A Phenomenological Inquiry into the Experience of Receiving Individual Cognitive Behavioural Therapy (CBT) for Psychosis within a Psychosis Recovery Outreach Programme in Lebanon

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Abstract

Cognitive Behavioural therapy has been recognised as an evidence-based intervention for varied psychological and emotional difficulties and applied worldwide. However, CBT like other psychological interventions has been developed in Western, developed countries and therefore holds certain assumptions and values underlying the cultural context of its origin. The cultural context of individuals however does not only determine the expression of psychological distress but also constructions of cultural systems of healing and help-seeking behaviour. With this, questions arise around how individuals from different cultural contexts come to understand their experience of this intervention and what aspects of the intervention are useful and appropriate. Therefore, the current research aims to elucidate this question through a phenomenological inquiry. Four semi-structed interviews were conducted in English with four participants who received individual CBT for psychosis in a 'psychosis recovery outreach programme' (PROP) in Beirut, Lebanon. The phenomenon under study was explored by adopting a methodology informed by Max Van Manen's hermeneutic phenomenology. The findings highlighted the importance of incorporating religious or spiritual beliefs in the conceptualisation and ways of coping with distress. The research also found the importance of beginning with certain interventions such as behavioural and social tasks over cognitive interventions. Problematic areas identified, included: the need to assess psychological readiness, the timing of interventions and therapists' communication style within the therapeutic work. The implications for the field of Counselling Psychology and other allied health professionals are reviewed to offer an insight into individuals' experience of this intervention. Finally, limitations of the study are identified and discussed.

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PART I: INTRODUCTION

Introduction

Individuals from different cultural backgrounds interpret and experience the world from a different lens (Avasthi, 2011; Rathod, 2017), which will inevitably bring about different interpretations of the human mind, the definition of illness/health and norms of behaviour across different cultural contexts. With this in mind, considering that psychological theory, practice and research reflect the cultural context in which it flourishes, developing an understanding of the application of psychological models in different cultural settings is significant and requires careful attention.

Research Terminology

Before introducing the chapter, it is important to clarify the terms used throughout this study. I will be referring to certain parts of the world as 'Western' and 'non-Western'. I acknowledge categorising individuals/cultures and beliefs into one or the other can be problematic since cultures are not static and are interlinked with one another. As Rathod et al. (2019) stated, "each individual has a unique culture that is part of a broader culture and is constantly changing as a result of various influences depending on tensions between the individual and their value systems at relational interfaces" (p. 1). However, for clarity and simplicity, I will be utilising these terms within this research study. Thus, 'Western' countries and cultures are those located in Europe, Australasia and the Americas, while 'non-Western' are those located in the Middle East, North Africa, South Asia, Central Asia and the Far East (Thompson & Hickey, 2005).

The term 'cross-cultural' used within this study is in reference to the psychological knowledge and theories that have been developed in a certain cultural context and are being used in a different cultural context that holds different values, assumptions and beliefs. For

the purpose of this research, the psychological intervention (i.e., Cognitive Behavioural Therapy for psychosis [CBTp]) originates from what is termed as a 'high-income country' and is being utilised in a low-to-middle-income country: Lebanon. Therefore, it is important first to define culture. The term 'culture' has attracted uncertainty around how to understand this concept and several definitions have been proposed over the years. Shiraev and Levy (2020) described it as:

> [… a] set of attitudes, behaviours, and symbols shared by a large group of people and usually communicated from one generation to the next. Attitudes include beliefs (political, ideological, religious, moral, etc.), values, general knowledge (empirical and theoretical), opinions, superstitions, and stereotypes. Behaviours include a wide variety of norms, roles, customs, traditions, habits, practices, and fashions. Symbols represent things or ideas, the meaning of which is bestowed on them by people. A symbol may have the form of a material object, a colour, a sound, a slogan, a building, or anything else. People attach specific meanings to specific symbols and pass them to the next generation, thus producing cultural symbols. (p. 35)

As described in this definition, cultural backgrounds can and will shape an individual's conceptualisation of illness, the way individuals express illness (thoughts, feelings and behaviour) and their help-seeking behaviour (Yalvac et al., 2015). Therefore, one way to understand individuals' meaning making of the world is by giving them the voice to narrate their unique and subjective lived experiences.

Setting the Scene

The following research will examine Lebanese individuals receiving a cross-cultural psychological intervention, mainly individual Cognitive Behavioural Therapy for psychosis (CBTp) in Beirut, Lebanon. The proliferation of psychology around the world has become

the method for promoting mental health in mainstream Western culture, perhaps partly because of its basis in natural science. The globalisation of Western psychotherapy should, however, be understood in relation to local culture, knowledge and understandings.

My experiences, personal beliefs and views are of relevance to this research as it determines what is included, reviewed and how experiences are interpreted. Being Lebanese, I am mindful that I come from a similar cultural heritage to the participants interviewed for this research. My cultural background may have shaped certain assumptions, beliefs and ideas that naturally informed my research practices. These assumptions and beliefs, however, will be acknowledged and explicated throughout the research, as the chosen methodology necessitates the researcher to be transparent in this way.

As a clinician, I first worked with people experiencing psychosis who were detained under the mental health act in the United Kingdom. I was interested in the many contextual layers that contributed to their presentation and wondered about the wider systemic complexities that appeared to play a role in what they experienced at different stages of their journey. Furthermore, I was intrigued by the complexity of working with both men and women from different cultures that brought with it a new perspective on how meaning was constructed, understood and (sometimes) misunderstood. I have wondered whether discourses on psychological interventions are mainly captured and conveyed by a distinctively Western language. When theories, research and practices originate in developed Western countries, there is often an assumption that they are universally applicable. While Cheung (2000) questioned whether psychological knowledge is simply transposable when transported to other cultures, little attention has been given to the applicability of the theories and practice outside of Western countries.

Psychologists working internationally and cross-culturally has grown significantly (Marsella & Pedersen, 2004). However, Western values (e.g., individualism, free will, materialism and cognitivism) and knowledge claims linked to psychology may not assist the population they are aiming to support (Christopher et al., 2014). The application of Western methods of intervention may not only be inappropriate when applied cross-culturally but can be harmful if not examined closely.

My musings and experiences provided the impetus for this research, which is to explore individuals' experiences of a cross-cultural intervention; a research study that appears to be the least-explored area in counselling psychology and the most challenging to many aspects of counselling psychology work (Woolfe et al., 2003). The applicability of psychological intervention from one cultural context to another is a significant issue to explore and understand in increasing our knowledge base for counselling psychology.

Research Aims

The purpose of this research is to explore the lived experience of individuals receiving individual Cognitive Behavioural Therapy for psychosis in the context of an early intervention service: The Psychosis Recovery Outreach Programme (PROP) in Beirut, Lebanon.

This phenomenological inquiry aims to remain as close as possible to individuals' experiences of this phenomenon, as it is immediately lived in their own contexts. As such, taken-for-granted understandings of the phenomenon might be uncovered. To date, most research exploring psychological interventions in different cultural contexts have adopted an etic approach by deriving knowledge from individuals who have not directly experienced the phenomenon (Eckensberger, 2004). Few studies have focused on individuals' subjective experiences of this phenomenon. Therefore, in this study, an emic approach has been adopted

to focus on individuals' subjective experiences of a particular phenomenon in their own context. There is a paucity of research in the field of counselling psychology exploring subjective experiences of individuals receiving cross-cultural psychological interventions in their own context. This research hopes to highlight to practitioners (i.e., counselling psychologists and other allied health professionals) an insight into how Cognitive Behavioural Therapy for psychosis as a psychological intervention is experienced in a different cultural context.

Phenomenological Research Approach

Moving from my wonderings and experiences, my journey within this research study extended towards developing an understanding of a research approach that would address the research question and enable this inquiry. Upon reading various literature on methodologies used during cross-cultural research and discussions with several academics including my research supervisor, a research approach known as hermeneutic interpretive phenomenology, as described by Max van Manen (1997), was considered as most appropriate. This research approach was congruent with the focus of the research and my way of being, both as a person and as a researcher. The adopted research approach within the current study places emphasis on sensitivity to context. The importance of attending to the sensitivity of the context has been often mentioned in the literature and particularly when working cross-culturally; this is important to consider, as contingent on how a culture understands certain experiences will influence how they are experienced (Sachs et al., 2008). Another influential factor of this chosen approach is its emphasis on honouring the experience: it not only endorses respect for the autonomy and welfare of individuals but demonstrates sensitivity to the quality of data evolving and allows the phenomenon to unfold organically. The chosen research approach will be further explicated in the methodology chapter.

Finally, it is crucial to note that since the research is adopting a constructivist view as its epistemology, what will be presented in this research is, therefore, not the 'truth' about the topic; instead, it should be considered a construction relevant to the research foci.

PART II: Literature Review (Conceptualisation)

Overview

This chapter will explore how psychosis is conceptualised and the associated implications of its conceptualisation across different cultural contexts. An overview of the literature on cross-cultural psychological interventions will be provided with particular attention paid to the more contemporary use of psychological interventions. Finally, the context of where interviews will take place will be provided to locate the research.

Defining Psychosis

Before a definition is provided, it is important to reflect on the unspoken and psychological meanings of classifying people as 'psychotic, 'schizophrenic', 'mad' etc. Providing definitions points at the propensity of individuals towards categorising people into groups and labelling them. Perhaps humans require a label or a category to describe our experience to ourselves and to others in the illusion that they can further explain something. Consequently, in this paper, a definition will be provided not because it is the 'truth', but because it is what the participants of the research and others are confronted with.

Psychopathology, based on the Western biomedical model—which continues to be the dominant paradigm for research and clinical treatment—conceptualises distress in terms of 'illness' and 'health'. Based on the biomedical approach, difficulties are either psychological or physical and act predictably in a cause-effect way (Pollio et al., 1997). In Western mental health, according to the *Diagnostic and Statistical Manual of Mental Health, Fifth Edition* (*DSM-V*; American Psychiatric Association [APA], 2013), a diagnosis of a psychotic disorder is dependent on the presence of one or more key symptoms categorised into clusters: Hallucinations (sensory experiences in the absence of a real-life stimulus, for example, hearing voices other people do not hear); Delusions (fixed and unusual beliefs that

are not amenable to change even in the presence of contradictory evidence); Disorganised Thinking (often recognised due to disorganised speech, such as switching from topic to topic very quickly in a disorganised fashion); Negative Symptoms (withdrawal behaviour and difficulties with day-to-day functioning); and Disorganised Behaviour (which refers to unusual behaviour) (Morris, 2017). The concept of 'psychosis' covers a range of different conditions such as schizophrenia, schizophreniform disorder, schizoaffective disorder, affective psychosis, non-affective psychosis and substance-induced (APA, 2013). In Western psychiatry, schizophrenia remains the main diagnostic criteria for individuals who experience psychosis.

The diagnosis approach to understanding individuals' experiences has been widely critiqued for its absence of reliability and validity (Bentall, 2003; Johnstone, 2008; Read, 2013). It has further medicalised human experiences, individualised difficulties that may be contextual and relational (Rapley et al., 2011), and has proved difficult to eliminate/challenge once a person has been labelled with a psychiatric diagnosis (Read, 2013). Although a diagnosis can be useful in terms of having a common language to describe an experience, it also medicalises problems and shifts the emphasis on symptom reduction, perhaps neglecting to recognise the contextual factors which inhabit the individual (Boyle, 2002). Historical, cultural and prevailing social issues are part of how humans are positioned in the world, and how they come to understand and interpret experiences (Winter, 2003), thus forming part of the complexity of what it means to be human. Therefore, one might assert that diagnostic approaches are partial, functional and lack cross-cultural validity, as they are based upon the biomedical model—a primarily Western conceptualisation of distress and wellbeing (Bhugra & Bhui, 1997). One as such may oversight the bias inherent to diagnosis and confuse the perception of a phenomenon with the reality of the phenomenon (Biehl et al., 2007).

Lately, there has been a move to viewing experiences of psychosis as lying on a continuum, an alternative to viewing the experience as abnormal (Johns & Van Os, 2001), which suggests that psychotic experiences perhaps do not have to be regarded as problematic, and the experiences do not determine 'illness' unless it affected the individual's functioning in some way. This way of viewing psychotic experiences has also initiated a move away from using terms such as 'schizophrenia' and has given rise to key organisations such as the Hearing Voices Network, which support individuals that hear voices and/or have visions.

Psychosis, as conceptualised and understood in the Western biomedical model, is only one way (of many) to understand this experience. Different cultures come to understand and experience mental health phenomena differently. The concept of 'mental health' itself is Eurocentric, and the Western biomedical model of distress implies that the mind and body are distinct entities. Western thinking has conceptualised 'illness' as separate from the individual experiencing it (Fernando, 2010). This paradigm emphasises the role of feelings, thoughts and symptoms in a rather reductionist manner; focusing within the individual and endeavouring to 'treat' problems at an individual level (Fernando & Keating, 2008). The experience and understanding of the psychotic phenomena are rooted in a web of local meanings that differ from one cultural context to another. Peoples' view of the world, the content of their thoughts and, as such, the form and quality of the illness will be influenced by their cultural context (Koç & Kafa, 2019)

Mental illness in ancient Greece was perceived as something unwanted, unsettling and harmful to society (Fabrega, 1990). In Hellenistic times, over the 16th Century, Catholic practice regarded 'madness or insanity' as a form of sin (Fabrega, 1990), and many cultural contexts continue to view and conceptualise mental illness in this prevailing theme. Within South Asian communities, distress is understood and conceptualised more relationally with the mind, body and spirit considered as one entity, rather than distinct entities (Malik, 2005).

For example, in Punjabi culture, distress is conceptualised in a physical sense—a 'sinking heart'. According to Malik (2005), culture is key to how individuals construct meanings of distress and their expression of emotion. Other communities, such as Arabs, various other South Asian communities and some African communities, come to understand distress as being caused by supernatural or social causes (Hamid & Furnham, 2013). Within African-Caribbean communities (e.g., Jamaican culture), mental distress is associated with 'Obeah', while in the Bahamas, distress is associated with 'Ju-Ju' (Ellis, 2015). In Jamaican culture, unusual behavioural changes are associated with supernatural causes such as possession, spirits, fate or evil wishes (Brent & Callwood, 1993). Therefore, the primary manner to conceptualise mental health and illness in Jamaican culture is related to the term 'Obeah'.

Within British Pakistani families, the term 'psychosis' was not used to conceptualise their loved one's difficulties. Instead, their difficulties were viewed as a social problem caused by social stressors, or explanations of black magic was used (Penny et al., 2009). A diagnosis of psychosis within Chinese family members was understood as being caused by a mixture of social, spiritual and biological factors (Phillips et al., 2000). A study by Freeman et al. (2013) found that, when service users' beliefs about their psychotic experiences were associated with biomedically-orientated beliefs, they were less likely to engage with psychological therapies such as CBT and favoured medication over therapy.

The cultural context of the person has an impact on how experiences—like psychosis—are conceptualised, which in turn influences how individuals perceive and engage with psychological interventions. If different cultural contexts come to conceptualise and understand mental health and illness differently, then the assumption that psychological interventions can be applied universally requires careful attention. The need to consider cultural context as heterogeneous and polysemic in the conceptualisation of mental illness, and the impact on the use of Western psychological interventions across different cultural

settings, is a significant issue to explore. Therefore, despite the biomedical model remaining the dominant paradigm, there has been a growing shift to come and understand mental health difficulties as a complex interplay between individuals' biological, social and psychological factors (Tripathi et al., 2019). This therefore provides a holistic understanding of individuals' difficulties including their cultural, social and historical backgrounds. Based on this premise appropriate and culturally sensitive psychological interventions can be delivered.

Western Psychological Interventions

Following on from the dominant conceptualisation and understanding of psychosis, it is expected that methods of healing will be developed and shaped to understand this phenomenon within a certain social and historical context. Western models of psychological interventions— psychodynamic, humanistic, behaviour, cognitive and integrative models— come to understand the phenomenon of psychosis in different ways. Through the use of positivist science, each model was 'approved' as an evidence-based practice. However, according to Cushman (1996), while models of psychological interventions are often viewed as a scientific practice, there is no 'correct' way to conceptualise individuals' difficulties or a 'correct' way to treat them. He further argues that the ideologies underlying Western therapeutic interventions have been widely accepted and practitioners have drifted away from incorporating cultural, political and societal factors into their thinking and practice. One of the many accepted ideologies relates to the concept of 'self'. In the West, the self is viewed as an individual separate from the community, while health entails an independent and controlled self, with the ability to regulate emotions and behaviour to function within society (Cushman, 1996). Additionally, certain thoughts, emotions and behaviour can be viewed as problematic. However, different cultural backgrounds will come to understand and view the

self differently and the varied assumptions about thoughts, emotions and behaviour may not be shared with the assumptions held in the general concept of therapy; this is crucial to consider when working with individuals with diverse cultural backgrounds.

Western models of psychotherapy depend heavily on positivist science, generalised from the physical sciences as a way to rule social and cultural disciplines. There is a propensity to perceive Western ideas about health and illness as objective and scientific, and, consequently, in a 'correct' way; The Western positivist science is positioned then as superior to other approaches, which tend to be perceived as outdated practices and as 'less-than' (Said, 1978). Therefore, when adopting this position, there is a tendency to view any non-Western culture as the 'other' who is infantilised and requires the 'true' methods of Western science to heal it (Nandy, 1983). Orientalism, as defined by Said (1978, p. 11), is "a Western style for dominating, restructuring, and having authority over the Orient". The construction of an inferior 'other' permits Western science to impose their influence concerning ways to understand and conceptualise ideas around mental health and illness; this is perhaps because the 'other' is regarded as incapable to comprehend their own health, and that they require an adult figure (in this case, Western science) to intercede and teach the 'correct' manner of psychological healing. The traditions of Western science continue to be the dominant influence in the field of psychology, which can potentially have a harmful impact by colonising other non-Western science fields. Such colonising is viewing the 'ill' mind as only being capable of being healed by disowning traditional practices and internalising psychological science developed in the West as being on the correct path to healing. In this way, the idea that there are multiple understandings gets overlooked, and more consideration is needed as to how Western psychological interventions are practised cross-culturally.

Case Example: Western Psychological Models Are Not Universal

The subsequent case example, as described by Moghnieh (2015), demonstrates the potential for harm and inaptness when applying Western psychotherapy in different cultural contexts without exploring and understanding their applications first. The case example is situated in Lebanon following the 2006 war between Israel and Lebanon. Although the case example focuses on psychological support as offered by humanitarian aid workers and the context may not be related to this research, it highlights the importance of listening to the individuals themselves about their experience and conceptualisation of distress before applying therapies as 'universal'; this is significant to this research.

There was an influx and rush to provide support from Western developed countries, therefore many humanitarian aid workers and psychologists travelled to Lebanon to offer psychological support. As they arrived, there was an assumption that the concept of trauma would be the dominant expression of distress and, as such, treatment models were tailored to address trauma with the use of post-traumatic stress psychological support. The rationale for assuming that treatments would be related to trauma came from the idea that a universal traumatic experience is triggered after a violent incident and requires immediate attention and treatment. With these assumptions, humanitarian workers were ready to deliver tailored psychological interventions such as eye movement therapy, exposure therapy, stress debriefing and grief therapy. Studies looking into the prevalence rates of PTSD in Lebanon were initiated and this seemed to extensively vary between 2% to 25%. Issues were raised around the validity of questionnaires since many voiced that if one is looking for trauma in a survey one will find what one has set out to find. Several ethical questions and concerns were raised as, despite the increased reports of depression among the population, the support offered was trauma focused. Questions arose as to whether the Lebanese people were experiencing a different kind of suffering and distress than what was being assumed by Western humanitarian aid workers. In an interview with a Lebanese psychologist, she said:

"Let me tell you we have problems in assessing trauma because PTSD, I always say, is a Western concept." (Moghnieh, 2015, p. 9). Another interview featured a field worker who stated, "We don't do trauma programmes anymore" (Moghnieh, 2015, p. 8), as she felt this was not helpful nor did it reflect people's experience of distress post-conflict.

It was concluded that, although the support was well-intended, little attention was given to the cultural understanding of individual experiences. However, this is perhaps not surprising given the literature concerning the internalisation of psychology. Although there has been a movement to try and understand what aspects of psychological interventions are useful—and which are not—in different cultural contexts, the dominant vision of Western psychotherapy being the 'true' method of healing possibly inhibits the recognition that every intervention is inevitably indigenous, and the product of its cultural and social context; therefore, applying it cross-culturally is significant and requires careful attention.

Context

As the interviews were conducted with Lebanese participants, I will sketch a general image of the story of the Lebanese nation as it is known today, intended to serve as a basic backdrop to locate and better understand the private worlds of the Lebanese participants, and situate the research.

Political Stability and Mental Health Provision

With a geographical area of 10,452 km^2, Lebanon is located at the Eastern end of the Mediterranean Sea. It is surrounded by the Syrian Arab Republic in both the north and east, and by Israel to the south. The country includes a large mix of religious and cultural groups, as well as different nationalities. The official language is Arabic and other commonly spoken languages are English, Armenian and French (World Health Organisation [WHO], 2010). In the last century, two decades of civil war and an armed conflict with Israel in 2006 left a

significant impact on peoples' mental health. Since the war ended in 2006, intermittent spells of violence (mainly bombings in civilian areas) alongside economic and political instability have continued to induce a sense of fear, anxiety and insecurity in its civilians. For the past two years, Lebanon has been experiencing a significant economic crisis, which has led to a catastrophic social impact and left more than half of the population in poverty, with unemployment being on the rise. Shortage of medication, food and fuel led to electricity blackouts across the country. A diagnosis of depression, anxiety, somatoform and stress-related disorders appeared to be the most diagnosed among the Lebanese population, followed by psychotic disorders (WHO, 2010). However, the provision of mental health support and legislation has been minimal. The most significant factor perhaps limiting the establishment of mental health services is a lack of funding, followed by a lack of trained mental health staff (El- Khoury et al., 2018). The mental health service delivery model in Lebanon is mostly offered via the private sector, offering hospital-based care to individuals who can afford the expense of receiving mental healthcare (El- Khoury et al., 2020). Over the past ten years, the government has not developed mental health services within the state sector and has preferred to subsidise inpatients beds in private hospitals where needed. The mental health sector in Lebanon is poorly funded with individuals on average contributing 20% towards any mental health care or medication (El-Khoury et al., 2020). The Lebanese government has allocated 5% of its total expenditure on mental health services. This means a large proportion of the population are not health-covered resulting in individuals residing in long-term stay facilities with no outpatient care.

Individuals treated as having a psychotic illness within mental health outpatients facilities totalled 29%, with 21% in community-based psychiatric inpatient units and 37% in long-term psychiatric hospitals (El- Khoury et al., 2018). Several deficits persist despite efforts to improve the general conditions. Primary care staff are not trained adequately in

mental health, and communication between the primary care and other mental health sectors is limited. Only 1.26 psychiatrists are estimated to be available per 100,000 population in Lebanon (El-Khoury et al, 2018), thus covering only a small percentage of the need. Since a diagnosis of psychotic disorders has shown to be the most prevalent in long-term psychiatric hospitals, this emphasised the need to establish new mental health services for psychosis. The aim was to reduce delay in treatment, decrease admission and relapse rates, educate families about psychosis and set a long-term plan to maintain mental health. Based on this premise, the first early intervention programme for people experiencing psychosis was established in 2016, named the Psychosis Recovery Outreach programme (PROP). PROP was initiated at the American University of Beirut Medical Centre and covers the Beirut metropolitan area. PROP adopted policies, legal frameworks and evidence-based treatment from the United Kingdom (El-Khoury et al, 2018). By 2018, PROP—where the interviews took place—had a turnover of 50 patients who had received mental health support through the programme.

Psychosis Recovery Outreach Programme

Worldwide, there has been an interest in improving clinical, social and personal outcomes for people experiencing psychosis through early detection and intervention. The rationale is that untreated psychosis for a prolonged period may have a negative impact on individuals' quality of life. Early intervention services have been recommended as an evidence-based treatment for individuals experiencing psychosis (NICE, 2014).

EIPSs conventionally work with individuals aged between 14-35 who are experiencing an episode of psychosis (Shiers & Smith, 2010). EIPSs aim to work holistically by using a combination of psychological, medical, occupational and social interventions to support service users and family members (Shiers & Smith, 2010). Early intervention

services adopt a recovery-based approach that aims to reduce distress and empower individuals to live the life they want, regardless of whether their experience continues or not (Cooke, 2017). A key feature of early intervention services is to offer individual CBT for psychosis and family interventions (Burns et al., 2014).

As mentioned, PROP was initiated at the American University of Beirut Medical Centre and covers the Beirut metropolitan area; it is the first integrated community service that supports individuals with psychosis. The service consists of different allied health professionals (psychiatrists, psychologists, nurses and occupational therapists) offering psychological, medical and psychosocial support to individuals experiencing psychosis. Care and treatment are offered to both individuals with a diagnosis of psychosis and their families in the form of psychoeducation, individual therapy (CBTp), group therapy (support groups, social skills training), psychiatric consultations and nurse check-ups. Affordability was essential to the programme and therefore individuals within PROP receive weekly drop-in checks with nurses, free of charge. However, as for receiving psychological therapy or consultations with psychiatrists, individuals self-fund and/or rely on private insurances to cover some of the expenditure. When developing the service, special attention was given to counties that have long-established early intervention services, such as the United Kingdom and Canada. Therefore, PROP adopted a model that is practised within early intervention services, such as offering evidence-based treatments—CBTp and family interventions. However, therapy models are rooted in white individualistic Western Eurocentric societies (Orlans & Van Scoyoc, 2009), and little attention has been given to the applicability of the theories and research of psychological knowledge in different cultural contexts. While reviewing the literature to interview individuals in their own cultural contexts, there appeared to be a great paucity of research looking into psychological interventions offered in Lebanon. Interestingly, there appeared to be extensive literature exploring Lebanese individuals'

experiences of interventions for physical health (e.g. oncology patients receiving palliative care and understanding Lebanese family caregivers in cardiac self-care). This in itself may reflect the country's emphasis on physical illness as opposed to understanding psychological distress. According to Hayes and Iwamasa (2006), Lebanese people are among the most neglected in the literature regarding psychological interventions, which reinforces the gap in the literature around exploring individuals' unique experiences from a different cultural background and the lack of knowledge of their experiences of CBTp in the field of counselling psychology.

Dominant Psychological Interventions of Psychosis

Various psychological explanations have been suggested to understand psychotic phenomena and it is imperative to explore the theoretical underpinnings of the psychological approaches to the understanding of this phenomena.

Psychodynamic Theory

One paradigm used to understand peoples' experiences of psychosis is psychodynamic theory. A key feature of this approach is the idea that the experience of psychosis (e.g., hallucinations and delusions) serve a protective function to the unbearable circumstances the individual may be facing. Martindale (2007) suggests that it is important in the psychodynamic approach to identify emotions that have, in the past, overwhelmed the person and to be attentive to the content of hallucinations and delusions that may share significant relationships with emotional experiences. Therefore, in psychodynamic therapy, careful attention is paid to understanding individuals' experience of reality, which has been disintegrated as a response to unbearable circumstances instead of 'digested' and integrated. Emphasis is placed on understanding this disintegration by processing the psychic pain and anxiety underneath one's experience (Martindale & Summers, 2013).

Within the psychodynamic approach, the role of family relationships has been highlighted as important in understanding psychosis in particular the concept of 'expressed emotion' (EE; Brown, 1985). Key components of EE include emotional-over involvement, critical comments, warmth and hostility. These can indicate the 'emotional temperature' of a relative's response to the psychotic phenomena and to the person experiencing psychosis.

Although the role of family relationships is integral to this approach, psychodynamic theory has been critiqued for its focus on the self with little commitment to understanding one's cultural context in shaping psychically complex experiences (Groark, 2009). The author further argued that interpretations within therapy can therefore result in psychological reductionism further reinforcing the eurocentric models of the mind and human experiences.

Attachment Theory

This theory proposes that early significant relationships influence the development of 'internal working models', which act as a platform for the way individuals relate with the world and others in adulthood (Bowlby, 1969). There is extensive evidence showing that adult attachment styles can be a predictor for interpersonal difficulties and mental illness and can have an impact on social functioning (Berry et al., 2006; Platts et al., 2002). Developing a secure attachment style in adulthood may be associated with resilience, comfort in forming relationships, and the ability to manage distress and painful experiences. On the contrary, it is hypothesised that an insecure attachment style in adulthood may increase one's vulnerability to developing psychosis (Korver-Nieberg et al., 2014). Research has suggested that attachment theory could be a significant framework for conceptualising psychosis (Berry et al., 2019). Bucci et al. (2017), found that individuals with anxious and avoidant attachment styles experienced higher positive symptoms of psychosis, such as auditory hallucinations and paranoia.

To address attachment difficulties, Gilbert (2009) suggested compassion focused therapy: an approach that postulates that individuals with severe psychological difficulties are likely to be dominated by the threat system. Through exploring shame and self-criticism, perception of threat and enhancing self-compassion, this approach may positively influence attachment systems and, as such, improve one's ability to cope with experiences such as psychosis (Gumley et al., 2014b).

Acceptance and Commitment Theory (ACT)

This theory is based on six principles that, when adopted, can promote 'psychological flexibility'. The six principles are: acceptance; self-as-context; being in the present moment; value-based living; defusion; and committed action (Hayes et al., 2009). Psychological flexibility has been described by Levin et al. (2012) as:

> … rather than directly attempting to change the frequency or intensity of distressing internal experiences (i.e., thoughts, feelings and sensations), the model focuses on changing how people relate to distressing internal experiences, and on engaging in values-based actions independent of these experiences. (p. 742)

Therefore, the focus in ACT is not on reducing symptoms and content of inner experience. Instead, emphasis is placed on acceptance and validation, and changing the relation of the symptoms to behaviour, which is encouraged through the use of value-driven behaviour.

Within ACT therapy, the self is reinforced as an "enduring self from the perspective of an observer, clinically termed *Transcendent Self*, *Self-as-Context* or the *Observer Self*" (Fung, 2015, p.568). This way of viewing the self suggests that the self exists and is permanent. However, this view and conceptualisation of the self within this approach has been critiqued as incompatible with different cultures who conceptualise and view the self as changeable and not permanent. This was particularly highlighted within Asian and collectivist cultures

whereby the term “stable-observable self” was adapted and the use of “no-self” was deemed more appropriate. The “no-self” concept was understood in relation to ‘impermanence’ and the notion that no stable self can exist (Hanh, 2006). Therefore, the strategies adopted within this approach can become problematic if some of the strategies are countercultural and not given specific attention when delivered in different cultural contexts.

Cognitive Behavioural Model

Early difficult childhood experiences have been shown to have an impact on individuals’ cognition, such as developing negative views of the self and the world (Garety et al., 2001). Morrison (2001) suggests that psychosis can be understood as cognitive intrusions and the interpretation of these intrusions is what generates distress. The interpretations or misinterpretations are influenced by the self and social knowledge, and both the cognitive intrusions and their interpretations are perpetuated by physiology, emotions, thoughts and behavioural responses (Chadwick & Birchwood, 1994). Over the years, cognitive behavioural approaches to understanding and treating psychosis has become the dominant psychological treatment, alongside pharmaceutical interventions (e.g., antipsychotics) and family interventions.

In the 1950s, psychology was mainly dominated by behavioural therapy that aimed to remove symptoms using scientifically based techniques. While this was significant when treating anxiety disorders, such therapy proved inadequate when dealing with symptoms of depression (Wright, 2013). Consequently, this gave rise to a theory that highlighted the importance of cognitive processes. Cognitive Therapy (CT) proposes that certain thoughts affect how people perceive the world (Wright, 2013). Theorists believed that a person’s belief system caused an emotional reaction, rather than an activating event that caused distress;

subsequently, this affected peoples' behaviour. Thus, central to the therapeutic work was the role of cognitive processes and modifying underlying dysfunctional beliefs (Beck, 2011).

The merging of these two therapeutic models led to the development of Cognitive Behavioural Therapy. As described today: "Modern CBT is derived from the legacy of behaviour therapy with its emphasis on the importance of behaviour change in overcoming mental health problems, and CT with its emphasis on understanding and changing the meaning of events" (Kennerly et al., 2016, p. 20).

CBT is a time-limited and structured approach designed to alleviate distress (Fenn & Byrne, 2013). CBT suggests that the way we think, feel and behave are all interlinked, and changing the way we think about ourselves, our experiences and the world around us changes the way we feel and what we can do (Wright, 2013). CBT is a problem-orientated approach that emphasises the current situation and improvement of the client's current state of mind (Fenn & Byrne, 2013). This approach asserts that clients are active agents in their treatment and the key principle of CBT is a collaboration whereby the therapist and client work together to develop a shared understanding of the difficulties.

Treatment Model for CBT and Psychosis

Cognitive Behavioural Therapy for psychosis (CBTp) has been recommended by the National Institute for Health and Care Excellence (NICE, 2014) as a plausible treatment of choice for psychosis. CBT was initially developed as a treatment for depression and anxiety (Beck et al., 1979), but has since been extended to relate to the understanding of different illnesses like psychosis and personality disorders (Beck et al., 1990). The first studies of CBTp were initiated in the UK in the late 1980s, unlike CBT for other difficulties that were mainly developed in the USA (Tarrier et al., 1988). Since these trials, CBTp has continued to advance on both sides of the Atlantic, with the essential techniques remaining the same but

practised differently (Tarrier, 2005). CBTp is usually offered over several months to develop a shared understanding of the clients' symptoms, thoughts, experiences and behaviour. The aim is to reduce the distress associated with delusions and/or hallucinations. CBT for psychosis maintains the importance of working collaboratively to engage in a process whereby the client is gently challenged about their delusional beliefs to reach their own conclusions about the accuracy of their beliefs. This process is called collaborative empiricism (Alford & Beck, 1994). CBTp emphasises the applicability of the theory into practice by including behavioural exercises as homework, such as keeping a mood diary and challenging threatening voices.

Critique of the CBT Model

Like other psychological interventions, CBT is underpinned by values and beliefs of individualistic cultures: the USA and the UK (Hays, 2009). It is a psychological intervention developed in the West and, therefore, holds beliefs specific to the Western culture (Naeem et al., 2010). The cultural assumptions and beliefs (e.g., individualism, assertiveness and independence) of protocol-driven interventions may not be transportable and translated to other cultures without initially developing an understanding of the cultural context (Ametaj et al., 2018). The CBT model holds Eurocentric assumptions around family/societal structures, the expressions of distress and therapeutic interventions (Williams et al., 2006). Longstanding concerns have been raised around the applicability of the CBT model when working with people from different cultural backgrounds. CBT encourages clients to apply a formal-logic approach to their difficulties, which may not be a welcomed universal approach across different cultural contexts (Hoffman, 2012). If cultural norms are not attended to sensitively, culture may become a hindrance in the behavioural and cognitive change process, mainly if the concept of change does not overlap with cultural models. An example is the perception of 'individualism vs collectivism' of some cultural groups, who emphasise family and societal

groups as a unit instead of the individual as in the West (Rathod & Kingdon, 2009). Thatcher and Manktelow (2007) explained individualism as:

> In the West people tend to be intolerant of contradiction and, when confronted with it, will try to resolve it in favour of one position over another (Peng & Nisbett, 1999)…Secondly, Western science contains the notion that objects can be detached from their context and studied in isolation and in detail, while Eastern science is more holistic…Thus the over-emphasis on individualism that Fox (2000) and others have identified as a fault-line in psychology can be seen to be part of a wider current of Western culture. (p. 32)

Despite research suggesting CBTp is an effective model for people who experience symptoms of psychosis, the application of empirically supported CBT within diverse cultural contexts is scarce. Diverse cultural groups are not usually included within the treatment studies that form the evidence base (Hall, 2001). When thinking about different cultural contexts, there is a tendency to view culture as something 'exotic' and belonging to 'other' people. Culture however exists within everyone and every group in society (Fernando, 2008). Western ideas tend to be viewed as objective, scientific and, therefore, the 'correct way', despite these beliefs being just as influenced by historical and cultural processes (Kirmayer, 2012). Furthermore, the dominant cultural values are rooted in a wide range of psychological interventions and risk being different or in opposition to other cultures with different values. Consequently, it is in this perspective that the current study is exploring the experiences of individuals that have received CBTp in their own cultural context.

Most research that investigates individuals' subjective experiences of psychological interventions in their own cultural contexts (e.g., Pakistan, China and ethnic minorities in the UK) focused on adapting the CBTp model. There has been no research exploring individuals'

experiences of CBTp within Lebanon and, as such, the literature will focus on studies from different contexts that have looked into individuals' subjective experience of CBTp.

There has been an increasing shift in adapting CBT approaches when working with individuals from diverse cultural backgrounds. The literature around adapted CBT recognises that transporting CBT from one cultural context to another is insufficient without accepting differences held within diverse cultures. Therefore, two main approaches to adapting CBT emerged to connect with clients from diverse cultural backgrounds. Firstly, culturally adapted CBT (CA-CBT) and secondly culturally sensitive CBT (CS-CBT). These will now be explicated followed by a critique of these approaches.

Culturally Adapted CBT (CA-CBT)

The CA-CBT approach takes an existing therapy and then adapts it for a specific community (Beck et al., 2019). The focus here is to include culturally relevant concepts, analogies and metaphors into the model. This approach proposes that staff who are also members of that community, and who have an understanding of the language, beliefs and values of that specific community, engage in the therapeutic work (Beck et al., 2019). Outlined below are several studies that utilised CA-CBT.

Acarturk et al. (2019) focused on adapting CBT for Turkish adolescents experiencing mood and anxiety disorders. The authors described the importance of using culturally specific assessments of somatic complaints (e.g., headaches, dizziness and appetite increase/decrease) and cultural syndromes (e.g., being possessed by the evil eye). They demonstrated how adaptations, such as using Turkish metaphors and religious concepts to explain CBT principles, improved individuals' acceptability of the intervention for a group of adolescents. The authors concluded that determining local conceptualisations of distress, how to heal

distress and the use of these during assessment and treatment supported the adaptation of CBT for Turkish adolescents.

Li et al. (2017) explored mental health professionals, carers and patients' views about their understanding, causes and treatment of psychosis in a Chinese teaching hospital. This was in the view to further develop an understanding of their experiences and to aid the adaptation of CBTp in China. In total, 45 individuals participated in this study. Mental health professionals voiced the importance of incorporating cultural and spiritual values within therapy. In their view, cultural beliefs influenced patients' understanding of illness, its causes and treatment. Professionals emphasised the importance of using a bio-psycho-social-spiritual model to understand their clients' experience of psychosis. A common theme expressed among individuals' experience of CBTp was wanting the psychologist to provide 'guidance'. Similarly, this was expressed by professionals who felt that taking on a collaborative approach in therapy acted as a barrier to therapy. Instead, a directive style and providing guidance appeared to add value to individuals receiving CBTp. One professional went further to describe such therapy as being 'instructive' and taking on a 'teacher-student' relationship. Many writers have argued that working in a directive style within therapy—in particular with Chinese clients—showed that the therapist is professional and knowledgeable (Chen & Davenport, 2005). On the contrary, failure to be directive may lead to the rupture of the therapeutic relationship. Participants under the directive style within therapy expressed finding their therapists more empathic and cross-culturally competent (Guo & Hanley, 2015).

Lie et al.'s (2017) study was not without its limitations, however. Interview questions were taken from a previous study completed for CA-CBT. Therefore, the interviews helped researchers explore areas that had already been considered vital prior to the interview. This in itself can limit the data by not permitting new emerging themes to be explored. A further limitation that also possibly limited the data is the chosen methodology (content analysis),

which may have not captured the full lived experiences of individuals. Content analysis postulates its criteria for analysis beforehand by identifying certain words or phrases that may capture the experience. By doing so, researchers adopting this methodology suggest that they are already aware of the participants' experience and how it is experienced (Van Manen, 1997).

Culturally Sensitive CBT (CS-CBT)

CS-CBT seeks to enable mental health professionals with identifying and appreciating the diversity of different cultural groups. The approach proposes that therapists work closely with supervisors and different team members to make adaptations to evidence-based therapies, to further enable them to fit with the context and culture of the client (Beck et al., 2019).

An example of CS-CBT practice was reported by Rathod et al. (2010), whose main aim was to develop a culturally sensitive CBTp for practitioners working with individuals from specific ethnic minority groups in the UK (South Asian Muslims, African-Caribbean and Black African/Black British). The authors identified and interviewed 15 clients with a diagnosis of psychosis, 22 CBT therapists and 52 lay members from selected ethnic communities. The data was analysed using a systematic content and question analysis. A common problem expressed by therapists was that therapy was "the same for everyone", asserting that they would follow similar formats for all clients accessing the service. The most common themes expressed by clients who had accessed the service for support was feeling "less than equal to others" or "labelled as a number". Most common beliefs about the causes of illness were related to previous wrong-doing, supernatural beliefs and specific attributions (e.g., drug-induced). Participants voiced different help-seeking behaviours and

pathways: seeking help from religious healers, dealing with mental illness within the family and seeking advice from elders or Imams was favoured over therapy.

The interviews produced rich data and the authors have made numerous recommendations from their research, such as the use of the mind and body model when working with individuals from the particular ethnic backgrounds mentioned in this study. Second, the use of behavioural and social tasks should be prioritised over the use of cognitive models—especially in earlier sessions. The authors concluded that to determine whether CBT is appropriate if adapted, one needs to understand that individuals from different cultures will have a different view on life; this, in turn, will influence the choice of lifestyle, the conceptualisation of illness and ways of treatment (Rathod et al., 2010).

Although being responsive and/or adapting CBT to the cultural needs of the clients' context has become the prevailing paradigm, several critiques have been highlighted. A significant critique is that the underlying Western–Eurocentric beliefs and fundamental values of the model remain unchallenged by both approaches (Guo & Hanley, 2015). Incorporating an understanding of diverse cultural groups in the therapeutic framework and practice continues to receive the least attention (Rathod & Kingdon, 2005). For example, this may be harmful as the model was developed for one group and is then transported and adapted to be used with other groups (Hall et al., 2016). Consequently, this 'top-down' approach further reinforces those certain assumptions and values that are being imposed on those from diverse cultural backgrounds. Additionally, most CBT studies that originally form the evidence-based practice do not integrate different cultural perspectives into the theory and practice (Hays & Iwamasa, 2006). While this prompted different organisations, such as NICE, to mandate the inclusion of different cultural backgrounds in all funded research, a paucity of incorporating minority groups in research remains (Ingman et al., 2016).

Therefore, NICE guidelines may risk taking on a one-size-fits-all approach and be considered a universalist service (Levin, 2012).

While adjustments to the model are significant to fit individuals' experiences and views about the world, which can provide the client with a sense of collaborative production, CS-CBT and CA-CBT can be critiqued if the fidelity of the therapeutic intervention is weakened. Elliott and Mihalic (2004) argued that adaptations can perhaps reduce the fidelity of the intervention and, as such, undermine the effectiveness of the model. Maintaining a balance between fidelity and effectiveness remains a crucial challenge for the development of culturally adapted therapeutic interventions. The benefits of using such models take place when psychological interventions are evidence-based and when culture does not oversight the core components of the intervention (Berliner et al., 2014).

In recent years, although data has shown promising evidence that adapted CBT merits evidence-based psychological interventions, there continue to be inconsistencies (Benuto & O'Donohue, 2015). There is some evidence suggesting that, instead of being sensitively responsive or adapting CBT, exploring and understanding explanatory models of illness and psychological interventions in the United Kingdom and abroad may be useful (Naeem & Kingdon, 2012b). At present, Western values and assumptions dominate psychiatry and the individualistic models of care are given priority, while the views and experiences of people who do not share similar values and beliefs are perhaps disparaged or even worse disregarded (Naeem & Kingdon, 2012).

Gaps in Research and Relevance to Counselling Psychology

Quantitative research rests on a positivist foundation and fails to capture individuals' subjective meaning. However, the subjective meaning is significant for psychologists to understand how individuals may experience reality. Lived experience, as defined by Morris

(2017), is a "person's awareness and comprehension of both internal and external stimuli" (p. 3). Exploring individuals' unique lived experiences enables professionals and readers an opportunity to understand the context of individuals' experience of CBTp. There is various qualitative research in the field of psychosis and experience of CBTp, although this is not necessarily specific to different cultural contexts. This abundance highlights that exploring peoples' views about psychological interventions is a significant topic, thus demonstrating its importance as an area for research. However, when it comes to people from different cultural contexts, the picture becomes a little more complex and research becomes scarce. Exploring the lived experience of cross-cultural interventions appears limited in the field of counselling psychology. The gap makes this research potentially relevant to CoPs providing cross-cultural therapy in the UK, or who are exporting CBT models abroad. Pluralism has been coined by Cooper and McLeod (2007) as an "ethical and political commitment to respecting, valuing and being inclusive towards otherness; other worldviews and respectful to our clients" (p. 136). This concept is particularly important and encouraged in the field of counselling psychology, whereby accepting the multiple cultures, faiths and views of others is significant.

As mentioned above, although the philosophical, cultural, social and historical underpinnings of psychological interventions have originated in the West, the issue is its application has been attempted in different cultural contexts that had a minimal contribution—if any—to the formation of these widely used prevalent and models. Psychological research in different cultural contexts requires attention and exploration in the context of individuals' specific cultural backgrounds. Rahimi (2015) suggested that "Current theories of human subjectivity converge on an important idea: that human subjectivity is fundamentally context-dependent–a cultural context, woven out of political and historical threads" (p. 1).

Therefore, in light of the literature review and upon identifying gaps in the current knowledge, the following research question has been developed:

What is the lived experience of individuals receiving a cross-cultural intervention such as CBT for psychosis within PROP in Lebanon?

PART III: METHODOLOGY

Introduction

This chapter will revisit the rationale for the chosen methodology: hermeneutic interpretive phenomenology and the impact it has on the research process from inception through to data analysis. Initially, a summary of the historical context of science and research will be explicated, and how this informs the ontological perspectives. Furthermore, an exploration of the underlying epistemological assumptions underpinning qualitative methodology will be presented and, in particular, in the narrower context of cross-cultural research. Next, phenomenology—as informed by van Manen—will be addressed followed by the procedure of the research including the background of the study, recruitment and gathering of data. A description of the analytical process of the data, as well as the relevance of validity and rigour of the study, will be addressed. Lastly, ethical considerations and how these were addressed will be explicated.

Revisiting Rationale

The principal aim of this research is to capture the lived experience of a phenomenon. While I appreciate that quantitative approaches can be valuable in circumstances where concepts can be 'measured', I am more interested in the subjective and unique experiences of individuals and, therefore, quantitative methods of research were not appropriate to address the research question.

There are various qualitative methods, so it is important to select an appropriate research method and stipulate a rationale as this is an ethical and theoretical issue (McLeod, 2003). Qualitative methods of inquiry concern themselves with the way individuals make sense of the world and the meanings they associate with their experiences (Ponterotto, 2005). Phenomenology is a qualitative approach that aims to understand the subjective and unique meaning of human experiences (van Manen, 1997). To understand this human experience, getting as close as possible to individuals' experiences is significant. In other words, it is to enter their world and look at the world through their eyes (Willig & Billin, 2012). The phenomenological method chosen for this research has its roots in hermeneutics, which proposes all human experience is interpretive and it is 'this' interpretation that should be focused upon (Willig, 2008). The chosen methodology—hermeneutic interpretive phenomenology—is a strand of phenomenology as described by van Manen that adopts an interpretative rather than a descriptive stance. A descriptive phenomenology maintains that experience is a 'pure' description and there is no scope for interpretation of the experience within this phenomenology. On the contrary, interpretive phenomenology maintains that description and interpretation are related, and when a phenomenon is under study, its parts have to be understood with the whole and vice versa. Van Manen highlights the importance of the researcher's interaction and subjective stance with the data alongside the experience of the participants. This methodology necessitates the researcher to be open to challenge one's fore conceptions; it allows them to be affected and engaged with the data as an individual and

a researcher. As such, this methodology encourages the engagement of the researcher with the method instead of adhering to a set of techniques.

Willig and Billin (2012) described the chosen method in this study as:

> A version of the phenomenological method that is particularly suitable for the exploration of embodied human experience... it seeks to capture and portray the quality and texture of research participants' experiences and to explore its meanings and significance... acknowledges the importance of the frames of reference which the researcher brings to the data during the process of analysis... Phenomenological knowledge aims to *understand* human experience. In order to do this, the researcher needs to find a way of getting as close as possible to the research participants' experience, to step into their shoes and look at the world through their eyes, in other words, to enter their world. This means that the researcher assumes that there is more than one 'world' that can be studied. (pp. 117-119)

A key factor for this chosen methodology is its emphasis on context. Often mentioned in the literature is the importance of attending to the sensitivity of the context when working cross-culturally (Sue et al., 2009). This is crucial to consider as contingent on how a culture understands certain experiences and how they are influenced by what they experienced (Sachs et al., 2008). A further rationale that influenced this chosen methodology in the context of existing research on individuals' experience of a cross-cultural intervention is its emphasis on honouring the experience. It not only endorses respect for the autonomy and welfare of individuals but demonstrates sensitivity to the quality of data evolving and allows the phenomenon to unfold organically. This is particularly important when working cross-culturally.

Epistemological and ontological assumptions underpinning the research methodology will now be explored.

Defining Science

To understand the epistemology and the epistemological position of the chosen method, it is important to understand what is meant by 'science'. Science can be defined as a "systemic quest for knowledge" (Ponterotto, 2005, p. 127). The conceptual roots underlying science called the philosophy of science are assumptions around epistemology, ontology, axiology and methodology. The philosophy of natural science first emerged in the wake of the positivist movement, which claimed that philosophical statements are to be objectively assessed. When understanding human experience, natural science conceptualises humans as suitable for systemic research, assuming outcomes are static, predictable and constant. However, there is debate among philosophers as to whether science can reveal the truth and is indeed an infallible exercise, or whether it fluctuates and is shaped depending on the socio-historical context. How knowledge is sought, how it is interpreted, and the implications of not only its explicit conclusions but also its assumptions on truth and the nature of existence has changed since written history began. In other words, the form and acquisition of knowledge have transformed symbiotically with cultural and historical movements. As an alternative to natural science, post-modern constructivists—which originated out of a dissatisfaction with the positivist stance—argues that the self is co-created within a dialectical involvement of historical, cultural, environmental and socio-political circumstances (Ponterotto, 2005). That is to say, the self is constantly creating (Cooper, 2007). Therefore, how a science is understood holds various implications, such as whether its object of study is fashioned based on the foundation for the preceding theory, thus assuming the present as a stationary entity and truth as fixed, or whether ideas and findings are inextricably linked to historical and intellectual frameworks of understanding, implying that phenomena are more complex and unpredictable.

Theoretical Approach

The underlying assumptions on the nature of human experiences dictate the method with which a particular human experience is investigated. There are several qualitative methods, each having uniquely contributed to the development of human science, such as discourse analysis (including Foucauldian discourse analysis), phenomenology (divided into descriptive and interpretive) and grounded theory. One's research question should inform which method is chosen (Willig, 2013), and the aforementioned approaches will now be explored.

Grounded theory seeks to develop new and innovative theories. It takes on an inductive approach, starting with descriptive data and increasingly subjecting this data to a level of conceptualisation. Grounded theory does not encourage a review of the literature before engaging with the study, as researchers' over-commitment to existing theories may stop them from making new discoveries (McLeod, 2003). The researcher is expected to adopt a somewhat detached, objectivist stance towards the data. Although this theory explores individual experiences, the aims of developing a new theory were found to be inconsistent with the aims of this research and, as such, this methodology was eliminated.

Discourse analysis (including Foucauldian discourse analysis) is an approach that stresses the importance of understanding how language is used and understood in a collective and social context (Willig, 2013). When applying this method, language is seen as an active agent used to mediate as well as a structure in which humans are mediated. This research aims to elucidate individuals' experiences holistically, rather than taking the position that language mediates experience. Therefore, I felt this method might have inhibited the capturing of participants' full experiences; therefore, this method was disregarded.

Phenomenology

Phenomenology is a philosophical discipline associated with postmodernism. Phenomenology is the plural structure of a phenomenon. Etymologically, the term 'phenomenon' means "that which appears, and logos means word or study" (van Manen, 1997, p. 27). Although phenomenology stems from a philosophical discipline, phenomenological research has been increasingly pursued within psychology. It seeks to explicate human experience exactly as it is experienced. Van Manen (2014) describes it as:

> Phenomenological method is driven by a pathos: being swept up in a spell of wonder about phenomena as they appear, show, present, or give themselves to us. In the encounter with things and events of the world, phenomenology directs its gaze toward the regions where meanings and understandings originate, well up, and percolate through the porous membranes of past sedimentations—then meaning and method infuse, permeate, infect, touch, stir us, and exercise a formative and affective effect on our being. Phenomenology is more a method of questioning than answering, realizing that insights come to us in that mode of musing, reflective questioning, and being obsessed with sources and meanings of lived meaning. (pp. 26-67)

Phenomenology's epistemological foundations are divided into two schools: the analytical school and the continental school. The analytical philosophy concerns itself with logical rigour and reason and uses scientific discoveries and common sense as their basis for experience (Dummett, 2014). On the other hand, continental philosophy concerns itself with descriptions of individual experiences, rather than an analysis of collective experiences. Continental philosophy is further divided into existential and transcendental phenomenology (Hein & Austin, 2001). Transcendental phenomenology, which originated from Edmund Husserl, is in essence the study of lived experience in the "lifeworld" (Husserl, 2013). Its emphasis is on the world as lived by the individual and not the world as separate from the individual (Valle et al., 1989). Husserl suggested that suspension or the bracketing of the

researcher's beliefs and assumptions during research is possible through a technique called *epoché* (translated from ancient Greek as a 'suspension of judgement'). The aim of doing so is to see the essence of something and approach it as if for the first time (Wertz, 2005). Husserl critiqued the positivistic approach, arguing reality could be studied as it appears to us.

Existential phenomenology, founded by Husserl's student Martin Heidegger, argued that the process of *epoché* is unachievable (Kisiel & Sheehan, 2007). Heidegger suggested engaging with the process of acknowledging one's presumptions through self-reflection. When applied as a research method, this approach not only attends sensitively to the narratives of the participants, but to the researcher's own narrative that is the fore structure of understanding (Tindall, 2009). The fore structure is essential and must be acknowledged during the process of interpretation (Van Manen, 2014), which was further argued by Heidegger who claimed: "nothing can be encountered without reference to a person's background understanding" (Laverty, 2003, p. 8). Heidegger believed bracketing was not possible as hermeneutics presumed prior understanding. In other words, he saw description and interpretation as inseparable and, when a phenomenon is under study, its parts have to be understood with the whole and vice versa. This concept—called the 'hermeneutic circle'—implies that interpretation is dynamic in that the researcher will bring their prior knowledge and assumptions when trying to understand the meaning participants have communicated. However, it is important to be aware that all interpretation is 'aspectival'; it is captured from a particular viewpoint (Jones, 1977). Alternative interpretations will inevitably exist or further interpretations carried out on the initial interpretive framework offered by a researcher. As such, when prior knowledge and assumptions are acknowledged, they may then be challenged and modified when engaging with the data (Willig, 2013).

To better understand existential phenomenology, it is essential to further examine the work of Martin Heidegger. Heidegger's concern is outlined as the "situated meaning of a human in the world" (Laverty, 2003, p. 24). To highlight this concept, Heidegger used the term *Dasein* to refer to 'their being' instead of 'human being'. Dunne (1997) describes *Dasein* as the "fundamental existential and the original character of human life itself" (p. 110). The concept of *Dasein* constructs the individual and the world as an integrated unity, and an understanding of 'being' resides to 'being in the world' (Heidegger, 2001). Therefore, individuals make sense of their world through their existence. The approach of Heidegger to phenomenology highlighted the significance to understand 'being' and, as such, his approach was centrally focused on ontology—the study of being. Heidegger (1996) described it as:

> Ontology and phenomenology are not two distinct philosophical disciplines among others. These terms characterise philosophy itself with regard to its object and its way of treating that object. Philosophy is a universal phenomenological ontology. (p. 34)

Max van Manen, as the forerunner of hermeneutic interpretive phenomenology, shall now be explicated. Two fundamental understandings of this study are captured by hermeneutic phenomenology. Primarily, this research is phenomenological as the inquiry explores a particular phenomenon, namely, the experience of a cross-cultural intervention; and secondly, this research is adopting a hermeneutic stance*,* which means the inquiry necessitates the researcher to be open about one's fore conception while revealing the essence of the phenomenon in the process.

Hermeneutic Interpretive Phenomenology

Hermeneutic phenomenology, as described by van Manen (1997), is a strand of phenomenology influenced by existential phenomenology. Van Manen (2014) proposed that "a real understanding of phenomenology can only be accomplished by actively doing it" (p.

8), because phenomenological research encourages an attitude to be adopted in the research, which is to be: observant, alive and attentive. As a researcher, one must influence and be influenced by the research experience itself so that the research has a sense of continuity and purpose. As the researcher begins to develop an awareness of the phenomenon under study, the phenomenological way becomes "a letting-go and trusting that the thinking and new understandings will come and will lead" (Smythe et al., 2008, p. 17). This methodology necessitates the researcher to be open to challenging one's fore-conceptions and encourages engagement with the method instead of adhering to a set of techniques, van Manen (1997, pp. 30-31) suggested six dynamic research activities to implement the method. These activities are as such:

1. Turning to a phenomenon that seriously interests us and commits us to the world;

2. Investigating experience as we live it rather than as we conceptualise it;

3. Reflecting on the essential themes that characterise the phenomenon;

4. Describing the phenomenon through the art of writing and rewriting;

5. Maintaining a strong and orientated pedagogical relation to the phenomenon;

6. Balancing the research context by considering parts and whole.

Similar to van Manen, Hans-Georg Gadamer (1994) suggested that existence in the world is always prejudiced and our cultural and historical notions are inherited in this prejudice. Gadamer not only considers bracketing one's own fore-conceptions as impossible but as "absurd". A critical point of Gadamer's theory is the notion of language and Gadamer (1994, p. 381) suggested: "everything presupposed in hermeneutics is but language". In other words, tradition is embodied by language through transmitting meanings pre-reflectively. That is to say that when understanding phenomena, one already has preconceptions that influence

perceptions. Therefore, one must be in a continuous 'hermeneutical circle', which involves a back-and-forth circling movement towards reaching the essential meaning of the phenomenon under study.

In summary, van Manen recognises that communication is a constructive act whereby individuals are active human beings who understand and co-create meaning within their social-historical context. Based on this premise, constructivism was chosen as an epistemological stance for this research. Meaning is constructed by engaging our minds with the world and as such, there exists "multiple realities" (Denzin & Lincoln, 2005). Furthermore, this epistemological position emphasises that lived experience is mediated by context, which is significant to this research since it involves working cross-culturally. Finally, the corresponding ontological position of this qualitative method is that of relativism – the view that several constructed realities exist. According to Ponterotto (2005), "constructivism adheres to a relativist position that assumes there are multiple, apprehendable, and equally valid realities" (p. 120). The relativist approach suggests that only relative to a particular context (societal, cultural, intersubjective and material) knowledge can be produced.

Now, the specific procedures that have been utilised during this phenomenological research will be discussed.

Beginning the Phenomenological Inquiry

To be a phenomenological researcher is to be involved in a reflective research process that continuously evolves. Within this process, an adjustment to my preconceptions and their impact, as well as the movement of the phenomenon under study is significant. The fundamental point here is that the path (method) is found through my relationship with the research text (Heidegger, 2003). The path as suggested by van Manen (1997) "cannot be determined by fixed signposts. They need to be discovered or invented as a response to the

question at hand" (p. 29). As such this method is not conceptualised as a set of techniques, it is instead a method that depends upon the phenomenon under study, informed by the philosophical literature and through my lived experiences as the researcher. In conclusion, this methodology as such turns towards a phenomenon rather than concerns itself with prescribed steps to follow.

Ethical Approval

This doctoral research, entitled "A phenomenological inquiry into the experience of receiving individual Cognitive Behavioural Therapy for psychosis within a Psychosis Recovery Outreach Programme in Lebanon" was approved by the ethics board at the University of East London and American University of Beirut Medical Centre.

Recruitment Process

The initial plan for participant recruitment was to travel to Beirut, Lebanon, and recruit from PROP which is situated within the department of psychiatry at the American University of Beirut Medical Centre (AUBMC). AUBMC is a private, teaching centre that includes 420 hospital beds and offers medical care and referral services in a wide range of specialities including medical, nursing, psychiatric and paramedical training programmes.

However, due to the global pandemic (COVID-19), the intended recruitment procedure was not possible and a different strategy was initiated. It is important to acknowledge the impact this had on the research. After encountering significant delays with the ethics application re-amendments (switching from face to face to online interviews) and the initial challenges with recruiting participants, I decided not to conduct a pilot interview. A pilot interview would have been useful by gaining feedback about the clarity of the core questions and a chance to identify whether the questions elucidated participant's experience as aligned with the research question.

However, instead I had several discussions with the clinicians at the collaborating service (PROP) who advised on the prompt questions.

Psychologists and psychiatrists working at the department initially identified participants that have completed therapy. Fifteen participants were initially identified as finished therapy, which was crucial as contacting participants after they have completed therapy enables them the choice to consider their involvement in the research outside of therapy. The research assistant who worked at the department contacted potential identified participants. Due to the pandemic, the department was closed for walk-in patients and potential participants were not able to view the research flyer at the department. The research assistant was chosen as the main contact for contacting participants since she had no association therapeutically with patients; this was also to avoid pressurising potential participants or participants feeling obliged to engage. Out of the fifteen potential participants, four expressed their interest and willingness to engage in the research. Four participants declined and seven other participants did not reply. First, the interested participant's treating physicians (psychiatrists) were approached by the research assistant and consulted about their mental state and wellbeing, and whether they were fit to consent. After approaching their clinical team, interested participants were then screened by the research assistant as to whether they fit the inclusion criteria. All four participants were mentally stable and fit to consent, and this information was relayed back to the researcher. The research assistant then obtained a verbal confirmation via telephone from participants to pass on their details (email and phone number) to the researcher. To be considered for participation in the research, participants were required to have:

- Functional diagnosis of psychosis (schizophrenia, schizophreniform, delusional disorder or any other psychotic disorder) for a minimum of six months;
- Completed a minimum of 12 sessions of individual CBT;

- A working level of spoken English;
- Consent to be audio and/or videotaped;
- Be above the age of 18 years old;
- Be of Lebanese nationality.

Once the researcher contacted participants, a convenient date and time for the online interview was scheduled. These interviews then took place online via Microsoft Teams and lasted between 60-90 minutes each. Although van Manen does not stipulate any sampling guidelines, potential participants were chosen based on purposive and homogenous sampling. To gain a better understanding of a specific experience, all potential participants had to share the same experience (Smith et al., 2009); in this case, individual CBTp.

Sample

Table 1 (see below) describes the demographics of the participants who volunteered to participate in the research study. There were two females and two males, and their ages ranged from 21-33. All had experienced psychosis and received individual CBTp within the department.

Table 1

Participant Demographics

Assigned Name	**Gender**	**Age Range**	**No. of CBTp Sessions**	**Interview time**
A1: “Sami”	Male	21-33	12+	60 minutes
A2: “Ella”	Female	21-33	12+	75 minutes
A3: “Zain”	Male	21-33	12+	60 minutes
A4: “Jenny”	Female	21-33	12+	45 minutes

Challenges When Commencing Phenomenological Research

The challenges associated with this methodology lies in the complexity and lack of specificity. There was a need for me to embark on a path to uncover the method within the philosophical literature, while simultaneously endeavouring to locate myself and my way of being in the research. I began to understand that the challenge was to uncover essential meanings of the phenomenon under study in everyday lived experiences. As such, I had to explicate the unseen and taken-for-granted understanding of the phenomenon.

Interviews

The intention was to interview interested participants in a designated room at the department of psychiatry in Beirut, where confidentiality could be preserved. Due to the global pandemic, this was changed from face-to-face interviews to online interviews using Microsoft Team—a secure online platform. Participants were interviewed in their own homes, in a private and confidential room. Interviews were conducted in English instead of Arabic. The rationale behind the chosen language is due to the difficulties working with interpreters and the implications this has on the data by translating the data by the interpreter only to apply another interpretation- phenomenological.

The phenomenological interview aims to obtain a rich description of a lived experience in this case experience of individual CBTp. Since being motivated by financial incentives may bring its own challenges, participants were not paid for their contribution.

The interview process began by creating a safe environment with an emphasis on the relationship in the context, which is significant to what is ultimately created (Polkinghorne, 1983). This was even more significant when interviewing participants who did not wish to turn on their video camera and instead preferred to be audio recorded. A lack of social cues necessitated a deliberate effort in establishing rapport before the interview and actively

engaging in dialogue to demonstrate listening and understanding. Beginning to understand individuals' unique experiences necessitates a way of being and a way of behaving in the research and not so much the involvement of intellectual and mental processes (Grondin, 2003). The researcher through a stance of openness is ready to surrender, what they currently know; in return, the researcher has the potential to be transformed.

Interviews were video and/or audio recorded with the explicit written permission of participants. In the case that participants did not consent to video recording, they had the option to turn off the video and the interview was audio recorded. At the start of each interview, I communicated information regarding the research, including the following:

- A short introduction of myself, place of residence, my educational and cultural background and area of study;
- The duration of the interview lasted approximately between 60-90 minutes;
- The right to withdraw at any time without explanation or consequences;
- My motives and how the interview will be documented.

Participants were asked open-ended semi-structured questions, as supported by phenomenology's aim. In keeping with this, I had asked two main questions to the participants:

- Can you tell me, in your own words, how you experienced individual Cognitive Behavioural Therapy?
- What support did you find most helpful?

In addition to the two core questions, I had various prompt questions that fell into four categories: i) the journey; ii) support; iii) experience of CBT; and iv) general issues.

Data Analysis

After the interviews were recorded on Microsoft Teams, the data was then formatted by transcribing what was said word-for-word. The transcribed data omitted any identifying information about participants (e.g., names and places) to protect the confidentiality of participants.

The deepening analysis of individuals' experiences necessitates the researcher to unpack the essential meanings currently taken for granted of the phenomenon under study. Analysis occurs as phenomenological writing and is ongoing. Van Manen (1997) described the analysis as:

> Making something of a text or of a lived experience by interpreting its meaning is more accurately a process of insightful invention, discovery or disclosure-grasping and formulating a thematic understanding is not a rule-bound process but a free act of seeing meaning. (p.88)

Several ways to analyse transcripts was proposed by van Manen including "The wholistic or sententious approach", "The selective or highlighting approach" and "The detailed or line-by-line approach". I have chosen the selective approach, whereby the transcripts are read multiple times to identify sentences, statements and idioms that capture the experience of receiving CBTp. The phenomenological statements were then grouped into themes. Themes were created through 'sensitive listening' to the meaning structures which found the experience of receiving CBTp. This process involves being open to being touched and changed by the phenomenon while endeavouring to let go of assumptions so that the participants' lifeworld may be entered.

The need to use logical deduction and the need for certainty has been a challenge for me throughout the research process. The analysis seeks to uncover the hidden meanings. I came to appreciate that the seeing of meanings unveils possibilities rather than certainty, and I began to understand the significance of my way of being with the text. In this way, van Manen described

it as the researcher's opportunity to 'see' the phenomenon and appreciate the moment as being revelatory rather than a theoretical deduction. This method as such necessitates the researcher to adopt an attitude of openness to allow the unforeseen and hidden meanings to arise (Mostert, 2002). The writings of Mostert (2002) to describe phenomenological writing resonated with the challenges I described above: For Mostert (2002) phenomenological writing is like "Falling forward into the darkness, in that it seeks to communicate that not yet known through deep description of what has been lived" (p. 4).

Rigour and Validity

Rigour in data collection and analysis has been supported by many researchers. However, historically qualitative research has been plagued with a lack of consensus regarding the criteria for assessing the adequacy of research (Armour et al., 1986). Some have dismissed the very idea of establishing any criteria (Seale, 2002), while others have claimed that criteria must be recognised within a specific paradigm (Healy & Perry, 2000).

According to Armour et al. (1986), the researcher must begin with the challenges specific to a particular inquiry. Therefore, Yardley's (2000, 2008) criteria for assessing validity and quality was employed in this study. The four significant facets are:

- Sensitivity to context;
- Commitment and rigour;
- Transparency and coherence;
- Impact and importance.

These principles were demonstrated from the outset of the research throughout as a commitment to the participants. Sensitivity to context, commitment and rigour took priority. A careful reading of existing literature on CBTp informed the research question and selection

of methodology. The method was selected based on its suitability to be applied cross-culturally as it seeks to honour the experience; this demonstrates sensitivity not only to the quality of data emerging but promotes respect for the autonomy and wellbeing of participants. Phenomenology concerns itself with those who have had a shared experience; in this case, it is the experience of individual CBTp. Developing and maintaining rapport with those who allowed and facilitated access to participants called for a level of sensitivity. Sensitivity throughout the interviews to the unfolding relational process was key so that any arising issues could be managed. This necessitated a multitude of skills and capacity to attend to many things simultaneously to achieve quality in-depth interviews including but not limited to: building relationships, being aware of the power dynamics and taking appropriate action when needed, encouraging participants to stay close to the phenomenon without being dismissive, engaging with empathy and simultaneously bearing in mind the theoretical modalities which form the foundations of this work. In the analysis, sensitivity to the context of the data was important when drawing out the phenomenological essences so that any assertions made were well-grounded in this way, thus promoting rigour and meticulousness.

An important aspect that interpretive phenomenology acknowledges—and van Manen's method highlights—is the researcher's interaction in the meaning-extracting process and the value of making this explicit. This is significant as the researcher's assumptions and biases of the phenomenon under study are not bracketed through a technique called epoché. Instead, the researcher's fore-structure is embedded and crucial to the interpretive process. The researcher is invited to be transparent and reflect on their position and experiences explicitly. This will be further explicated within the reflexivity section discussed in later chapters.

Ethical Considerations

Careful attention was paid to the ethical standards in this particular study as this research involved participants often described as 'vulnerable'. Only during the latter part of the 1980s did ethical issues become significant in psychology (Hayes, 2000). Since then, it has been at the forefront of planning, implementing, and publishing psychological research. Before explicating the ethical dilemmas in this study, ethics will be defined. Ethics is not defined as a good or bad practice but rather concerns itself with the act of questioning and considering what the implications of one's behaviours and actions are (Jennings, 2003). The actions of the researcher who may already hold positions of power, perceived, or otherwise can maintain broad and lasting effects which cannot be all predicted with accuracy. Therefore, it is vital to consider the impact this may have on participants before, during and after the research. As a researcher, one must be open about one's personal vantage point, the professional guidelines one is following and the thought for potential deviations from these (Bond, 2015).

The British Psychological Society (BPS) has stipulated core principles and a foundation upon which researchers must draw to inform their work throughout (BPS, 2014). As a researcher, I will now describe some of these principles in relation to the research.

'Respect for the autonomy and dignity of persons' and 'Maximising benefit and minimising harm'

As a trainee Counselling Psychologist, I am mandated to protect the participants' rights to privacy, self-determination, personal liberty, and natural justice as specified in the BPS. The BPS also stipulates that "psychologists should avoid potential risk to psychological wellbeing, mental health, personal values and dignity" (BPS, 2014, p. 11). Therefore, from inception and throughout, significant knowledge was gathered around ethical issues when working with human participants as well as specificities of cross-cultural research and psychological research with participants experiencing psychosis. Reading of existing literature has also informed the

research question and selection of methodology. The method was selected based on its suitability to be applied in cross-cultural research as it seeks to honour the experience; this illustrates sensitivity not only to the quality of data emerging but promotes respect for the autonomy and wellbeing of the participants. Before the research commenced, a proposal detailing the literature review, rationale, proposed method and ethical considerations were submitted to the University of East London for approval. The proposal was also submitted to the ethics board at the collaborating institution, the American University of Beirut Medical Centre. Both ethics boards approved the research. In addition, many conversations were held with academic staff and other senior lecturers with experience of working cross-culturally and the ethical concerns such as tailoring the informed consent and the information sheet. Contact with my academic supervisor was maintained throughout in discussing any potential risk issues that arise concerning participants and researcher and how to mitigate these risks.

Scientific Value

The BPS stipulates that "research should be designed, reviewed and conducted in a way that ensures its quality, integrity and contribution to the development of knowledge and understanding" (2021, p. 8). The study began with identifying gaps regarding its knowledge contribution. An extensive and in-depth review of existing literature on cross-cultural psychological interventions was initiated. After recognising what existed and what did not in terms of how the experience of a cross-cultural psychological intervention is understood, a sound foundation of knowledge was shaped as a result informing the trajectory of the research. In addition, the quality and standards of the research study were supervised by academics to ensure the correct explication of the research findings was represented.

The Interview

According to the BPS (2021), participants should be protected from potential harm. As a researcher, I was aware of the sensitive nature of this study and that perhaps some participants may have felt psychologically distressed or uncomfortable during the interview or after. Asking questions about therapy may have reminded participants of the issues they were discussing while in therapy, or differences in their mental health in comparison to now. Therefore, throughout the interview, the researcher strived to demonstrate empathy and curiosity so that the lifeworld of the participants may be entered. Sensitivity throughout the interview to the unfolding relational process was also crucial so that any arising issues were managed. To assess and manage distress, the researcher followed the distress protocol which included steps and measures to take if distress arises and if participants wish to stop the interview altogether (see Appendix J). Additionally, participants were made aware of the limits to confidentiality: the need to break confidentiality if a risk to themselves or others was disclosed. In the first instance, the researcher would contact the participant's clinicians (psychologist and psychiatrist) to request that they contact the participants and offer containment and support.

Confidentiality

The collected data was in the form of voice/video recordings, electronic consent forms and transcripts written verbatim. Participants were informed that the raw data was to be stored securely for a period of time as specified by the ethics committee; afterwards, the data would be destroyed.

Participants were made aware that any information that could identify them would be removed and a pseudonym will be used instead of their names to remain anonymous. Participants were informed about the use of transcript quotations in the research and the possibility of other professionals and academic bodies reading the anonymised transcripts for academic purposes only.

Harm to the Researcher

Ethical concerns related to the researcher, as opposed to participants, are often omitted entirely from research studies. Nevertheless, even in this study ethical concerns relating to the researcher were included at the end, almost as an afterthought. Yet the emotional impact on researchers when studying potential difficult and distressing topics can be significant. Although the interviews did not include any questions about participants' traumas and life experiences of being admitted to inpatient units, participants alluded to their past. This combined with my extensive research in the field provided enough detail to get an understanding of the trauma related to being restraint as inpatients. Therefore, to protect my wellbeing I regularly reflected and monitored my mood to identify any changes such as feeling low in mood. I regularly used both supervision and personal therapy to reflect on my feelings and identify any changes, or strong emotional reactions I had.

Summary

The theoretical foundation of the selected methodology, procedural steps for data collection and analysis, and related ethical considerations have been detailed in this chapter. An exploration of the phenomenological themes will now follow in the analysis chapter.

PART IV: ANALYSIS

Introduction

In this chapter, the themes that emerged from the analysis of the data will be described and unpacked. These themes were formed and re-formed in the writing-reading-rewriting-rereading interpretive process and shape the basis of the next chapter to provide a deeper appreciation of the individual experience of CBTp.

As seen in phenomenological research inspired by Max van Manen, writing does not merely enter the research process as a final stage. Creating a phenomenological text is the object of the research process (van Manen, 2016). The movement of the research was a turning between the phenomenon of the experience of CBTp in participant's stories, my own stories and my hermeneutic interpretations. Thus, the interpretive writing process moved from descriptions and interpretations of each participant's stories to deepening interpretations that drew upon the writings of van Manen. My writing has developed as I have become more attuned to the essential meanings of the phenomenon under inquiry.

Phenomenological inquiry suggests that the researcher is required to embody the question, and essentially 'become' the question (van Manen, 1990). In summary, van Manen stipulated that "a phenomenological question must not only be made clear, understood, but also lived by the researcher" (p. 44).

The lived experiences of the participants provided rich and deep material from which themes were created. It would be wrong to assume that themes are conceptual formulations or categorical statements. Rather, as described, by van Manen (1997), "themes are more like knots in the webs of our experiences, around which certain lived experiences are spun and as such experienced as meaning wholes" (p. 90). Phenomenological themes are dependent on the phenomenon and have been given attention so that meaning can be drawn from them.

Summary of Emergent Themes

The participants' experiences of CBTp have been subsumed into Table [2], which summarises their experiences into 10 sub-themes. This will be followed by a more in-depth elucidation of each theme, including extracts from the transcript to highlight participants' understanding of their experience.

Table [2]

[Emergent themes]

Stage One	**Navigating the beginnings of therapy**	• The hidden self • Constricted space • "Psychosis is a bad disease": Cured vs Treatment • A spiritual explanation

		• Shifting self
Stage Two	**Journey of therapy**	• Self in relation to others • "The problem is with society" • A safe space
	End of therapy	• Constructing new meanings • Life beyond psychosis: Moving forward

Introduction to the Setting

Participants were selected from an early intervention programme for psychosis in Lebanon named the Psychosis Recovery Outreach Programme (PROP). This department is situated within the American University of Beirut Medical Centre (AUBMC), a teaching hospital. The psychiatry department consists of a 10-bed inpatient unit for individuals experiencing psychosis, PROP and an outpatient service. Clients are assigned to one of these services depending on individual needs. It is important to note that PROP is dominated by the medical establishment, which is also reflected in participants' narratives. Before proceeding to explicate the themes, it is important to define how participants classified their experiences. Participants came to understand and narrate their experiences as two separate stages: stage one and stage two (see Table [2]). One participant (Sami) called it "first part of CBT" and "second part of CBT". Two other participants (Zain and Ella) called it "Phase one" and "Phase two". I have attempted to capture their categorisation as close as possible to their experience and as such the word 'stages' was adopted. The two stages will now be unpacked.

Stage One

Stage one was described as a detached phase from reality, where participants were receiving CBT therapy but felt they were not ready to engage with the content of the therapy. In this stage, participants described their state of mind as not being present and not able to take things in referring to the techniques of therapy. They associated this stage of psychological instability with the medication they were taking, suggesting the medication was not fully effective. It seemed all participants shared similar experiences around medication being the primary healing factor. In this stage, all participants expressed the wish to be given the space to talk freely and have their experiences validated without being offered any techniques of CBTp.

Stage Two

In stage two, while they continued to receive CBT therapy, all participants described this period as receiving the "right help", which was defined by participants as receiving the right medication. For participants, medication enabled them to become more psychologically present and engaged with the therapy being offered to them. In this stage, participants talked about their engagement with the content of therapy, their relationship with the self, the therapist and the wider society. In this stage, participants expressed the wish to be guided and offered techniques of CBTp.

Overview of Super-ordinate Themes

The first super-ordinate theme—navigating the beginnings of therapy—captures participants' challenges around starting therapy; it also highlights their understanding of what psychosis is, and their preferred method of healing.

The second super-ordinate theme—journey of therapy—highlights participants' journey of the self in relation to therapy and others.

The third super-ordinate theme—end of therapy—captures participants' search for the meaning of life beyond their experiences of psychosis.

Now that the setting has been outlined, the two stages of therapy, as categorised by participants, and with the three super-ordinate themes explicated, I will go on to expand upon the 10 sub-ordinate themes.

Key Symbols for the Chapter

[…] Omitted text

[I] denotes interviewer speech

Stage One

Super-ordinate Theme one: Navigating the Beginnings of Therapy

Sub-ordinate theme one: The hidden self. A theme that emerged strongly from all participants during stage one of therapy was the struggle being honest and open with the therapist about their difficulties. Participants' use of the word "hiding" to describe their experience of therapy seemed not only to infiltrate the therapy room but appeared to permeate into their life outside of the therapy space; this will be explicated further below.

Their accounts refer to the different manifestations of their struggle to engage in the therapy, from their ambivalence and fears of being judged. Ambivalence seemed to represent not only the physical embodiment of attending therapy but also ambivalence about sharing one's true self for fearing being judged.

One participant—Sami—described his experience as not being convinced he needed therapy, which affected how he engaged in the initial stages. He described one of the techniques used in therapy as the therapist challenging his thinking by using what is called the 'detective technique'; a method that involves looking at evidence that supports/refutes the delusions. He described himself as being resistant to thinking about his thoughts and looking for evidence that could challenge his thinking. Sami described 'hiding away' in therapy, needing to act convinced for the therapist that some of his thoughts were delusional in nature when he, in truth, was not convinced. Sami described not feeling ready to consider an alternative perspective to his thoughts, explaining that he had a 10% doubt that his thoughts were not grounded in reality, and a 90% belief that his experience had an objective reality, stating:

> When I first started the sessions, I wasn't really convinced that I should be in therapy because of the delusions and some of the thoughts that I had. So, it started out like pretty normal, just sitting there listening to what the therapist had to say, not really caring. (Sami, p. 4, lines: 181-183)

Like other participants, Zain described his experience of attending therapy as a struggle, as he was not ready for change and feared being judged. The struggle for Zain was finding the right balance between being honest about his thoughts and experiences but not too honest, out of fear that he would be labelled as "sick". It appeared the fear of being labelled as someone who is "sick" perhaps extended beyond the idea of having a mental illness but was rather associated with strong feelings of shame. His use of the phrase "people would like

point fingers at me" captured feelings of shame connected not only to the therapist but with the wider society.

Zain's description of the therapist as "trying to interfere" seemed to also illustrate a divide between 'his' and the 'therapists' world. The description seemed to further illustrate the *self* as trying to protect its experiences from any disequilibrium caused by the *other*, which was experienced as a strong force attempting to penetrate and cause instability in his world.

> I was really sticking to my beliefs […] Everything I'm going to do and say the therapist will think I'm sick, I am wrong and this might offend me because ok I might be sick but I am also a grown man and take responsibility for my actions and I know what's happening around me, so I didn't want everything to be talked about in therapy. (Zain, p. 3, line 146; p.3, lines 164-167)

There seemed to be a longing to be treated and be seen as an ordinary human being capable of being in control of his actions and life. This appeared to reflect a wish that life has a meaning unrelated to that of being a "patient with psychosis" and, consequently, a hope that his experiences and the whole *self* are not viewed completely as being "sick".

For Ella, her struggle in therapy was experienced as an existential struggle, divided into two worlds: an internal, non-visible world and an external, visible world. Ella's account suggests the inner world was her experience of 'non-reality', which was filled with despair and fear. While the external world was the 'reality' in which the therapist was situated, filled with hope and optimism. Notwithstanding her longing for hope and optimism, it seemed remaining in the 'non- reality' was a safer experience than being drawn out into reality. There is a sense in Ella's description that she is being pulled out prematurely from her experiences, possibly as a way to eliminate distress. However, being pulled out of her experiences created

a different form of distress: a back-and-forth struggle between both realities. The following quote portrays Ella's experience of this struggle:

> It was more of you know, trying the therapist to convince me you know that what I'm going through is hard and challenging, but I have to be practical and have to work on myself to get better like it was, there was more, you know push and pull kind of a feeling so between me and her trying to find a balance for me, that was the hardest part. Just trying to get me back to reality and give me some kind of hope that things will get better, so I was in a very bad place. (Ella, p. 2, lines 66-70)

Sub-ordinate theme two: Constricted space. For participants, the notion of being heard not only represents the physiological act of listening but is also associated with a deeper meaning: being cared for during a time of stress and fear that was present during stage one. Within their descriptions, all participants in their various ways, talked about an absence of a space for expressing frightening thoughts and emotions in a freely manner without their voices being eclipsed by the techniques of therapy.

Ella talked about feeling emotional, anxious and having disturbed feelings when she started therapy, which was followed by a sense of feeling scared and lost. Her wish to vent out her feelings and say what was on her mind was significant for Ella. However, she described being met by the therapist with a set of techniques and tasks to complete at home. On the one hand, she noticed the value of these techniques at a later stage in therapy. However, her wish to have the space to freely express her thoughts and feelings was her way of sharing her pain and distress with another person. Instead, her use of the word "bombarded" when referencing techniques seemed to suggest a form of an external attack on the mind, abolishing the space to speak and to be heard, and leaving her feeling confused and fearful of her internal world (i.e., thoughts and feelings): "During this phase, I just want to be

understood that maybe there was nothing that the therapist could do to help me at the moment except for just sit and listen" (Ella, p. 2, lines 79-80).

Sami described a vicious loop that his mind was trapped in. The loop would start with a delusional thought, making him feel frightened and stressed and, in return, would intensify his delusions. When trapped in his mind, Sami described being dismissive of any techniques offered to him that challenged his thinking and felt it was a "waste of time". Sami's wish to be "just monitored" and understood seemed to signify a way of being in the therapy room: to be observed and listened to. The concept of being monitored represented not only the act of listening but also to be seen and accepted during a stressful and frightening time, wherein he felt more vulnerable. Sami's repeated use of the word "monitored" throughout the interview appeared to extend beyond an act of care. The idea of "monitored" perhaps had a parallel meaning to being monitored when one is physically unwell. Therefore, being monitored during times of stress and vulnerability perhaps signified two functions: being cared for and normalising his psychotic experiences.

> Basically, like with a nurse and they just ask you like routine questions, they check your blood pressure […] to monitor you a little bit […] The counseling person should be and know exactly that they might just need to monitor what's happening instead of like giving techniques and things (Sami, p. 9, lines 471-472; p. 10, lines 538-540).

Jenny talked about her experience of coming into therapy as having a "lazy" mind, describing how her mind stopped and could not function as it did in the past. She said she felt a continuous sense of fear and low mood which made her want to sleep for 12 hours a day. Although Jenny described some awareness of her thoughts as "not being right" when she started therapy, she did not want to change or think about her thoughts. Jenny described being

given sheets and homework to complete at home but felt that she only realised their value at a later stage in therapy:

> I understand the subject and we are going through communication like I adapt something before I realised but I didn't adapt. When I am getting through the communication with my therapist, she helped me a lot and she give me sheets and homework at home but I realised it later and I helped myself. (Jenny, p. 2, lines 48-50)

Sub-ordinate theme three: "Psychosis is a bad disease: Cured vs Treatment".

This theme highlighted the impact participants' understanding of distress had on the manner in which they perceived and engaged in therapy. When describing their experience of CBTp, participants often spoke about antipsychotic medication. Medication conveyed significance in a myriad of ways: to take medication was to be cured from the disease. The concept of being cured illustrated an eradication of difficulties through a quick and fixable solution, as opposed to therapy—a process of learning how to cope with ongoing symptoms and improve one's quality of life.

During the interview with Sami, I asked the core question, "Can you tell me in your own words, how you experienced individual Cognitive Behavioural Therapy for Psychosis?". Sami appeared confused by the question and clarified whether I was asking about the effectiveness of the intervention. I got the sense from Sami that the word 'effectiveness' perhaps resembled some of the language often used when referring to medication. Sami repeatedly referred to therapy in stage one as "no amount of talking can help" and described seeking religious support during the period when his medication was not yet 'effective'. Seeking religious help and emphasising the effectiveness of medication depicted Sami's

understanding of the illness as being a combination of biological and spiritual/religious causes. Therefore, the idea that 'talking' can heal was inexplicable.

> The main thing was clozapine I think or being or finding for each one they have their medication and it was finding this right medication that really helped honestly [..] So, this was the first line of defence if you would like to call it, but also at some point of the treatment when the medications weren't working and because I told you I went to a different medication before I was fixed on the one that helped me. So, I also seek like religious council from a clergyman (Sami, p. 8, lines 437-443).

Sami's use of the word "first line of defence" further illustrated his experience of support as perhaps having a hierarchical structure, starting with medication as being the most helpful support followed by speaking to religious healers and, lastly, engaging with CBTp. For Zain, the idea of starting therapy was described as "it is going to work like magic". The use of the word 'magic' seemed to communicate Zain's expectations of therapy. On the one hand, 'magic' illuminates a sense of power, as if the good force (therapy) can triumph over the powerful evil force (psychosis). On the other hand, there seemed to be a parallel function between Zain's description of magic and medication in that perhaps both can offer a quick solution to difficulties. However, the view of therapy as being 'magic' seemed to have faded away once Zain started therapy.

> [I]: I wondered whether the same view stayed while engaging in CBT?
>
> Zain: No [laughs]
>
> [I]: Can you tell me a bit more?
>
> Zain: I remember the first time I saw my therapist she was in the old offices[..] I was very shy. I was very embarrassed like I never talked to someone about everything like this openly and had an open discussion. But I was smiling, like with joy I had this

> good feeling that everything's going to be ok from now on and I can, I can change, someone can believe in me. At the end, someone can tell me that I know how harsh it is what you've been through, and you're not alone. A lot of people have been through tough things in their life and they came out stronger. So, I was having this whole idea in my head. But when we started talking and stuff like this, I know that it's not something magical that I'm going to have to stick to, whether I have to work to it, I'm going have to like to put all the effort and it's all from my side like she was just trying to give me the road map and I'm going have to walk it alone. Yeah, so it's not like something magic, so it's not a click. It's going to take time but at the end, we're going to reach where I want to be with or without therapy. (Zain, p. 7, lines 361-377)

Ella talked about stopping her antipsychotic medication and switched to taking vitamins and supplements in the hope that this would heal her body, which in turn would heal her mind. From Ella's description, it appeared that perhaps 'illness' was viewed in the body and mind, and, as such, the concept of 'health' was when both are healed: "At some point, I started taking like vitamins. Uh, I stop my medication started taking vitamins and minerals and I thought that these would and supplements, basically nutritional supplements, I thought these would help me out" (Ella, p. 3, lines 94-96).

For Ella, medication (whether antipsychotic or nutritional supplements) was viewed as the primary healing method. Engaging in therapy was viewed as an add-on, supporting her with what she coined as "the social world". What this meant for her was learning social skills to equip her in dealing with her family and society.

Sub-ordinate theme four: A spiritual explanation. All participants during the interview identified elements of spirituality. Spirituality was particularly important during stage one, whereby participants were endeavouring to understand and make meaning of their

experiences. Spirituality described by participants appeared to hold a twofold function: one is seeking God and religion as a way to understand their experiences of psychosis, and second is a way to manage distress associated with their experiences.

> So, I seek religious council from a clergyman and he like we discussed what's happening to me. He read some prayers to help me [..] Basically, like it's a refuge because in the religious teachings they teach you that the *Kalimas* that you face during your life are here to purify you from sin and purify you from wrongdoings. (Sami, p. 8, lines 439-440; lines 448-449)

In the extract above, Sami referred to Islamic beliefs as a way to make sense of his difficult experiences which in turn encouraged him to seek religious support. While for Ella, a belief in God helped her manage the distress by feeling that she was not alone during this difficult experience. However, for Ella, religion also became an anxiety-provoking experience as she described her psychotic beliefs to be built around religious concepts such as demons and Jesus.

When Sami believed that medication was 'not effective', he decided to seek religious help. Sami talked about reading the *Kalimas* (six Islamic phrases based on beliefs that should be practised and incorporated into one's life) alongside the religious clergyman. Sami's phrase of "purify from sin and wrongdoings" (p. 9) seemed to capture the fifth *Kalma*:

> I seek forgiveness from ALLAH, who is my Creator and Cherisher, from every sin I committed knowingly or unknowingly, secretly or openly. I also seek His forgiveness for all sins which I am aware of or am not aware of. Certainly, You (O ALLAH!), are the Knower of the hidden and the Concealer of mistakes and the Forgiver of sins. And there is no power and no strength except with ALLAH, the Most High, the Most Great.

During the interview, Jenny often used the word "*Inshallah*" (an Arabic language expression for "if God wills" or "God's willing"). The word "*Inshallah*" and "it is not clear" seemed to suggest Jenny's limited knowledge of a possible explanation to understand her experiences. Therefore, it appears that through spirituality she was able to accept her distress reluctantly. The word *Inshallah* also refers to the future; hoping that God will not cause her the same suffering as in the past.

> Yes, and he goes over to the mountain for three-four days and leaves me by myself in the restaurant, which is good like I do accounting, cooking, serving the people. It is not easy working in a restaurant. However, at first, I couldn't do anything.
>
> [I]: Why do you think you couldn't do anything?
>
> I don't know why. I don't know how I have been like I said ok something happened in the past and it is not clear. I said ok this is what happened, bit by bit I start to work on myself. And I work it through so life is going ok, but all I can say that in the past life was not ok like what we have […] Inshallah we will be good and thank God (Jenny, p. 4, lines 156-158, 162-165).

Her references to "we" instead of "I" suggested that suffering was a collective experience including her father, brother and cousins.

Unlike Ella, who sought comfort and closeness to God, Zain described finding it difficult to maintain a relationship with God during a time where he was struggling with the dichotomy of reality vs non-reality. From Zain's description, the dichotomy of reality vs non-reality appeared to extend to feelings of losing control of his reality and therefore to re-gain a sense of control is to let go of the spiritual element which represents the non-reality.

> I am religious I like to I don't like to use this power I know that God exists and that I can pray for anything and stuff like this, and I do, but I like I don't want to be

> dependent on someone I can't see on someone I can't talk with and someone I can't like feel so I try to keep it real as possible, like I want tangible things that I can have control over (Zain, pp.6-7, lines 334-337).

Sub-ordinate theme five: Shifting self. This theme is concerned with participants' account of the relationship with themself and others as shifted; this was understood as moving away from their inner experiences into the outer experience; understood as the relationality with the other.

While experiencing psychosis, Jenny described the self as absent, depicting a non-existent self. While the move away from this absence was described as "I am free", this experience exemplified a person being captured and trapped in their mind, and to be free signified the act of being unshackled of the pain and distress of her mind. As Jenny was able to free herself from her mind, this seemed to create a space for her to notice the value of therapy and begin engaging: "When I started therapy, I wasn't good, yeah, I wasn't good at all […] however, I have learnt to ignore many things that weren't right, I am free now I avoid everything away that wasn't true" (Jenny, p. 4, line 129).

Sami's use of the word "evolved" seemed to represent not only the shift within the self but also relationally with his therapist. This, as such, enabled Sami to actively engage in therapy, as compared to his level of engagement in stage one. Being actively engaged in his therapy and working through his thoughts with the therapist allowed the relationship to evolve into a positive therapeutic one.

> I was initially detached from the actual counselling but when time went by and I started getting better, I started to get more interacting in the sessions, telling the truth. Actually, talking about my delusions and then she would like [to] talk to me about like thinking about them. Just giving me the evidence, she was saying some really like

really obvious things that I really can't think of to dispute these delusions. (Sami, p. 4, lines 188-194)

Sami's description of the shift from a detached self to a more present one influenced the relationship between the self and the other.

I have organised the themes into two stages because of their importance to the participants of this study in how they came to understand their experience of therapy. Stage two represents participants' readiness and willingness to engage with therapy. I will now describe the themes I have associated with stage two.

Stage 2

Super-ordinate Theme two: Journey of Therapy

Sub-ordinate theme one: The self in relation to others. All participants located the concept of 'illness' within their cultural and societal contexts. The way participants came to understand and/or misunderstand illness was the way they relayed their experience of illness. Participants talked about their illness in relation to society, their families and friends. As the concept of illness was interrelated and defined in relation to other (wider) systems, so was therapy. Participants described CBTp therapy as a learning space whereby they valued the behavioural and social tasks of therapy, and what this meant for all participants was learning how to be with other people (friends, family and society).

Jenny referred to the process of therapy as being taught by the therapist about her experiences and learning how to improve her communication with other people. In Jenny's narrative, it appeared the term "communication" not only characterised the imparting or exchanging of information through language, but also embodied Jenny's existence as a social

being who thinks, feels and acts in existence with other people. Jenny's description of learning how to improve her communication echoed other participants' experiences. The need to learn how to act and express her emotions—in particular with her family and friends—seemed significant for Jenny: "Like I have been angry with this person, I say ok anger doesn't help, it is a problem but like what should I say to this person like how I communicate with him" (Jenny, p. 2, line 56).

Sami narrated and categorised his experience of therapy similarly to the two stages described above. When referring to the second part of CBT therapy, re-building his social life and learning how to manage his behaviour and mood when surrounded by his family became a priority. The following quote illustrates Sami's example of learning how to act and deal with family conflict:

> So, it helped me how to deal with my family, how to hide things. For example, if I'm feeling I'm watching a movie and I start having these disturbing thoughts, I used to be abrupt by getting up and just walking away and saying I don't watch this movie. So, what my therapist helped me to do was to like to soften the edges of how to act in front of people. Even if those delusions are hurting, like I would say hello guys, you know by starting to prepare them that I don't watch to watch the movie and then say I'm thinking of going and reading in my room so this will avoid the stress that will come to these people that you don't want to really get stressed because they already had dealt with a lot of things. So, for example, this and we talked about this and CBT and how to control your reactions and how to stay calm (Sami, p. 3, lines 160-170).

From Sami's description, there appears to be an emphasis on what is deemed appropriate behaviour and what is not. Perhaps, a controlled and capable self of regulating behaviour and emotions in front of other people is what was deemed appropriate within Sami's family.

For Ella, being connected to the community and people around her was strongly emphasised during the interview, which was one of her main goals for therapy. CBT helped Ella in gaining what she termed as "social skills": learning how to behave and manage her emotions around other people. Ella lost some of her close relationships upon their learning of her illness. Therefore, discovering how to foster that connection again with people seemed important to her.

> Learning skills or role-playing, for example like me, put myself in an interview or work scenario, there is a problem or issue and I get stressed, and I start feeling maybe depressive a little bit, I have mood imbalance and then how would I act in this regard? You know how I can approach for example my boss or how can I approach this person and tell them how I'm feeling for example. (Ella, p. 3, lines 161-165)

Ella often referred in the interview to her experience of psychosis as a mood imbalance. It appeared that conceptualising her difficulties as stemming from a mood imbalance was more accepted by other people around her than conceptualising it as psychosis.

Sub-ordinate theme two: "The problem is with society". As in much of the world, having mental health difficulties or emotional problems carries a certain stigma within society. However, for participants, this was particularly emphasised and had implications on the psychological support they received.

Sami described the need to keep his mental health difficulties secret and this was described as the second toughest obstacle he dealt with. Holding on to a secret seemed to represent a double-edged sword: on the one side, it was painful and disturbing, while on the other side it protected him from the stigma associated with having a mental illness. However, this further reinforced the idea of psychological support as being at the bottom of the hierarchical structure of support, as previously discussed. Perhaps the idea of taking

medication extended beyond his meaning-making of illness: it was viewed as a discrete method of healing that can be taken in one's home, while receiving psychological support was viewed as less discrete and necessitated an exposure to society.

For Sami, stigma was not only associated with people's judgements towards him but his worries that it would affect his job prospects, which are described as an important aspect of his life. Sami talked about the fear associated with employers knowing about his mental health problems that might encourage perceptions that he is not a good prospect for the job. The fear described by Sami could be associated with the societies pressure on men having to be the breadwinners of the household. Sami's fears were also evident throughout the interview, whereby he asked if he could keep his camera off. He highlighted at the end of the interview the importance of keeping his records private and anonymous, which was the sole reason why he decided to participate in this research. Although the fear of stigma was strongly present during the interview, I was left with an enigma: Sami repeatedly used the word "you know" to highlight his point, which perhaps indicated that, despite the fear, he positioned me as an insider who could understand his experiences.

> So what CBT helped me was my lifestyle choices or how I dealt with it with my friends or how I communicated with my colleagues because like it was like I was keeping it like a secret from everyone except five or six friends and family members so that it also helped me how to hide it. Because when I was for example in the hospital we made up a scenario of why I was in the hospital (Sami, p. 3, lines 144-148).

Ella described losing a few family members and her fiancé after they learnt about her mental health difficulties. Her use of the words "weird" and "helpless person" was some of the phrases she was told by her family members. For Ella, the idea of having a psychotic

experience was so frightening, isolating and stigmatising that there was a strong wish to view her experiences as having anxiety: “all I needed was anti-anxiety maybe”. The notion of being accepted versus rejected was evident during therapy. Ella’s wish was to spend more time on certain “lessons”, such as learning techniques to help herself feel more accepted by other people. Ella, in particular, referred to her extended family as coming from a generation where appearance and reputation were important, and the deeply rooted traditional beliefs about women’s appropriate behaviour were stressed. Any deviation from these appropriate behaviours was deemed as unacceptable. Therefore, Ella’s description of wanting more lessons to learn how to accept herself possibly represented her response to feeling rejected.

> Yeah, so at times when I thought when it started being like when it started improving and getting out of my episode, I felt like yes maybe I don't need to go this time, maybe I can, just, you know, push it back to next month, you know because I don't really have problems to talk about anymore. I didn't have issues (Ella, p. 7, lines 270-272).

Sub-ordinate theme three: A safe space. The use of certain words by participants when talking about their experiences—feeling lost internally, spaced out and drifting away from reality—seemed to capture a sense of being non-existent in the real world. What appeared to bring about a sense of existence and safety for participants were meeting the same therapist regularly, which signified a solid sense of stability in their whirlwind life. Providing a solid and stable foundation appeared to then foster a sense of safety and an environment where participants felt able to be open in therapy.

Sami described two safe places: one fostered by his parents and the other by the walls of the therapy room. Although Sami described feeling safe to talk to his parents about his difficulties, the idea of being fully honest about his illness was not possible. The fear of

hurting his parents was at the forefront of Sami's mind if he was to express how he was feeling and thinking. Therefore, the idea of being constricted in his thoughts led Sami to seek another safe space where the fear of hurting another person or affecting them by his experiences was minimal. Sami talked about safety being fostered by the walls of the therapy room. For Sami, it seemed the walls provided a sense of security, strength and protection from the outside world that instilled a sense of fear, danger and judgement in him. The idea of being with a therapist when confined by these protected walls made it then safe for Sami to talk freely.

> So, like if I want to like a safe place to talk, I can talk to my parents, but this will make them stressed, and they are not really well equipped to deal with what's happening to me. On the other hand, if I talk to my therapist, it's a safe ground because like we are protected by walls […], so I was able to communicate and get things off my mind (Sami, p. 4, lines 214-217)

For Ella, having a consistent space every week fostered a sense of motivation to engage in therapy and achieve her goals. The idea of being able to share with the therapist the small achievements she worked on during the week conveyed a sense of accomplishment and reward. Ella's use of the words "someone being with me all the time" signified a sense of closeness to the therapist. Similarly, to Sami, talking freely to a therapist eliminated the stress associated with speaking to a family member.

> Having just someone with me all the time who saw me in this but was not familiar like my mom or my you know, who was someone there professional who knew what they were doing and what they were seeing basically because my parents they don't know how to deal with the person. Where there is ample mental issues or mental

> disorder but having that comfort and that relief that there's someone who can help me out there professionally with what I'm experiencing (Ella, p. 4, lines 203- 207).

For Zain, there seemed to be a real struggle in building a trusting and warming relationship with his therapist. The act of stopping and re-starting therapy a few times, therefore, signified his struggle. However, being able to return and see the same therapist upon deciding to re-start therapy fostered a sense of security and acceptance of being held by the therapist: "And knowing that whatever happens in life, you can have, you can always go back to someone who you can trust and talk to, and it's going to always make their best to help you" (Zain, p. 4, lines 217-219).

Super-ordinate Theme Three: End of Therapy

Sub-ordinate theme one: Constructing new meanings. Participants' accounts allude to the emergence of what appears to be a move towards positive utterances and perceptions of their experience affording them with a perspective of "good and bad" happening in their life. Negotiating new ways of understanding and constructing their experiences as more than just "darkness" seemed to signify a shift and readiness to hold a concept beyond the distress and pain, which was once unbearable to hold. Participants held different views on what helped them to move beyond the darkness.

For Ella, developing new structures of meaning about her life of which she was previously not cognisant was a significant stage. Medication, praying, reading scriptures and therapy enabled her to redefine her experiences. Her use of the phrase "I think I live both worlds", therefore, represented the idea of being able to hold on to both concepts the "bad" and the "good". Despite the fear and anxiety associated with her experience of psychosis, Ella talked about constructing a different and balanced narrative to the one she held. Being exposed to a "huge imagination" was Ella's phrase to describe the upside to her experience.

She identified herself as being a creative person and talked about her experiences as enabling her a different level of creativity:

> Psychosis is something that is so tiring it's so tiring to the soul and it's it can be very scary and I think that comes with an upside of being creative. You know, I've always been creative I've worked in the creative field for so long and just having this huge imagination can sometimes be the death of a person or be the best thing that ever happened and I think I live both worlds but yeah. (Ella, p. 10: 410-413)

For Sami and Jenny, family support was strongly emphasised alongside medication, religion and, lastly, therapy. The combination of these four factors enabled a platform to construct a different narrative to their experiences. For Sami, rather than viewing his experience of psychosis as an invasive and long-standing disease, he talked about his perception shifting to viewing it in an episodic way; being able to accept that what he is experiencing is a difficult episode but also recognising that it will go away. With every difficult episode, Sami held on to the notion that he will become a stronger person as described in the religious scriptures he read:

> So, it was like a safe haven for me to always think that it's true that I'm going through tough times, but that like that these tough times will build my character and they will help me to become a better person and a more awake person […] These problems are here to like, to awaken us or to like. Teach us a lesson and then they will go away. (Sami, p. 12, lines 450-458).

Sub-ordinate theme two: Life beyond psychosis - moving forward. Despite the pain and distress described by participants, they all expressed an orientation towards the future in the last stages of therapy. For some participants in the beginning, the idea of having

a future was not possible, and being consumed with despair and hopelessness had engulfed them. During the interview, each participant spoke about their current life and achievements.

For Ella, striving to create a future for herself was central to the way she made sense of her experience. She talked about being viewed as the "helpless" and "weird" woman in the family who, at most, will not be able to achieve much for herself in life. She was, therefore, determined to prove her extended family wrong, and decided to study and become a registered dietitian. In the following extract, she described using her life experiences and the support she received as a way to navigate difficulties:

> I felt like I was doomed, you know and then, yeah thankfully I got out of it with the medication, with the therapy and everything with the right doctors. I was, you know, recovered […] And I'm in an amazing place right now, I'm so happy with my life, I'm you know dietitian, studying to become a registered dietitian now, so I'm yeah, I'm super happy. I learned from all my experiences. (Ella, p. 15, lines 602-603)

For Jenny, working in her father's restaurant and managing other employees by herself was one of her main goals in therapy, as it enabled her to have a sense of independence and a separate identity from that of being the woman with 'schizophrenia'. However, due to the political instability, as well as the explosion that took place in Beirut destroying much of the city recently, Jenny and her father fled the city to live in the mountains. Despite not being able to work in the restaurant, Jenny maintained a sense of hope for the future during the interview.

Summary

In this chapter, each of the presented themes was grounded in the voices of the participants and attempted to capture the essence of participants' experience of CBTp. The analysis provided here presents a phenomenological account of participants' experience of

CBTp and an inter-subjective construction of meaning, whereby the researcher aims to make sense of participants making sense of their experience.

This chapter illuminated participants' journey in therapy, from their ambivalence and ongoing struggles in engaging with CBTp to the transition of developing a safe and trusting relationship with the therapist, thus affording them a medium through which to speak about their experience of psychosis. All accounts indicated CBTp as both challenging and overwhelming in stage one, which highlights ongoing struggles with the therapist, the loss of self, uncertainty and a lack of hope. In this stage, all participants wanted a platform to speak freely and to be heard as opposed to cognitively engage with the techniques of the therapy.

Against this backdrop, while CBTp in stage one was experienced as being bombarded with how to act and feel, the interweaving of the educational process of CBTp—creating a safe place and incorporating other forms of support—enabled a shift in perspective from a life of darkness and fear to a life that is about more than just psychosis. This framework offered the participants a reference from which to make new constructs and meanings about their psychotic experiences.

PART V: DISCUSSION

"*What would it be like to have not only colour vision, but culture vision? The ability to see the multiple worlds of others*?"

Bateson (1994, p.53)

Introduction

The study's analysis (Part IV) centred around participants' experience of individual Cognitive Behavioural Therapy for psychosis (CBTp). Understanding this experience involved acknowledging the role of the researcher alongside the participant in the co-creation of knowledge. Interpretations of the data were grounded in participants' accounts, supported using extracts from the data to evidence a transparent reading. In this chapter, the main findings will be contextualised within the wider literature, concluding with a discussion around the study's limitations, a reflexive overview and implications for counselling psychology.

The current study aimed to explore the lived experience of individuals with a diagnosis of psychosis, all receiving one-on-one cognitive behavioural therapy in the context of the 'psychosis recovery outreach programme' (PROP)—an early intervention service—in Beirut, Lebanon. Four participants in total were interviewed, and their experiences were categorised broadly into 'stage one' and 'stage two'. Stage one was experienced as not being psychologically stable to engage with the content of therapy, while stage two was participants' readiness to engage with the therapy. From these two categories, three super-ordinate themes were drawn out—navigating the beginnings of therapy, journey of therapy and the end of therapy—which were further branched into 10 sub-ordinate themes:

- The hidden self;
- Constricted space;
- "Psychosis is a bad disease": Cured vs Treatment;
- A spiritual explanation;
- Shifting self;
- The self in relation to others;
- "The problem is with society";

- A safe space;
- Constructing new meanings;
- Life beyond psychosis: Moving forward.

The subsequent section will locate the three super-ordinate themes within the existing literature.

Navigating the Beginnings of Therapy

The process of starting therapy is complex, and a sense of ambivalence and fear was experienced by all participants in the initial stages of CBTp. The existing literature has often noted fear and hypervigilance to be present in the initial stages of therapy with individuals who experience psychosis; some studies have highlighted this fear to be a result of the perceived threat of the therapist not being trustworthy and previous experience of therapy making the voices worse (Lawlor et al., 2015), while others found individuals doubting the benefits of therapy (Kilbride et al., 2013). While participants voiced their struggles in starting therapy, the struggle seemed to capture a psychological phenomenon related to what Corrigan and Watson (2002) conceptualised as the "self-stigma". Self-stigma was conceptualised as including stereotypes (negative views of oneself), prejudice (negative emotional reactions) and discrimination (behavioural reactions in response to the prejudice). Participants also voiced what Corrigan and Watson (2002) named "public-stigma", in line with research that has shown people tend to disapprove of individuals with mental illnesses more than individuals with physical illnesses (Socall & Holtgraves, 1992). This was the case for Sami, who described feeling confused as to why he could not be supported and viewed by others as a "hero" who is battling with a mental illness, like someone battling cancer is often seen.

In addition to the fear and ambivalence, participants described experiences of not being listened to and validated in stage one. A common feature in delivering CBTp is the

importance of developing a strong therapeutic relationship in the initial stages; not surprising given the extensive literature recognising the challenges with engaging individuals who experience psychosis (Sivec & Montesano, 2012). Chadwick et al. (1996) stressed the importance of holding back from pushing individuals to challenge their thoughts before they are ready. From participants' accounts, most felt they were not ready to think about their thoughts, let alone to start challenging them. Attempts by the therapist to question participants' thoughts—even if out of concern—was perceived as threatening and invalidating their 'reality'. Siven and Montesano suggested that provisionally suspending one's own reality to try and understand participants' experience of psychosis can be anxiety-provoking for therapists and can lead them to quickly move to reality-based assumptions, moving possibly at a quicker pace than the client. Enabling clients to talk openly about their voices or delusions and listen in a curious and non-judgemental way without questioning the 'reality' is significant to developing a therapeutic relationship (Corstens et al., 2008).

Explanatory models are significant and embedded in individuals' cultural, social and religious beliefs. Explanatory models as such play an important role in peoples' understanding of difficulties, their expression of distress and help-seeking behaviour (Joel et al., 2003; Lloyd et al., 1998; Naeem et al., 2016). Most participants in this study held more than one cause to understand their experiences, such as biological, religious (sin and wrongdoing) and a holistic understanding of illness being located in the mind and body. However, a common cause expressed by all participants was a biological cause that necessitated medication. Medication was described as the primary healing method enabling participants' self to be "freed" from the distress and pain of their inner experiences. Sami went as far as to describe his experience of psychosis as "neurotransmitters in the brain [that] are firing up" (p. 7, line 337). Since psychiatric diagnosis and medication are deeply rooted within a medical model, medications become the default in addressing human distress; this

can leave little scope for different methods of interventions. Undoubtedly, antipsychotic medication can offer a form of relief, but there is a supposition that medication benefits all individuals.

Participants' attribution of psychosis to biological causes influenced their views on receiving psychological support and the notion that talking can help, which echoed previous literature exploring individuals' understanding of psychosis in different cultural contexts. Naeem et al. (2016) explored individuals' views about psychosis, and its causes and treatment, to adapt CBTp in Pakistan. The authors reported that most participants focused on physical health and the need for medication. The participants voiced their wishes and expectations of "quick remedies" (Naeem et al., 2016, p. 49) and the need to be cured. Two participants (Sami and Jenny) held religious causes for their illness, with Sami associating his to sin and wrong doings while Jenny, to God's will; Ella referred to spirituality as guiding her and supporting her to manage distress. The use of religious or spiritual beliefs within therapy is often cited in various literature as significant when working with individuals from different cultural contexts (Phiri, 2012; Beck, 2016). Pargament (2001) argued that using religion or spirituality to cope served five purposes: self-development, spiritual (finding hope and/or meaning), restraint (of emotions and behaviour), sharing (closeness to others) and resolve (self-efficacy) (p. 72). For Sami, self-development ("be a better person") and spirituality ("hope that tough times will build my character") were particularly important, while for Ella, praying embodied a sense of closeness with a "significant other"—referring to God.

Journey of Therapy

> If we concentrated on the culture we would be in danger of viewing the person within a stereotypical box and likewise, if we concentrated on the self only we would be trying to understand a person without a context. In other words, we would not be viewing the whole, only parts of it. At all times, the relationship between the triad that is the person, the familial system and the cultural context needs to be considered (Baba, 2015, p.4).

From participants' accounts, it was clear that the self was not a separate concept but was holistically situated within one's social, historical and cultural context. This theme further highlighted the dichotomy of the self in a collective versus individualistic society when referring to methods of healing. Participants stories highlighted their views about what entails health, and that the self is interrelated with a harmonious balance with the wider community and family. According to Dumit et al. (2015), "Lebanese culture is family-oriented, whereby family members not only support each other in all aspects of life including health care, but they are also required to preserve family values and integrity" (p. 3320).

All participants referred to the techniques of CBTp as being educational. The educational aspect is consistent with the principles adopted in CBTp literature (Messari & Hallam, 2003). As the self was viewed in relation to others, participants voiced three aspects of therapy as being important: behavioural tasks (e.g., behavioural activation), social skills and dealing with family conflicts. For most participants, the focus on emotions and cognitive aspects of the work was not welcomed such as for Ella; while for some, cognitive aspects of the work was acknowledged at a later stage in therapy (stage two). Ella described wanting "hands-on advice" referring to "how to behave". She said this resonated with her while being given homework to rate her mood and write down affirmations was viewed as "not me". The findings of this theme resonated with studies conducted by Rathod et al. (2010) and Phiri

(2012): both identified the importance of beginning therapy with a focus on behavioural (rather than cognitive) interventions to minimise disengagement and foster a sense of trust and hope.

The stigma around mental health difficulties worldwide has been cited in the literature for many years, with psychosis being at the end of the spectrum (Morris, 2017). Exploring individuals' experiences of stigma relating to symptoms of psychosis, Jenkins and Carpenter-Song (2009) found that 96% of participants described stigma as permeating their lives. In Lebanon, stigma has been particularly cited as being a challenge to individuals seeking support for their mental health (Arafat et al., 2020; Noubani et al., 2020). Losing contact with family members, holding mental health difficulties a secret and preferring to be viewed as having anxiety difficulties (with healing being dependent upon anti-anxiety medication) were some of the participants' stories.

End of therapy

All participants' accounts resembled Zain's metaphor of a "roadmap" to describe their experiences. The roadmap was filled with "darkness", "fake happiness", "loneliness" and "fear". However, at the end of the roadmap lay bright, shining light that brought with it a sense of relief and peace knowing that life was more than just "psychosis". For most participants, embarking on a transformation journey began with shifting their views from psychosis being "all good" or "all bad" into a balanced view: a combination of good and bad. This way, participants accepted their experiences, which in turn allowed them to move on and focus on different aspects of their lives such as career and having a fulfilled life. There is a growing body of literature pointing to individuals' ability to develop a hopeful outlook on their experiences, so they accept and cope with their experiences better (Abba et al., 2008; Goodliffe et al., 2010; Hayward & Fuller, 2010). Romme et al. (2009) researched 50

individuals that experienced voice-hearing and had subsequently recovered. The authors found that concepts such as acceptance, being valued as an ordinary human being who hears voices as opposed to being a patient, and reconstitution of the self were common across all participants' accounts concerning their recovery journey.

In stage one, all participants referred to medication as being the most 'effective' intervention, while participants had different views in stage two. For some, family support, medication, religious help and individual therapy (Sami, Jenny and Ella) enabled this transformation journey, while for others (such as Zain) medication and support from his friend were identified as enabling this journey.

While the findings of this research study echoed existing literature, there is one aspect of the finding that was striking. This was mainly in relation to participants' description of the two stages of CBTp. There was an emphasis in stage one on the need to be heard, empathised and validated. As such there was a need for the therapist to take on a more non-directive style, encouraging the participants to talk freely about their experiences without guiding or further exploring. While in stage two, participants' voiced the need to be guided by the therapist and offered more techniques and tools, taking on a more directive approach. Participants placed great emphasis on therapists' communication style and the different approaches they preferred in each stage. The findings here were unique to this study as previous literature suggested taking on a more directive approach within the initial stages of therapy and then moving to a more collaborative approach if appropriate (Naeem et al., 2019). While in other studies, it was suggested to adopt a directive approach all throughout therapy as this was the preferred method of communication by clients (Li et al., 2017).

Limitations of the research

Hermeneutic interpretive phenomenology, as described by Max van Manen, was chosen as the appropriate methodology to understand the deeper meanings of the experience of receiving individual CBTp. As with other methodologies, van Manen's offering is not without its limitations and has been critiqued; one being the lack of generalisability, meaning the findings of this study cannot be generalised to every individual CBTp experience through PROP in Lebanon. However, this research inquiry by no means claims that the results can be representative of individuals' experiences due to their idiographic nature. The participants' experiences are confined to their uniqueness and the co-constructed interview experience. However, the results of this study did provide valuable insight into the experience of receiving a cross-cultural psychological intervention in participants' contexts.

In-depth semi-structured interviews were conducted with four participants. It is important to mention that, although a sample size of four fits well within the methodological framework of hermeneutic interpretative phenomenology, this may have placed limits on any new emerging nuances to the identified themes. Literature citing van Manen's (2016) approach does not stipulate a sample size, however, he recommends a small sample due to the time-consuming and challenging nature of this type of analysis (van Manen, 2016). Although I intended to interview more participants, substantial difficulties were encountered with recruitment related to the context where interviews took place. As interviews were conducted online, the shortage of electricity in Lebanon that affected individuals' access to the internet limited the number of participants able to engage in the research. Many people were fleeing the country, seeking a more stable life outside of Lebanon, which also meant limited access to participants. It is, however, important to note that the challenges associated with the recruitment further highlighted the significance of being sensitive to the context of

participants when working cross-culturally. Despite these difficulties and the smaller sample size, participants' accounts offered rich, in-depth narratives of their lived experiences.

Another limitation identified in this study, and one also observed during interviews, was participants' need to speak highly of the service and the treatment offered. This may have had an impact on the information provided by participants, which might in turn have influenced how much they disclosed about their experience. It could be argued that two factors influenced participants' demeanour in the interview. First, some participants continue to receive treatment from the service in the form of pharmacological support and regular check-ins with their psychiatrist, which could have left participants worried about any consequences of receiving continuing treatment if they were to express any negative experiences. Second, participants' may have felt obliged to maintain harmony, respect and loyalty to people regarded as holding high social statuses (i.e., psychiatrists and therapists). This is significant and viewed as an obligatory feature within collective societies. To manage this limitation, I ensured that each interviewed commenced with me going through the information leaflet and consent form with the participant, emphasising their right to stop and/or withdraw without any consequences to their continued treatment within the service. With Jenny, I felt the need to highlight her right to withdraw and/or stop in her native language (Arabic), as she asked me twice in English to clarify what I meant by "no consequences to her treatment". I thought this was necessary to make sure she understood she was not obligated and that participation was completely voluntary. Research involving human participants necessitates following ethical guidelines and this is particularly important during cross-cultural research (BPS, 2014).

Another challenge encountered during this research inquiry was the use of language. Hennink (2008) offered that, "Language is used in powerful ways to understand the emic (insider, participant) perspectives on the issues and the social context" (p. 24). Language is also

viewed as critical when working cross-culturally and adopting a qualitative research approach. Arabic was participants' native language, and English was their second and/or third. While fluency in English was an inclusion criterion for this study, it was difficult to ascertain their level of fluency prior to the interview stage. As such, it became obvious that participants had varying levels of fluency: some spoke to a high standard, while others spoke at a more intermediate level. Therefore, their fluency in English and the restricted use of vocabulary may have prevented some participants from being fully able to express their experiences of CBTp. One method of managing this was my advantage of being a bilingual interviewer; this allowed participants to express a word or sentence in Arabic if they were struggling during the interview to relay their experience in English. However, bilingual interviews, and potentially being viewed as an insider, also comes at a cost, which will be further explicated below. It is, however, important to note that participants should not be excluded from research based on language. Difficulties with language perhaps reflect some of the challenges faced when working cross-culturally and goes someway to explaining the limited research into individuals' experiences across different cultural contexts.

Finally, I believe holding 'insider' knowledge was beneficial; it possibly allowed participants to be open about their experiences during the interview. However, this familiarity also created some challenges and possibly limited this study. I noticed myself over-identifying with some participants and holding a wish to relate to them. I noticed this desire particularly increased when participants spoke in their native Arabic language. I noticed different emotions being triggered, which made it more difficult to remove myself from participants' experiences. Another challenge of being an 'insider' was my demeanour during the interview, which was particularly highlighted when one participant informed me that he Googled me and found that we attended the same university. I noticed the impact this had on my way of being during the interview: I gave reassurance and possibly avoided questions in

fear that the participant would feel judged. One way to manage those challenges was to keep a reflective journal, which will now be expanded upon.

Reflexivity

Reflexivity was described by Shacklock and Smyth (1998) as a "conscious revelation of the underlying beliefs and values held by the researcher. From an epistemological perspective, a reflexive approach recognises knowledge as constructivist, developed throughout the research process and contingent upon existing understandings and beliefs" (p. 7). Similarly, Lincoln and Guba (2003) suggested that reflexivity takes on a constructionist approach, which takes the research into social, relational and contextual levels. In other words, without sensitivity to context, knowledge is not possible. Therefore, reflexivity and this relational way of thinking situates the researcher into a context. My position of embarking on this study stems from the fact that I come from a dual ethnic background—Lebanese and Polish, and residing in the UK—which has a significant cross-cultural aspect to the therapy I will provide.

Personal reflexivity

I attended numerous training courses in CBT for psychosis, which I feel gave me insight into the treatment model being offered as a 'default' therapy for this group. My clinical experience of using CBTp with individuals who experience psychosis from different cultural backgrounds has left me curious about how this type of therapy is being experienced by individuals in different cultural contexts. How I dealt with the issues of cultural understanding became a prominent factor. An understanding of participants' cultural norms was significant for this research and has enabled insightful interpretations of the phenomenological text. On the contrary, Gerrish et al. (2003) suggests that it can be challenging to separate between the role of the researcher and the position of an 'insider'. In this instance, I have perhaps been

considered as an insider since I share an ethnicity with the participants. However, it is important not to assume that a shared ethnicity results in a complete understanding of one another. According to Liamputtong (2008), "an intimacy with a culture may lead to complacency, whereby an over-familiarity […] can result in a disregard to particular nuances" (p. 37). Therefore, as a researcher who shared a similar ethnicity to the participants, keeping a personal log became significant as it sought to promote transparency when interpreting the data.

I found the interview process challenging on various levels. My first interview was with Sami, who had his camera turned on when he joined Microsoft Teams but a minute into the interview he turned it off. I quickly became anxious wondering whether I said something that upset him. I noticed my demeanour changed as I actively attempted to build some relationship despite being unable to view Sami and determine how he was feeling. I then used my therapeutic skills and I gently asked whether he was OK and wished to continue with the interview. I noted down my anxieties in my reflective journal to both acknowledge my feelings and record them if a similar situation arises with my next participant.

Zain rescheduled the interview three times and, at one point, did not respond to my emails. A few weeks later, I received an email from him saying he was having some difficulties at work but did wish to go ahead with the interview. Zain also chose to not turn his camera on, and he informed me that he Googled my name and found out that we both attended to the same university in Beirut. I wondered whether his rescheduling of our interview on multiple occasions was him feeling uncertain about speaking to me, as he held some fear that I would recognise him. The interview with Zain remained with me even after we finished. Zain talked about the Beirut explosion that took place in August 2020, and the near-death experience he and his family encountered; this strongly resonated with me as my family were affected by the explosion and I noticed a pounding in my chest as he was talking

about it. Taking deep breaths during the interview helped me manage my anxieties and calmed me down.

When speaking to Ella, I was incredibly moved by her experiences. Throughout the interview, I noticed myself becoming quite sad and, at times, disappointed with the service that was initially offering her treatment. She described being given a diagnosis of psychosis without any explanation or an understanding of what it is. She was worried to talk about her symptoms with the doctors in the fear that she might be "strapped down". I wondered whether my feelings of disappointment stemmed from feeling responsible in some way as I completed an internship in the outpatient service back in 2013 when I lived in Lebanon.

With Jenny, I noticed the impact limited language had on the interview process. It was difficult at times to understand what Jenny was trying to communicate and I noticed myself actively thinking of simple words and phrases to use with her. Jenny also did not have her camera on as her computer did not have a camera setting and this made the process more difficult due to lack of social cues. Also, at one point during the interview while she was talking, she paused and said "hello" as if to check whether I was still there. I then noticed the need to speak more and offer verbal cues such as "hmm" to show that I was listening to her.

Throughout the research process, I have often reflected on the tension with interviewing participants in their second language- English versus interviewing in Arabic and using translators. I noticed most cross-cultural research in different cultural contexts were conducted in English. This made me wonder whether similarly to the use of Western psychological interventions, English was viewed as the default and 'correct' way of interviewing. Whereas different languages were perhaps viewed or categorised as more complex and less-so used when conducting research. Therefore, the use of English within this study inherently posed difficulties. I wondered whether some of the participants' voices were

constricted and their original meaning was being suffocated using a second language. Therefore, it was important to minimise this tension by giving participants the opportunity to use words or sentences in Arabic if needed to narrate their experiences. This allowed for flexibility and a commitment to be sensitive to the verbal and non-verbal communication within the interview space.

Cross-cultural Challenges

As a novice researcher, I quickly came to learn the importance of planning when conducting cross-cultural research. In the initial stages of this research, I faced substantial delays due to difficulties with receiving ethical approval in the UK and a delay in response from the collaborating service in Lebanon. These unexpected delays had a discouraging psychological effect on me. I was anxious about the impact this delay would have on the recruitment and data collection process.

When completing the ethics form for approval from the UK, I faced numerous challenges on different levels. However, I was particularly struck with a dilemma when completing the form concerning some of the questions and guidelines in the form. I came to realise that the cross-cultural aspect of the research began with the ethics form itself, and the notion that the ethical standards and regulations of researching with human beings were developed in one cultural context; perhaps its applicability in a different cultural context was not as relevant. I found discussions with my director of studies in the UK, feedback from the ethics board and discussions with the collaborating institution in Lebanon useful in managing those dilemmas.

Once I received my approval, I was faced with a second challenge: not being able to recruit participants. Many times, I felt frustrated and ‘left in the dark’ as, due to the pandemic, I was not able to travel to the collaborating service and be physically present

during the recruitment process. However, I noticed the need and support I received from the collaborating service during data collection, which made me reflect on the meaning of 'collective support'; this perhaps reflected the cultural norms of the country.

Implications for counselling psychology

As explicated in the literature review chapter, there is limited research exploring cross-cultural psychological interventions such as CBT for psychosis in an individual context. The most available research is exploring the efficacy of the intervention using quantitative methodology. It is hoped that the current research will fill a gap in knowledge and clinical experience for counselling psychologists working in the UK and abroad.

One of the principles of counselling psychology is its emphasis on growth and development, and its focus on context and culture in understanding and conceptualising human experiences (Orlans & Van Scoyoc, 2008). The latter is situated within the humanistic values suggesting, "human beings have their existence in a uniquely human context" (Schneider, 2009, p. 3). Therefore, as counselling psychologists, the knowledge of individuals' difficulties, as well as an understanding of their political, social and cultural context, is significant. Thus, increased awareness and knowledge of others beyond one's confines enables a platform to begin deconstructing the notion of a 'universality' to human difficulties, human response and the psychological support offered in response to those difficulties. Incorporating individuals' contextual factors, alongside developing an understanding of what constitutes 'illness' versus 'health', positions practitioners as healers who offer appropriate and culturally sensitive psychological interventions.

The current study highlighted several important issues such as developing an understanding around participants' categorisation of therapy as two separate stages. Additionally, participants' conceptualisation of illness was mediated and influenced by the

social context. This, in return, influenced participants' perception of therapy and the need to heal the *self* in relation to the *other.* Good (1997) suggested, "Cultural interpretations of mental illness held by members of a society or social group strongly influence their response to persons who are ill and both directly and indirectly influence the course of the illness" (p. 234).

Participants' categorisation of their experience into two separate stages communicated a narrative of 'readiness' versus 'not ready' for therapy. Erskine (2019) proposed that therapists' empathic attunement (developing an understanding of individuals' psychological state and the capacity to respond in congruence to clients' needs) is significant. Being attuned to clients' needs and readiness necessitates an assessment of the psychotic phase, knowledge of appropriate tasks in each phase and the ability to adjust their therapeutic response (Fuller, 2021). To reduce the risk of using language that categorises individuals into 'ill/well' or 'psychotic/not psychotic', and to assess clients' readiness for therapy, psychologists are encouraged to question the premise of conceptualising experiences through the bio-medical lens of 'psychosis': to instead view 'illness' in its variable forms. One method to achieve such a perspective could be through the use of the SEL model (Surviving, Existing, Living), as proposed by Fuller (2013). The model offers three phases and eight domains that are not rigidly defined categories; instead, they lie on a continuum to assess clients' psychological abilities and needs, allowing therapists to consequently determine the type and timing of interventions. Additionally, the two stages as described by participants highlights the need for practitioners to be aware of the directive vs non-directive approach within the therapeutic work.

The findings from the study, particularly in stage one, highlighted participants' belief in spirituality. The use of religious explanations of human distress and incorporating religion as a way of coping with distress, therefore, is essential in such therapy. Spirituality may

create a dilemma for some practitioners who view spirituality or religion as insignificant or challenging in the therapy room. Therefore, an awareness of the therapists' own beliefs and assumptions of spirituality are significant. A study by Post and Wade (2009) demonstrated that therapists were more likely to pathologise or disregard spiritual beliefs when they held a limited understanding of them. Another study by Rathod et al. (2010) found that therapists admitted to feeling overwhelmed and would avoid dealing with religious or spiritual beliefs. One way for practitioners to incorporate spiritual beliefs when exploring clients' experiences is what Ade-Serrano (2017) coined as the "working definition model" (p. 76). This model creates a definition of spirituality specific to clients' understanding of their experiences. One way to include spiritual beliefs into clinical practice is to actively incorporate discussions about spiritual or religious beliefs during the assessment and formulation phase. Seeking religious support was also used by some participants as a healing method. Therefore, in the early stages, practitioners are encouraged to establish clients' multi-dimensional help-seeking pathways, as it may indicate clients' understanding of psychological interventions and how they will engage with them. Additionally, collaborative work with members of the clergy (e.g., Imams or priests) may equip practitioners to better understand their clients' spiritual beliefs. This work can also foster a sense of trust between the therapist, religious clerics and the client, and enable better engagement in the early stages of therapy.

Participants' views of what constitutes 'illness' or 'health' were situated within their historical, social and cultural context. The concept of health was viewed as the self living in a harmonious balance within its wider community. Being connected to the community and learning how to 'behave' socially was the primary goal for most participants. Therefore, in some instances, it might be appropriate for practitioners to start therapy with a focus on behavioural interventions and social skills, while cognitive interventions such as the appraisal of cognitive biases may need to follow at a later stage. A focus on behavioural interventions

can also give clients the sense that they are active participants in their own care, which will continue throughout therapy. Finally, in some instances, the use of the mind and body model can be more appropriate when conceptualising psychotic phenomena. According to the U.S. Department of Health and Human Services (2001) *Mental Health* report:

> The meaning of an illness refers to deep-seated attitudes and beliefs a culture holds about whether an illness is “real” or "imagined," whether it is of the body or the mind (or both), whether it warrants sympathy, how much stigma surrounds it, what might cause it, and what type of person might succumb to it. (p. 26)

In summary, it was clear from the findings of this study that participants held different explanatory health beliefs, which consequently brought with it various methods of health-seeking behaviour. Therefore, adopting a pluralistic health approach when working with these clients may be most appropriate. However, this is not to say psychological and medical interventions are not appropriate; there simply seems to be scope for other possible strategies that could enhance engagement and treatment. Landy (1977) argued that, when health pluralism is adopted, the cultural, political and social features of treatment can be significant, depending on the type of treatment one seeks and the beliefs about the outcome of treatment. According to Beck (2016), “it might be necessary for therapists and service users to integrate explanations and work within two explanatory models in order to bring about improvement in functioning” (p. 96).

Conclusion

This is the first study to have explored the experience of individuals receiving CBTp in Lebanon. I have adopted Max van Manen’s (2016) methodology— hermeneutic interpretative phenomenology—due to its congruence with the focus of the research, its sensitivity to context, and my attitude and believes about the significance of elucidating

individuals' subjective experiences. By exploring participants' subjective and unique experiences, different aspects were captured through identifying, describing and interpreting the findings within the three super-ordinate themes.

I have optimism that this study has highlighted some of the complexities associated with conducting cross-cultural research, and the implications and importance of asking the proposed research question. I would hope that the findings reported here draw some attention to the needed exploration of cross-cultural psychological interventions within individual contexts, as Brown and Lent (2008) described: "When we are unaware of cultural issues, it is difficult to know what we do not know; this lack of awareness significantly restricts understanding, sensitivity, and appropriate responses" (p. 77).

The implications of the findings for counselling psychologists and other clinicians include the importance of assessing readiness for psychological interventions, all the while considering: spirituality or religion within the therapeutic work; being aware of therapists' communication style; beginning therapy with behavioural interventions and social skills; and, finally, adopting a pluralistic health approach where appropriate.

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Appendices

Appendix A: Approval letter from UEL ethics committee

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Florentia Hadjiefthyvoulou

SUPERVISOR: Claire Marshall

STUDENT: Mariam Annan

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: A phenomenological inquiry into the experience of receiving individual Cognitive Behavioural Therapy (CBT) for psychosis within a Psychosis Recovery Outreach Programme in Lebanon

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

Approved

Minor amendments required *(for reviewer)*:

I would like the student and supervisors to have a discussion about the possibility of researcher distress as this sounds like a sensitive topic and interviews with vulnerable people and think a bit more about researcher protection

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*

Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☒ MEDIUM (Please approve but with appropriate recommendations)

☐

LOW

Reviewer comments in relation to researcher risk (if any).
My concern is more about researcher protection. So as per my recommendation supervisory team to discuss with student what to do in case of distress. There is a good protocol for participant distress- a similar one for researcher distress should be discussed

Reviewer *(Typed name to act as signature)*: Florentia Hadjiefthyvoulou

Date: 09/09/2020

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Appendix B: Approval letter from AUBMC ethics committee

AMERICAN UNIVERSITY OF BEIRUT
INSTITUTIONAL REVIEW BOARD (IRB)

APPROVAL OF RESEARCH

January 7, 2021

Dear Dr. El-Khoury,

On January 7, 2021, the IRB reviewed the following protocol:

Type of Review:	Initial, Expedited
Project Title:	A phenomenological inquiry into the experience of receiving individual Cognitive Behavioural Therapy (CBT) for psychosis within a Psychosis Recovery Outreach Program in Lebanon

Appendix C: Research integrity certificate

CERTIFICATE of ACHIEVEMENT

This is to certify that

Mariam ANNAN

has completed successfully

Research Integrity Modules

28 January 2020

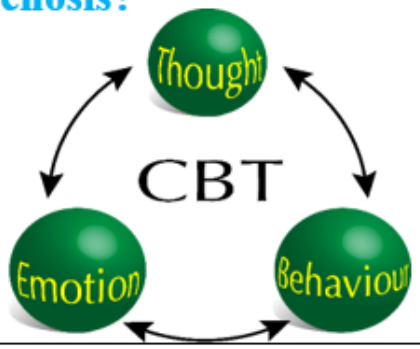
End of course quiz - Social and Behavioural Sciences Grade: 80.00 %

Appendix D: Research study flyer

Are you receiving or have completed individual Cognitive Behavioural Therapy for Psychosis?

AUBMC

University of East London



If you answered YES then please get in touch! I am interested to learn about your experience of receiving individual Cognitive Behavioural therapy within the Psychosis department.

Contact Us

- For any inquiries about this leaflet please contact our research assistant Ms. Lynn Adam, email:
- You can also speak to your individual therapist for more information on the study and how to sign up.

Appendix E: Participant information letter

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am Mariam, a postgraduate student in the School of Psychology at the University of East London and am studying for a professional counselling psychology doctorate. As part of my studies, I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research to find out what it is like to have received individual Cognitive Behavioural therapy for psychosis at the Psychosis department. I am particularly interested in hearing from you directly about your experiences.

My research has been approved by the School of Psychology Research Ethics Committee and the Institutional Review Board at the American University of Beirut Medical Centre. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to involve adults who have experienced psychosis and who have been offered individual Cognitive Behavioural Therapy for psychosis.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to do the following:

- Access to a laptop/computer with audio and video access.
- Find a safe and confidential room in the house to have the interview.
- Sign a digital consent form that will be emailed to you.
- Take part in an informal discussion with me as the researcher via video link – Microsoft Teams. This discussion will last between 60-90 minutes.
- The discussion will be video and/oraudio recorded and then typed up into text – which I will do myself. I will change your name and any identifying details when I write the research up to ensure your confidentiality.
- I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

- You will not be identified in the data collected (the recordings and transcript), on any written material resulting from the data collected, or in any write-up of the research. Comments made in the interview will be used in the write up of the research, however all information that might identify you (for example: names and places) will be removed.
- You do not have to answer all questions asked and can stop participation at any time, you will not have to give me a reason for doing so.
- The only time that confidentiality would not be preserved is if you disclose any risk to yourself or other people and any other safeguarding concerns that would require immediate attention. Your clinical team at PROP will then be informed about the risk.

What will happen to the information that you provide?

Your participation will be kept confidential.

- The digital consent form and the transcript of our discussion will be saved on a separate password protected USB memory sticks, and only the researchers (Ms Mariam Annan, Ms Lynn Adam, Dr. Joseph-el Khoury & Dr. Claire Marshall) will have access to them.
- The digital consent form will be deleted once this research has been submitted and assessed. The transcript of our discussion will be kept after the study has finished with the view to develop the research further (e.g., for publication) for 5-years- after this it will be reviewed and if no longer needed - safely destroyed.
- The study will be written up and submitted as a research project as part of a Doctorate in Counselling Psychology.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have participated data, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Mariam Annan Email:

Or

Lynn Adam Email:

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr. Claire Marshall School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: c.marshall@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: t.lomas@uel.ac.uel

Appendix F: Participant consent form

UNIVERSITY OF EAST LONDON/AMERICAN UNIVERSITY OF BEIRUT MEDICAL CENTRE

Consent to participate in a research study

A phenomenological inquiry into the experience of receiving individual Cognitive Behavioural Therapy (CBT) for psychosis within a Psychosis Recovery Outreach Programme in Lebanon.

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. The only time that confidentiality would not be preserved is if I disclose any risk to myself or other people and any other safeguarding concerns that would require immediate attention. My clinical team at PROP will then be informed about the risk. In the case of any psychological or emotional distress, I understand that my primary clinician (psychiatrist) will be informed for assessment and further intervention/referral if needed. This will be offered free of charge.

Consent to videotape the interview. The research team would like to video record this interview as to make sure that they remember accurately all the information you provide. Please note that the research team prefers that the interview be videotaped. However, if you do not wish to be videotaped, you have the option to turn off your camera.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw; the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

……

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..

Appendix G: Interview Protocol

The interview questions will then follow after informed consent has been established. This will take the form of two core questions and then secondary areas of interest. The areas of interest are not compulsory. Flexibility of interview style is given presidency to allow the phenomena to arise organically.

Core Question:

- Can you tell me in your own words, how you experienced individual Cognitive Behavioural Therapy for Psychosis?

- What support did you find most helpful?

Appendix H: Prompt to interview questions

The journey

How did you feel about coming into the service?

How do you understand your experience of having psychosis?

How do you feel about being given the label psychosis?

How do you define your own label?

Support

Have you sought any other methods of support?

What is your understanding of therapy?

Have you had any previous therapy and what was is it like?

Experience of Cognitive Behavioural Therapy for psychosis

What is your understanding of Cognitive behavioural Therapy?

How did you experience the therapeutic relationship with your therapist?

What was most helpful in therapy?

Would you change anything about how therapy is conducted?

Additional prompts

Is there any other way you can tell me that would help me understand your experience?

Would you like to draw it?

Appendix I: Participant debrief form

AUBMC
AMERICAN UNIVERSITY of BEIRUT MEDICAL CENTER
Department of Psychiatry

University of East London

PARTICIPANT DEBRIEF LETTER

Thank you for agreeing to participate in this research. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The video and/or audio-recorded interviews will be transcribed and only the researchers (Ms Mariam Annan, Ms Lynn Adam, Dr. Joseph El-Khoury & Dr. Claire Marshall) directly involved have access to it. All names, dates, addresses and any other identifying details will be taken out from the transcripts to ensure that participants cannot be identified. Your written/electronic informed consent will be scanned into the computer and later destroyed once the research has been submitted and assessed. Information provided for the purpose of this study will remain strictly confidential. The transcripts will be kept after the study has finished for 5 years in case of publication- after this it will be reviewed and if no longer needed-safely destroyed.

If you would like to withdraw from the study within 3 weeks of the interview, your data will be destroyed.

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following contact helpful in relation to obtaining information and support in the department:

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Mariam Annan email:

If you have any questions or concerns about how the research has been conducted please contact the research supervisor -Dr. Claire Marshall, School of Psychology, University of East London, Water Lane, London E15 4LZ,

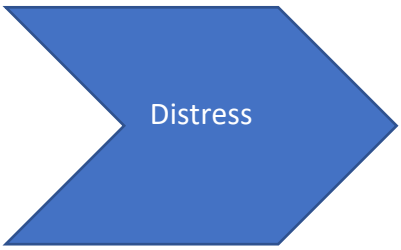
Email: c.marshall@uel.ac.uk

or

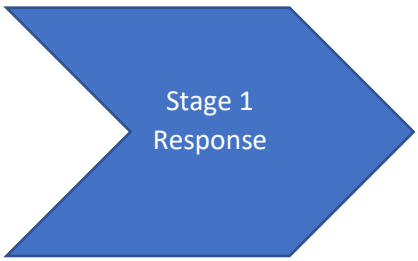
Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: t.lomas@uel.ac.uk

Appendix J: Distress protocol

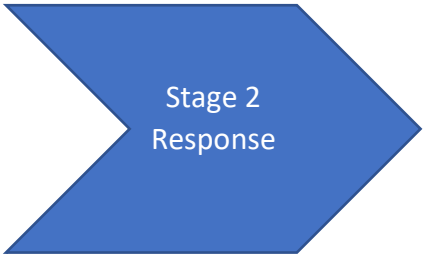


- **Participant indicates they are experiencing stress or emotional distress**
  OR
- **Exhibit behaviours suggestive that the interview/discussion is too stressful such as uncontrolled crying, shaking etc**



- **Stop the discussion/interview.**
- **Assess mental state by asking the following questions:**
  Tell me what thoughts are you having now?
  Tell me what are you feeling now?
  Do you feel safe?

- **Ask participant whether they are able to carry on; resume interview.**
- **If participant is unable to carry on, go to stage 2.**



- **End the interview with participant and allow some time for a debrief.**
- **Encourage participant to contact the support provided on the debrief letter.**
- **If researcher is concerned about participants mental state then inform participant about speaking to their clinical team.**