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Exploring Perceptions of "Wellness" in Black Ethnic Minority Individuals at Risk of Developing Psychosis

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Background: The NICE Schizophrenia guidelines (NICE, 2009, Update) recommend that services should address cultural differences in treatment, expectations and adherence, and clients' explanatory models of illness should be better understood. Service users from Black African and Black Caribbean communities are overrepresented in psychosis services in the UK, yet there is no literature on how wellness is understood by this group. **Aims:** This study explored perceptions of wellness in Black African and Black Caribbean individuals with an At Risk Mental State (ARMS) for psychosis. **Method:** A Q set of potential meanings of wellness was identified from a literature search and interviews with people at risk of developing psychosis. From this, 50 potential definitions were identified; twenty Black African and Black Caribbean ARMS clients ranked these definitions. **Results:** Following factor analysis of completed Q sorts, six factors emerged that offered insight into perceptions of wellness in this population. These factors included: sense of social purpose explanation, the surviving God's test explanation, the internalization of spirituality explanation, understanding and attribution of symptoms to witchcraft explanation, avoidance and adversity explanation, and seeking help to cope explanation. **Conclusions:** Although preliminary, differences between the factors suggests that there may be perceptions of wellness specific to these groups that are distinct

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from the medical view of wellness promoted within early detection services. These differences may potentially impact upon engagement, particularly factors that clients feel may facilitate or aide their recovery. It is suggested that these differences need to be considered as part of the assessment and formulation process.

Keywords: At Risk Mental State (ARMS), psychosis, prodrome wellness, Black African and Black Caribbean, Q methodology.

Introduction

Within services in the United Kingdom, it is widely recognized that there is a higher prevalence of psychotic disorders in Black African and Black Caribbean populations (Cantor-Graee and Selten, 2005; Sharpley, Hutchinson and Murray, 2001; Fearon and Morgan, 2006). Research reports elevated rates of psychosis in the Black African and Black Caribbean populations in the UK ranging between two and fourteen times higher than for the White British population (Cantor-Graee and Selten, 2005; Sharpley et al., 2001). This increased incidence has been found to be consistent over time and it has been documented that there is an elevated risk of developing psychosis in second and third generation immigrants (Cantor-Graee and Pedersen, 2007). The unwavering high rates of psychotic disorders in second and third generation immigrants in different European countries relative to their White counterparts, and the absence of raised rates in native countries (Cantor-Graee and Selten, 2005; Selten et al., 2001; Veling et al., 2006), raises the question as to whether there is a strong environmental component involved in the development of psychosis. Furthermore, it has been found that the pathway to care for Black African and Black Caribbean service users can be convoluted, and presentation habitually occurs at crisis point rather than during the earlier stages of this disorder (Morgan, Mallett and Hutchinson, 2005).

It is important to note the significantly negative experiences of Black African and Black Caribbean service users accessing mental health services in the UK. A glaring account of such discrepancies, detailed in *Breaking the Circles of Fear* (The Sainsbury Centre for Mental Health, 2002), indicates why research into mental health service provision is necessary. Indeed, this population is more likely than their white counterparts to have a compulsory admission under the Mental Health Act (Mental Health Act Commission, 1999), over diagnosis of schizophrenia and under diagnosis of depression (Lloyd and Moodley, 1992) and are less likely to be offered psychological treatments (Lloyd and Moodley, 1992). The London Boroughs of Lambeth and Southwark, where this study took place, have the highest proportions of Black African and Black Caribbean clients in the UK (The Sainsbury Centre for Mental Health, 2002); hence the perceived relevance of exploring the beliefs about wellness that this population hold. There is currently a paucity of research exploring the experience of Black African and Black Caribbean clients accessing psychosis services and, specifically, their perceptions of what it means to recover and be well. Against the backdrop of research indicating a high prevalence of psychosis in the Black African and Black Caribbean populations, this seems a particularly important question for early detection services aiming to treat ARMS (at risk mental state) clients and intervene during the prodromal period and prevent transition to a frank episode.

Exploring how wellness is understood by Black African and Black Caribbean groups might be helpful in understanding how to improve the pathway of care for this group. In fact, the

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recent schizophrenia guidelines (NICE, 2009) recommend that psychosis services should address cultural and ethnic differences in treatment, expectations and adherence and that clients' explanatory models of illness should be better understood by service providers. This has also been documented by McCabe and Priebe (2004) who compared explanatory models of UK White, Bangladeshi, African–Caribbean and West African people with schizophrenia. These authors found that supernatural causes of illness were cited by the non-White groups more frequently than their White counterparts who attributed their symptoms to biological causes. African-Caribbean and Bangladeshi groups were also noted to cite social causes more regularly (McCabe and Priebe, 2004). Within psychosis services, Cognitive Behavioural Therapy (CBT) is the most widely used and recommended psychological treatment (NICE, 2009). It has been suggested that whilst CBT as a therapeutic model does not ignore the social context of illness, factors such as ethnicity, culture and religion are not well integrated within CBT (Summerfield and Veale, 2008). In response to Delivering Race Equality (DOH, 2005), a mental health action plan that called for culturally appropriate and effective psychological interventions, Rathod, Kingdon, Phiri and Gobbi (2010) explored the cross cultural use of CBT. Literature from non-Western cultural groups has found that CBT may be effective cross culturally; this is dependent, however, on how successfully it is adapted (Rathod et al., 2010). Sensitivity to cultural norms, understanding of psychological intervention and beliefs about wellness and about illness may not be consistent with the Western influenced framework in CBT, which promotes reasoning approaches and a collaborative relationship with the therapist (Rathod et al., 2010).

The recovery model has recently gained much support as an optimistic and empowering approach to viewing serious mental health disorders including schizophrenia (Warner, 2009). Recovery, however, suggests the overcoming of an illness. As the "at risk mental state" is not yet a formal diagnosis, and services offering help to individuals with an at risk mental state aim at preventing the onset of severe mental health problems, it seemed more appropriate to refer to wellness rather than recovery. A wealth of literature exists around the concept of wellness and its definition (Adams, Bezner and Steinhardt, 1997; Ryff and Keyes, 1995; Diener and Lucas, 2000). Adams et al. (1997) defined wellness as "a manner of living that permits the experience of consistent, balanced growth in the physical, spiritual, psychological, social, emotional and intellectual dimensions of human existence" (p. 214). This definition assumes that when people perceive themselves as attending to all wellness dimensions equally, they are healthier. The Ryff and Keyes (1995) model of psychological well-being includes the following six components: "self acceptance, personal growth, purpose in life, positive relations with others, environmental mastery, and autonomy" (Ryff and Keyes, 1995, p. 720). Wellness can also be understood as the absence of undesirable negative emotional states such as anxiety as well as the experience of positive moods and emotions (Diener and Lucas, 2000).

The concept of wellness may have different meanings in different ethnic groups. Triandis (2000) emphasized the personal meaning the client ascribes to their difficulties and how their cultural beliefs are interwoven with this. The role of identity is likely to be important. Culture and environment have an impact on how identity develops and the individual's belief system and understanding of concepts such as "wellness" (or the meaning of symptoms) may be derived from this. Indeed, according to Markus and Kitayama (1991), the individual's concept of the self, identity, cognitions, emotions and motivations are being driven by culture. It has been suggested that a Western understanding of wellness is habitually applied to all clients

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who receive help in the UK (Diener, Diener and Diener, 2009). As a result, relatively little is known about the understanding of wellness in ethnic minority groups.

Dudley, Siitarinen, James and Dodgson (2009) explored what people think caused their psychosis using a Q methodology approach. Similarly, the current study aims to explore perceptions of wellness in a Black African and Black Caribbean ARMS sample using Q methodology. Within this study, definitions for culture and ethnicity have been taken from the Collins English Dictionary (2012). Here, culture refers to the behaviours, beliefs and characteristics of a particular group (e.g. social, age or ethnic). Ethnicity refers to the common characteristics of a group of people (e.g. religion, culture or language). It is hypothesized that:

1. Perceptions of wellness in the Black African and Black Caribbean ARMS population will be associated with cultural beliefs, for example, religious or spiritual explanations of symptoms.
2. Understanding perceptions of wellness will provide insight into how clients access and engage with services.

Method

Q methodology

Q methodology approaches research with different assumptions to conventional methods, thus allowing for diversity, rather than attempting to reduce it (Aldrich and Eccleston, 2000). Inspired by a study by Dudley et al. (2009), Q methodology was thought to be an appropriate approach for this study and population as it offers a dynamic and accessible tool through which participants can express their views non-verbally (Jones, Guy and Ormrod, 2003).

In the current study, Q methodology consisted of two main stages. The first involved the development of the Q set (i.e. statements that encompass beliefs about wellness and how it is achieved). The Q set was developed following semi-structured interviews with professionals and OASIS service users and a systematic search of relevant literature. The second stage involved administration of the Q set in the form of a Q sort to Black African and Caribbean ARMS clients. Following this, the data were analysed and the results taken back to a selection of participants for discussion. Each stage of Q methodology will be presented separately for clarity.

Stage 1: development of the Q set

In accordance with Kitzinger (1987) the following techniques were employed by the researcher to gain an impression of the range of viewpoints that may be expressed about wellness:

1. Initial informal discussions with colleagues and specialists in the area were conducted.
2. A literature search using Psychinfo, Ovid and Medline between 1980 to January 2010 was carried out. Search terms included: wellness, well-being, ethnicity, culture, African, Caribbean, psychosis, at risk mental state, and mental health.
3. Hand searching of key journals
4. In line with the principles of Q methodology, collection of subject material from a range of sources is encouraged to facilitate the development of a comprehensive set

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of statements. In this study, formal interviews were conducted with 2 clinicians and 7 OASIS service users to elicit their understanding of "wellness". The clinicians and services users were recruited within the constraints of the inclusion criteria, using strategic or theoretical sampling (Stenner and Marshall, 1995) in order to gain a wide range of viewpoints.

Creation of the final Q set

Material from the interviews was noted and statements that reflected wellness were generated from this using a thematic analysis approach. This initial sample of 202 statements was reduced in a number of stages following an accepted procedure (Watts and Stenner, 2005). First, ambiguous or repetitious statements were excluded (Shinebourne and Adams, 2009) and the process was reviewed and repeated by the research team. This process is known as "triangulation" and resulted in the final Q set of 50 items, which represented a number of points of view of what wellness is or means. These statements can be seen in Appendix 1. A Q set is usually between 40–60 items (Watts and Stenner, 2005). Dudley et al. (2009) explored what people think caused their psychosis using a Q methodology approach with 21 participants and a Q set of 58 items.

Stage 2: administration of the Q sort

Participants were instructed to think of their ideas of wellness and to look at the Q statements. They were then asked to sort the provided statements into three initial piles, according to whether they felt they were related to wellness, unrelated to wellness, or unsure. They were then instructed to pick the statements that they related to wellness and place them in the positive end of the grid. This pattern continued with the three piles of statements until they all fit into a grid shape that was provided in the results sheet. At all stages it was made clear that the statements could be moved about until a final representation of the participants' perspectives was reached. The results sheet consisted of a Q grid ranging from +5 to –5. Participants were also asked why they placed the statements in the +5, +4, 0, −4 and –5 parts of the grid, and to comment on any of the statements that they found difficult to place.

Statistical analysis

The completed Q sorts were analysed using PQ method 2.11 (Schmolck, 2002). A Principal Components Analysis (PCA) of the factors was computed to explore both commonality and specificity of the Q sorts. Factors were then rotated using the varimax procedure. This maximizes the degree of association with one particular statement. The significance level for rotated factors was set at 0.49. According to Watts and Stenner (2005), this level minimizes confounding of factors and maximizes the number of significant loadings on each factor.

Reflexivity

It seems relevant to consider the researcher's knowledge of some participants through a previous therapeutic encounter and how this may have encouraged particular accounts from

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participants. It is also pertinent that the researcher is from a Black African background and this may, to some extent, have impacted on how participants responded.

Ethical considerations

Research ethics approval was obtained from the National Research Ethics Service (REC number: 09/H0715/88). Participants provided written informed consent prior to commencement of the study.

Results

Participants

A total of 20 individuals with at high risk for psychosis were recruited via Outreach and Support in South London (OASIS), a community mental health team for help-seeking young people, aged 14–35, with an At Risk Mental State for psychosis (ARMS) (Broome et al., 2005). The At Risk Mental State was identified using the Comprehensive Assessment for the At Risk Mental State (CAARMS) (Yung et al., 2005). Briefly, participants met one or more of the following criteria: (a) attenuated positive psychotic symptoms; (b) brief limited intermittent psychosis (BLIP: psychosis present for less than 7 days); or (c) a recent decline in functioning, together with either schizotypal personality disorder or a first-degree relative with a psychotic disorder.

Participants were approached via care coordinators and therapists, were between 18 and 35 years of age, from a Black African or Black Caribbean heritage, had been accepted into the OASIS service, and had a good command of the English language. Ethnicity was determined through self-report. In line with the exclusion criteria for the OASIS service, participants were excluded if they had already experienced a psychotic episode, had a diagnosed learning disability or were over 35 years of age. Within this study, participants under 18 years of age were also excluded due to ethical considerations. Twenty-eight people were considered suitable for inclusion in this study and were invited to participate. Twenty (71%) agreed to take part. Six men (24%) and 14 women (76%) aged between 18 and 35 years (mean 22.2 years, *SD* 4.3 years) were included in the study. Participants who chose not to participate tended to be male and were reported to have disengaged from the OASIS service. Consequently, this sample was over-represented by female participants. Overall, clients from a Black African background participated more readily than Black Caribbean clients.

Participants had been receiving OASIS services for between 3 months and 2 years. Three participants had been discharged from OASIS or chosen not to engage with the service. These clients were included as their reasons for disengaging may provide insight into differences in their perceptions of wellness compared to those still engaged with OASIS. Demographic details and characteristics of the participants are listed in Table 1.

Factor analysis

A Principal Components Analysis (PCA) of the factors revealed six factors with eigenvalues above 1 and together explained 66% of the variance (see Table 2). Factors were then rotated using the varimax procedure, the results being listed in Table 3.

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Table 1. Characteristics of the sample ($n = 20$).

Presenting problems to the OASIS service	*N*	% of total
Paranoia	6	30
Auditory hallucinations	9	45
Visual hallucinations	2	10
Withdrawn/isolated from others	10	50
Anxiety	6	30
Low mood/depression	5	25
PTSD	1	5
Racial composition of sample		
Black African	12	60
Black Caribbean	8	40
Adult migrants to the UK		
Yes	3	15
No	17	85
Care received from OASIS service		
Cognitive Behavioural Therapy (CBT)	8	40
Monitoring/care-coordination	5	25
Disengaged	3	15
Completed 2 years treatment	4	20

Note: Some participants presented with more than one difficulty

Table 2. Individual loadings onto each factor

Participant statement	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
1	**0.75**	−0.02	0.12	−0.12	0.37	0.17
2	**0.56**	0.17	0.26	0.24	0.13	0.09
3	0.13	0.10	0.08	**0.84**	0.23	−0.06
4	0.48	0.06	−0.04	−0.23	0.21	**0.65**
5	0.32	0.15	0.11	−0.29	0.32	0.40
6	−0.24	0.13	**0.81**	−0.06	0.09	−0.03
7	0.21	−0.16	0.55	0.12	−0.08	0.48
8	0.40	0.47	0.44	−0.02	0.24	−0.00
9	0.07	−0.10	−0.03	0.04	**0.74**	−0.16
10	−0.02	0.24	0.16	−0.00	−0.0	**0.68**
11	0.54	−0.20	0.18	−0.33	0.42	−0.13
12	0.23	0.18	0.29	**−0.60**	0.40	0.12
13	0.50	0.17	−0.06	0.41	0.02	0.32
14	0.17	0.23	−0.02	0.14	**0.77**	0.18
15	0.09	−0.46	0.14	0.29	0.49	0.30
16	0.29	**0.67**	0.14	0.13	−0.26	0.24
17	**0.64**	0.28	−0.14	0.09	−0.14	0.08
18	0.34	−0.01	**0.74**	−0.05	−0.01	0.22
19	0.08	**0.86**	−0.00	0.03	0.20	0.20
20	−0.2	0.04	−0.37	−0.37	0.54	0.25
Eigenvalue	5.05	2.36	1.86	1.49	1.29	1.02
Cumulative % of explained variance	14%	24%	35%	44%	58%	66%

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Table 3. Rotated factor matrix and defining Q sorts

Participant statement	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
1	**0.75**	−0.02	0.12	−0.12	0.37	0.17
2	**0.56**	0.17	0.26	0.24	0.13	0.09
3	0.13	0.10	0.08	**0.84**	0.23	−0.06
4	0.48	0.06	−0.04	−0.23	0.21	**0.65**
5	0.32	0.15	0.11	−0.29	0.32	0.40
6	−0.24	0.13	**0.81**	−0.06	0.09	−0.03
7	0.21	−0.16	0.55	0.12	−0.08	0.48
8	0.40	0.47	0.44	−0.02	0.24	−0.00
9	0.07	−0.10	−0.03	0.04	**0.74**	−0.16
10	−0.02	0.24	0.16	−0.00	−0.0	**0.68**
11	0.54	−0.20	0.18	−0.33	0.42	−0.13
12	0.23	0.18	0.29	**−0.60**	0.40	0.12
13	0.50	0.17	−0.06	0.41	0.02	0.32
14	0.17	0.23	−0.02	0.14	**0.77**	0.18
15	0.09	−0.46	0.14	0.29	0.49	0.30
16	0.29	**0.67**	0.14	0.13	−0.26	0.24
17	**0.64**	0.28	−0.14	0.09	−0.14	0.08
18	0.34	−0.01	**0.74**	−0.05	−0.01	0.22
19	0.08	**0.86**	−0.00	0.03	0.20	0.20
20	−0.2	0.04	−0.37	−0.37	0.54	0.25
Eigenvalue	5.05	2.36	1.86	1.49	1.29	1.02
Cumulative % of explained variance	14%	24%	35%	44%	58%	66%

Factor interpretation

An overview of each factor is presented with relevant defining statements. Further elaboration is in the discussion section.

Factor 1: sense of social purpose explanation. Participants 1 and 17 loaded onto this factor and this explained 14% of the total variance. Feeling connected to society and feeling socially connected was integral to this Factor. Participants considered wellness to be associated with living successfully in spite of symptoms. Feeling connected to culture of origin and prayer was placed negatively. This seems incongruent with a definition of wellness as being able to be engaged with society, having a purpose and feeling socially connected. The following Q set statement that defined Factor 1 was found to be negatively significant:

Wellness can be achieved through prayer (−2) (Statement 21) ($p = 1.17$)

Other factors that were significant in defining this factor were:

42. Wellness is being able to live successfully despite my problems (+5)
10. Wellness is when I feel socially connected (+4)
11. Wellness is when I have a purpose (job) in society (+3)
7. Wellness is when I feel a connection to my culture (−2)

Factor 2: the surviving God's test explanation. Factor 2 accounted for 10% of the total variance. Participants 16 and 19, both second generation Black Caribbean females, positively loaded onto this factor. Participants perceived wellness as being when they felt they had a

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sense of control over their lives. This control appeared to be related to surviving God's test which, for these participants, was mental health difficulties. Participants experienced auditory hallucinations that were perceived as being associated with God. For them, symptoms were a test from God that had to be endured. Factor 2 was defined by the following statements:

Wellness is achieved when I feel more control over my life (+5) (Statement 12) ($p = 2.04$, $p > .01$)
Wellness is achieved when I've come through my mental health problems which are a test from God (+4) (Statement 22) ($p = 2.02$, $p > .05$)

Other statements strongly associated with Factor 2 included:

5. Wellness is when I don't feel paranoid (+3)
43. Wellness is eating and sleeping well (+3)
49. Wellness is when I don't hear voices (that aren't real) (+3)

Factor 3: the internalization of spirituality explanation. Loadings on this factor were significant for participants 6 and 18 (both female participants) and explained 11% of the overall variance. Participants considered wellness to be when their spirit is well, located in the soul and when they are free from witchcraft, spirits or supernatural forces. Participants in Factor 3 were adult migrants from both African and Caribbean countries. This factor highlights cultural differences in the location of wellness and the significance of spirituality in its achievement. Factor 3 was defined by the following statements:

Wellness is achieved through prayer (+5) ($p = 2.19$, $p < .05$) (Statement 21)
Wellness is when my spirit is well (+4) ($p = 1.08$, $p < .01$) (Statement 18)
Wellness is located in my soul (+3) ($p = 1.88$, $p < .01$) (Statement 19)
Wellness is achieved when I've come through my mental health problems which are a test from God (+2) ($p = .90$, $p < .01$) (Statement 22)
Wellness can be achieved once I am free from witchcraft, negative spirits or supernatural forces (+2) ($p = .69$, $p < .01$) (Statement 20)

Factor 4: understanding and attribution of symptoms to witchcraft explanation. This factor explained 9% of the variance and participants 3 and 12 (both male participants) loaded onto this factor. This factor reflected the participants' need to be free from witchcraft phenomenon and feelings of paranoia that come with this. It is interesting that one participant loaded positively onto this factor (+5) and one negatively (−5) yet they both emphasized the importance of witchcraft. It seemed important that participants commented on the importance of professionals having the same understanding of their difficulties. Symptoms were attributed to witchcraft rather than a mental health problem. The following statements defined Factor 4:

Wellness can be achieved once I am free from witchcraft, negative spirits or supernatural forces (+5) ($p = 2.89$, $p < .01$) (Statement 20)
Wellness is achieved if professionals have the same understanding of my difficulties as me (+3) ($p = 1.44$, $p < .01$) (Statement 33)
Wellness is being able to live successfully despite my problems (+3) ($p = -1.00$, $p < .05$) (Statement 42)

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In order to gain a richer understanding of this and to help define this factor, consideration was given to other statements associated with Factor 4.

Wellness is when I don't feel paranoid (+4) (Statement 5)
Wellness is eating and sleeping well (+3) (Statement 43)
Wellness is achieved though understanding my difficulties and making sense of them (−3) ($p = -1.59$, $p < .01$ (Statement 41)

Factor 5: avoidance and adversity explanation.. This factor explained 13% of the variance and had two significant loadings. Participants included one male (participant 14) and one female (participant 9). Participants reported explanations of wellness related to ongoing environmental difficulties and adversity across the lifespan and emphasized drug use. Demographic information revealed that these participants had erratic engagement patterns, experienced significant anxiety and used cannabis on a daily basis. Drugs appeared to be used as a coping mechanism and means of self-medication. This may be associated with their desire to avoid thinking about the past. Within this factor participants identified the following factor as an indicator of wellness:

Wellness is improved when I have a better living environment (+5) ($p = 2.65$, $p < .01$) (Statement 14)

In order to create a more comprehensive narrative of Factor 5, a number of statements associated with it were also considered:

Wellness is hard to achieve because of my start in life (+2) (Statement 13)
Wellness is when I don't take drugs (−4) ($p = -2.01$, $p < .01$) (Statement 40)
Wellness is when things aren't building up in my mind (+4) (Statement 25)
Wellness is when I do things just for me (+3) (Statement 3)
Wellness is when I stop thinking and feeling certain things (+3) (Statement 26)
Wellness is when I'm not stressed (+3) (Statement 31)
Wellness is when I stop dwelling on things in the past (+3) (Statement 32)

Factor 6: seeking help to cope explanation.. Factor 6 accounted for 9% of the total variance. Participants 4 and 10 had a significant positive loading onto this factor. Participants considered wellness as being associated with being able to understand and make sense of difficulties, to be able to live successfully despite their problems and to talk to someone about their experiences. It is emphasized that wellness is easier to achieve if professionals are able to understand the participants' cultural, spiritual and religious beliefs. It was felt that wellness is separate from environmental issues such as housing and finances. The following statements were found to be significant in Factor 6:

Wellness is achieved through understanding my difficulties and making sense of them (+5) ($p = 2.09$, $p < .01$) (Statement 41)
Wellness is achieved when I get used to the idea that I don't have to solve my problems myself and can talk to someone (+4) ($p = 1.81$, $p < .01$) (Statement 34)
Wellness is easier to achieve when I can talk to someone about my problems (+3) ($p = 2.45$, $p < .01$) (Statement 46)
Wellness is inseparable from social issues like housing, money, living in an inner city environment etc (−5) ($p = -2.45$, $p > .0$) (Statement 15)

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Consideration was also given to the following statement that was associated with this factor:

> Wellness is easier to achieve when professionals understand my cultural, spiritual or religious beliefs (+3) (Statement17)

Discussion

This study used Q methodology to explore which factors Black African and Black Caribbean individuals at risk of developing psychosis perceived as being related to wellness. Analysis revealed six factors. In line with the original hypothesis, these findings are consistent with the view that perceptions of wellness may be associated with cultural beliefs (Veenhoven, 2007) and may differ from explanations of wellness focusing on symptom reduction that are traditionally emphasized within mental health services including early detection and early intervention services. This conclusion may, however, only be viewed with caution due to the methodological limitations of both this study and Veenhoven's (2007), particularly the absence of a comparison group. This study hypothesized that differences in perceptions of wellness may provide insight into how clients access and engage in services. It is plausible to infer from these findings that clients with perceptions of wellness that differ from those espoused by mental health services may choose not to access or engage as a consequence of this disparity.

Factor 1 endorses feeling socially connected and having a sense of purpose such as that achieved through employment. One participant reported feeling unable to connect to her community due to feelings of shame about being a service user and unemployed. Previous studies (Kessler, McGonagle and Zhao, 1994) found that unemployment is associated with a decline in mental functioning, a sense of isolation, reduction in opportunities for social interaction and psychotic symptoms. Pertinent to this factor is Mallett, Leff and Bhugra's (2004) suggestion that this achievement mismatch is a risk factor for developing psychosis in clients from ethnic minorities. Morgan et al. (2005) found that social disadvantage and isolation are more common in Black Caribbean clients than in White clients. These issues are particularly pertinent in the South London boroughs of Lambeth and Southwark where this study took place. Employment figures from the Office of National Statistics (2011) report 9.8% and 9.7% unemployment in Southwark and Lambeth respectively. If these factors are considered in the treatment of ARMS clients, it may be that for people with this perception of wellness, there is a strong rationale for the clinician to deconstruct the meaning of factors such as unemployment. It would seem that the meaning ascribed to the experience of unemployment and the subsequent cognitive processes that are evoked may be of greater importance than the experience of unemployment itself. An emphasis on care-coordination and support around social inclusion and employment may be beneficial for these clients.

The emphasis within Factor 2 indicated that wellness was associated with surviving a test (mental health difficulties). Participants reported that a reduction in symptoms was positive but it appeared that attainment of this was through a seemingly passive yet punitive relationship to religion. It is interesting to consider the differences between factor relationships to religion. This factor differs from Factor 3 in which control and maintenance of wellness is achieved through prayer and a positive internalization of spirituality. There is a sense that control is only achievable once psychotic symptoms, which were thought to be a test from God, are

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lived through. This difference can, perhaps, be understood in terms of Factor 3 having a more active relationship with religion as opposed to the more passive stance adopted in Factor 2.

Factor 3 highlighted spirituality and the use of prayer in achieving wellness. It appeared that the location of wellness was rooted within the spirit or soul and disturbances to this were viewed as a test from God. Distinct from Factor 2 and Factor 4, this explanation of wellness focuses on the internalization of spirituality (Statement 18, 19) as a means of achieving wellness. Adverse influences such as witchcraft (Statement 20) may affect spiritual wellness but are not the principal focus of this factor as in Factor 4. Unlike Factor 2, relief from psychotic symptoms were not given importance. The role of religiosity within Factor 3 is indicative of its use as a resource to prevent mental decline. This can be substantiated through research that has found that religious beliefs are used to cope with the stress that mental illness can cause (Tepper, Rogers and Coleman, 2001; Reger and Rogers, 2002). As an example of how spiritual and religious needs can be addressed within mental health settings, Fallot (2001) suggested taking a spiritual history as part of the assessment process and connecting clients to faith communities and spiritual resources. Clinically, validation of the significance of religion to the client may help with the engagement process. Koenig (2007) commented that the traditionally negative views of religion in mental health services and lack of value ascribed to the client's religious beliefs leads to disengagement and disenfranchisement from services.

Factor 4 seemed to present a dichotomous understanding of the role of witchcraft in wellness. Whilst one participant felt it was of great import, another regarded it as being insignificant. It is interesting that exploration revealed that both believed that witchcraft is a present and real concept. This factor was focused on an understanding of wellness and attribution of symptoms to witchcraft. Unlike Factors 2 and 3, in Factor 4 witchcraft was understood as a cause of symptoms. Being free from witchcraft and supernatural forces suggests that within this Factor, symptoms are related to being possessed by something negative. Witchcraft is viewed as being irreligious and something that the internalization of spirituality exhibited in Factor 3, could help combat. Culturally, witchcraft phenomenon and occult discourses are common within the Black community (Parish, 2005). Whilst this is incongruous with the Western medical conceptualization of illness it would seem that raising awareness of this explanation would be beneficial to professionals working in multi-cultural settings.

Factor 5 highlighted an avoidance and adverse environment explanation of wellness. Participants endorsing this factor appeared to perceive their consumption of cannabis as a method of coping. This seemed to be associated with their desire to avoid thinking about past and current adversity. Factor 5 differed from the other factors due to its emphasis on substance misuse, adversity and a subsequent sense of avoidance of difficulties. There is increasing recognition of the role of cannabis misuse in emergent psychotic disorders (Henquet et al., 2005). In order to better understand this factor, it is interesting to refer to Veling et al.'s (2006) marginalized ethnic identity position in which the individual identifies with neither host nor home country. This may explain the sense of disconnectedness experienced by participants and the seeming absence of meaningful connections. Clinically, exploration of participants' attachment relationships may be useful (Berry, Wearden and Barrowclough, 2007; Gumley and Schwannauer, 2006), or it may be that focusing on generating alternative coping strategies, psychoeducation around substance misuse and mental health difficulties may help. Having the opportunity to discuss distressing events from the past and the generation of alternative narratives (Lysaker, 2003) may also be beneficial.

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Factor 6 endorsed the need to seek help to cope and promoted the benefit of talking through difficulties and making sense of them. Interestingly, the need for professionals to understand cultural, spiritual and religious beliefs was emphasized. This may be associated with participants being previously known to the researcher in a therapeutic capacity, and feeling more at ease having a therapist from a similar ethnic background. Whilst research suggests (Ziguras, Klimidis, Lewis and Stuart, 2003) that having a clinician from the same ethnic background can be beneficial, this was not clearly delineated in this factor. The impact of researcher ethnicity upon data collected and the process of therapy would be an interesting focus for future research. From a wider clinical perspective, Factor 6 emphasizes the importance of the therapeutic relationship and need for a holistic assessment and formulation of the client. It is arguable that whilst CBT for psychosis (Garety, Kuipers and Fowler, 2001; Morrison et al., 2005), theoretically accommodates an exploration of these factors, it may lack consideration of how cultural, spiritual and religious beliefs can be integrated into treatment (Summerfield and Veale, 2008).

It is pertinent that none of the identified factors reflected a "medical model" understanding of psychosis. Similar to Dudley et al.'s (2009) findings, this suggests that psychosocial rather than biomedical explanations of symptoms are more accessible to this population and perhaps more in line with Ryff and Keyes's (1995) model of wellness. Medical models have attempted to understand how the individual with a psychotic disorder makes sense of their symptoms (Becker and Maimon, 1983). Application of such models may represent a disparity between the views of the ARMS clients who may not view their symptoms as an illness or hold illness beliefs (Kinderman, Setzu, Lobban and Salmon, 2006; McCabe and Priebe, 2004). Indeed, ARMS clients have not typically been given a diagnosis of psychosis and thus an understanding of what "wellness" means to these clients may provide most insight into how this population understand their difficulties. The medical model reflects the dualism of Western beliefs between mind and body, thoughts and emotion and does not accommodate the interconnectedness of mind, body and spirit that permeates non-Western cultural beliefs. This is likely to be particularly important for ARMS clients within this study who are from a non-Western heritage.

Limitations

Whilst the results of the study offer interesting findings, there are limitations that need to be considered. One limitation refers to the sample size and representativeness. According to Stainton Rogers (1995), an "ideal" number of participants has not been identified for use in Q methodology; however, the sample should be large enough to ensure that the subject area has been sufficiently represented and that there is an adequate number for robust statistical analysis. Due to accessibility of participants, this study included 20 participants. Results reported that only 66% of participants ($n = 13$) loaded onto a factor and the number of loadings on factors was relatively low in comparison, for example, with Dudley et al. (2009), in which all participants loaded onto one factor, although different criteria were used. A further limitation related to low numbers and time constraints (this research was part of a doctoral thesis) is the lack of comparison group, which may arguably have added weight to the significance of our findings. A further limitation is the use of the terms Black African and Black Caribbean in reference to participants invited to participate in this study. Whilst this imposes some heterogeneity on the group being researched, it is arguable that, due to the

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constraints of a small sample size, this study was not able to accommodate the vast number of sub-groups under these umbrella terms. Finally, a disproportionate number of females took part in the study (24% male ($n = 4$) 76% female ($n = 16$). It is possible that perceptions of wellness may be influenced by gender. However, this bias is arguably reduced by the methodology of Q, which allows for different "accounts" or "versions" to be reflected within the factor analysis regardless of the numbers of participants that endorse it. Overall, whilst interesting, these findings should be viewed with caution and would benefit from replication with a larger and more clearly defined sample.

Conclusion

Using Q methodology, the current study explored how Black African and Caribbean ARMS clients perceive wellness. Although tentative, results suggest that differences between factors indicate that there may be perceptions of wellness specific to the ARMS Black African and Caribbean community. These seemingly culturally specific perceptions of wellness are distinct from the medical view of wellness promoted within early detection services. It is possible that these differences may impact upon engagement with early detection services and need to be considered as part of the assessment and formulation process. From a clinical perspective, it is arguable that awareness of this may help generate alternative engagement and treatment approaches for these clients. Future research further investigating differing cultural attitudes towards wellness and exploring how culture may impact upon engagement with services may help expand our awareness of how to improve the accessibility of the services we offer.

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Appendix 1. Final list of Q statements

1. When I don't experience racism and discrimination
2. Easier when services understand the impact racism has on me
3. Achieved when I do things just for me
4. Achieved when I do things with and for others
5. Expressed differently in different cultures
6. Is the same for everyone regardless of their culture
7. When I feel a connection to my culture
8. Feeling part of the British culture
9. Feeling part of both my culture of origin and the British culture
10. When I feel socially connected
11. When I have a purpose (job) in society
12. When I feel more control over my life
13. Hard to achieve because of my start in life
14. Improved when I have a better living environment
15. Inseparable from social issues like housing, money, living in an inner city environment etc
16. Easier if I don't experience violence (physical, emotional or sexual)
17. Easier to achieve when professionals understand my cultural, spiritual or religious beliefs
18. When my spirit is well
19. Located in my soul
20. Can be achieved once I am free from witchcraft, negative spirits or supernatural forces
21. Can be achieved through prayer
22. Achieved when I've come through my mental health problems which are a test from God
23. Achieved if I'm protected by deceased loved ones/the spirit world
24. Is achieved through spiritual guidance
25. When things aren't building up in my mind
26. When I stop thinking and feeling certain things
27. When I feel that I know and understand myself
28. Is achieved when I feel better connected to my family
29. When I sort myself out/get a grip
30. When I don't feel under pressure
31. When I'm not stressed
32. When I stop dwelling on things in the past

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33. Something I achieve by smoking weed (or other drugs)
34. Feeling more relaxed
35. When I can block out negative thoughts
36. When I don't take drugs
37. Achieved if professionals have the same understanding of my difficulties as me
38. Achieved when I get used to the idea that I don't have to solve my problems myself and can talk to someone about them
39. Achieved in services where there are professionals from my culture working within them
40. Easier to achieve when services are tailored for people like me
41. Achieved through understanding my difficulties and making sense of them
42. Being able to live successfully despite my problems
43. Eating and sleeping well
44. Getting on well with other people
45. When I stop getting aches and pains in my body
46. Easier when I can talk to someone about my problems
47. Associated with feeling like I belong
48. Is when I don't hear voices (that aren't real)
49. Is when I don't have strange beliefs that no others share
50. When I can balance my spiritual/cultural mind and my more logical Western mind

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