard, Burnard, Coffey & Hannigan, 2002). Collins and Cutliffe (2003) argue that when technical elements of treatment, such as those prescribed in CBT are prized above the relationship, the personhood of the client and a sense of hopelessness is exacerbated.

Moreover, there has been increased interest in using modified forms of psychoanalytic therapy for people with Schizophrenia. Rosenbaum Martindale, and Summers (2013) compared psychodynamic psychotherapy for psychosis to standard treatment in Two - Hundred and Sixty- Nine patients with first episode Schizophrenia, in a longitudinal study over two years and found significant improvement in the intervention group, in comparison to the Treatment alone group. This suggests that there are other methods other than CBT that can be effective for individuals diagnosed with schizophrenia. However, it has been argued that it is not necessarily the type of therapy or methods that enable change, but rather the therapeutic relationship itself. The evidence surrounding the therapeutic relationship in relation to schizophrenia, will be explored in the following section.

Evidence Surrounding the Therapeutic Relationship and Schizophrenia and common factors

Common factors are the variables of the treatment setting that comprise client, therapist, relationship, expectancy and techniques which are not exclusive of a specific model. These factors establish the core components and commonalities that are shaped by different therapies (Norcross, 1999). It has been argued that it is these commonalities that enable change in therapy and not the specific techniques among the different therapies. Miller, Duncan and Hubble (1997) four-factor model included extra therapeutic factors, relationship factors, placebo, hope, expectancy factors and models and techniques. Client and extra therapeutic factors were estimated to contribute Forty percent towards the change. King (2001) suggests similar findings, suggesting that the working alliance is responsible for up to Thirty - percent of all treatment outcomes across approaches.

There exists consistent and overwhelming research evidence concerning the significance of the therapeutic relationship in positive outcomes (Orlinsky, Grawe & Parks, 1994; Lambert & Barley, 2001). Research has tended to focus more on the technical aspects of working with this client group and less on the therapeutic relationship (Bentall et al, 2003). Studies which have focused on the therapeutic relationship have significantly shown that the strength of the therapeutic relationship is a pertinent contributor towards change and that the therapeutic alliance has shown to be consistently profound across a variety of therapeutic approaches (Horvath, 2002; Cooper, 2008; Gelso, 2011; Markin, 2014). Paley and Shapiro (2002) argue that research on psychotherapy for Schizophrenia has ignored the contention that even for Schizophrenia the "equivalent outcome paradox" (common factor) is applicable and that differing models of intervention often result in similar outcomes.

Review findings in relation to Schizophrenia and psychotherapy have found that the superiority of CBT diminished, when compared with other therapies adopting equal amounts of therapist attention. Haddock et al (1999) also found no difference between CBT and supportive counselling in a pilot study with recent onset patients. Raue, Goldfried and Barkham (1997) investigated the quality of the therapeutic relationship in psychodynamic and CBT amongst Fifty-Seven people. Results showed that higher

alliance scores were positively correlated with high impact sessions (e.g., readiness to go beyond superficial discussion of emotions), session depth, smoothness and people's rating of mood, irrespective of the type of psychological technique employed.

Howgego, Yellowlees and Owen, (2003) reviewed Eighty-Four published articles and found that the therapeutic alliance improved outcomes. Furthermore, studies have found that clients diagnosed with Schizophrenia reported viewing the therapeutic relationship as the most important element of psychiatric care (Johnson & Eklund, 2003). More recent studies have shown the therapeutic relationship to be essential for clients with psychosis who undertake psychotherapy (Priebe, Richardson, Cooney & Adedegi 2011; Goldsmith, Lewis, Dunn & Bentall, 2015). Shattock, Berry, Degan and Edge (2017) review on therapeutic alliance in psychological therapy, found evidence to suggest that alliance predicts overall psychotic symptomatic outcomes, reduced hospitalisation and improved self – esteem. Therapist related factors such as empathy, trustworthiness and genuineness were associated with better alliance.

The therapeutic relationship has been found to be important for all types of psychotherapy with Schizophrenia, due to the necessary sense of safety it provides (Nelson, 1997) and a trusting relationship is valued over technical skills (Institute for Healthcare Development). Good therapeutic relationships with psychotherapists has also shown more compliance with medication regime among clients (Frank & Gunderson 1990). NICE (2010) guidelines also highlight the importance of practitioners developing empathetic relationships with individuals diagnosed with Schizophrenia and highlight the therapeutic alliance to be an integral aspect of practice. However, due to the interpersonal difficulties that are associated with Schizophrenia, relationship formation can be difficult and such issues will be addressed below.

Challenges in the Therapeutic Relationship and Schizophrenia

It must be acknowledged that there may be relational challenges in working with this client group. Several studies in the literature have drawn attention to lack of insight, positive and negative symptoms, attitude towards treatment, medication, social functioning and attachment insecurity as being inhibitors for developing an effective therapeutic bond with clients with psychosis (Jung, Wiesjahn, Rief, &Lincoln, 2014; Wittorf et al, 2010). Post draws attention to one of her own clients called David and discusses how while he longed for intimacy and love, he feared that getting too close would only lead to more pain (Post,1982). Understanding how earlier attachment experiences can impact upon the therapeutic relationship is essential when working with this client group. This may suggest a need for therapy to be adapted to a more person – based approach and one that considers traumatic attachment experiences.

Lotterman (2016) suggests that standard psychotherapy techniques should be modified when working with individuals diagnosed with Schizophrenia, as they have often lost their ability to use words to describe their inner states. Countertransference emotions are critical in Schizophrenia, as in many instances this is the only place where some of the client's fantasies and emotions will appear in the treatment process. He draws attention to the disturbance in the capacity for emotional attachment, highlighting that individuals with Schizophrenia approach relationships very cautiously and these connections are carefully made and can very easily be disrupted, resulting in abrupt withdrawal. Allen (2001) draws attention to issues around attachment and asserts that attachment trauma damages the safety regulating system and negatively impacts upon the traumatised persons capacity to use relationships to establish feelings of security. Research has shown that individuals who exhibit more of an insecure attachment, may find the therapeutic exchange frightening or overwhelming, which may explain the detachment from therapeutic interventions (Macbeth, et al 2011).

Diener and Monroe (2011) looked at therapeutic alliance by conducting a meta-analysis of existing literature and found that the greater the attachment security, the stronger the reported alliance. This suggests that individuals with psychosis have the capacity to modify ways of relating to others" (Berry, Wearden & Barrowclough, 2007). What

seems to be increasingly clear is that it is not what the therapist does, but how the therapist creates the emotional climate of the relationship that encourages the client's engagement in therapy (Mackie, 1981; Flores, 2004; Daniel, 2006). However, this is based on therapist being able to understand their own patterns of defence related to attachment, to enable them to withstand what is likely to be a turbulent relationship with clients who present to therapy with attachment difficulties.

Lakeman (2006) argues that psychotherapy for individuals who experience psychosis, needs to be adapted and argues for an approach that adopts more "supportive therapeutic interventions." This involves empathetic communication, which conveys a sense of understanding of how an individual feel in relation to their situation, acceptance and positive regard. Garfield (1995) points out that while the therapeutic relationship is integral when working with this client group, it is also important to highlight that the changes that take place maybe subtle and minimal, which may make it easy for the therapist to lose track of them throughout the course of treatment. These and other complexities of the dialogue are challenges for the psychotherapist who must demonstrate empathy, patience, attunement capacities and a creative mind (Robbins, 1993). Chadwick (2006) Person centred based CBT approach towards Psychosis highlights the importance of developing a "radically collaborative" therapeutic relationship, where the client is placed at the heart of the therapeutic process, which can reduce the impact of clients including therapists in their delusional belief systems.

Such approach challenges prevalent symptom based psychological approaches where the focus is on "patient management" and highlights the importance of a genuine and "real relationship," which fosters empowerment and meaningful change. Barker (2001) challenges the medical model of mental health by arguing that it is the nature of human problems and development that needs to be the focus, as oppose to diagnosis and packaging. Hansen (1999) argues that this focus on pathologizing has virtually wiped out humanistic conceptualisations and treatments of disturbed clients. There is a need for a service and treatment approach which prioritise the centrality of the therapeutic relationship and emphasises the personal dimensions of individual problems promoting healing through support, understanding and acceptance (Barker 2001; Repper, 2002).

The next section will focus on counselling psychology's conceptualisation and theoretical contribution towards Schizophrenia and the importance of the therapeutic relationship.

Counselling Psychology's relationship with Schizophrenia

It has been argued that the medical concept of Schizophrenia is maintained and justified through medical discourse (Repper, 2002). Certain versions of social reality are privileged over others and power structures are therefore maintained (Coyle, 2006). Service users have criticised the use of the Diagnostic Statistical Manual (DSM) due to the sense of powerlessness and alienation it brings (Davidson & Cambell,2007). Self-stigma refers to applying negative stereotypes to oneself accompanied by feelings of shame. Feelings of unworthiness and incompetency have been shown to be associated with self-stigma which may undermine therapy (Livingston & Boyd, 2010) and lead to the "why try effect" (Corrigan, Larson & Rusch 2009).

Furthermore, studies have shown that self-stigma undermines help seeking behaviour (Vogel, Wade & Hackler, (2007) and engagement to psychosocial treatment (Livingston & Boyd, 2010 and impacts upon social relationships (Yanos, Roe, Markus & Lysaker, 2008). It has been found that clients that have more of a recovery orientation present with less self-stigma and that increased self-stigma might hinder the therapeutic alliance (Cavelti, Kvrgic, Beck, Rusch & Vauth, 2012). Recovery refers to restabilising a self-determined and meaningful life despite of mental illness and a new identity is negotiated, as well as gaining a sense of control over one's life (Deegan,1996). Recovery as a motivational process may enhance engagement in the therapeutic alliance, due to the emphasis on striving for the attainment of individual life goals. The recovery model of rehabilitation could be viewed as an alternative to the medical model and more compatible with counselling psychology's ethos.

Counselling psychology's primary contribution is the value it places on the subjective experience (Woolfe,1996). There has been concern around counselling psychology retaining a humanistic value base, within a framework dominated by a medical model of distress, in which treatment guidelines focus on disorder (Golsworthy,2004). Milton, Craven and Coyle (2010) highlight the tensions that counselling psychologists may find

themselves in, as they are subject to the dominant discourses that shape the applied context in which they practice. Corrie and Callahan (2000) argue that if counselling psychology is to further progress in the NHS, then it must completely embrace the ideology of scientist practitioner. There has been some concern that the scientist practitioner model is unable to capture the essence of the therapeutic relationship, which is integral to the work of counselling psychologists.

Knudson and Coyle (2002) study highlight the importance of counselling psychologists' attending to the clients meaning making and subjective experience, rather than pathologizing their difficulties in Schizophrenia. Larsen, Loewenthal and Brooks (2012) study looked at how counselling psychologists constructed the diagnosis of Schizophrenia. They found that discourses in relation to the values which counselling psychology places on the subjective experience, was present in most of the psychologist's speech and the therapeutic relationship was positioned as an alternative to the psychiatric system. Barker and Jackson (1996) advocate that exploration of the person's lived experience through narrative, should surpass "psychotechnology" which focuses on defining and "fixing" illness. Rather than defining ourselves by our techniques, it could be better to describe ourselves in terms of our metatheoretical position. Humanistic psychology challenges us to reflect upon the metatheoretical assumptions of human nature and causes of distress. However, it is important to distinguish between humanism as an ethic underlying psychological practice and a specific type of therapeutic intervention (Cooper, 2007).

By applying a Humanistic base to all therapies, counselling psychologists can foster the stance that human beings have an inherent tendency towards growth, development and optimal functioning. While at the same time, acknowledging that while counselling psychology is a humanistic discipline, it does not have to only involve the practice of humanistic therapy (Gillion,2007). However, a pluralistic approach to therapy in counselling psychology advocates the use of various known methods of therapeutic enquiry and practice to meet the needs of the client in a non – prescriptive manner (Cooper, 2009). The principles within this approach can sufficiently be used for assimilative integration (Athanasiadou,2012) allowing for a more flexible and tailored approach towards practice. Such approach would be fundamental when working with

the complex needs of individuals diagnosed with Schizophrenia and furthermore, BME groups.

BME's and Psychological Therapy Literature

African-Caribbean people are the most over-represented ethnic group in mental health services. It has been argued that existing conceptualisations of mental illness are mainly western constructs and that mental health and illness are defined differently by different cultural groups (Odell, Surtees, Wainwright, Commander & Sashidharan,1997). Such conceptualisations have had implications for African - Caribbean interactions with services and has resulted in misrepresentation and exclusion, leading to distrust and dissatisfaction with mental health services (Keating & Robertson, 2004). African - Caribbean groups are likely to have poorer health outcomes and less likely to be offered psychological therapy and some authors have suggested that this is due to this group being perceived as "untreatable" due to cultural differences and stereotypes (Eleftheriadou,2010). Moodley (2000) asserts that for the small minority of BME individuals who do access psychotherapy, a "not knowing mode" seems to be present within the relational dynamic, resulting in BME clients feeling disenchanted with psychotherapy, as fundamental issues have failed to be addressed. Several studies have attempted to further understand and explore the experiences of BME group's and adapt practice to meet the specific cultural needs and requirements.

A qualitative study by Rathod, Kingdon, Phiri & Gobbi (2010) aimed to produce a culturally sensitive adaption of an existing CBT manual for therapists working with patients with Psychosis from specified ethnic minority communities (African-Caribbean, Black African/ Black British and South Asian Muslim's). The study used semi structured interviews with (n=15) individuals with Schizophrenia and lay members from selected ethnic communities (n=52) semi structured interviews with CBT therapists (n=22) and mental health practitioners who work with clients from ethnic minority communities (n=25). The study found that Twenty-One percent of the participants agreed or strongly agreed that staff were sensitive and considerate of their culture, irrespective of the ethnicity of the practitioner and was key to success in therapy. The study recommended that assessment and formulation would need to

consider the implications of cultural beliefs and experiences and issues of religion and spirituality was also crucial for many BME groups and used as coping strategies.

Agoro (2014) study aimed to elicit BME service user experiences of engaging in psychological therapy in Leeds and York partnership NHS Trust. Data was collected though semi structured telephone interviews (nine) and analysed using content analysis. There was an emphasis on having a therapist who was empathetic and warm, tailoring therapy to their individual needs and being open to culture helped the process. However, Telephone interviews can be a downfall due to the lack of contextual and non – verbal cues, which can inhibit rapport building and interpretation of data. However, cultural understanding and empathy is a prevalent theme in both pieces of research.

Culture and the Therapeutic Relationship

Culture maybe defined as a shared system of beliefs, perspectives and values held by a specific race or ethnicity or geographical region (Asnaani & Hofmann, 2012). The need for therapists to be culturally sensitive or responsive has been acknowledged for numerous years (Zane, Nagayama, Hall, Sue, Young & Nunez, 2004). Hall (2001) asserts that there is a scientific and ethical imperative for developing culturally sensitive therapy, which involves the tailoring of psychotherapy to specific cultural context. Bohart and Greenberg (1997) highlight the importance of entering the experiential world of another person who is inevitably different and stress this to be a fundamental activity of all therapists irrespective of theoretical orientation. This is essential for "cultural" or "ethnocultural empathy (Ridley & Lingle, 1996). Sue (1998) proposes that culturally specific expertise is important but not sufficient. An essential skill is understanding when to generalise and when to individualise. The therapist must identify when and how cultural values or cultural group characteristics maybe relevant to the client's problem, but also to view the client as an individual.

Jim and Pistang (2007) study aimed to investigate how culture may contribute towards the therapeutic relationship for Chinese clients and used a qualitative phenomenological approach and Eight Chinese participants. The focus was to elicit what was helpful or unhelpful in the working relationship. The study found that it was not so much the therapist's cultural knowledge, but the therapist's skill in being able to understand the

unique dilemmas and distress within the context of cultural values. These cultural formulations seemed to enable the clients themselves to achieve greater awareness of the cultural aspects of their difficulties and minimise self – blame and distress.

Owen, Leach, Tao, Rodolfa, (2011) refer to a term, Multi-Cultural Orientation (MCO) which is a "way of being" with the client, led mainly by the therapist philosophy or values about the importance of cultural factors such as racial/ethnic identity and cultural background of the client. The study's aim was to examine whether the client's perceptions of their psychotherapists' MCO, was associated with their psychological functioning, working alliance and real relationship scores. The study used a retrospective cross-sectional design. Clients perceptions of MCO was positively related to psychological functioning, working alliance and real relationship. Perceiving that therapists were more orientated towards cultural issues, may have led to them viewing the therapist as more credible and built up a sense of comfort in the therapeutic process. The study was conducted in the United States which demonstrates the lack of research in the United Kingdom, pertaining to how culture impacts upon the therapeutic process.

Relevance to Counselling Psychology/Proposed Research

The literature concerning the therapeutic relationship is vast and had to be limited due to the constraints of this research. However, the therapeutic relationship in relation to Schizophrenia is scarce and much of the research has been quantitative studies although beneficial, there is little research that has explored the subjective experience of this client group. Counselling psychology as a profession is grounded in the therapeutic relationship and it is therefore surprising that little contribution has been made towards this area of practice. The consensus in the literature is that individuals diagnosed with Schizophrenia do benefit from psychotherapy when it is tailored to the needs of the individual and that the therapeutic relationship is crucial aspect of this process. Counselling psychology embraces a pluralistic approach to therapy, employing various methods of therapeutic enquiry and practice to meet clients' needs in a non-prescriptive manner (Cooper & McLeod, 2011). The profession could therefore make a valuable contribution.

Cooper (2009) draws attention to Levina's concept of "welcoming the other" which could be applied to the context of this research as individuals diagnosed with Schizophrenia are a marginalised and oppressed group and being from an African-Caribbean background adds another layer of complexity. Moodley (2003) draws attention to the multiple socio-cultural and political identities of groups termed as the "other" and the impact upon the therapeutic relationship and implications for counselling practice. The findings from the literature in relation to BME groups and psychotherapy is that the acknowledgement of an individual's cultural context is an important aspect of the therapeutic relationship. The professions pluralistic underpinning embraces difference and cultural diversity. It is clear from the literature that African-Caribbean people are more likely than other groups to be diagnosed with Schizophrenia and more likely to drop out of psychological therapy.

It is evident from the literature that the therapeutic relationship has been linked to positive outcome and overall satisfaction in therapy. Dryden and Reeves (2008) highlight that the increasing presence of cultural diversity within clients presenting for counselling necessitates that counselling psychologists increase their awareness of how cultural difference impacts their clinical work. Therefore, exploring how this group experience the therapeutic relationship from a counselling psychology perspective, using a phenomenological approach, may elicit further understanding of the needs of this group and the qualities and characteristics in the therapist that they experienced as helpful, as this may contribute towards improving practice in this area.

The main questions that this study will address are:

- What were the qualities and characteristics that participants found helpful in the therapist?
- Were there cultural needs met within the relationship?

- How did participants feel within the therapeutic space?

CHAPTER 2: METHODOLOGY

The following chapter shows a description and rationale of the research method and methodology concerning the research question and aims. The initial part of the chapter will begin with a reflexive statement which conveys the researcher ontological and epistemological position. This will then be followed by an introduction to Interpretive Phenomenological Analysis (IPA) and why this research method was chosen. It will also provide an outline of the participants, procedure, interview schedule and ethical considerations

Position of Researcher

The epistemological stance that resonates the most with my own personal and professional values as a trainee counselling psychologist is critical realism (Bhaskar,1978). I strongly value subjectivity and the meanings that clients give to their unique experiences and fully embrace the therapeutic relationship, whist also taking into consideration the impact that the social world has on human experience. It is well known that two opposing views, constructionist and realist perspectives have been the dominant philosophies that underpin research in the field of psychology. The objectivist stance assumes an objective reality that is independent of human values, interpretation and experiences and the purpose of research is to uncover an objective truth. In contrast, a constructionist perspective rejects the notion of a causal understanding of the social world and acknowledges that there is a diverse amount of "realities" that are influenced by our social interactions and the way in which we interpret our social world. Furthermore, our knowledge and understanding of the world around us is not only shaped by previous experiences, but also influenced by our cultural context and values (Houston, 2001; Eatough & Smith, 2006).

Critical realism aims to provide a framework which considers both human agency, whilst experiencing and interpreting our social world, while also taking into consideration the impact of social structures, such as economics and politics and other societal systems. It assumes that there is a reality that exists independent of human perception and experience. Unlike positivist approaches, critical realism rejects cause and effect relationships and acknowledges the interactive role of people and social

systems, in how people can both shape and be shaped by these structures (Houston, 2001, Elder-Vass, 2012). In terms of the researcher's role and the findings of this study, critical realism positions a persons' narrative at the starting point of the research. However, it must be acknowledged that the knowledge gained from such research is not to be viewed as an objective truth, but as a transitive view of the world (Houston, 2001) which is influenced by language, culture and experience of both the participants and researcher. This by no means invalidates the research, although it must be taken into consideration that such enquiry generates knowledge located within a specific context and time.

I feel that this epistemological and ontological position is well suited with my research topic, as both counselling psychology and the therapeutic relationship in relation to African-Caribbean's with a diagnosis of Schizophrenia are constructs situated within cultural, political and social contexts and systems, which have shifted over time and are constantly in interaction with individuals. Adopting a critical realist stance is also in line with the pluralistic value base of counselling psychology and its approach to theory, knowledge and practice, showing an openness to embrace diversity and strongly placing human experience in the context of the social world.

Rationale for Qualitative Design

A qualitative methodology was adopted for this research which is concerned with meaning, quality and texture of experience and aims to capture how people make sense of the world and experience events (Smith, Flowers & Larkin, 2009). The objective is to describe and possibly explain events, but never to predict (Willig, 2008). Unlike qualitative methods, quantitative methodologies approach knowledge empirically and focus heavily on observations and measurements, with an emphasis on making predictions concerning outcomes. Qualitative research does not tend to work with preconceived "variables" that are defined by the researcher at the start of the research process, but is primarily interested in gaining understanding about the meanings which participants attribute to events, which is the aim of this current research. An inductive approach is taken towards research, rather than a hypo-deductive position, which rejects the notion that there are truths that are waiting to be uncovered (Langdridge & Hagger-Johnson, 2009). Therefore, a qualitative design, in this case an Interpretive Analysis

was deemed as the most suitable method to answer the research question, that was centred around how African-Caribbean groups with a diagnosis of Schizophrenia, experience the therapeutic relationship in psychological therapy.

Phenomenological Methods

Phenomenology is concerned with how the world is experienced by human beings within a specific context and time and hold the view that how individuals perceive phenomena will vary from individual to individual (Willig, 2008). A significant concept in phenomenology is Husserl's notion of Intentionality. Objects have different meanings to different people and no experience is necessarily viewed as the same, as people are subjective (Smith Flowers & Larkin,2009). There are three important principles when gaining understanding in phenomenological research methods: Epoche, phenomenological reductionism and imagination variation. Epoche requires bracketing out presumptions and assumptions, interpretations and judgements and fully allow ourselves to engage with what is presented before us. Phenomenological reduction would mean describing the phenomena as it presents itself in its entirety, which would include, size, texture shape, facial and physical features, as well as feelings and emotions that may appear in our consciousness. While it can be acknowledged that there are diverse phenomenological approaches, they can all generally be categorised as either being descriptive or interpretive.

Descriptive phenomenologists such as Husserl emphasise the importance of the researcher bracketing out assumptions and past knowledge concerning the phenomena they are researching and focus solely on the participants experience of the phenomenon. However, phenomenologists such as Heidegger who glean towards the Hermeneutic traditions, do not view description and interpretation as being distinct, but view description as another aspect of interpretation (Willig, 2008). This research has adopted an interpretive approach and will draw on the method of Interpretative Phenomenological Analysis (IPA).

Introduction to IPA

IPA is theoretically grounded in critical realism (Bhaskar,1978) and the social cognition paradigm (Fiske & Taylor, 1991). Critical realism advocates that there are enduring and stable elements of reality that exist separately from human conceptualisation. Differences in the meanings individual's attach to experiences are considered possible because they experience different parts of reality. IPA was developed by Smith and Osborn (2008) and aims to capture the quality and texture of individual lived experience and is influenced by the hermeneutics version of phenomenology. Double hermeneutics refers to the dynamic where participants attempt to make sense of their own experience and the researcher tries to make sense of their experience (Smith & Eatough, 2007). However, this approach recognises that such experience is not directly accessible to the researcher and the researcher's subjectivity may influence interpretation and therefore takes a reflexive stance (Smith & Osborn, 2008).

IPA adopts an idiographic approach which involves an in-depth analysis of single cases, examining individual perspectives of study participants in their unique contexts (Smith,2011). Due to IPA's idiographic focus on individual case studies, a small and homogenous sample size is recommended (Smith & Eatough, 2007). This fits well with the purpose of this study, as the aim is to give a voice to a very small and specific group. IPA is also influenced by symbolic interactionism, which refers to the process whereby individuals develop their understanding of the world by socially interacting with other people using significant communications (Howitt, 2013). IPA starts from the assumption that peoples accounts tells us something about their private thoughts and feelings and that these in turn are implicated in people's experiences, therefore producing knowledge of this nature.

Consideration of Alternative Qualitative Methods

Discourse analysis focuses on the role of language in the construction of reality. The aim of the method, including critical discourse analysis (Fairclough, Mulderrig & Wodak, 2011); narrative analysis (Willig, 2008) and discursive psychology (Willig, 2008) is to understand how people use language to construct and position identities.

However, the aim of this research is to understand the meaning that this group attach to the phenomena at hand and gain a rich and in-depth account. However, if this study was concerned with how African - Caribbean's with schizophrenia construct the therapeutic relationship and the power implications involved in such constructions, then I would have considered a critical discourse analysis (Parker, 1997) as this may have been interesting.

Grounded theory is a method that's concerned with the generation of theory. It involves testing developing knowledge and theoretical formulations through the data that is generated (Strauss & Corbin 1994). The approach aims to uncover and gain insight into social processes. It could be argued that grounded theory takes a more deductive approach towards discovering knowledge. This is quite different to the inductive approach of IPA, where the focus is more on the meaning that the individual brings to the experience and gaining insight and understanding into the persons world. While both approaches do hold some similarities in terms of analysis and attending to meaning, the idiographic focus of IPA was deemed as more appropriate for this study, due to the emphasis on phenomenology. Thematic analysis was also considered, due to its focus on exploring the experiences of a specific group (McLeod, 2011) which is similar to IPA. However, unlike IPA, thematic analysis is not underpinned by any set of theoretical assumptions. Due to the nature and purposes of this study, IPA was deemed as a more suitable approach due to its philosophical base.

Moreover, much of the research within this area has adopted quantitative approaches. However, a limitation of such approach is that the individual meaning and context is omitted and does not allow for an exploration of the subjective experience, which is an integral aspect of the aims this research. Therefore, the epistemological stance of IPA is suitable for the proposed research question and allows for a subjective exploration of this groups lived experience. Qualitative research can give voice to those accounts that would usually be marginalised (Willig, 2001). Furthermore, no research so far has explored this topic area using IPA as a methodology. The phenomenological approach of IPA closely aligns with counselling psychology's value base, due to its emphasis on the individual lived experience. Individuals diagnosed with Schizophrenia are considered a marginalised group and being from an African-Caribbean background adds a further layer of complexity, due to the multiple socio-cultural and political identities

(Moodley, 2003). As IPA attends to how participants perceive their world, such approach is sensitive to cultural context and therefore an appropriate and empowering method for exploring the topic at hand.

Strengths and Limitations of IPA

A limitation of IPA is that it describes the lived experience of individual's but does not go further to explain it (Willig, 2008). Moreover, one could argue that before an experience can be explained, it first needs to be understood and the meanings people attach to their experience explored (Macran & Shapiro, 1998). The role of language is also another criticism of IPA, as participants describe their experience to the researcher through the language they use. It has been argued that language constructs rather than describes reality, as when we describe an event, we are constructing a version of that experience (Willig,2001).

Participants

Five participants were recruited for the study, three men and two women from an African-Caribbean background, all with a diagnosis of Schizophrenia. The age ranged from Twenty-Four to Fifty- Four (see table 1). Three of the participants were recruited from a forensic supported living accommodation in South London and one was recruited from a Hearing Voices Group in Surrey and one participant was from a supported living organisation, also in South London. One participant also had a physical disability and was wheelchair bound and another had several health issues. All five participants received at least six sessions of psychological therapy, to ensure that a firm therapeutic relationship had formed. All five participants engaged in psychological therapy which ranged from six months to one year. Four participants therapy took place within an NHS context: with a clinical psychologist, counselling psychologist, psychotherapist and one with a BACP counsellor, within a charity setting. Only one participant had a therapist who was from a similar cultural background. Moreover, a homogenous sample was achieved, which is essential for an IPA data analysis (Smith, Flowers & Larkin, 2009). Additional information is provided in the table below.

Table 1.

Summary of participants' details

Participant	Age	Background of Participants	Therapeutic model	Therapist type	Therapist cultural background
David	52	Black British Caribbean	Counselling	Counselling Psychologist	White/welsh
John	42	Nigerian	CBT	Clinical Psychologist	White British
Diane	24	Black British Caribbean	Integrative	Psychotherapist	White British
Julie	52	Black British Caribbean	Counselling	Counselling Psychologist	White British
Patrick	47	Black British Caribbean	Counselling	Counsellor	Black Caribbean

Sampling

The recommended and suggested sample size for IPA is between four and ten interviews for a professional doctorate research (Smith, Flowers & Larkin, 2009). Due to the purposive nature of sampling within IPA, the intention was recruit between six and eight participants. However, due to difficulties and challenges with accessing this client group and having one participant change their mind at recruitment stage, five participants took part in the study. As the main aim of IPA is to gain in - depth data (Larkin & Thompson 2012) sample sizes are usually kept small. Participants were selected according to the criteria of relevance to the research question (Willig, 2001). The chosen participant group for the study comprised of adult men and women between the ages of Eighteen to Sixty-Five, with a diagnosis of Schizophrenia and who identify as being from an African - Caribbean background. This is in line with IPA's requirement of homogeneity.

African - Caribbean will be used in the context of this study to describe people with African ancestry who migrated from the Caribbean isles, African groups, second generation Black British and some forms of mixed-race parentage. As aforementioned, the rationale for choosing this participant group is due to the poorer therapeutic outcomes and higher prevalence of schizophrenia among African - Caribbean's. Participants needed to either currently be undergoing psychological therapy and

received at least six sessions or had completed psychological therapy and engaged with at least six sessions. The psychological therapy received among participants could be of any modality, as indicated by the literature - the therapeutic relationship is considered a common factor within all psychotherapy types (Horvath, 2002).

It was also important that participants selected for the study all had full capacity to consent and understand the interview. Due to the nature and vulnerability of the client group, a screening took place where potential participants were asked a set of questions to determine their suitability to participate in the research. Exclusion criteria for the study included anyone who was not of the stated ethnic group, due to the purpose of the research question and study, anyone with severe psychotic symptoms that could affect mental capacity or significantly affect their ability to participate in an interview (thought disordered or distressed by symptoms) and anyone that did not agree to consent and also non – English speaking, due to the difficulty of conducting an interview

Ethical Considerations and Recruitment of Participants

This study was carried out as part of the Professional Doctorate in Counselling Psychology at London Metropolitan University and supervised by an academic member of the faculty. The project was approved by the Research Degrees Committee. Recruitment posters were emailed to several different mental health charities across London, Hearing voices groups and supported living organisations were also visited, and posters were given by hand and made visible to individuals. In one of the organisations, a presentation was carried out, allowing individuals to gain more information concerning the research. Participants that were interested, made contact via email and were contacted by the researcher. Further information concerning the study was sent out by email, such as the participant information sheet and consent forms. Participants were then contacted by phone and the procedure was explained and an interview date was arranged.

Before the interviews took place, participants had the opportunity to ask further questions about the study, issues around confidentiality, recording data storage and disposal was discussed and participants were given a consent form to sign, which again

detailed the aims of the research and outlined participants rights. Participants were informed verbally that were free to withdraw from the research at any time without consequence/ or without having to provide a reason, up until the time and stage of analysis. It was explained that in case of potential publication, anonymised transcripts would be kept for five years and then destroyed. Also, that a copy of the thesis would be kept in the library of London Metropolitan University and made available for viewing by researchers, students, teaching staff and examiners. Any data collected and all signed forms will be kept in a locked cabinet in the researcher's home and electronic data will be kept and stored in a password protected home computer. Identifying information will also be removed to ensure that anonymity is maintained. The BPS Code of Human Ethics (BPS, 2010) make it clear that confidentiality may have to be omitted, should anything be disclosed that may pose a danger of harm to self or others, or if anything is revealed that may raise serious ethical concerns.

The researcher took seriously into consideration that the subject under investigation was one of a sensitive nature which required participants to reflect on their personal experiences of therapy, which could invoke painful material. Also taking into consideration the vulnerability of the client group, a distress protocol was followed which used a three – step protocol detailing signs of distress, which the researcher observed closely, to ensure the appropriate action would be taken if necessary. This involved paying attention to the body language of participants, such as tearfulness, restlessness, shaking and other forms of discomfort, and pausing or terminating if necessary. The researcher is a trainee counselling psychologist, and therefore experienced at being able to identify and manage situations where distress may occur. The researcher thoroughly went through the debriefing form after each interview, and participants were asked whether they needed any more information concerning the study or whether they had any issues. The researcher also went through the list of organisations that could provide support and advice, should they have any concerns, or in need of further support.

Interviews/Materials

Data was collected using semi - structured interviews and an interview schedule was constructed (see Appendix F). Semi structured interviews are an appropriate method of

data collection, as it provides a focus and structure, whilst also allowing for other emerging and relevant topics to be explored with participants, enabling more rich and in-depth data (Smith, Flowers & Larkin, 2009). The interview schedule was peer reviewed and used as a guide to conduct the interviews. The interview began with a question around how long-ago participants received psychological therapy and then went on to explore their experience of therapeutic relationship and questions were asked about their therapist qualities and characteristics and how they felt during therapy.

Other materials used included audio recorder, participant information sheets (see Appendix B), informed consent forms (see Appendix C), debrief sheets (see Appendix D), distress protocol (see Appendix E) and lists of psychological services. To assess whether participants were appropriate for the study and were not actively experiencing psychosis, The Clinicians - Rated Dimensions of Psychosis Symptoms Severity Scale was completed by each participant. The scale is an 8- item measure that assesses the severity of mental health symptoms that are important across psychotic disorders, including delusions, hallucinations, disorganised speech, abnormal psychomotor behaviour, negative symptoms (i.e., restricted emotional expression or avolition), impaired cognition, depression and mania (see Appendix A). A reflective diary was also kept, enabling the researcher to record events after each interview. Participants were also asked to complete a demographic questionnaire after the interview, to gain background information.

Pilot Study

To ensure the feasibility of data collection, a pilot study was conducted prior to recruitment (Leon, Davis & Kraemer, 2011). A trainee who was also enrolled on the Counselling Psychology Doctorate at London Metropolitan University participated in the pilot study, although this was not included in the final sample. The purpose of the pilot study was to examine the practicality of the interview schedule with the target sample and to practice interviewing techniques. It was evident from the pilot study that the interview schedule allowed the participant to elaborate about his experience in enough detail and all the questions asked were comprehensible, therefore no amendments were made to the schedule.

Analytic Procedure

An idiographic approach was adopted for the analysis as suggested by (Smith, Flowers & Larkin's (2009) guidance, which allowed for each transcript to be examined in detail, before moving onto the next. The analysis began with reading and re reading the transcript over and over a few times to enable familiarisation with the text, as suggested by (Smith, Flowers & Larkin, 2009). After full engagement and saturation into the text, initial responses and questions concerning the material, was written down in the left-hand margin (Smith & Osborn, 2008). This included personal emotions and thoughts that were triggered, to facilitate reflexivity. Initial notes were then looked at again in more detail, with the aim of trying to make sense of the material by attending to strong emotions, thoughts and expressions that stood out.

The transcript was then read through a few more times to ensure that the collated notes reflected the original data. The next step involved compiling emergent themes and then noting them on the right-hand side of the transcript, for each section of the text. This aspect of the analysis and coding is more interpretative and draws on some psychological concepts. The next stage involved listing all the identified themes and looking at them in relation to one another and similarities across the themes were explored and identified and from this clusters were formed (Willig, 2001). Descriptive labels were allocated to the clusters of themes that appeared significant and relevant to the research question (Smith & Osborn, 2008). To ensure that the identified themes made sense in relation to the original data, it was necessary to move back and forth between the list of themes and the transcript.

The next stage of the analysis involved producing a summary table of the structured themes, alongside quotations that illustrated each theme. During this stage, some of the initial themes were disregarded, due them not being representative of the text and the more significant material that was related to the studies aims was drawn out. The table included the cluster labels, alongside their subordinate theme labels, brief quotations and references to where the relevant extracts were to be found in the interview transcript. The same step was followed for each transcript and every effort was made to

bracket out previously identified themes, whilst acknowledging that the analytic process would inevitably be influenced by the former analysis (Smith, Flowers & Larkin,2009).

The next state of the analysis involved looking across each individual case, to identify any existing patterns with the intention of integrating the themes. This involved looking at similarities and differences across the themes of participants. An inclusive list of master themes and subordinate themes was generated, reflecting the experiences of participants as a whole. These themes were again checked against the transcript to ensure that the master themes reflected the original data. Lastly, a narrative account was developed which aimed to provide an analytic interpretation of the lived experience of African-Caribbean's with a diagnosis of Schizophrenia and how they experience the therapeutic relationship, presenting transcript extracts to support the analytic commentary (Willig,2001).

Quality and Validity in Qualitative Research

There are several principles that support good quality qualitative research. This section will demonstrate how the current research has met the criteria and quality and rigour that has been outlined by (Yardley, 2000).

Sensitivity to context

Yardley (2000) states that the researcher must show sensitivity to context when carrying out good quality research. Before the research question was developed, a rigorous review of the literature enabled awareness and understanding concerning the background of the topic, which allowed for an exploration of the socio-political context, as well as the scope of the research available. This was to ensure that the topic of how African-Caribbean individuals with a diagnosis of Schizophrenia experience the therapeutic relationship could be explored in an open-minded and ethical manner. The method of IPA was chosen as it allows for idiographic experiences to emerge and considers the individual from within a specific context. The interview schedule was constructed in a way that allowed for individual accounts to be open and explorative and not restricted by any agenda of the researcher. Keeping a reflective diary supported

this process and allowed the researcher to bracket out any preconceptions and expectations.

Commitment and Rigour

The research was carried out over a considerable period of time and during this process a good amount effort was spent by the researcher immersing themselves into the relevant data and literature concerning the topic and a thorough engagement with the analytical process. The knowledge of skills needed to conduct this piece of research was gained from the taught component of the professional doctorate programme, as a well as prior knowledge gained through completing a Master level dissertation. Several research days were also provided by the university, which required full participation and commitment from the researcher, and this allowed for further knowledge to be gained to support the research, further increasing skills within this area. Participants were screened against the inclusion criteria before the interview process, to ensure that the sample was homogenous, which is a preferred requirement for IPA (Smith, Flowers & Larkin, 2009). During the interviews the researcher was thorough at probing further when necessary, which elicited more in-depth and interesting findings. Smith, Flowers and Larkin (2009) process of coding through to the development of themes was rigorously adhered to and every effort was made to ensure that the voice and individual experience of participants is reflected in the material.

Coherence and Transparency

The study's findings are placed in a clear context and presented in relation to a clearly defined research question. There is a clear fit between the research question and the philosophical perspective that has been adopted (Yardley, 2000). The study's findings are shown in the context of reflexive statements on the research process and appropriate quotes by participants. Transparency is shown through accessible data sourcing and procedure of analysis, as the reader can clearly follow how the data was analysed and how results were reached (Yardley, 2008). Furthermore, there is a clear distinction between participant narratives and the researcher's interpretation of such accounts (Elliott, Fischer & Rennie, 1999). Transparency was also apparent in the analysis

process as the researcher's interpretations of the data was shared with her research supervisor, whereby theme meanings were discussed, explored and negotiated.

Reflexivity on the Research Process

Reflexivity is a fundamental aspect of conducting an IPA analysis, as this enables the researcher to bracket out any prior assumptions concerning the research process (Smith, Flowers & Larkin, 2009). This section will demonstrate engagement with the reflexive process during the research.

I fully acknowledge how I may have impacted the research process, especially as a black female counselling psychologist (in training) in the role of a researcher. As my research was looking at the experiences of African-Caribbean's and being from this background myself, may have led to feelings of familiarity and assumptions both from participants' and myself as the researcher. This may have influenced how participants responded to my questions and how they felt during the interview, as being from the same cultural background may have allowed participants to feel more comfortable at discussing quite a sensitive issue. There may have been an expectation of me being able to relate to their experience, due to my own background, on both sides. Such expectations and assumptions of shared experiences could possibly have led to misunderstandings. I engaged in this research with prior knowledge and experience of the topic area and have delved deeply into the available literature. Having worked with this client group within a placement setting in the role of a counselling psychologist trainee, whilst this enabled insight and helped with the formulation of the research question, there is a possibility of bringing presumptions and biases to the interview and analysis.

Using an interview schedule and prompts as a guide, was helpful to avoid leading questions. However, it would be naive not to consider that participants may have noticed a bias in my responses and any enthusiasm in my body language such as nodding and any changes in the tone of my voice towards certain responses, which may have all influenced what participants decided to speak about. Keeping a reflective diary seemed to help this process, as it allowed a distance and space away from the analysis that allowed for reflection. It must be acknowledged that the IPA study reflects my

interpretation of participants' meaning making and individual experiences. I'm aware that my interpretations of the material are my own individual stance and influenced by my own personal interest in the topic and that it is likely that another researcher would have been drawn to other aspects.

I'm aware of how my position as a trainee counselling psychologist may have also influenced the research process, in terms of how participants responded to me. After the interviews, one of the female participants asked if I could stay in contact with her and asked whether I could provide her with counselling. Also, the other female participant asked if I could recommend her a therapist. After reflecting on this, I wondered what I might represent to both participants and considered that there wish to extend the researcher relationship into a therapeutic one, not only mirrored some of the material that came up in the analysis from both participants, but also caused me to further reflect on how being a black female trainee counselling psychologist, may have impacted upon the entire research process.

CHAPTER 3: RESULTS

In this section the results of an Interpretative Phenomenological Analysis (IPA) of five African-Caribbean individuals with a diagnosis of Schizophrenia and how they experienced the therapeutic relationship in psychological therapy will be discussed. The analysis resulted in the emergence of three master themes, which encapsulate the lived experiences of the participants. The themes are as follows:

1. **Love with Judgement "Never condemned"**
2. **A Chance to be Heard (Fear vs Freedom)**
3. **Separation from the Therapeutic Relationship**

The master themes and contributing subordinate themes will be developed into a written narrative in the remainder of this chapter and will be illustrated with verbatim extracts from interviews. This chapter conveys one possible account of how African-Caribbean individuals with a diagnosis of Schizophrenia may experience the therapeutic

relationship in psychological therapy. This account aims to draw attention to the varied experiences reflected across the data set, also demonstrating the similarities and differences between individuals. Every issue raised is not covered, but only those that were the most pertinent to the research question. It must be acknowledged that the themes are not entirely separate from one another but are strongly associated (See theme table 2).

SUPERORDINATE THEMES	**SUBORDINATE THEMES**	**CORRESPONDING QUOTE**
LOVE WITHOUT JUDGEMENT ("Never condemned")	Feelings of Nurture (going beyond)	*"well that guy was even more loveable, the guy would make you two cups of tea, orange there, he would even give you a biscuit and you sat in an office in ……. hospital in Lewisham for an hour, and we use to talk…* ***(David 269 – 275)***
	"Feelings of acceptance"	*"He understands me quickly, he understands everything I do, very understanding and very loving, because for me I don't like people condemning or not listening…"* ***(John 52 – 54)***
	A sense of safety	*"She felt, I feel like she was trying to, she was really trying to understand me and ermm at time it felt like she was actually feeling my emotions"* ***(Diane 430 - 432)***

	Beyond colour **(**Cultural needs vs therapist qualities**)**	*"It weren't an issue to me no, sometimes you do find it an issues talking to somebody who that is not your colour or ethnic background, I'll be honest with you, I've come across some people like that…"* ***(Julie 263 -269)***
A CHANCE TO BE HEARD **(Fear vs Freedom)**	Intimacy vs resistance	*"Erm to tell you the truth yea, I tried to like erm play down like I wasn't gonna do it, but at the same time I know I had to something, I just said Il do, to see what I can get out of it innit…quite serious my condition"* ***(Patrick 249 – 252)***
	A sense of release	*"when I was with him… I had peace of mind, even though I'm struggling, but I know I'm going to see him on Thursday, I normally see him on Thursday, so I always wait for Thursday and I talk to him, you know most of the time I cry…"* ***(John 37 - 40)***
	A new sense of Empowerment	*"I felt for one moment I was an adult, I was the voter, I thought I put my card into the poll station box, I had a voice, I had the right to vote, I had the right to be this person, I was not just an object…"* ***(David 295 -298)***

SEPARATION FROM THE THERAPEUTIC RELATIONSHIP	Coping beyond therapy (Loss)	*"but I was just very unhappy at the time when he left and my psychiatrist left at the same time, without really telling me they were going to leave, so they just sprang it on me and I didn't know"* ***(Julie 18 - 20)***
	New Beginnings (Hope)	"*Made me feel for once in life, I was going in the right direction, I could stand on my own two feet and I could explain things, I could reach the heights of grandiose and survival and you know erm, and become get a professional life, get married…"* **(David 453 – 456)**

Love without Judgement ("Never Condemned")

Overview

This theme aims to encapsulate the aspects of the therapeutic relationship that were viewed to be the most meaningful, focusing on the qualities and characteristics that were conveyed by the therapist during therapy. Love can be viewed in this context, as a deep sense of respect and care that was shown by the therapist. This theme demonstrates the expression of this fundamental human need, to a client group that could be viewed as stigmatised and negatively judged (Stuart, Arboleda-Florez & Sartorius, 2012). Participants narratives therefore could be compared to a corrective

emotional experience (Kohut,1984), where the therapist was able to provide an environment of love and acceptance that led to an alteration in their perceptions of themselves and others.

Feelings of Nurture (Going Beyond)

This theme details how participants experienced a sense of feeling "cared" for by their therapist that went beyond "traditional" interactions in the therapeutic relationship, as boundaries were slightly relaxed. It demonstrates how there was a feeling of the "whole" person being catered to, due to the acknowledgement of other needs.

For some participants, "care" went beyond emotional needs, which led to a sense of informality in the relational dynamic:

> David: *"well that guy was even more loveable, the guy would make you two cups of tea, orange there, he would even give you a biscuit and you sat in an office in ……. hospital in Lewisham for an hour, and we use to talk, we didn't even talk about sick be matters…we'd talk about the football, or we'd talk about the weather, or the pint of beer we had last night, talked about erm weight lifting".*

David seems to be expressing a sense of "casualness" that seemed to be present between him and his therapist. This seemed to provide an atmosphere that was experienced as being "relaxed" and less "formal". There is a strong sense of the therapist being more "reachable" and down to earth, making him more "loveable". A feeling of humility seemed to be sensed by David and received as the therapist not only caring about his emotional needs, but a willingness to go beyond and feed him physically, which was experienced as "nurturing".

John also has a very similar experience with his therapist, as he also speaks about a "relaxed" atmosphere, where needs were met beyond emotional:

> John: "*For me the relationship was him was a very good relationship, very lovely, good relationship, very very good one, because we start you know at*

times he would get me some water and he would make a cup of tea for me, wants to make sure I'm relaxed before we start he wants us to start on a good atmosphere, on a good state, on a better state of mind you know…very very good and he's concerned about my wellbeing and everything, my hygiene and everything, you know which is amazing…".

John also experiences something very nurturing about his therapist's concern around his physiological needs and wanting to ensure that he is fed and comfortable, much like how a care giver would ensure that the fundamental needs of a child were met. The atmosphere created by his therapist seemed to be experienced as soothing and warm. John experienced his therapist as being concerned with every aspect of him, which allowed him to feel valued in the relationship.

This sense of being nurtured and feeling valued was also captured in Diane's experience, as she expressed how her personal qualities were recognised by her therapist:

Diane: "*She said that I'm funny kind, outgoing, always kind of happy, have a lot of talent… like creative artistically wise, good at poetry she said, I let her read some of my poems that I wrote, this was ages ago, but I let her read it and she said it was really good...so she basically saw me*".

Diane seems to be expressing a sense of 'openness' and admiration that came from the therapist, that seemed to be experienced as 'affirming words' and encouragement, as a mother to a daughter. It's as if a deeper aspect of herself was 'recognised 'and accepted, as her personal characteristics were acknowledged. For Diane, the therapist went as far as reading her "poetry", which may have been experienced as "special treatment". An atmosphere was created that enabled Diane to be "herself" within the therapeutic relationship and reveal sides of herself that she would usually conceal, which in this case was her creative abilities. There was a sense of the therapist "nurturing her gifts".

Feelings of Acceptance

This theme highlights how the therapeutic relationship provided an atmosphere that was free from judgement and condemnation, which seemed to encourage a sense of value in participants.

> David: *"Yes I was, I felt good…I could never talk to my parents the way I talk to those people, my parents were very proud people, they believed in academic success and if you don't give them that, they will turn away from you, and they won't listen"*

David seems to be contrasting he's experience of the therapeutic relationship, with the experience of his upbringing and strongly emphasises that "he could never" have that kind of relationship his own parents. There is a feeling of an unconditional type of "love" and acceptance that he never had to earn, that was created within the therapeutic space, that he never experienced with his own parent's, that was free from criticism and shame, which enabled him to feel worthy.

> John: **"***because for me I don't like people condemning or not listening to me…some people don't really understand you, you know, they think your just being silly and just making it up in your head or something, so…he really really understands…"*

For John, acceptance seemed to provide him with a sense of validation and a "change" from his reality of being disbelieved and having to prove himself to others. It is easy for people with a diagnosis of schizophrenia to internalise negative societal stereotypes, leading to self-stigma (Vogel, Wade & Hackler,2007). Having a label and diagnosis, positions him in a place of judgment, leading to a sense of inferiority. For John, a strong sense of understanding came from the therapist, where he felt that he did not even have to explain himself. The therapeutic space was a place where he could be understood and not "condemned", which seemed to provide him with a sense of acceptance.

> Julie: "*What did I like…just at the fact that I could talk to him and tell him anything I wanted to, and he would sit and listen and that was a good thing as well, somebody that would just sit and listen, but not pass judgement".*

Again, like the above account's, being listened to without judgement, was an important characteristic in the therapeutic relationship for Julie. This allowed for a strong degree of openness, which seem to lead to feelings of trust.

Patrick's sense of acceptance was different from the rest and was more about his feelings of "identification" with the therapist, due to his perception of therapist's background, which enabled him to feel understood and accepted.

> Patrick: *"That was good to relate to relate to innit, knows where I'm coming from…I'm a street kid as well so…"*

Patrick seemed to see aspects of the therapist in himself and appeared to strongly identify with him. He viewed the therapist as being from a "street" background and his perception was that the therapist was also able to identify this similarity in him also. Conceiving the therapist in this way, seemed to provide Patrick with a sense of being on an 'equal level' with him and someone that he could "relate" to easily, due to a mutual understanding. Again, there was a sense of Patrick not having to explain himself to the therapist, as he already "knows where he's coming from" and therefore less judgement would be anticipated. This sense of acceptance may also be strengthened by the fact that both Patrick and his therapist were both from similar cultural backgrounds.

A Sense of Safety

This theme conveys a fundamental aspect of the therapeutic relationship, as it is concerned with feelings around safety within the therapeutic space, and how the therapist was able to facilitate an environment that enabled participants to feel contained.

> John: "*Well when I was with him, I feel safe, I felt safe when I was with him, I felt so free, I feel so free… when I was with him…*"

John describes his experience with the therapist as a space where he feels contained, which seems to have led to a strong sense "freedom", where he could let go and not hold back. There is a sense of John being allowed to be his 'true self' in this

environment, where every expression is welcomed and accepted. Britton (1993) viewed this process as a "sanctuary" providing safety, security and form. The repetition in John's description, is his way of trying to emphasise the extreme to which he felt these feelings.

For Diane, her sense of safety came from feeling "felt" and held by her therapist:

> Diane: "*She felt, I feel like she was trying to, she was really trying to understand me and ermm at time it felt like she was actually feeling my emotions… It felt that way sometimes Umhum, especially when I was speaking about certain subjects, she did kinda, I felt like, she felt she was there with me…"*

Diane seems to be describing a relationship with her therapist where there was a strong degree of mirroring and empathy. Empathy has been shown to be associated with attachment, as it leads to sensitive responsiveness (Quinn,1991) and essential in establishing a therapeutic bond, leading to feelings of safety in the therapeutic alliance (Teyber & McClure 2010). A strong sense of intimacy seemed present in the therapeutic relationship, where Diane was able to be vulnerable and open to the extent where her therapist became like a "container" that was highly responsive and able to hold and carry her painful emotions.

David's sense of safety within the therapeutic relationship seemed to be around not feeling judged by his therapist, which enabled feelings of trust to develop:

> David: "*stood there, and I poured my soul out to this man, he never questioned me, never condemned me and never went to my consultant and said this guy is perverse, or wicked, or stupid or black or just erm a menace, he never said that, he never told anything I said to him to anybody, that was good"*.

David's expression of "pouring out his soul" suggests a kind of 'emptying' of his self, where nothing was held back or contained. It seems there was something about the therapeutic environment where he did not feel loathed, judged or criticised. His character was never questioned, neither his "blackness" and there was a sense of all of him being 'allowed'. There was a sense of David feeling although his perceived flaws and vulnerabilities were protected and understood by his therapist, which minimised

any sense of shame. There is a feeling of their being an acknowledgement of the power that the therapist holds, due to the access he has to other professionals, although for David this power was never abused, as his therapist never betrayed his trust.

Different to the rest, Julie "sense of safety" was compromised around issues of power and confidentiality.

> Julie "*Well you have to be careful what you say to them as well, you can't tell them everything, you just can't tell them everything, but as I said .... hospital the ... unit I wouldn't really want to end up going back in there".*

For Julie, there seem to be a need to be careful about what she disclosed to the therapist, as there was a recognition of the therapist being part of a wider and quite powerful system, where confidential information could be passed on. This seemed to be driven by a sense of fear, which in this case was a concern over rehospitalisation, which challenged her sense of safety. Irrespective of the therapeutic bond with the therapist, there was still a doubt about complete trust and therefore a need to hold some things back and "not tell them everything".

Beyond Colour (Cultural Needs Vs Therapist Qualities)

This theme highlights whether the therapist's ethnicity and cultural differences, or similarities, impacted the therapeutic relationship and how these needs were met. It explores whether the therapist qualities and characteristics where more significant and important than any other differences.

> David: "*Even though he was welsh, ……was welsh, he was welsh, he had this way of erm…..humour, he would sit in front of you and he would laugh and then all your troubles came out, just came out, there was no erm, there's no object there, there's no hurdle, plain sailing it just came out, what was wrong with you, what you like, what you did, what was your problem, problem with women, job, parents, your brothers, beat you up, all these things came out, he's a nice guy…."*

David is drawing attention to the cultural difference here, so there is an acknowledgement of there being a difference. However, straight away he begins highlighting his therapist's quality of humour and how this seemed to lighten the atmosphere and provide an environment where everything "came out", unhindered and "plain sailing". There was a sense of him being able to tell the therapist anything and this being due to his personal characteristics, which seemed to surpass any differences in culture.

Again, Julie like David is acknowledging the difference in colour and ethnicity but then goes on to place emphasis on her therapists' qualities:

> Julie: *"It weren't an issue to me no, sometimes you do find it an issue talking to somebody who that is not your colour or ethnic background, I'll be honest with you, I've come across some people like that, but with (therapists name) I didn't, he was… I don't know, he was kind of upper class really…but you know but he was really…very intelligent, he would listen to me and if I said something he wouldn't come across and say that I didn't agree with that, or whatever…."*

Julie is acknowledging the difficulties that maybe present with a therapist who is not of your "colour" and can even identify with this feeling herself and highlights that even though her therapist was a white man, she did not experience any challenges with him in this sense. There is a further recognition of his "class" and "intelligence" suggesting he was someone of stature, which in a sense is conveying him as the stereotypical powerful 'white middle class male'. However, it seems she is expressing that despite his social status and the difference in power that existed between the two of them, that she never felt belittled or undermined and this was due to his ability to listen and not judge.

For Diane, the thought of a cultural difference did not even come to her mind:

> Diane: ***"****I don't really think of culture anymore, cos I know that we are all one race, I don't really think of culture as a thing, I know I have my side where I go to parties and like listen to music and stuff…I think for me it's more about the person seeing me, not about the colour."*

Diane is expressing that cultural differences were insignificant, as she does not really view herself as belonging to a culture. Her main concern was that the therapist saw and valued her, above anything else.

Different to the rest of the participants, Patrick had a black therapist, which led to expectations about the therapist concerning cultural understanding:

> Patrick: "*Well he's was black aswell innit, so he would know what to do…to expect from a black yute cos he's black himself…."*

Patrick is identifying that the therapist is also "black" himself and is therefore highlighting the similarity between them. There seems to an assumption, that because he and the therapist are both black and from a similar cultural background, that he will in some way be able to identify with his experience. It seems that in this case having a black therapist, led to feelings of assurance and confidence that his cultural needs would be met.

John highlights a challenge in the therapeutic relationship where there was a misunderstanding of culture and how this more likely would have been identified by someone of his own culture:

> John: *"I said because I respect her, but he doesn't really seem to understand that, but if you are from my background a black person will know that you need to respect everybody, people that are older than you and there are ways to talk to them and everything, so…. yeah"*

John is expressing a difference in perception between him and his therapist that related to his culture. This seemed like something they were not able to agree on, as his therapist was looking at the situation from a western viewpoint, not recognising the cultural differences that were inhibiting John in this situation. Similarly, to Patrick, there was an assumption that a "black person would know" and again have an automatic understanding, as its culturally embedded. It was not so much about needing to know about the culture, but for John it seems there was a need for the therapist to respect this difference.

A Chance to be Heard (Fear vs Freedom)

Overview

This theme aims to capture how the therapeutic relationship provided a space for the participants to express themselves and be heard and a place where their emotional needs were met. However, it also demonstrates challenges and fears around intimacy and how this was managed throughout the therapy process. It conveys the conflict between wanting and needing the therapeutic relationship, but also a sense of fear around being "naked and vulnerable" to another human being. However, once these hurdles were overcome, it demonstrates a sense of power and freedom that participants experienced in being able to speak and be listened to, which seemed to be different from their normal everyday experiences.

Intimacy Vs Resistance

This subtheme highlights the challenges that participants experienced within the therapeutic relationship in terms of having to negotiate how much of themselves to "open up", while also experiencing the desire for intimacy and closeness.

For Diane, the struggle was about which layers of herself she should reveal and how this would be received.

> Diane: *"Like the real me, but she did kinda see the real me, it that makes sense..the person that I'm trying not..not that I'm scared of, but many people don't like, not cos of like its bad or anything, but you know cos everybody has so many faces.. and so many levels to themselves and so many layers, good, bad ugly, evil or whatever, we all have them, it's just some people are not willing to accept, without judging".*

Diane is expressing her initial fears around being "seen" by her therapist and concerned about her real self being "exposed" in some way. She is expressing the internal struggle that she went through, which involved negotiating how much of herself she should she reveal within the therapeutic relationship. She was worried about how much and "which

parts of herself" would be received and accepted, as there seemed to be a fear of judgement and rejection.

John also expresses similar concerns around having to reveal personal aspects of himself, although for him this may also be influenced by gender:

> John: "*Yea I had concerns, because for me… like other men, I don't like talking about the way I feel, I don't like talking about the way I feel, I realise I need to talk, but I don't like talking about the way I feel, so I was worried about going to somebody strange and talking to the person about me…"*

John is expressing his initial fears around having to express his difficult feelings and partly associated this with being a male. It seems he may hold the belief that men are expected to not show any signs of weakness and expressing emotions places him in a vulnerable position. There seemed to be a conflict around "needing to talk" and the fear of having to "pour out" and build such an intimate relationship with someone new.

This was also similar for Patrick, as he also had concerns around beginning therapy and tried to minimise his need for help:

> Patrick: *"Erm to tell you the truth yea, I tried to like erm play down, like I wasn't gonna do it, but at the same time I know I had to something, I just said Il do, to see what I can get out of it innit…quite serious my condition"*.

Again, like John, Patrick's reluctance in the beginning may have been due to being male also, as there was a sense of him trying to "play down" his need to talk and express his difficulties. It seems he may have gone through a state of denial, where he tried to minimise his psychological distress. There seem to be a sense of shame present in needing to access therapy. However, after negotiating with himself he decided to give in, as his condition was becoming worse. Therefore, it may have been his state of deterioration and desperation for change, that enabled him to push past his initial fears.

However, this was not the case for David, as he expressed no fears around entering the therapy relationship:

David: "I asked for it…. erm somebody to listen to erm…erm…someone to erm……someone to erm…listen put a shoulder on".

In David's case, there seem to be a longing for intimacy and something that he could not wait to experience, as there was no expression of any initial fears. This was also something that he felt he deserved, as he asked for it. There seem to be a sense of desperation, for a space where someone would be able to listen and where he could feel understood and supported.

A Sense of Release

This subtheme captures the point of the therapeutic relationship where participants felt able to "let go" and where they felt able to share some of their most intimate and most difficult experiences. It also shows where the therapeutic relationship became a place of freedom and a space where there struggles and conflicts were embraced, as someone was willing to "hear them".

Diane sense of release was experienced like a process of unravelling, as many difficult emotions came to the surface:

Diane: *"I think the first three four session we spoke about everythink, my childhood traumas and stuff like that and stuff I went through and relationships and stuff like that, within the fourth session I was crying, I would leave the session, my session would be on the Tuesday I think it was or a Thursday or one of those days, and like I would leave and two days later I would be fine…and good, I would start crying, but these weren't tears tears, they were like proper tears, you know when you can't stop yourself from crying"*

Diane is expressing where she opened up to her therapist and spoke about some of her most traumatic memories, although the impact of revealing these painful experiences seem to surface later. There is a sense of Diane's buried emotions being unearthed and her constant flow of tears seem to represent a strong feeling of "release", as she is finally getting to express emotions that have been withheld for years.

John also experienced a similar feeling of release, whilst with his therapist, although the relationship also provided a sense of escape:

> John: "*when I was with him… I had peace of mind, even though I'm struggling, but I know I'm going to see him on Thursday, I normally see him on Thursday, so I always wait for Thursday and I talk to him, you know most of the time I cry, he understands me and most of the time…".*

There is a sense of soothing that John seems to experience from the relationship, despite all the chaos and struggles, the therapeutic environment seemed to provide a calming atmosphere. There is a sense of anticipation for his next session and a longing to be in this space again, week after week, as it seemed to provide an escape from his difficult reality. To express that he "cries most of time", maybe him demonstrating the sense of liberty that he felt in the therapeutic relationship, as he was able to lay himself bare.

For Julie, it was about knowing there was someone there, that would embrace her in any emotional state:

> Julie: *"I don't know you know, he was just somebody that I could talk to and just let off on you know".*

There is a sense of Julie being able to be open within the relationship and it being a place where she could go with anything and be able to completely "release" herself. There is also a feeling of her missing this space, as it seemed to provide an outlet for Julie that was unrestricted, where all feelings and emotions were allowed and accepted as she was able to just "let off".

Sense of Empowerment

This subtheme encapsulates how the therapeutic relationship enabled a shift in self - perception and led to the development of a stronger sense of control, over one's sense of self.

For David, the therapy relationship was experience as an emancipation from his feelings of suppression and inferiority:

> David: "*I felt for one moment I was an adult, I was the voter, I thought I put my card into the poll station box, I had a voice, I had the right to vote, I had the right to be this person, I was not just an object, I was (participant states his name) …"*

David seems to be expressing that for once in his life, he felt significant. His expression of feeling like an "adult", suggests that there was a growth that seemed to take place, that was enabled though the therapeutic relationship. His metaphor of being a "voter" and putting his "card into the box", may suggest that Joseph felt a sense of justice, in finally having his voice heard and taken seriously by someone who was in a position of power, this enabling him to feel valued.

For Diane, her sense of empowerment seemed to come from the therapeutic relationship providing a space, where a new realisation of herself was reached:

> *Diane: "your soul, I feel like when all three of them are connected as in one, that's when it's quite scary, cos as your spirit, you can allow. your spirit to feel things, but your soul will then intervene at one point and say no you can't hide from it anymore, I feel like I've been hiding from my inner emotions for years."*

Diane seems to be expressing a sense of connection that she felt had taken place from within, as she no longer feels fragmented and disconnected from her feelings and emotions. There is a sense of her coming back to herself as one "body mind and soul". The therapeutic space allowed Diane to reach a place where she had to face reality, which meant she could no longer hide from painful and difficult feelings. The therapeutic relationship provided a place where she could reconnect with herself, which allowed for self – discovery and a new sense of awareness, which seems to have provided her with a sense of liberation.

Empowerment for Patrick, came from how the therapeutic relationship itself, fostered an environment of where change was possible:

Patrick: "*Yea it was, it was cos he knows how to get well the best results don't he, he knows, how to get the best results from me"*

Patrick's trust in his therapist skills and expertise, seem to provide him with a sense of motivation and confidence. It also seemed that the relationship that he built with the therapist enabled a stronger sense of self-belief, as the therapeutic environment seemed to enable a sense of growth.

Separation from Therapeutic Relationship

Overview

This theme addresses the experiences of participants when the therapeutic relationship came to an end and how this separation was processed. Some individual's experienced more of a sudden ending due to personal factor's, or the therapist having to leave, while for others, the ending was more planned. For some participant's, the experience was negative and left a void and feelings of frustration and even anger, due to the relationship having to come to an end. While for others, it was experienced as a new beginning, signalling maturity and personal growth. Each subtheme captures the thoughts and feelings that came up for each person and the stages they passed through after the end of their therapy journey.

Coping beyond Therapy (Loss)

This subtheme discusses how participants managed the end of the therapeutic relationship and the emotions and challenges that come up for them.

The therapeutic relationship came to a sudden end for Julie and this was experienced as a shock and quite distressing:

> Julie: *"but I was just very unhappy at the time when he left and my psychiatrist left at the same time, without really telling me they were going to leave, so they just sprang it on me, and I didn't know"*.

For Julie, separation from the relationship was experienced as quite a painful loss, which was further exacerbated by the fact her psychiatrist was also leaving. Julie is expressing her frustration around the lack of preparation for her therapist's departure, which seem to invoke strong feelings of abandonment. She experienced a loss of two people she was close too at the same time and felt a sense of disregard by both. This may have also caused her to question the validity of the relationship.

Unlike Julie, Diane was prepared months in advance, however the "loss" of the relationship was still painful:

> Diane: "*and I was kinda upset by it and I told her, and she was like you only have one more week left, she told me months in advance, but I was still upset"*.

Despite being told months in advance, the reality of the end of the relationship was experienced as very difficult, due to her strong attachment towards her therapist. There is a sense of Diane pleading and trying to extend this time with her therapist by expressing her feeling's, although it was made clear that her time was almost up.

For John, the end of the relationship signified worry around not been able to hold himself together:

> John: **"***Yeah, I was satisfied with the fact that I could go to him and sit there with him every week, even when I stopped, I was worried about how I was going to cope, so I kind of enjoyed talking to him and pouring out my heart to him"*.

The separation from the relationship, seem to leave John feeling a sense of vulnerability, as he was now left to have to "cope alone", "without the safety" of the relationship. He no longer had that person that enabled him to feel contained. Feelings of grief also seem present, as John seems to be reminiscing over the intimate times that

he shared with his therapist. The end of this relationship seems to have left a void, that could not easily be replaced.

Separation for Patrick, came from circumstances that were beyond his control, due to his health:

> Patrick: *"Yea it was quite satisfying, someone out there that I could relate and make an effort with, but erm…my physical health, I couldn't continue treatment, but they made another appointment, I'm going to make an effort with…. actually, strong enough to do the counselling again".*

Patrick's sense of satisfaction and intimacy with his therapist was cut short by challenges with his physical health. However, due to feeling stronger in himself, he now feels able to continue counselling. There is a sense of excitement and anticipation in his tone, of the thought of being reconnected with his therapist.

Separation for David was different from the rest and experienced as a new beginning which led to a sense of evolvement:

> David: "*it's like when you're a baby, you have to make you first moves, your growing up, your first steps, then you gradually become, you stagnating to erm to a new born, into nursery school, into comprehensive, so forth, you have to make your mind up, you have to be the one to do something, unless you want to end up nowhere"*.

David's experience of the end of the relationship, was his chance to grow up and move to a new stage of his life, where he could now be responsible for his feelings and actions. His analogy of a baby represents his need for nurture in the early stages of the therapeutic relationship and as time progressed, he became less dependent. Therefore, the "ending" was a chance for David to "spread his wings" and finally become a man.

New Beginnings (Hope)

This subtheme looks at the future expectations and aspirations of participants, in terms of personal growth and life beyond the therapy relationship.

John's sense of hope came from a new-found belief in himself:

> David: "*Made me feel for once in life, I was going in the right direction, I could stand on my own two feet and I could explain things, I could reach the heights of grandiose and survival and you know erm, and become get a professional life, get married, and erm move away, go away some place, maybe even one day go to a distant country where no one knows you."*

David seems to be describing a shift in his perspective of himself, where there is growth and a stronger sense of identity. There is a sense of him moving forward and reaching a new stage of maturity. There is a sense of him experiencing an emotional high and new feelings of confidence around being able to meet his own needs and "survival". For David, it seems although a new strength within himself was discovered, which led to feelings of excitement about achieving the things for his life, that he may once of thought were never possible.

Diane's, sense of hope also comes from a place of personal growth:

> Diane*: Errrm…. It taught me how to deal with things a lot more, calmly, but then if I do if it does get to much, I do go into my little moments, but it's made me a lot more calmer, just to deal with life a little bit more, not as much as I would like to, but… just a little bit, its helped a little bit.*

Diane is identifying that there were certain skills that she did not have before she began therapy and after entering this relationship, she was able to learn how to better manage her emotions, which enabled and empowered her to manage her life better. There is a sense of her expectations of change not being fully met, although despite this, there is a feeling of Diane taking more ownership over her life and a shift in her sense of awareness; which seemed to have brought her a modest sense of hope.

However, John's perception of change and growth is different to his therapists, which has left him with a sense of hopelessness:

John: "*Yeah yeah…when I saw the comments on the letter, I was like oh… thought I had made some improvements, but I haven't made anything according to his assessment"*

John: "*Well it made me feel worse and bad…. frustrated as well, frustrated as I don't know what to do, you know I don't know what to do again, as I'm finding that I'm improving, but I'm not according to him…really frustrated"*.

John seems to be expressing feelings of confusion, as he has noticed positive changes within himself, although his therapist had a different opinion. There seems to be a strong sense of depletion and discouragement, as in John's mind, if the "professional" feels there is no change, then perhaps there really isn't any, as his opinion holds stronger. This has led to strong feelings of frustration, bewilderment and hopelessness. These feelings may have been experienced as even more conflicting for John, due to the strong therapeutic bond that existed between him and his therapist. Therefore, John's sense of hope has to some extent been overruled by his therapist's judgement.

For Julie, due to the nature of how therapy relationship ended, there is a sense of stagnation, rather than hope:

Julie: "*but I 'm just disappointed… because of what's happened, I was just not expecting that at all"*

Julie: "*To be left on your own just to get on with it"*

For Julie, despite benefiting from therapy and having a positive relationship with her therapist, the sudden ending seemed to have dampened the whole experience, due to the lack of closure. Julie seemed consumed by her feelings of disappointment and there is a strong sense of her feeling "dumped" and "left" to get on with it alone. This seems to have left her feeling disregarded and interrupted her growth process, causing her to feel slightly lost.

CHAPTER 4: DISCUSSION

This chapter begins with a summary of the main findings and will be followed by a discussion of the findings in relation to existing theory and research underpinned by the research question of the current study. Limitations of the study will be addressed and the implications for theory and practice in relation to counselling psychology will be discussed. This chapter will conclude with a reflexive statement and suggestions for future research will be discussed.

Summary of Main Findings

This study found that qualities and characteristics of the therapist, significantly contributed to how individuals experienced the therapeutic relationship and how a safe environment fostered by therapist, enabled a secure attachment to be formed within the therapeutic relationship. This seemed to be more important than the ethnicity or race of the therapist. However, there was an expectation from some participants that having a black therapist would lead to an automatic cultural understanding, which would enable aspects of themselves to be better understood. However, not having a therapist of the same cultural background did not undermine the therapeutic relationship in anyway and rather it was the therapeutic environment that was created by the therapist, that was the most important factor. The relationship was highly valued by participants and offered a space where participants could open up and be listened to, which provided a sense of release and empowerment. Furthermore, most participants felt a sense of loss when therapy ended, which seemed to be due to the bond that was created. For some participants, the end of the therapeutic relationship signalled growth and the development of a new sense of self and experienced as a child growing up and leaving home and separating from parents. For others, the loss was experienced as devasting, leading to a sense of hopelessness, although this was dependent on the nature of the ending.

Contextualising Main findings in the Literature

Love without Judgement (Never Condemned)

The first superordinate theme captured the qualities and characteristics that participants felt were important in the development of the therapeutic relationship and how this enabled an environment where they felt safe and contained, which helped to foster a secure attachment base. Studies have shown that the strength of the therapeutic relationship is a significant factor towards change, irrespective of the therapeutic approach adopted (Orlinsky, Grawe & Parks, 1994; Lambert & Barley, 2001). All the participants in the current study engaged in different types of therapy, CBT, counselling and psychotherapy. However, all report on the therapist characteristics of warmth, genuineness and acceptance. This seems to support the findings that it is not necessarily the type of therapy that is received that enables change, as they all result in similar outcomes, but rather the quality of therapeutic relationship (Paley & Shapiro, 2002). It would be important to discuss some of the core features that enabled the development of a strong therapeutic alliance.

Most participants reported a sense of casualness, an informal style of interaction with the therapist which resulted in an environment that was "open and free" as they felt although the therapist was able to speak to them on an equal level. Laugharne et al. (2012) study draws attention to how individuals with psychosis felt a need for a shift in the balance of power at times within the relationship. This could be conveyed in friendly conversations around shared interests, or through self-disclosures of staff and led to feelings of trust. While these findings are not in the context of psychological therapy, it could still be argued that such concept around power can be applied to the current research, as the sense of informality that the participants are describing seems to be around a balance of power that was created within the therapeutic environment. There is a sense of therapist being "down to earth" and reachable, enabling feelings of trust to develop. Totton (2010) draws attention the concept of boundlessness in therapy, that allows abundance, attention and care to be conveyed that may go beyond normal realms of therapy. This sense of informality was also experienced as the therapist "going beyond" their normal duties and providing a relationship that surpassed meeting psychological needs alone, allowing for a "human to human" connection.

The client and therapist relationship can be viewed as an attachment relationship (Parish & Eagle, 2003; Daniel, 2006; Collins, 2007). Previous research has shown that the stronger the attachment security, the stronger the therapeutic alliance (Diener & Monroe, 2011). Participants spoke about their therapist providing them with food, which led to a feeling of being cared for and looked after. Another participant spoke about the therapist showing interest in her writings and poetry and being able to bring this to sessions, which allowed her to feel although the therapist had a genuine interest in every aspect of her, all of which are characteristics that are demonstrative of a "mother "to a child. Markin, (2014) asks the question, "what type of relationship does my client need" and argues that this is something that all therapist need to consider. It was this sense of nurturing that was provided from the therapist, that seemed to encourage the formation of the therapeutic bond between participant's and their therapist.

Due to the nature of the relationship described by participants, it seems that interactions with their therapist also allowed for their social needs to be met, as the relationship was not only an "emotional container", but also provided a consistent space where participants could attend and interact with another human. Research indicates that individuals with severe and persistent mental health problems often have deficits in social functioning and strained social and family ties making the therapeutic relationship a vital source (Buck & Alexander, 2006). Several studies suggest that attending to emotional and social factors appears to be relevant to social/community functioning in those diagnosed with schizophrenia (Bola & Mosher, 2003; Ciompi & Hoffman, 2004; Guo et al. 2010; Pijnenborg et al. 2008). Moreover, research has shown that attending to a client's interpersonal needs can not only help in reducing symptoms of schizophrenia, but also at times without the use of anti-psychotic medications (Bola & Mosher, 2003; Ciompi & Hoffmann, 2004).

Laleman (2006) highlights the importance of empathetic communication with participants and an approach that encourages acceptance and positive regard when engaging in psychotherapy with individuals with Schizophrenia. All participants described a feeling of acceptance within the therapeutic relationship and felt the environment created by the therapist allowed them to be themselves. One participant

mentioned that the relationship provided him with an unconditional type of love, that he never even experienced with his own parents. Robbins (1993) outlines the importance of therapists who work with individuals experiencing psychosis to demonstrate empathy, patience and attunement capacities. Some participants spoke about a sense of validation that the relationship provided, as for once they were not being judged or viewed negatively. Vogel, Wade and Hackler (2007) draw attention to how individuals with severe mental health problems, such as those with a diagnosis of schizophrenia, can internalise societal stereotypes and judgements, which results in self – stigma. Livingston and Boyd (2010) found that feelings of self - loathing and unworthiness undermined therapy. The therapy environment provided a space free from "condemnation and judgement", allowing participants to internalise a new perception of themselves.

Research has shown that African-Caribbean people are less likely to access mental health services and psychological therapy which is due to stereotypical beliefs, perceived discrimination and institutional racism (Mckenzie & Bhui, 2007; Singh, 2007). Research has also shown that when African - Caribbean people do engage with therapy they are more likely to drop out and have a poorer working alliance (Walling, Suvak, Howard, Taft & Murphy, 2012). African - Caribbean people with a diagnosis of Schizophrenia carry the shame of diagnosis, in addition to issues around perceived discrimination, which may impact upon engagement in psychological therapy. The sense of acceptance and non - judgement that participants expressed to experiencing in the therapeutic relationship, allowed them to feel although every aspect of them was valued and led to a sense of safety. Only one participant had a black therapist and his account slightly differed as his sense of non - judgement and acceptance came from a sense of identification with the therapist. This supports Holland's theory around people being attracted to people who are like them, as similar types act as reinforcing environments for each other (Taber, Leibert & Asaskar, 2011).

Allen (2001) highlights the difficulties in the capacity for emotional attachment when working with individuals with a diagnosis of schizophrenia. She advocates that attachment trauma damages the safety regulating system and negatively impacts upon the traumatised persons capacity to use relationships to establish feelings of security. All participants described a sense of safety that was present in the therapeutic

relationship and how this enabled a strong attachment to form between them and the therapist. It is only when the analyst shows that he or she knows the patient's fear and anguish and thereby becomes established to some degree as a calming, containing, idealised other, that the patient begins to feel safe enough to allow his or her subjective life to emerge more freely *(Stolorow, 2014, p.50).* This safety was described by participants as freedom to be one's self and fully open up to the therapist, which enabled intimacy.

Julie expressed that she did not feel entirely safe and was careful about that she disclosed, as she was aware that information regarding risk could be passed onto other professionals, which made her concerned about re-hospitalisation. Research has shown that African - Caribbean people have difficulties trusting mental health services, which is based around fear of hospitalisation and coercion (Keating & Robertson, 2004). Studies have shown how the threat of coercion from mental health professionals towards individuals with acute mental health problems erode the therapeutic relationship, resulting in a lack of trust (Gilburt, Rose & Slade, 2008). It is clear from this current study that a sense of safety within the therapeutic seemed to enable feelings of trust. This supports the literature in that "trust" seems to be an important factor in why African – Caribbean groups are less likely to engage with mental health services and likely to have a poorer alliance, due to not feeling safe with mental health professionals.

Empathy and attunement from the therapist were important in allowing participants to feel secure within the therapeutic space, as some participants spoke about feeling although there "emotions were felt" and that they felt able to "pour out" due to the therapeutic environment. The literature indicates that empathy is essential in establishing a therapeutic bond, often leading to feelings of safety in the therapeutic alliance (Teyber & McClure 2010). Agoro (2014) study found that therapists who were empathetic and warm and who tailored therapy to the individual needs and being open to cultural issues, helped the therapeutic process. All participants felt that the therapist's qualities and how they were made to feel within the therapeutic space, was more important than the therapist's race or culture.

Rathod, Kingdon, Phiri and Gobbi (2010) aim was to produce a culturally sensitive adaptation of an existing CBT manual for therapists working with individuals with Psychosis. The study found that irrespective of the practitioner's ethnicity, sensitivity towards culture was a key to success in therapy. Most participants within the current study felt that their cultural needs were met. However, one participant while he had a strong bond with his therapist, expressed that he did not feel although these needs were met fully, as the therapist could not understand how a culturally specific issue, played a part in his distress and the therapist found it difficult to accept and understand this difference. This seemed to reflect the findings in Jim and Pistang (2007) study as it was not so much the therapist's cultural knowledge, but the therapist skill in being able to understand the unique dilemmas and distress within the context of cultural values that was significant for John.

He further expressed that he felt that a black therapist would have understood this without any explanation. Moreover, another participant had a therapist who was from a similar cultural background and felt that his therapist understood his needs as a "black man" and it was assumed that this was because the therapist was also "black himself". Clarkson, (2005) mentions the facilitative transference and how an individual's culture, style and similarities between client and therapist can work in a facilitative way. There was a strong sense of identification with the therapist and feelings of admiration. Both participants assume that a black therapist would have a better understanding of their cultural needs.

In this case, while the participant felt although his therapist could not fully understand something that was cultural, this did not necessarily fully undermine the relationship. Furthermore, the participant with the black therapist felt that his cultural needs were fully met, due to therapist portraying an "orientation" like his own. Again, this seems to have been strengthened by his sense of identification with the therapist, which appeared to enhance the therapeutic alliance, which supports (Owen, Leach, Tao & Rodolfa, 2011) findings around client perceptions of Multi-Cultural Orientation being positively related to psychological functioning and the therapeutic relationship. The remainder of participants did not highlight any issues within the therapeutic relationship regarding their cultural needs. Sue (1998) asserts that while cultural expertise maybe necessary, it is not enough, and therapists must know when to generalise and when to individualise.

Perhaps for some participants, there experience of an individualised approach from their therapist enabled their cultural needs to be met automatically. An approach that is truly tailored to the individual should create a curiosity within the therapist, that should allow them to consider every aspect of the person, including their culture and how this might be implicated in their distress.

A Chance to be Heard (Fear vs Freedom)

The second superordinate theme exemplifies some of the feelings that participants experienced within the therapeutic relationship and some of the challenges of having to establish a relationship with someone new and the freedom and sense of release that the therapeutic relationship eventually provided. The literature has highlighted challenges and difficulties that may become present in the therapeutic relationship with clients with psychosis, in terms of issues around attachment insecurity and fear around establishing a relationship (Lotterman, 2016; Jung, Wiesjahn, Rief & Lincoln, 2015; Wittorf et al, 2010). In the current study it could be argued that all participant developed quite strong attachments with their therapist, although most participants did report fears around intimacy and ambivalence around having to get close to somebody during the initial stages of therapy. Hycner (1993) advocates that resistance is a manifestation of just how vulnerable an individual is and is a form of self-protectiveness. Some participants expressed worries around feeling exposed and having to reveal aspects of themselves that could be judged, which seemed to indicate fears around rejection and not being accepted.

John expressed that he felt uncomfortable at the thought of having to speak about his feelings, especially as a male. It seems that there was some shame in having to access therapy and that as a man he should be able to handle these feelings, which is in line with the literature regarding the help seeking attitudes of men (Berger et al, 2013). Patrick similarly expressed that he was unsure of therapy at first, but felt he had to, due to deterioration in his mental state. The literature has indicated that African – Caribbean people are less likely to access mental health services voluntary and that this is even more prevalent among black males, as they are likely to disengage with mental health services and report poorer experiences (Wagstaff Graham, Farrell, Larkin & Nettle,

2016). John and Patrick may not have disengaged or reported negative experiences but were initially ambivalent about beginning the therapy process.

The literature indicates that those with schizophrenia-spectrum diagnoses often have smaller social circles, which is primarily made up from family and mental health professionals, which makes the therapeutic relationship potentially beneficial or harmful due to the clients fears around potential loss of the relationship (Berry, Wearden & Barrowclough,2007). In the current, study the early stages of the relationship seem to be met with this conflict, although once participants moved past their initial fears around intimacy, there seem to be a strong sense of release and freedom that participants experienced. The relationship provided a space where participants could speak openly about their feelings and emotions and was a consistent base where they could attend week after week, which minimised any feelings of isolation and loneliness. Buck and Alexander (2006) also found that clients reported that the therapist "being there" was a very important factor in the therapeutic relationship. The relationship enabled participants to feel supported and seem to provide their lives with a stronger sense of meaning, as all participants described a sense of feeling valued in the relationship. These characteristics were also present in (Ware, Tugenberg & Dickey, 2004) study.

Fitzpatrick et al. (2006) found that productive self-disclosure from clients and active receptivity helped to develop and strengthen the therapeutic relationship, which was similarly found in the current study. Participants described how they reached a place where they could be open with their therapist, which caused them to feel a sense of exposure, but also a sense of liberation at being able to speak about their difficult feelings. Noyce and Simpson (2018) study further complements the current study and found that participants felt that they were able to connect with their therapist on a deeper level when they arrived at a point where they felt completely understood, which enabled them to fully open – up, allowing themselves to feel vulnerable. John expressed the feelings of anticipation that he felt every week, knowing he was going to see his therapist and how he would often "cry" during sessions. This vulnerability allowed him to be free and was due to the sense of peace and safety he felt within the therapeutic space. David similarly expressed how he was able to "pour out" to his therapist.

The therapeutic relationship also enabled participants to develop a sense of empowerment and enabled them to have more awareness and understanding of themselves, providing them with a sense of purpose and self – worth. Therapy seemed to provide David with a voice, as someone was "finally listening to him" and showing him compassion and empathy, rather than him being silenced by medication. He finally felt like a person with needs and feelings, which allowed him to feel valued. Diane's sense of empowerment came from a sense of reconnection with herself and emotions. Knudson and Coyle (2002) study conveys the importance of counselling psychologists attending the subjective world of the client and individual meaning making. This sense of empowerment seemed to demonstrate a shift in the perception of participants sense of selfhood. As aforementioned, (Deegan 1996) refers to "Recovery" as restabilising a self-determined and meaningful life despite of mental illness and the negotiation of a new identity and sense of control. Cavelti, Kvrgic, Beck, Rusch and Vauth, (2012) study found that clients that presented with more of a recovery orientation presented with less self-stigma. All participants seem to demonstrate a sense of feeling more in control of their lives and having greater awareness of their feelings and emotions providing a stronger sense of confidence.

Separation from the Therapeutic Relationship

The third superordinate theme describes how participants experienced the ending of the therapeutic relationship and the feelings that came up for them during this process. All participants except Patrick, remained in therapy until the agreed end date, although he did not leave willingly, and this was due to him becoming unwell with a stroke. Most participants experienced the relationship as a loss and was concerned about how they would cope beyond therapy. Few studies have investigated the feelings of clients concerning the termination of the therapy relationship (Roe, Dekel, Harel, Fennig & Fennig, 2006) let alone for individuals with a diagnosis of Schizophrenia ending therapy. Barnett, MacGlashan and Clarke (2000) advise that careful consideration needs to be given to the ethical responsibilities concerning the termination of therapy to prevent the client from hurt, or feelings of abandonment and instead endings should be a solidifying process that enables the integration of treatment.

Orlinsky, Ronnestad and Willutzki (2004) study concluded that while handling termination appropriately is important, that it is probably what happens in therapy prior to the ending, that has the most impact. This was not the case in the current study, as some participants experienced the therapeutic relationship to end suddenly and prematurely, leaving them with a sense of abandonment. This was mainly the case for Julie, as this was not what she was expecting, as it came at a time when her psychiatrist who she had known for years, was also leaving. The nature of the psychotherapy process involves trust, power, and caring (Pope & Vasquez, 2007). Managing the ending appropriately, helps avoid betrayal of the trust and abuse of power. Appropriate termination also prevents harm and conveys caring and ethical treatment. Julie felt disregarded and felt although her feelings were not considered and that she was not valued by her therapist, which seemed to undermine the relationship. Research has also shown that when terminations are forced or unplanned, clients experience more anger, mourning, anxiety and frustration; whereas planned terminations lead to more reactions of pride, excitement and determination to finish (Cicchitto, 1983; Goldthwaite, 1986; Saad, 1984). Furthermore, (Penn, 1990) has argued that some clients may feel rage over what they experience as abandonment or betrayal by the therapist, or sadness over the loss of the therapist as a "significant object". Usually these affective reactions to premature termination, mirror the client's responses to losses earlier in life (Bostic et al, 1996).

Furthermore (Vasquez, Bingham & Barrett 2008) assert that endings should be managed sensitively, so they can provide a model of how healthy relationships should end. This would provide a forum for patients to work through such ''endings'' in a new and more adaptive way, than perhaps they have in past relationships. Furthermore, it can play the role of a corrective emotional experience (Gould, 1977), in which the client learns to cope with separation and loss. Individuals with a diagnosis of Schizophrenia often have issues with relationship formation and issues around trust (Diener & Monroe, 2011). Research has also shown the difficulties with earlier attachment trauma and Schizophrenia (Varese et al, 2010; Shannon et al, 2011; Bonoldi et al, 2013). Therefore, more consideration needs to be given to this group. Even for participants who did not experience a sudden ending, the termination of the relationship was still experienced as very difficult.

Ambiguous loss refers to a lack of finality or closure that can leave those grieving confused about how to properly mourn their loss (Boss, 2000). While the therapist is not dead, they are no longer accessible to the client, which can make the grief process more unusual and therefore important for the therapist to validate this loss and normalise feelings of grief. Diane was told in advance when her therapy was ending, but still felt although she needed "more" of her therapist and did not feel ready to end. For other participants, there was a fear about coping without the therapist and no longer having a secure base to return to. Penn (1990) argues that clients with a history of multiple losses or insecure attachment need a longer warning period. Also, the warning time for termination should be increased for clients who have become considerably attached to their therapist. This allows for the trauma of the loss of that attachment relationship to be processed by the client, while still within the safety of the therapeutic relationship (Bostic et al, 1996).

Dewald (1967) compares the end phase of therapy to adolescence, with the client/teen moving away from the comforts and gratifications of therapy/childhood to enter the 'real world' and face problems of independence and identity. The termination phase of therapy for most participants led to a sense of growth and a stronger sense of self, resulting in feelings of empowerment and more hope for the future. David for example, experienced the ending as a new beginning, where he finally felt although he had "grown up" and was now equipped for the "real world". In Knox et al (2011) study it was found that those who had a positive termination experience, had a strong therapeutic relationship and positive outcomes in therapy. David's experience of termination was planned, and he also had a very secure relationship with his therapist, which seemed to allow for a positive ending and enabled growth. Julie on the other hand, due to the sense of abandonment that she experienced as a result of the premature termination, resulted in her experiencing a sense of despair, rather than growth and hope. Graybar and Leonard (2008) assert that good therapy outcome is characterised by the client's capacity for self-analysis after therapy comes to an end.

Furthermore, a positive ending in therapy is thought to have long-lasting influence of ongoing internalisation" (Bellows, 2007). Therefore, if an ending is experienced as unplanned or difficult, this may have implications for how the therapy experience is internalised.

John's relationship with his therapist was very strong, although at the end of therapy, John received a letter from his therapist which stated that he felt John's condition had deteriorated and that he had not made much progress. This was experienced by John as being very conflicting, as he felt that he had improved and was surprised that his therapist held this view, which resulted in John feeling discouraged and bewildered by the therapy experience. Wachtel (2002) advocates the importance of the departing therapist acknowledging that therapeutic work remains to be done, although this requires humility from the therapist, and is in the best interest of the client because it leaves room for continued growth.

Penn (1990) postulates that closure should include summing up some of the major themes in therapy, including progress and any new therapeutic skills acquired. It seems that for John, his progress in therapy was not discussed during therapy, or the termination phase, which caused him to feel misled and slightly betrayed. John's experience of the therapy process was positive until the termination phase, which completely shifted his perception, as he internalised his therapist's view of him not having made any progress, despite feeling although he had. This demonstrates the importance of therapists being mindful about the way they present feedback to clients and the need to remain transparent throughout the course of therapy to maintain trust.

Recommendations for Future Research

This study offers a detailed account of how individuals from an African – Caribbean background, with a diagnosis of Schizophrenia experience the therapeutic relationship in psychological therapy. There is little qualitative research that explores how individual's with Schizophrenia experience the therapy relationship in general, let alone African-Caribbean groups. This study explored the lived experiences of this group and seems to be one of the first that has used an IPA to examine this topic and has helped to enhance our understanding surrounding the factors that impact upon the therapeutic relationship and how culture may also be implicated in this.

An important finding from the study was the importance of participants feeling accepted and not judged by their therapist, as this seemed to lead to feelings of safety. This seemed to be more important than the therapist being of the same cultural background

of the participant. Participants reported a relaxed and informal therapeutic environment, and sense of casualness where the therapist was open and nurturing. They described the boundaries of the therapeutic space as being flexible at times and food and drinks were offered, which made participants feel valued and cared for and such approach seemed to balance out the power differences between the therapist and client and went beyond the normal realms of therapy. African/Caribbean people often have difficulty in trusting mental health professionals, due to the fear of coercion and mistreatment as indicated by research. A casual and relaxed environment appeared to reduce fears around coercion, which seemed to enable trust between therapist and client, which is an important finding for future research to explore, as more needs to be understood about how this sense of "casualness" can be applied by practitioners when working with this client group, as it fundamental in enabling trust to develop with this group.

Moreover, feeling "understood" by their therapist, was very important for participants and where issues that concerned culture did arise, like in John's case, there seem to be an assumption that this would have been understood by a "black therapist". The literature has indicated that cultural misunderstanding has been one of the factors that contribute towards the dissatisfaction of how African-Caribbean individuals experience mental health professionals (McKenzie & Bhui, 2007; Singh, 2007). Furthermore, attending to issues around culture, has shown to strengthen the therapeutic process (Agoro ,2014). Therefore, future research could explore how psychological therapists understand and respond to the cultural needs of African-Caribbean individuals with a diagnosis of Schizophrenia in therapy.

Another significant finding from the current study, was that psychological therapy seemed to provide participants with a sense of release, and a place where they could express difficult and painful emotions, which led to a sense of empowerment and a stronger sense of self, despite ambivalence about entering into the therapy relationship, therapy gave them a voice unlike in other arenas where they were medicalised and pathologized, which was empowering. Previous research has demonstrated the self-stigma and sense of shame that having a diagnostic label brings, and this is further exacerbated for individuals from an African/Caribbean background who also have to grapple with institutional racism, and perceived racial discrimination, all of which can be barriers in the therapeutic process. It is therefore no surprise that the sense of

empowerment participants experienced during therapy, lifted feelings of marginalisation, providing participants with a sense of worth.

It is clear from the findings, that the group studied significantly benefited from psychological therapy, and whilst this study does not claim to be generalisable to all African/Caribbean groups with a diagnosis of Schizophrenia, it does highlight concerns around why this group are less likely to be referred for psychological therapy in the first instance, which is clearly stated in the literature. Future research needs to explore the barriers to this group receiving therapy by gaining an understanding of the attitudes of referring professionals, as this may help uncover hidden biases and discriminatory attitudes that may exist towards this group. Furthermore, considering that this group can respond well to psychological therapy, if the right conditions are met in the therapeutic environment more research needs to be carried out for therapists to understand the factors that inhibit this group in experiencing a safe, empowering and nurturing environment in therapy. This will help to reduce disengagement and provide more sensitive and culturally appropriate formulations and treatment plans, that take into consideration social context and the implications of diagnostic labelling on identity and the impact of racism/discrimination.

Moreover, an important finding to emerge from the study was the impact that the end of the therapeutic relationship had upon participants. The current study supports the findings in the literature concerning the difficulties that clients may experience with ending therapy, especially unplanned and sudden terminations. However, there is no research that has investigated the impact of termination, with individuals with a diagnosis of Schizophrenia, let alone individuals from an African/Caribbean background, which is an area that requires further exploration. Considering that this group are already vulnerable, psychological therapists/clinicians need to ensure that the end of therapy is managed in a way that is planned and transparent with clients', to prevent re-traumatisation and the therapy experience being undermined by sudden endings, as this could be more damaging than never having therapy.

Strengths and Limitations

This study had several strengths and limitations. One of the strengths included the use of a qualitative analysis, which allowed for an in-depth exploration and rich data, which provided insight into the topic at hand. Close attention was given, and care was taken throughout the analysis process to ensure rigor within the study in capturing participant's accounts and fostering a high level of interpretive engagement with the material. Furthermore, another strength was that all participants had engaged in and completed psychological therapy within the last two years, which allowed for a more clear and detailed recall of their experiences. IPA fosters an idiographic approach which does not aim to find definitive answers, or generate theory, hence why it was not the aim of this study to generalise the findings to all African – Caribbean individuals with a diagnosis of Schizophrenia. However, the transferability of the findings should still be taken into consideration. While it must be acknowledged that other African – Caribbean individuals with a diagnosis of Schizophrenia may have similar experiences of the findings presented in the study, this research provides in-depth insight into the experiences of the individuals who were interviewed and it is for this reason that transferability of the findings must be considered in context (Smith & Osborn, 2003). The findings of the study were relatively supported by the current literature, although the current study also developed some new findings, that require further exploration which was discussed in the above section.

One of the main challenges of conducting this research was the recruitment of participants and despite widening the scope of advertisement, this remained an issue as only five participants came forward after introducing incentives in the form of gift vouchers. Due to the nature of the topic and client group being investigated, there was some anticipation of difficulty, which may reflect the concerns in the literature of issues around "trust" with this client group. However, IPA allows for a smaller sample size, whereby the group is broadly homogenous (Smith & Osborn, 2003). As the focus of an IPA study is detail and an in-depth exploration of one's lived experience, having a smaller sample size was not necessarily a disadvantage for the current study, but allowed for more meaningful and rich data. In relation to homogeneity, this was present in the sample of participants interviewed, since they were all from an African - Caribbean background with a diagnosis of Schizophrenia. There were differences in the

types of psychological therapy that participants received, and this may to some degree have had an impact upon their experience of therapy. However, the aim of this research was to explore the experience of the therapeutic relationship and the literature indicates that irrespective of therapeutic approach used, it is the therapeutic relationship that enables change.

There are several criticisms of qualitative research and the methods used, including issues concerning researcher bias, rigour and subjectivity (Silverman, 2000). However, to counteract such obstacles, a reflexive stance was taken throughout the research. As someone with little experience of conducting research on this scale, every effort was made to ensure quality through attempting to gain a comprehensive understanding of IPA, through reading and supervision. Furthermore, having worked in the role of a trainee counselling psychologist with this client group, this may have led to certain preconceptions in relation to the research findings and could potentially have impacted upon how the data was interpreted. However, to help mitigate any bias, notes and themes were thoroughly cross checked and verified during supervision.

Conclusion/Implications for Practice

The aim of this research was to explore how African - Caribbean's with a diagnosis of schizophrenia experience the therapeutic relationship and to examine the qualities and characteristics that participants found to be important in their therapists. Several recommendations for counselling psychology and clinical practice will be discussed. The study highlights the importance of the therapeutic environment and participants reporting an atmosphere which was free from judgment and condemnation, which seemed to enable a sense of acceptance. This seemed to allow for feelings safety, enabling trust and a stronger degree of intimacy between participants and their therapists. The qualities of the therapist seemed to be more important than their culture and ethnicity, although issues around cultural understanding did surface in the study, around how culture can be implicated in a person's distress.

Furthermore, there was an assumption by both John and Patrick that a "black" therapist would have a natural understanding about certain issues in relation to culture. However, this misunderstanding between John and his therapist did not completely undermine the

therapeutic relationship, as there were other qualities that subsided this, such as warmth and acceptance and a sense of humility that came from the therapist. Patrick was the only one in the study to have a black therapist and there seem to be a sense of identification that he felt towards the therapist. This may have been possibly due to him being another black male that he could relate and look up to.

Moreover, some of the warmth and "love" that participants described experiencing from their therapists', had a feature of going beyond the 'normal' realms of psychological therapy and meeting the more human needs of the client and providing a sense of nurture. At times therapy felt relaxed and informal and the therapist was down to earth and reachable to participants, which seem to balance out the power difference and enhance participants sense of safety within the therapeutic relationship. The literature has shown that trust among African - Caribbean groups towards mental health services and professionals has been an issue that prevents this group from accessing services. Furthermore, when this group do encounter services, it is more likely to be through coercion, resulting in a fear of mental health services.

Psychological therapy not only provided participants with a sense of release, and "having someone to let off on", but also gave them a voice, as there was a feeling of being heard which led to a sense of empowerment. Research has shown the self-stigma and negative perceptions of the self that an individual with a diagnosis of Schizophrenia may carry. This maybe further exacerbated for African - Caribbean groups, due to perceived racism and negative stereotypes associated with this group. The literature has also indicated a more prevalent use of anti-psychotic medication, as oppose to talking therapy among this group. Therefore, for participants having a chance to speak about their feelings and emotions, allowed for something different from medication, and allowed them to feel valued within the safety of the therapy relationship.

Given the current climate and upheaval of protests across the UK around institutional racism and systematic inequalities and mistreatment of black people, psychology as a profession has a responsibility to speak up and challenge the oppression of such groups in society, especially in support of the Black Lives Matter movement. Even though organisations such as the BPS no longer have regulatory power, they still accredit training courses and hold influence through guidelines and initiatives such as the

Inclusivity Strategy (BPS, 2015). The BPS could certainly do more to include anti-racist practice into counselling psychology training and teaching on the limitations of psychological knowledges as applied to BME groups. Previously the 'Race' and Culture Special Interest Group within the BPS existed to help challenge and confront issues around race and culture. This group was however met with opposition and criticism from the BPS since its inception; being first disallowed the status of a 'Section' and later dissolved in 2014 without consulting its members (Wood & Patel, 2017).

There is a pertinent need in clinical practice for an approach to be adopted by psychological therapists that recognises the power differences, perceived racism, institutional racism and social disenfranchisement of African/Caribbean groups. Therefore, a more flexible approach towards this client group, where there is a slight openness and humanness from the therapist or professional involved in the individual's care, that acknowledges systematic oppression as this will help to facilitate and strengthen therapeutic relationships with African/Caribbean groups. From an institutional level, this should happen in parallel with the decolonisation of psychological knowledge and practice (Paulraj, 2016). This can be supported with research directed at the profession towards this goal, with teaching during clinical training that considers the Whiteness of the profession and acts to deconstruct its many manifestations (Wood & Patel, 2017). Counselling psychologists, particularly from white middle class backgrounds would benefit from continuous conversations around these issues, so that they might be integrated into everyday conversations, going beyond 'one-off' occurrences.

All clinicians in the profession should be encouraged to take risks specifically on issues of race and diversity by constructively engaging with issues of difference (Mason & Sawyer, 2002). This needs to be done in a purposeful and genuine manner, not merely a tokenistic exercise, for it to be effective. Continuing Professional Development (CPD) courses which highlight best practice on working in a culturally sensitive, anti-racist and competent manner may be one way in which this can be implemented.

Furthermore, the therapeutic relationship was able to provide a 'corrective emotional experience' for most participants, based upon the bonds and changes that occurred as a result of therapy, although consideration needs to be given towards endings. In clinical

practice, practitioners need to mindful and considerate of how they end the therapeutic relationship, as it needs to be managed very sensitively with this group, given the likelihood of early traumatic experiences. Despite participants having a strong relationship with their therapist, when the ending was managed poorly, this seemed to undermine the entire therapy experience, and was emotionally damaging for participants. Clinicians needs to ensure that termination are planned, and that client progress is discussed transparently throughout the course of therapy with the client. Whilst termination will most likely be difficult for most clients, even with planned endings, having time to prepare and process the closure, will allow for a focus on growth, as it did in Diane's case. Moreover, when endings are managed poorly, this may damage the trust that was built and may negatively impact upon future relationships with professionals, which is already an existing barrier for African/Caribbean groups and more so for those with a diagnosis of Schizophrenia.

Finally, it is hoped that this thesis has made a valuable contribution to the knowledge base and research for counselling psychology and other professions by providing a rich insight into the experiences of this client group. It is hoped that the findings that have emerged will be considered by clinicians when working with African/Caribbean individuals with a diagnosis of Schizophrenia and that practice will be sensitive to the cultural needs of this group, whilst balancing this with the individual needs of the client. Furthermore, it is my hope that Counselling Psychology as a discipline fully embrace issues around social justice and work towards challenging discriminatory and oppressive practices towards African/Caribbean groups.

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Appendices

Appendix A: Clinician-Rated Dimensions of Psychosis Symptom Severity

Name: _____ Age: _____ Sex: [] Male [] Female
Date:_____
Instructions: Based on all the information you have on the individual and using your clinical judgment, please rate (with checkmark) the presence and severity of the following symptoms as experienced by the individual in the past seven (7) days.
Domain 0 1 2 3 4 Score
I. Hallucinations Not present
 Equivocal (severity or duration not sufficient to be considered psychosis)
 Present, but mild (little pressure to act upon voices, not very bothered by voices)
 Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices)
 Present and severe (severe pressure to respond to voices, or is very bothered by voices)

II. Delusions Not present
 Equivocal (severity or duration not sufficient to be considered psychosis)
 Present, but mild (little pressure to act upon delusional beliefs, not very bothered by beliefs)
 Present and moderate (some pressure to act upon beliefs, or is somewhat bothered by beliefs)
 Present and severe (severe pressure to act upon beliefs, or is very bothered by beliefs)

III. Disorganized speech
 Not present
 Equivocal (severity or duration not sufficient to be considered disorganization)
 Present, but mild (some difficulty following speech)
 Present and moderate (speech often difficult to follow)
 Present and severe (speech almost impossible to follow)

IV. Abnormal psychomotor behaviour
 Not present
 Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behaviour)
 Present, but mild (occasional abnormal or bizarre motor behaviour or catatonia)
 Present and moderate (frequent abnormal or bizarre motor behaviour or catatonia)
 Present and severe (abnormal or bizarre motor behaviour or catatonia almost constant)

V. Negative symptoms (restricted emotional expression or avolition)
 Not present
 Equivocal decrease in facial expressivity, prosody, gestures, or self-initiated behaviour
 Present, but mild decrease in facial expressivity, prosody, gestures, or self-initiated behaviour

□ Present and moderate decrease in facial expressivity, prosody, gestures, or self-initiated behaviour
□ Present and severe decrease in facial expressivity, prosody, gestures, or self-initiated behaviour

VI. Impaired cognition
□ Not present
□ Equivocal (cognitive function not clearly outside the range expected for age or SES; i.e., within 0.5 SD of mean)
□ Present, but mild (some reduction in cognitive function; below expected for age and SES, 0.5–1 SD from mean)
□ Present and moderate (clear reduction in cognitive function; below expected for age and SES, 1–2 SD from mean)
□ Present and severe (severe reduction in cognitive function; below expected for age and SES, > 2 SD from mean)

VII. Depression □ Not present
□ Equivocal (occasionally feels sad, down, depressed, or hopeless; concerned about having failed someone or at something but not preoccupied)
□ Present, but mild (frequent periods of feeling very sad, down, moderately depressed, or hopeless; concerned about having failed someone or at something, with some preoccupation)
□ Present and moderate (frequent periods of deep depression or hopelessness; preoccupation with guilt, having done wrong)
□ Present and severe (deeply depressed or hopeless daily; delusional guilt or unreasonable self-reproach grossly out of proportion to circumstances)

VIII. Mania □ Not present
□ Equivocal (occasional elevated, expansive, or irritable mood or some restlessness)
□ Present, but mild (frequent periods of somewhat elevated, expansive, or irritable mood or restlessness)
□ Present and moderate (frequent periods of extensively elevated, expansive, or irritable mood or restlessness)
□ Present and severe (daily and extensively elevated, expansive, or irritable mood or restlessness)

Note. SD = standard deviation; SES = socioeconomic status.

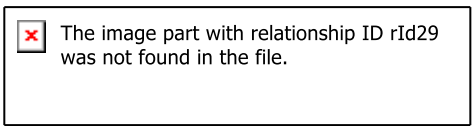
Instructions to Clinicians The Clinician-Rated Dimensions of Psychosis Symptom Severity is an 8-item measure that assesses the severity of mental health symptoms that are important across psychotic disorders, including delusions, hallucinations, disorganized speech, abnormal psychomotor behaviour, negative symptoms (i.e., restricted emotional expression or avolition), impaired cognition, depression, and mania. The severity of these symptoms can predict important aspects of the illness, such as the degree of cognitive and/or neurobiological deficits. The measure is intended to

capture meaningful variation in the severity of symptoms, which may help with treatment planning, prognostic decision-making, and research on pathophysiological mechanisms. The measure is completed by the clinician at the time of the clinical assessment. Each item asks the clinician to rate the severity of each symptom as experienced by the individual during the past 7 days.

Scoring and Interpretation Each item on the measure is rated on a 5-point scale (0=none; 1=equivocal; 2=present, but mild; 3=present and moderate; and 4=present and severe) with a symptom-specific definition of each rating level. The clinician may review all of the individual's available information and, based on clinical judgment, select (□) the level that most accurately describes the severity of the individual's condition. The clinician then indicates the score for each item in the "Score" column provided. The response on each item should be interpreted independently when assessing the severity of the psychotic disorder.

Frequency of Use To track changes in the individual's symptom severity over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide

Appendix B: Participant information sheet



Participant information sheet

You are being invited to participate in a study that will be exploring how African/Caribbean's with Schizophrenia experience the therapeutic relationship. Very little is known about the topic concerning individuals with this diagnosis and no research has looked at the specific experiences of this ethnic group. I am a student at London Metropolitan University, currently studying towards a Professional Doctorate in Counselling Psychology. I am hoping to do this piece of research as my doctoral thesis. For this study, I am looking for men and women between the ages of 18-65:

 Who are engaging in psychological therapy (received at least three sessions) or have done so in the last two years

 Who are from a black African/Caribbean background with a diagnosis of Schizophrenia.

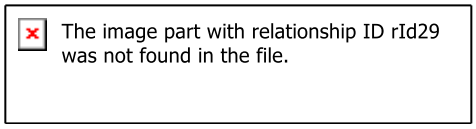
To participate you would be required to attend an in-depth interview about your experience of the therapeutic relationship during your course of therapy. The interview will last for approximately one hour. If you do decide to take part, you will be asked to sign a consent form. You are free to withdraw this consent at any time and without giving a reason. Also, you may find that talking in depth about the therapeutic relationship you experienced with your therapist can be a very personal, and potentially an emotional experience. If you find any of the interview questions difficult or intrusive you do not have to answer them and there will be no pressure put upon you.
A digital recording will be made of your interview to allow your responses to be reviewed in detail after the interview. The recording will be securely stored in at the researcher's premises. All information that is collected about you during the course of the research will be kept strictly confidential. Every piece of identifying information will be anonymised and will not be quoted in the study. The consent forms will be kept separately from the data and will only serve to verify that proper consent has been obtained. The name of this school will not be mentioned in the study. (Please note that confidentiality might not apply in certain circumstances, e.g., if information is disclosed that indicates a risk to someone's safety). Whether you chose to take part in the study or not - is entirely up to you.

Please note that my director of studies or the external examiner may request access to the raw data for verification purposes. Also, I am intending to submit the completed study for publication with a renowned journal. Successful publication would require me to retain all data for a certain length of time. This could be around five years, depending on the journal. All interviewees are invited to request a copy of the final study after completion of the project. This will be available in [specific date]. This study has been approved by the Research Ethics Review Panel at London Metropolitan University and

will be conducted in accordance with the ethical guidelines provided by the British Psychological Society. If you have any questions, comments or complaints about this study please get in touch with me, either in person, via phone or email. Alternatively, you can contact my Supervisor: Dr Catherine Athanasiadou-Lewis on: 0207 133 2669 on 0207 133 2667 or email at c.athanasiadoulewis@londonmet.ac.uk. Thank you very much for your time and interest, it is much appreciated. If you are interested in taking part in this study, please contact me either in person, via phone or email.

My details are below Kind regards, Veniece Thomas Email: Vet0052@mylondonmet.ac.ukPhone: 07943529253

Appendix C: Consent Form



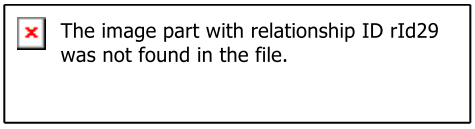
Consent form

Title of research: A phenomenological exploration of how African/Caribbean's diagnosed with Schizophrenia experience the therapeutic relationship
Description of procedure: In this research, you will be asked a number of questions regarding your experience of the therapeutic relationship within a voice recorded interview.

- I understand the procedures to be used.
- I understand I am free to withdraw at any time during the study without question. However, all data will be aggregated by the [specific date]; therefore, if I wish to withdraw it has to be done by [specific date].
- I understand that participation in this study is anonymous. My name will not be used in connection with the results in any way, a pseudonym will be used on the digital voice recording and all information that may otherwise identify me (e.g. address, friend's names) will be changed prior to transcription. There are limits to confidentiality however; confidentiality will be breached if any information is disclosed that indicates a risk to safety.
- I understand that the results of the study will be accessible to others when completed and that excerpts from my interview (minus explicit identifying information) may be used within the study.
- I understand that I may find this interview upsetting and that it may evoke a number of difficult and distressing feelings for me. I will be offered support and the opportunity to discuss these feelings at length post interview with the researcher. The researcher will also give information on further support available if required.
- I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given in the debriefing form. □ I understand that the data will be destroyed once the study has been assessed.

- Signature of participant:…….. Signature of researcher:…… Print name:…… Print name:…… Date: …… Date: ……

Appendix D: Debriefing Form



Debriefing form

Thank you for taking part in this research study. This is part of a Doctoral project that the researcher is conducting.
If you are interested in the results of the study, or if you have any questions about this study, or if you wish to withdraw, please contact the researcher on the following email addresses:Vet0052@mylondonmet.ac.uk . Emails will be checked regularly.

Please remember that if you wish to withdraw your date from this study it should be done by ******** as it may not be possible at a later stage. Equally, if you have any questions or concerns you are more than welcome to address them now.
If you have any complaints regarding any aspect of the way you have been treated during the course of the study please contact my research supervisor on:0207 133 2669 or Email: c.athanasiadoulewis@londonmet.ac.uk.

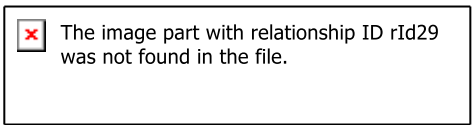
If participation has raised any concerns or issues that you wish to discuss further, a number of agencies can provide advice and support in confidence

 Samaritans Available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress, despair or suicidal thoughts. Number is: 24 hours 116 123 (UK). www.samaritans.org

 SANE line offers emotional support and information from 6pm–11pm, 365 days a year. Their national number is 0300 304 7000.
www.sane.org.uk/what_we_do/support/helpline

 If you feel suicidal or feel like harming yourself or other people:
Call 999 Go to your nearest Accident and Emergency department (A&E). You can search for your local department through the NHS Choices website

Appendix E: Distress Protocol



Distress protocol.

Protocol to follow if participants become distressed during participation: This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the present research study on How African/Caribbean's with Schizophrenia experience the therapeutic relationship. Such participants have a diagnosis of Schizophrenia so are already a vulnerable group and are speaking about a topic that requires them to reflect back on quite a personal and sensitive time.

Veniece Thomas is a trainee counselling psychologist at London Metropolitan University and has experience in managing situations where distress occurs. There follows below a three-step protocol detailing signs of distress that the researcher will look out for, as well as action to take at each stage. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. This is because most of the participants will have been accessed professional services within which there will usually be an existing structure set up to deal with extreme distress which professionals can implement. However, it is included in the protocol, in case of emergencies where such professionals cannot be reached in time.

Mild distress:

Signs to look out for:

1) Tearfulness
2) Voice becomes choked with emotion/ difficulty speaking
3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

1. Uncontrolled crying/ wailing, inability to talk coherently
2. Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
3. Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:

1. The researcher will intervene to terminate the interview/experiment.
2. The debrief will begin immediately
3. Relaxation techniques will be suggested to regulate breathing/ reduce agitation

4. The researcher will recognize participants' distress and reassure that their experiences are normal reactions to abnormal and distressing events.
5. If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6. Details of counselling/therapeutic services available will be offered to participant's
Extreme distress:

Extreme distress

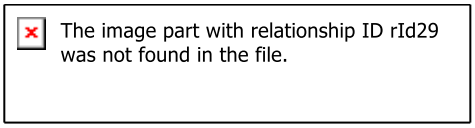
Signs to look out for:

1) Severe agitation and possible verbal or physical aggression
2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:

1) Maintain safety of participant and researcher
2) If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

Appendix F: Interview Schedule



Interview schedule

1. Could you tell me how long ago you received psychological therapy and how long it lasted for and what therapeutic approach was used?

2. Could you tell me about when you were diagnosed with Schizophrenia and what this experience felt like?
   (First two questions to build rapport)

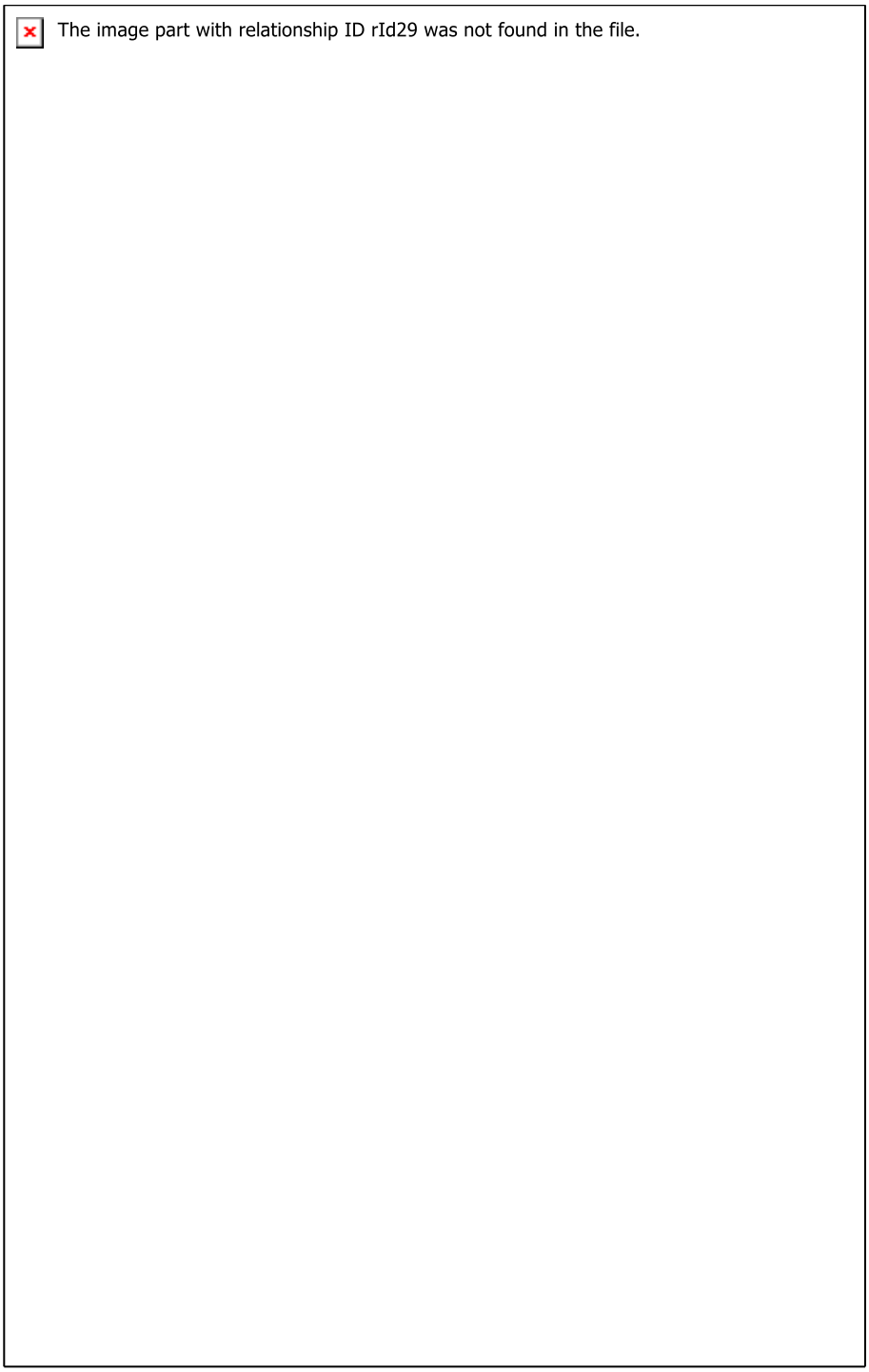
3. How would you describe your therapist and how did you feel towards them? (Prompt - how would you describe their qualities and characteristics?)
4. What was the ethnicity of your therapist and how did it feel having someone of the same /or different background?
5. How would you describe your experience of the therapeutic relationship and did having a diagnosis of schizophrenia impact upon this process?
6. What does culture mean to you and did this have an impact on the therapeutic relationship between you and your therapist?

7. Can you describe how you felt while you were you were in the room with your therapist? (Prompt- did you feel safe and contained within the therapeutic space)?
8. How did you feel about therapy before you received it and what has the process felt like? (what helped/ hindered the process?)

9. How do you feel your therapist experienced you?

   (Prompt – did you pick up on any feelings from your therapist, how did this make you feel)

Appendix G: London Metropolitan University Ethical Approval



Appendix H: Individual Theme Tables

David Theme Table

Master themes	Subordinate themes	Supporting quote
A chance to be heard (Sense of relief)	Medication vs talking therapy	*"I asked for it somebody to talk to" {line 109}*
	Relief (a chance to talk and be heard)	"He was a relief" *{line 155}*
	A sense of power (given a voice)	*"I felt for one moment I was the adult, I was the voter" {line 295}*
Never condemned (Love without judgement)	Feelings of acceptance	*"I could never talk to my parents the way I talked to those people" {lines 244-245}*
	The need to be nurtured	*"He would then even give you a biscuit" {line 270}*
	I poured my soul (Sense of safety)	*"I poured my soul out to this man, he never questioned me, never condemned me" {line 260}*
	Beyond colour (Cultural needs vs therapist qualities)	*"Even though he was welsh, …. was Welsh, he was welsh, he had this way of erm…humour {line 304-305}*
Heights of Grandiose (hope beyond the therapeutic relationship)	A sense of identification (stronger sense of identity)	"I could speak to my own sex and find results and find answer" {line 404-405}
	A new perception of self	"*More belief in yourself, more positiveness, more friend to yourself" {line 240-241}*
	Growth/change	*"I could reach the heights of grandiose and survival and become, get a professional life… {454 -455}.*
	A Sense of fulfilment	*"I found male attention, male company was the real answer…than a woman. line {408 - 409}.*

Diane Themes table

Master themes	Subordinate themes	Supporting quote
A sense of safety (emotional containment)	"Opening up"	*"she saw so many sides of me it was unreal" {line 203}*
	Feeling my emotions	*"At time it felt like she was actually feeling my emotions" {431 -432}*
	Feelings of nurture (a sense of going beyond…)	*I let her read some of my poems that I wrote, it was ages ago, but I let her read it and she said it was really good" {274 -275)*
	You can't stop yourself (a sense of Release)	*I would start crying, but these weren't tears tears, they were like proper tears" {line 281 -289}*
	Seeing beyond colour (Therapists qualities over colour)	*"I think for me it's more about the person seeing me, not about the colour {line 347-351}*
Stripping yourself bare (Fear of intimacy)	I don't really get too close (The threat of intimacy)	*"I just don't like getting to close to people anymore, there's always a barrier up" {line 239 -240*
	The real me (Fear of judgment)	*"it's just some people are not willing to accept without judging" {line 251 -252}*
	A sense of vulnerability	*"it's stripping yourself bare to someone you don't know" {line 128 – 129}*
	Feelings of resistance	*"at first I was really against talking and opening up" {line 199-200}*
Separation from the therapeutic relationship)	I didn't feel like it was enough	*"I didn't feel like it was enough" {line 362}*
	They shift you just a little (Change)	*"Yeah then I realized the changes in me…cos I think people didn't realise anything could change". {460 -461}*

John Themes table

Master themes	Subordinate themes	Supporting quote
An escape (Fear vs freedom)	I don't like talking about the way I feel (Resistance vs a need for help)	*"yea I had concerns, because for me like most men I don't like talking about how I feel" {Line 12 -13}*
	I felt So Free (a sense of safety and freedom)	"*well when I was with him, I feel safe, felt safe when I was with him, I felt so free" {line 134 -135}*
	Release	*"so, I always wait for Thursday and I talk to him, you know most of the time I cry" {line 37 - 40}*
The way he understood me	A sense of connection	*"okay what I particularly liked about him was the way he understood me" {line 46}*
	Loved and not judged	*"very understanding and very loving, because for me I don't like people condemning or not listening to me" {53 -54}*
	Nurtured needs (a sense of going beyond therapy	*"he would get me some water and he would make a cup of tea for me and make sure I'm relaxed" {77 -78}*
	A "Black person" will know (cultural misunderstandings)	*"A black person will know that you need to respect everybody, people that are older than you" {103 -104}*
How was I going to cope (Therapy and beyond)	Growth/change (Therapists perception vs clients)	*I thought I gained a lot, but the letter he wrote saying I'm worse than the state I came in" {111 – 112}*
	Challenges of separation	*"when I stopped, I was worried about how I was going to cope" {152 -153}*
	Hope vs confusion	*"you know I don't know what to do again, as I'm finding that I'm improving, but not according to him…really frustrated " {166}.*

Patrick Themes table

Superordinate themes	Subordinate themes	Supporting quote
Fear vs a need for help	A need for help	*"it sounded like a good idea and I think I needed help" {line 40}*
	Someone to relate to	"*yea it was quite satisfying, someone out there I could relate" {288 – 289}*
	I wasn't gonna do it	*"erm to tell you the truth I tried to play it down like I wasn't gonna do it, but at the same time I know I had to {249 -250}*
A sense of identification (seeing self in therapist)		
	A sense of connection	*That was good to relate to innit, knows where I'm coming from, I'm a street kid aswell so {Line 202-203}*
	Feelings of familiarity	*"He looked like my friend ….." {line 101}*
	He would know what to do (understanding "black male" needs)	*"well he was black aswell innit, so he would know what to do...to expect from a black yute "{line 185 -186}*
Separation from the therapeutic relationship	Growth/change	*"he knows how to get the best result from me {line 222}*
	A sense of hope	*"earning a place in stardom, actually getting there, actually getting a career" {line 205 -206}*
	Unexpected ending	*"but erm my physical health, I couldn't continue treatment, but they made another appointment, I'm going to make a effort with…line {289 – 291}.*

Julie Themes tables

Master themes	Subordinate themes	Supporting quote
It was like a lifeline **(A consistent relationship)**	Someone there to talk to	*"what can I say, it was like a lifeline, you know, I mean their people that you talk too, and you tell them basically everything" {110 – 111}*
	Release	*"it would be a bit of a release, someone that actually knows what I'm talking about" {205 – 206}*
	someone that would listen	*I could talk to him and tell him anything I wanted to, and he would sit and listen {line 166 -167)*
Left on your own (Loss of the therapeutic relationship)	Just sprang it on me (Sense of abandonment)	*But I was just very unhappy at the time when he left {line 18}.*
	Feelings of grief	*"to be left on your own just to get on with it" {line 393}.*
	Hope	*"I need to be busy you know, find something to do with myself" {343 -344}.*
	Helping yourself (Moving on)	*" you have to try and prove that your try to help yourself" {line 257}.*
A sense of safety **(feelings of trust in the therapeutic relationship)**	Not judged	*"Somebody that would just sit and listen but not pass judgement" {line 168}*
	A sense of genuineness	*"He would always be honest with me and everything" {line 127}*
	Empowered (a sense of worth)	*"well one thing he was a white man…he spoke to me on a level, didn't pass me no judgement on me, he didn't belittle me" {line 242- 244}*
	Beyond colour (therapist culture Vs qualities)	*Sometimes you do find it an issue talking to someone who is not your colour or ethnic background, Il be honest with you I've come across people like that, but with…I didn't {line 263 -269*

Appendix I: Integrated Theme Table

Master theme 1	David	Diane	John	Patrick	Julie
Love without judgement) (Never condemned)					
Feelings of nurture (a sense of going beyond)	Line – 269 - 275	Line 272 - 276	Line 77 - 78	Line 64 - 65	Line 244
Feelings of acceptance	Line 244-245	Line 350 - 351	Line 52 - 54	Line 202 - 203	Line 168
A Sense of safety	Line 260	Line 430 - 432	Line 134 -135	Line 101	Line 145 - 148
Beyond colour (Cultural needs vs therapist qualities)	Line 304 - 311	Line 347-351	Line 102 -105	Line 185 - 186	Line 263-269

Master theme 2	David	Diane	John	Patrick	Julie
A chance to be heard (Fear vs Freedom)					
Intimacy vs resistance	Line 155	Line 239 - 240	Line 12 -16	Line 249 -252	Line 110 -111
A sense of release	Line 109	Line 287 - 288	Line 37 - 40	Line 288 -289	Line 330 - 331
A Sense of empowerment	Line 295 - 298	Line 229 -303	Line 87-91	Line 222 - 223	Line 166 -167

Master theme 3	David	Diane	John	Patrick	Julie
Coping beyond therapy					
Separation from the therapeutic relationship	Line 444 - 449	Line 362	Line 152 - 153	Line 289 -291	Line 18 - 20
Hope (Beginning of the end)	Line 453 – 455	Line 452 - 456	Line 164 - 166	Line 205 – 206	Line 390-393

Appendix J: Transcript

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R. When you say it was the boxing ring, do you literally that's how it felt, you felt like you were attacked

P. Yes you feel like you were in the ring with frank Bruno, literally, Tyson, to get yourself heard, if you didn't, they would keep on ploughing this medication into you, and if you didn't complain, they give you more of it, your even worse, your so a seed inside, so wasteful, then became such a drunken brawl in there, you felt erm on your edge, tips of your toes, your arteries and veins were sticking out, your mind was in a muddle and they told you, …… your very lazy, you don't want to listen when you're doing your best, your trying to cooperate, there not understanding you, they'd rather listen to the white person sitting next to you, there not going to listen to you, they'd rather listen to the man watching Star wars all day long, there not going to listen to you,

R. so you felt like you wasn't heard

P. Yes, there not going to listen to you as a black person they don't listen to you

R. So as a black person you felt like you wasn't heard

P. yeah yeah and your surrounded by these black people, they look so erm, so erm...like cayote walking around the place, erm, erm, ragged and erm....and miserable and erm retched.,,,.. and like they came out from Cambodia, or erm or erm Africa in the jungle, as it was like congo...that's what it was like

R. And what were your initial thoughts about having therapy talking therapy, did you have any concerns?

P. I love it, t loved it, because truth of alt, I went to school and college to become a photo

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journalist, my parents told me to become a lawyer, didn't take notice of that, I weren't hell bent, 3 to 5, those to write and take pictures, that was my swing, I had nothing else that I ever wanted, I didn't care what my parents said, what they tried to do, I just picked up a book and dictionary, at night I would read books, I would read words, simple as that, there was no ever.„one and truly and my maths is so bad that when I left primary school and tried to get into Grammar school, they wouldn't allow me, they said my maths would let everybody down

R. How did you feel about seeing ….. your psychologist?

P. He was a relief

R. What were your expectations, how did you feel about it?

P. First of all he gave me that aura to erm use my dictionary sense, I even used French words in there, it even gave me time to linger on my erm phrases sentences, punctuation, passages, even wrote Shakespeare in there and erm.....errr..... a period just to erm use my English, be boastful about it, that was the whole significance of it, I was so proud of myself for doing that, I thought I was like Hue Grant..... the mogul his voice, and that's all I ever want to be... him, even his figure, I even wanted to do weight lifting to get his figure

R. Okay so what did you expect from therapy, when you went to see……., what did you expect P. I wanted to erm...to be understood , to erm...find love in a sense, to someone who tike me for who lam, I was very lonely, erm I was rejected, I was a failure, and erm I wanted someone to grab hold of me and say I love you, your not a fool, your (name) and you are a person, you are significant, you're like the branches...like the stalks, you have a reason to be a alive,

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The image part with relationship ID rId29 was not found in the file.	217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266	your purpose don't let anyone tell you that your nothing, you have no purpose, just like that tree... growing there, God put that on this earth, with photosynthesis to grow and to nourish and that's what I learnt R. so it was important for you to go in, gave you a sense of purpose p. yeah R and it gave you a sense of purpose right okay and you wanted to be loved P. Yes I did, I lived in a world where I was all by myself, I felt unloved, unwanted, I felt erm like err a scape goat, a pure scapegoat, I thought I smelt, I thought I smelled, smelling, thought erm, undesired, I felt I could never get a girlfriend, erm I thought I'd would never satisfy a woman at all, I'd never do that, I felt impotent, I felt the world was laughing at me even saw myself on television, even when it was not there... R. Okay it sounds that you were looking for a relationship from going to therapy, you wanted to build some kind of relationship, you wanted to be liked and understood P. Yes I did yes, one of the doctors told me (name) if you want a woman a steady girlfriend, you have to realise that erm.... getting all these women.... the wrong tactic, you have to talk to men, you have to be in the limelight of men, have to work on the same road, the same practicality, you have to erm, behaviour with yourself with men, understand men first, then women will come afterwards....and that worked...and learnt that women are interested in the same things....just like the man R. I understand, okay and you know before you had erm you know when you were looking for a therapist and when you wanted therapy, were you looking for a	The image part with relationship ID rId29 was not found in the file. The image part with relationship ID rId29 was not found in the file. The image part with relationship ID rId29 was not found in the file. The image part with relationship ID rId29 was not found in the file.

particular type of therapist, was there any type?

P. No, no I accepted anyone, I was very lucky there, in some countries they don't have the Welfare State, there are people out there that I know are in so much confusion, complex denial, regret, and there so catarrh and bleeding and know one's going to listen to them, they take a tablet, and then they go to prison and they become nothing, they become unheard, they become, become, rough, erm they become seedy corrupt, they become deaf, and erm, they just erm, they just military, military, they have no one, they worship nothing but themselves.....

R. so for you, you didn't want a particular therapist,

P. No no, no li took anyone

R. Male or female

P. I took anyone, anyone, anyone that would listen

R. Okay anyone that would listen, so that was most important and how would you describe your therapist?

P. How well do you think I'm doing at the moment?

R. Your doing well....

P. if I was an arts professor..... how much would you give

R. you're doing well Il give you a 10

P.(laugh),

R. how would you describe your therapist, how would you describe (Therapist), how did you feel towards

p. 10 out of 10, he was about in his mid-forties, very conservatively dressed, even when he was casual the guy walked in there dressed like a priest, errr.....cool jumper with a shirt, nice slacks, polished shoes, it was excellent R. What did you like about him?

P. what did I like about him, he would ask you a question and you

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27-9

	317	.	
	318	would answer and then the room	
	319	went silent for 5 to 10 minutes,	
	320	you looked out of the	
	321	window.....and then he would	
	322	answer your question and erm in	
	323	the period, in between where he	
	324	answered that question and you	
	325	gave answer and he replied, you	
	326	had time to marinate there, blend	
	327	and err and err become more	
	328	narrative, more belief in	
	329	yourself, more positiveness,	
	330	more friend to yourself, more	
	331	picture like, and you became,	
	332	became mature, you became an	
	333	asset, you became a missile.	
	334	R. So Did you feel listen to by	
	335	him	
	336	P. Yes I was, t felt good.....l	
	337	could never talk to my parents	
	338	the way I talk to those people,	
	339	my parents were very proud	
	340	people, they believed in	
	341	academic success and if you	
	342	don't give them that, they will	
	343	turn away from you, and they	
	344	want listen, this guy I told him	
	345	that I got a D in that erm that	
	346	erm English exam and it hurt me	
	347	to the core, I couldn't understand	
	348	why, a top subject I got a D in it,	
	349	come on..... History, I got the	
	350	history one, but English good	
	351	grief, something wrong with	
	352	me...	
	353	R. Okay so he listen to you, he	
	354	didn't judge you	
	355	P. He did, he listen to me	
	356	R. and you know, okay so, what	
	357	was the background of your	
	358	therapist, where was he from?	
	359	P. He was from Yorkshire, I think	
	360	R. Yorkshire, okay, and was it	
	361	important for you to have	
	362	someone as the same ethnic	
	363	background or race as you?	
	364	P. No No it was perfectly	
	365	okay.... first time in my life	
	366	someone stood there, and I	
		poured my soul out to this man,	
		he never questioned me, never	

	367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388	condemned me and never went to my - consultant and said this guy is perverse, or wicked, or stupid or black or just erm a menace, he never said that, he never told anything I said to him to anybody, that was good R. so he kept things confidential? P. Yes, he did yea R. Okay, and what about when you had the therapy with Steve Davis was it the same, was it the same experience? P. well that guy was even more loveable, the guy would make you two cups of tea, orange there, he would even give you a biscuit	

Publishable Article

A Qualitative Exploration of the Experiences of How African/Caribbean's with a diagnosis of Schizophrenia Experience the Therapeutic Relationship in Psychological Therapy

Veniece Thomas - Hibbert

Background: *African/Caribbean's are more likely than white and other ethnic groups to be diagnosed with Schizophrenia and tend to have poorer therapeutic outcomes. Yet very few studies that have examined the experiences of this group, in psychological therapy. This study aimed to address this gap by exploring how African - Caribbean individuals with a diagnosis of Schizophrenia, experience the therapeutic relationship in psychological therapy.*
Method: *Semi-structured interviews were conducted with five participants. Transcripts were analysed using Interpretative Phenomenological Analysis.*
Findings: *Three superordinate themes emerged; Love without Judgement (Never Condemned); A chance to Be Heard (Fear Vs Freedom); Separation from The Therapeutic Relationship. A description of these superordinate themes and the nine related subordinate themes are discussed. The findings indicate that the therapeutic environment enabled the establishment of a strong therapeutic relationship*
Conclusion *The study highlights the importance of the therapeutic environment and participants reporting an atmosphere which is free from judgment and condemnation, which seemed to enable a sense of acceptance. This seemed to allow for feelings of safety, enabling trust and stronger degree of intimacy between participants and their therapists.*

The dominant ideas and reading around Schizophrenia today are bio-medical perspectives (Boyle, 2002). There are accounts of psychotherapy and counselling, but contribution from counselling psychology is sparse within this area of research and practice (Larsson, Loewenthal & Brooks (2012). Counselling psychology's value base is embedded within a Humanistic framework and at the heart of the profession is the value placed upon therapeutic relationship (Woolfe, 1996; Health and Care Professions Council (2015). The therapeutic relationship is fundamental to the progress and outcome of therapy and the therapist plays an integral part in that relationship (Lewis & Bor, 1998; Orlinsky, Grawe & Parks, 1994; Lambert & Barley, 2001). Sensitivity, self - awareness, warmth and a non-judgemental attitude are advocated as essential characteristics for helpers (Barker, 2001; Watkins, 2001).

While there maybe challenges in the relational process, research suggests that this is no different for individuals with Schizophrenia and that the therapeutic relationship is viewed as the most important aspect of psychiatric care (Johansson & Eklund, 2003; Hewitt & Coffey, 2005; NICE Guidelines (2014). The dominance of the medical model and conceptualisation of Schizophrenia as being a biological disorder has led to an exclusion of the necessity of the therapeutic relationship and denied the possibility that psychotherapy can be beneficial to serious mental health problems (Repper, 2002). As a result, the approach of psychotherapy for individuals with a diagnosis of Schizophrenia is focused on treating symptoms, as oppose to adopting a more person-based approach that considers the nature of people's problems (Barker & Jackson 1996).

There is very little research that focuses on schizophrenia and the therapeutic relationship from a counselling psychology perspective in general, let alone more specific populations such as African - Caribbean groups. In this paper, the term African - Caribbean will be used to describe people with African ancestry who migrated from the Caribbean isles, African groups, second generation Black British and some forms of mixed-race parentage. Black and Minority Ethnic (BME) is a term used to describe and group together cultural and ethnic minorities in the United Kingdom. While this is done as an attempt to represent minority groups, the term can also neglect the variation of all the individuals it represents (Richardson & Fulton, 2010).

The literature indicates that African-Caribbean people have significantly raised incident rates of Schizophrenia in comparison to their white counterparts (Fearon, Kirkbridge & Morgan, 2006). Various reasons have been proposed in the literature, from migration effects, social exclusion, unemployment, lack of social support and racism (McKenzie & Bhui, 2007). People from black and minority ethnic communities are more likely to have poorer health outcomes and experience less satisfaction with mental health service provision than the white population (Raleigh et al, 2007; Department of Health, 2005). It is thought that a Lack of understanding among staff concerning cultural based issues, stereotypical beliefs, language barriers and institutional racism have all been suggested in the literature as reasons why black people experience less appropriate intervention and satisfaction (McKenzie & Bhui, 2007; Singh, 2007).

Poor engagement and mistrust of services lead to delays in help seeking and therefore BME communities are more likely to meet services at crisis stage, resulting in more coercive measures and involuntary detention under the mental health Act, reinforcing the "circles of fear" (Keating & Robertson, 2004; (Bhui, McKenzie, & Gill, 2004). BME groups are less likely to access therapy and when they do are more likely to drop out (Arnow et al. 2007; Wierzbicki & Pekarik, 1993) and have unsatisfactory outcomes (Cochrane & Sashidharan, 1996) and a lower working alliance than the white population (Walling, Suvak, Howard, Taft & Murphy, 2012). This group are also less likely to be offered psychological therapy and medication is often the most common form of treatment (Fernando, 2005). The National Service Framework for mental health: Delivering Race Equality (2005) aimed to address these inequalities in accessing services and aimed to promote well-being and improve services.

Several studies have attempted to further understand and explore the experiences of BME group's in psychological therapy and adapt practice to meet the specific cultural needs and requirements (Rathod, Kingdon, Phiri & Gobbi 201); Agoro 2014. Other studies have investigated the impact of culture on the therapeutic relationship (Zane, Nagayama, Hall, Sue, Young & Nunez, 2004; Jim & Pistang, 2007; Owen, Leach, Tao, Rodolfa, 2011). Dryden and Reeves (2008) advocate that the increasing presence of cultural diversity within clients presenting for counselling, necessitates that counselling psychologists must increase their awareness of how cultural difference impacts their clinical work. However, the accounts of African-Caribbean groups with a diagnosis of Schizophrenia, concerning psychological therapy are scarce in the literature. Therefore, exploring how this group experience the therapeutic relationship from a counselling psychology perspective, using a phenomenological approach, may elicit further understanding of the needs of this group and the qualities and characteristics in the therapist that they experience as helpful, as this may contribute towards improving practice in this area.

Method

Interview data was analysed using Interpretive Phenomenological Analysis (IPA), which adopts an idiographic approach, which involves an in-depth analysis of single cases, examining individual perspectives of study participants in their unique contexts (Smith,2011). Due to IPA's idiographic focus on individual case studies, a small and

homogenous sample size is recommended (Smith & Eatough, 2007). This fits well with the purpose of this study, as this study aimed to give a voice to a very small and specific group. Approval was granted by London Metropolitan University Ethics committee.

Participants

Five participants were recruited for the study, three men and two women from an African-Caribbean background, all with a diagnosis of Schizophrenia. The age ranged from Twenty-Four to Fifty – Four. Three of the participants were recruited from a forensic supported living accommodation in South London and one was recruited from a Hearing Voices Group in Surrey and one participant was from a supported living organisation, also in South London. One participant had a physical disability and was wheel chair bound and another had several health issues. All Five participants received at least six sessions of psychological therapy, to ensure that a firm therapeutic relationship had formed. All Five participants engaged in psychological therapy, which ranged from six months to one year. Four participants therapy took place within an NHS context: with a clinical psychologist, counselling psychologist, psychotherapist and one with a BACP counsellor within a charity setting.

Sampling was purposive. Recruitment posters were emailed to several different mental health charities across London, Hearing Voices Groups and supported living organisations were also visited, and Posters were given by hand and made visible to individuals. In one of the organisations, a presentation was carried out, allowing individuals to gain more information concerning the research. Participants that were interested, made contact via email and were contacted by the researcher and Five participants were recruited in total.

Data collection

Informed consent was received in writing before each interview took place. Participants were informed of their right to discontinue the interview at any time and that they could withdraw information up to the point of data analysis. Data was collected using semi - structured interviews and an interview schedule was constructed. Semi structured interviews are an appropriate method of data collection, as it provides a focus and structure, whilst also allowing for other emerging and relevant topics to be explored with participants, enabling more rich and in-depth data (Smith, Flowers & Larkin, 2009). The interview schedule was peer reviewed and used as a guide to conduct the

interviews. The interview began with a question around how long-ago participants received psychological therapy and then went on to explore their experience of therapeutic relationship and questions were asked about their therapist qualities and characteristics and how they felt during therapy. Further prompts were only used to encourage participants to expand further on topics already introduced by participants. Interviews lasted between Forty-Five to Sixty minutes. Interviews were recorded digitally and were later transcribed by the researcher. Pseudonyms were used before transcription, to protect the identities of participants.

Data analysis

An idiographic approach was adopted for the analysis as suggested by (Smith, Flowers & Larkin's (2009) guidance, which allowed for each transcript to be examined in detail, before moving onto the next. The analysis began with reading and re reading the transcript over and over a few times to enable familiarisation with the text, as suggested by (Smith, Flowers & Larkin, 2009). After full engagement and saturation into the text, initial responses and impressions, thoughts and questions concerning the material was written down in the left-hand margin (Smith & Osborn, 2008). Initial notes were then looked at again in more detail, with the aim of trying to make sense of the material by attending to strong emotions, thoughts and expressions that stood out. The transcript was then read through a few more times, to ensure that the collated notes reflected the original data.

The next step involved compiling emergent themes and then noting them on the right-hand side of the transcript, for each section of the text. This aspect of the analysis and coding is more interpretative and draws on some psychological concepts. The next stage involved listing all the identified themes and looking at them in relation to one another and similarities across the themes were explored and identified and from this clusters were formed (Willig, 2001). Descriptive labels were allocated to the clusters of themes that appeared significant and relevant to the research question (Smith & Osborn, 2008). To ensure that the identified themes made sense in relation to the original data, it was necessary to move back and forth between the list of themes and the transcript.

The next stage of the analysis involved producing a summary table of the structured themes, alongside quotations that illustrated each theme. During this stage, some of the

initial themes were disregarded, due them not being representative of the text and the more significant material that was related to the studies aims was drawn out. The table included the cluster labels, alongside their subordinate theme labels, brief quotations and references to where the relevant extracts were to be found in the interview transcript. The same step was followed for each transcript in turn, before carrying out a cross case analysis. A table was created for each superordinate theme, listing sub-themes, along with relevant quotes from the transcript.

Sensitivity to context

Yardley (2000) states that the researcher must show sensitivity to context when carrying out good quality research. Before the research question was developed, a rigorous review of the literature enabled an awareness and understanding concerning the background of the topic, which allowed for an exploration of the socio-political context, as well as the scope of the research available. This was to ensure that the topic of how African-Caribbean individuals with a diagnosis of Schizophrenia experience the therapeutic relationship could be explored in an open-minded and ethical manner and that individual experiences and values would surface. The method of IPA was chosen as it allows for idiographic experiences to emerge and considers the individual from within a specific context. The interview schedule was constructed in a way that allowed for individual accounts to be open and explorative and not restricted by any agenda of the researcher. Keeping a reflective diary supported this process and allowed the researcher to bracket out any preconceptions and expectations.

Results

The analysis resulted in the emergence of three master themes, which encapsulate the lived experiences of the participants, namely Love without Judgement ("Never condemned") A Chance To be Heard (Fear Vs Freedom) and Separation from The Therapeutic Relationship (see table 1).

Table 1: The Themes

SUPERORDINATE THEMES	SUBORDINATE THEMES
LOVE WITHOUT JUDGEMENT ("Never Condemned")	Feelings of Nurture (Going Beyond)
	"Feelings of Acceptance"
	A Sense of Safety
	Beyond Colour **(**Cultural Needs Vs Therapist Qualities**)**
A CHANCE TO BE HEARD (Fear Vs Freedom)	Intimacy Vs Resistance
	A Sense of Release
	A New Sense of Empowerment
SEPARATION FROM THE THERAPEUTIC RELATIONSHIP	Coping Beyond Therapy (Loss)
	New Beginnings (Hope)

Love without Judgment

This theme encapsulates the aspects of the therapeutic relationship that were viewed to be the most meaningful, focusing on the qualities and characteristics that were conveyed by the therapist during therapy. Love can be viewed in this context as a deep sense of respect and care that was shown by the therapist.

(i) Feelings of Nurture (Going Beyond)

This theme details how participants experienced a sense of feeling "cared" for by their therapist that went beyond "traditional" interactions in the therapeutic relationship, due to the boundaries being slightly relaxed. It demonstrates how there was a feeling of the "whole" person being catered to, due to the acknowledgement other needs. For some participants, "care" went beyond emotional needs, which led to a sense of informality in the relational dynamic:

> David: *"well that guy was even more loveable, the guy would make you two cups of tea, orange there, he would even give you a biscuit and you sat in an office in ……. hospital in Lewisham for an hour, and we use to talk, we didn't even talk about sick be matters…we'd talk about the football, or we'd talk about the weather, or the pint of beer we had last night, talked about erm weight lifting".*

> John: "*For me the relationship was him was a very good relationship, very lovely, good relationship, very very good one, because we start you know at times he would get me some water and he would make a cup of tea for me, wants to make sure I'm relaxed before we start he wants us to start on a good atmosphere, on a good state, on a better state of mind you know…very very good and he's concerned about my wellbeing and everything, my hygiene and everything, you know which is amazing…".*

Personal qualities and characteristics were recognised by the therapist and appreciated by participants:

> *She said that I'm funny kind, outgoing, always kind of happy, have a lot of talent… like creative artistically wise, good at poetry she said, I let her read some of my poems that I wrote, this was ages ago, but I let her read it and she said it was really good...so she basically saw me*".

(ii) Feelings of Acceptance

This theme highlights how the therapeutic relationship provided an atmosphere that was free from judgement and condemnation, which seemed to encourage a sense of value in participants.

> David: *"Yes I was, I felt good…I could never talk to my parents the way I talk to those people, my parents were very proud people, they believed in academic success and if you don't give them that, they will turn away from you, and they want listen"*

> John: **"***because for me I don't like people condemning or not listening to me…some people don't really understand you, you know, they think your just being silly and just making it up in your head or something, so…he really really understands…"*

> Julie: "*What did I like…just at the fact that I could talk to him and tell him anything I wanted to, and he would sit and listen and that was a good thing as well, somebody that would just sit and listen, but not pass judgement".*

For one participant, his feelings of acceptance came from a sense of identification with the therapist and he was the only participant with a therapist that was from a similar cultural background to him.

> Patrick: *"That was good to relate to relate to innit, knows where I'm coming from…I'm a street kid as well so…"*

(iii) A sense of safety

This theme conveys a fundamental aspect of the therapeutic relationship, as it is concerned with feelings around safety within the therapeutic space, and how the therapist was able to facilitate an environment that enabled participants to feel contained.

> John: "*Well when I was with him, I feel safe, I felt safe when I was with him, I felt so free, I feel so free… when I was with him…*"

For one participant, her sense of safety came from feeling "felt" and held by her therapist:

> Diane: "*She felt, I feel like she was trying to, she was really trying to understand me and ermm at time it felt like she was actually feeling my emotions… It felt that way sometimes Umhum, especially when I was speaking about certain subjects, she did kinda, I felt like, she felt she was there with me…"*

David's sense of safety within the therapeutic relationship seemed to be around not feeling judged by his therapist, which enabled feelings of trust to develop:

> David: "*stood there, and I poured my soul out to this man, he never questioned me, never condemned me and never went to my consultant and said this guy is perverse, or wicked, or stupid or black or just erm a menace, he never said that, he never told anything I said to him to anybody, that was good".*

Different to the rest, Julie "sense of safety" was compromised around fears around power and confidentiality.

> Julie "*Well you have to be careful what you say to them as well, you can't tell them everything, you just can't tell them everything, but as I said …. hospital the … unit I wouldn't really want to end up going back in there".*

(iv) Beyond Colour (Cultural Needs Vs Therapist Qualities)

This theme highlights whether the therapist's ethnicity and cultural differences, or similarities, impacted the therapeutic relationship and whether these needs were met. It explores whether the therapist qualities and characteristics where more significant and important than any other differences.

> David: "*Even though he was welsh, ……was welsh, he was welsh, he had this way of erm…..humour, he would sit in front of you and he would laugh and then all your troubles came out, just came out, there was no erm, there's no object there, there's no hurdle, plain sailing it just came out, what was wrong with you, what you like, what you did, what was your problem, problem with women, job, parents, your brothers, beat you up, all these things came out, he's a nice guy…."*

Again, Julie like David is acknowledging the difference in colour and ethnicity, but then goes on to place emphasis on her therapists' qualities:

> Julie: *"It weren't an issue to me no, sometimes you do find it an issue talking to somebody who that is not your colour or ethnic background, I'll be honest with you, I've come across some people like that, but with (therapists name) I didn't, he was… I don't know, he was kind of upper class really…but you know but he was really…very intelligent, he would listen to me and if I said something he wouldn't come across and say that I didn't agree with that, or whatever…."*

For Diane, the thought of a cultural difference did not even come to her mind:

> Diane: ***"****I don't really think of culture anymore, cos I know that we are all one race, I don't really think of culture as a thing, I know I have my side where I go to parties and like listen to music and stuff…I think for me it's more about the person seeing me, not about the colour."*

Different to the rest of the participants, Patrick had a black therapist, which led to assumptions and expectations about the therapist concerning cultural understanding:

> Patrick: "*Well he's was black aswell innit, so he would know what to do…to expect from a black yute cos he's black himself…."*

John also highlights a challenge in therapeutic relationship where there was a misunderstanding of culture and how this more likely would have been identified by someone of his own culture:

> John: *"I said because I respect her, but he doesn't really seem to understand that, but if you are from my background a black person will know that you need to respect everybody, people that are older than you and there are ways to talk to them and everything, so…. yeah"*

A Chance to Be Heard (Fear Vs Freedom)

This theme aims to capture how the therapeutic relationship provided a space for the participants to express themselves and be heard and a place where their emotional needs were met. However, it also demonstrates challenges and fears around intimacy and how this was managed throughout the therapy process.

(i) Intimacy Vs Resistance

This subtheme highlights the challenges that participants experienced within the therapeutic relationship, in terms of having to negotiate how much of themselves to "open up", while also experiencing the desire for intimacy and closeness.

> Diane: *"Like the real me, but she did kinda see the real me, it that makes sense..the person that I'm trying not..not that I'm scared of, but many people don't like, not cos of like its bad or anything, but you know cos everybody has so many faces.. and so many levels to themselves and so many layers, good, bad ugly, evil or whatever, we all have them, it's just some people are not willing to accept, without judging".*

John: "*Yea I had concerns, because for me… like other men, I don't like talking about the way I feel, I don't like talking about the way I feel, I realise I need to talk, but I don't like talking about the way I feel, so I was worried about going to somebody strange and talking to the person about me…"*

This was also similar for Patrick, as he also had concerns around beginning therapy and tried to minimise his need for help:

Patrick: *"Erm to tell you the truth yea, I tried to like erm play down, like I wasn't gonna do it, but at the same time I know I had to something, I just said Il do, to see what I can get out of it innit…quite serious my condition".*

However, this was not the case for David, as he expressed no fears around entering the therapy relationship:

David: "I asked for it…. erm somebody to listen to erm…erm…someone to erm……someone to erm…listen put a shoulder on".

(ii)A Sense of Release

This subtheme captures the point of the therapeutic relationship where participants felt able to "let go" and where they felt able to share some of their most intimate and most difficult experiences. It also shows where the therapeutic relationship became a place of freedom and a space where there struggles, and conflicts were embraced, as someone was willing to "hear them".

Diane: *"I think the first three four session we spoke about everythink, my childhood traumas and stuff like that and stuff I went through and relationships and stuff like that, within the fourth session I was crying, I would leave the session, my session would be on the Tuesday I think it was or a Thursday or one of those days, and like I would leave and two days later I would be fine…and good, I would start crying, but these weren't tears tears, they were like proper tears, you know when you can't stop yourself from crying"*

John also experienced a similar feeling of release whilst with his therapist, although the relationship also provided a sense of escape:

> John: "*when I was with him… I had peace of mind, even though I'm struggling, but I know I'm going to see him on Thursday, I normally see him on Thursday, so I always wait for Thursday and I talk to him, you know most of the time I cry, he understands me and most of the time…".*

For Julie, knowing there was someone there, that would embrace her in any emotional state:

> Julie: *"I don't know you know, he was just somebody that I could talk to and just let off on you know".*

(iii) New Sense of Empowerment

This subtheme encapsulates how the therapeutic relationship enabled a shift in self - perception and led the development of a stronger sense of control and authority over one's sense of self.

For David, the therapy relationship was experience as an emancipation from his feelings of suppression and inferiority:

> David: "*I felt for one moment I was an adult, I was the voter, I thought I put my card into the poll station box, I had a voice, I had the right to vote, I had the right to be this person, I was not just an object, I was (participant states his name) …"*

For Diane, her sense of empowerment was enabled by the therapeutic relationship providing a space where a new realisation of herself was reached:

> *Diane: "your soul, I feel like when all three of them are connected as in one, that's when it's quite scary, cos as your spirit, you can allow. your spirit to feel*

things, but your soul will then intervene at one point and say no you can't hide from it anymore, I feel like I've been hiding from my inner emotions for years."

Empowerment for Patrick, came from how the therapeutic relationship itself, as it fostered an environment of where change was possible:

Patrick: "*Yea it was, it was cos he knows how to get well the best results don't he, he knows, how to get the best results from me"*

Separation from The Therapeutic Relationship

This theme addresses the experiences of participants when the therapeutic relationship came to an end and how this separation was processed and the emotions that this "loss" brought up for each person. Some individual's experienced more of a sudden ending due to personal factor's, or the therapist having to leave, while for others the ending was more planned.

(i) Coping Beyond Therapy (Loss)

This subtheme discusses how participants managed the end of the therapeutic relationship and the emotions and challenges that come up for them.

Julie: *"but I was just very unhappy at the time when he left and my psychiatrist left at the same time, without really telling me they were going to leave, so they just sprang it on me, and I didn't know".*

Unlike Julie, Diane was prepared months in advance, however the "loss" of the relationship was still painful:

Diane: "*and I was kinda upset by it and I told her, and she was like you only have one more week left, she told me months in advance, but I was still upset".*

For John, the end of the relationship, signified worry around not been able to hold himself together:

John: **"***Yeah, I was satisfied with the fact that I could go to him and sit there with him every week, even when I stopped, I was worried about how I was going to cope, so I kind of enjoyed talking to him and pouring out my heart to him".*

Separation for Patrick, came from circumstances that were beyond his control, due to his health:

Patrick: *"Yea it was quite satisfying, someone out there that I could relate and make an effort with, but erm…my physical health, I couldn't continue treatment, but they made another appointment, I'm going to make an effort with…. actually, strong enough to do the counselling again".*

Separation for David was different from the rest and experienced as a new beginning which led to a sense of evolvement:

David: "*it's like when you're a baby, you have to make you first moves, your growing up, your first steps, then you gradually become, you stagnating to erm to a new born, into nursery school, into comprehensive, so forth, you have to make your mind up, you have to be the one to do something, unless you want to end up nowhere"*.

(ii) New Beginnings (Hope)

This subtheme looks at the future expectations and aspirations of participants, in terms of personal growth and life beyond the therapy relationship.

David: "*Made me feel for once in life, I was going in the right direction, I could stand on my own two feet and I could explain things, I could reach the heights of grandiose and survival and you know erm, and become get a professional life, get married, and erm move away, go away some place, maybe even one day go to a distant country where no one knows you."*

Diane's sense of hope also comes from a place of personal growth:

Diane*: Errrm…. It taught me how to deal with things a lot more, calmly, but then if I do if it does get to much, I do go into my little moments, but it's made*

me a lot more calmer, just to deal with life a little bit more, not as much as I would like to, but… just a little bit, its helped a little bit.

However, for John, his perception of change and growth is different to his therapists, which has left him with a sense of hopelessness:

John: "*Yeah yeah…when I saw the comments on the letter, I was like oh… thought I had made some improvements, but I haven't made anything according to his assessment"*

John: "*Well it made me feel worse and bad…. frustrated as well, frustrated as I don't know what to do, you know I don't know what to do again, as I'm finding that I'm improving, but I'm not according to him…really frustrated".*

For Julie, due to the nature of how therapy relationship ended, there is a sense of stagnation rather than hope:

Julie: "*but I 'm just disappointed… because of what's happened, I was just not expecting that at all"*

Julie: "*To be left on your own just to get on with it"*

Discussion

Studies have shown that the strength of the therapeutic relationship is a significant factor towards change, irrespective of the therapeutic approach adopted (Orlinsky, Grawe & Parks, 1994; Lambert & Barley, 2001). All the participants in the current study engaged in different types of therapy, CBT, counselling and psychotherapy. However, all report on the therapist characteristics of warmth, genuineness and acceptance. This seems to support the findings that it is not necessarily the type of therapy that is received that enables change, as they all result in similar outcomes, but rather the quality of therapeutic relationship (Paley & Shapiro, 2002). It would be important to discuss some of the core features that enabled the development of a strong therapeutic alliance.

Most participants reported a sense of casualness, an informal style of interaction with the therapist which resulted in an environment that was "open and free" as they felt although the therapist was able to speak to them on an equal level. Laugharne et al. (2012) study draws attention to how individuals with psychosis felt a need for a shift in the balance of power at times within the relationship. This could be conveyed in friendly conversations around shared interests, or through self-disclosures of staff and led to feelings of trust. While these findings are not in the context of psychological therapy, it could still be argued that such concept around power can be applied to the current research, as the sense of informality that participants are describing, seems to be around a balance of power that was created within the therapeutic environment.

There is a sense of therapist being "down to earth" and reachable, enabling feelings of trust to develop. Totton (2010) draws attention the concept of boundlessness in therapy, that allows abundance, attention and care to be conveyed that may go beyond normal realms of therapy. This sense of informality was also experienced as the therapist "going beyond" their normal duties and providing a relationship that surpassed meeting psychological needs alone, allowing for a "human to human" connection. Vogel, Wade and Hackler (2007) draw attention to how individuals with severe mental health problems, such as those with a diagnosis of schizophrenia, can internalise societal stereotypes and judgements, which results in self – stigma. Livingston and Boyd (2010) found that feelings of self - loathing and unworthiness undermined therapy. The therapy environment provided a space free from "condemnation and judgement", which seemed to allow participants to internalise a new perception of themselves.

Research has shown that African-Caribbean people are less likely to access mental health services and psychological therapy which is due to stereotypical beliefs, perceived discrimination and institutional racism (Mckenzie & Bhui, 2007; Singh, 2007). Research has also shown that when African - Caribbean people do engage with therapy, they are more likely to drop out and have a poorer working alliance (Walling, Suvak, Howard, Taft & Murphy, 2012). African - Caribbean people with a diagnosis of Schizophrenia carry the shame of diagnosis, in addition to issues around perceived discrimination, which may impact upon engagement in psychological therapy. The sense of acceptance and non - judgement that participants express to experiencing in the

therapeutic relationship, allowed them to feel although every aspect of them was valued and led to a sense of safety.

The literature has highlighted challenges and difficulties that may become present in the therapeutic relationship with clients with psychosis, in terms of issues around attachment insecurity and fear around establishing a relationship (Lotterman, 2016; Jung, Wiesjahn, Rief & Lincoln, 2015; Wittorf et al, 2010). In the current study it could be argued that all participants developed quite strong attachments with their therapist, although most participants did report fears around intimacy and ambivalence around having to get close to somebody new during the initial stages of therapy. Hycner (1993) advocates that resistance is a manifestation of just how vulnerable an individual is and is a form of self-protectiveness. Some participants expressed worries around feeling exposed and having to reveal aspects of themselves that could be judged, which seemed to indicate fears around rejection and not being accepted.

John expressed that he felt uncomfortable at the thought of having to speak about his feelings, especially as a male. It seems that there was some shame in having to access therapy and that as a man he should be able to handle his emotions and feelings, which is in line with literature regarding the help seeking attitudes of men (Berger et al, 2013). Patrick similarly expressed that he was unsure of therapy at first and didn't want to do it but knew he had too, as he was becoming worse. The literature has indicated that African – Caribbean people are less likely to access mental health services voluntary and that this is even more prevalent among black males, as they are likely to disengage with mental health services and report poorer experiences (Wagstaff, Graham, Farrell, Larkin & Nettle, 2016). John and Patrick may not have reported poor experiences and did not and disengage with therapy but were initially ambivalent about beginning the therapy process.

Most participants experienced the relationship as a loss and was concerned about how they would cope beyond therapy. Few studies have investigated the feelings of clients concerning the termination of the therapy relationship (Roe, Dekel, Harel, Fennig & Fennig, 2006) let alone for individuals with a diagnosis of Schizophrenia ending therapy. Barnett et al (2000) advises that careful consideration needs to be given to the ethical responsibilities concerning the termination of therapy to prevent the client from

hurt, or feelings of abandonment and instead endings should be a solidifying process that enables the integration of treatment.

Orlinsky, Ronnestad and Willutzki (2004) study concluded that while handling termination appropriately is important, that it is probably what happens in therapy prior to the ending, that has the most impact. This was not the case in the current study, as some participants experienced the therapeutic relationship to end suddenly and prematurely without much warning or preparation, leaving them with a sense of abandonment. This was mainly the case for Julie, as this was not what she was expecting and came at a time when her psychiatrist who she had known for years, was also leaving. Vasquez, Bingham and Barett (2008) argue that an essential clinical responsibility is to clarify the boundaries of the therapy relationship, and two of those boundaries are the beginning and the ending of psychotherapy. The nature of the psychotherapy process involves trust, power, and caring (Pope & Vasquez, 2007).

Managing the ending appropriately, helps avoid betrayal of the trust and abuse of power. Appropriate termination also prevents harm and conveys caring and ethical treatment. Julie felt disregarded and felt although her feelings were not considered and that she was not valued by her therapist, which seemed to undermine the relationship. Research has also shown that when terminations are forced, or unplanned clients experience more anger, mourning, anxiety and frustration, whereas planned terminations lead to more reactions of pride, excitement and determination to finish (Cicchitto, 1983; Goldthwaite, 1986; Saad, 1984). Furthermore, (Penn, 1990) has argued that some clients may feel rage over what they experience as abandonment or betrayal by the therapist, or sadness over the loss of the therapist as a "significant object". Usually these affective reactions to premature termination, mirror the client's responses to losses earlier in life (Bostic et al, 1996).

IPA fosters an idiographic approach which does not aim to find definitive answers, or generate theory, hence why it was not the aim of this study to generalise the findings to all African – Caribbean individuals with a diagnosis of Schizophrenia. However, the transferability of the findings should still be taken into consideration. While it must be acknowledged that other African – Caribbean individuals with a diagnosis of Schizophrenia may have similar experiences of the findings presented in the study, this

research provides in-depth insight into the experiences of the individuals who were interviewed and it is for this reason that transferability of the findings must be considered in context (Smith & Osborn, 2008).

The aim of this paper was to explore how African - Caribbean's with a diagnosis of schizophrenia experience the therapeutic relationship and to examine the qualities and characteristics that participants found to be important in their therapists'. The study highlights the importance of the therapeutic environment and participants reporting an atmosphere which is free from judgment and condemnation, which seemed to enable a sense of acceptance. This seemed to allow for feelings safety, enabling trust and stronger degree of intimacy between participants and their therapists. The qualities of the therapist seemed to be more important than their culture and ethnicity, although what was found was the importance of therapists considering how culture maybe implicated in aspects of an individual's distress.

Finally, it is hoped that the findings that have emerged will be considered by clinicians when working with African – Caribbean individuals with a diagnosis of Schizophrenia and that practice will be sensitive to the cultural needs of this group, whilst balancing this with the individual needs of the client.

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