A Qualitative Investigation of the Relationship between Psychosis, Positive Discontinuous Experiences, and Spiritual or Religious Beliefs

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Declaration

This thesis has not been submitted to any other institution or for any other qualification

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Abstract

Literature Review: This review seeks to describe some of the ways that individuals describe their psychotic experiences as shown in 23 papers that have used inductive qualitative methodology. The analyses presented by these papers is synthesised into a possible framework with seven types of theme; Identity Development and Negotiation, Attributions and Explanations for Experiences, Social Context, Emotional Reaction, Timescale, Coping Strategies, and Control. Issues of quality control and study design within qualitative methodologies are discussed.

Research Report: This study aims to explore the relationship between people's psychotic experiences, their explanations, and their spiritual/religious beliefs. Qualitative methodology was used to analyse the transcripts of semi-structured interviews with 8 participants who could be described as having experienced psychosis. The phenomenology of psychotic-type experiences seemed related to people's sense of self and their explanations for the world and their experiences. Spiritual explanations for experiences beyond consensual normality were often used for both positively and negatively appraised experiences. All types of explanation were characterised by sophisticated reasoning, including testing of explanations and biological alternatives. Individuals are concerned with hiding both their experiences and their explanations. Clinicians and services should encourage sharing and acceptance of individual's explanations for their experiences that might draw on religious frameworks and positive experiences.

Critical Reflection: The project's conception and conduction are reflected upon with reference to the author's personal beliefs and the learning that has followed.

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Contents

Inductive Qualitative Research Regarding Psychotic Experiences

A Review and Synthesis of the Recent Literature

Abstract

Clinicians within psychiatric services are encouraged by guidelines to aid service users in developing an understanding of their experiences. This review seeks to describe some of the ways that individuals describe their psychotic experiences. 23 papers that have used inductive qualitative methodology to investigate aspects of such individuals' experience are reviewed. The analyses presented by these papers is synthesised into a possible framework for understanding the issues that appear to be relevant. An arrangement of seven types of theme is suggested; Identity Development and Negotiation, Attributions and Explanations for Experiences, Social Context, Emotional Reaction, Timescale, Coping Strategies, and Control. Issues of quality control and study design within qualitative methodologies are discussed, and the implications of the content within these themes for clinicians and researchers is elaborated upon.

1. Introduction

Current guidelines for working with individuals who have experienced psychosis suggest that services should provide person-centred care helping individuals to understand their condition (NICE, 2002). Therefore, research enhancing our knowledge of how individuals understand their own experiences is important. Qualitative inductive research suits this aim, as its findings are derived primarily from original verbal reports (Smith & Dunworth, 2003).

1.1. Reviewing Qualitative Inductive Methods

A variety of qualitative methodologies exist, with both commonalities and differences in techniques used and epistemology underpinning the methods. This variety presents a challenge to the reviewer. The purpose of review and synthesis is to present an idiographic understanding of the findings from individual research articles, alongside a framework for understanding how the findings might be drawn studies together. The meta-synthesis methods in this review followed Walsh and Downe (2005), who recognise the methodological and epistemological contrasts between qualitative studies, and the resulting difficulties with the suggestion that such studies can be compared. However, Walsh and Downe recognise the danger that such positions can become isolationist, and increase the marginalisation of qualitative research within the evidence base. They advice that authors of meta-syntheses should include papers from a multitude of viewpoints and synthesise them in an interpretative manner, but should remain reflexive of their own position in making such decisions, and acknowledge these processes within the review.

The context for this review is a philosophy which comes predominantly from the writings on Interpretative Phenomenological Analysis (IPA; Smith, 2004). This suggests realist ontology (there is a real and objectively true world that does exist) alongside relativist phenomenological epistemology (the meaning of reality is dependent upon our view of it, and the nature of our engagement with it). IPA tries to understand individuals' relativist understandings of experiences through systematic analysis of first-hand accounts, producing findings that are meant to be grounded in these accounts whilst simultaneously recognising the inevitable process of interpretations made by the researcher.

Some of the qualitative research with psychosis has an underlying epistemology that fits this position closely, having a clearly identified phenomenological position (e.g. Koivisto et al., 2002; Hsiao, 2006). However, there are other examples of different philosophies; Grounded Theory studies (e.g. Roberston & Lyons, 2003; Stanghellini & Ballerinin, 2006) typically hold a less relativist position, believing more in the possibility of explaining something as objectively true; Discourse Analysis studies (e.g. Messari & Hallam, 2003) would be more relativist, seeking to explain the resources used to describe something without necessarily believing in an objective truth to the accounts. In deciding whether to include papers based on such contrasting epistemologies, any study (subject to the quality control criteria below) which used first-hand accounts as a primary source of data from which a synthesis of themes was derived from within a given sample of people was considered to fit with the authors' epistemology, and was included in this article. However, by translating said themes into a synthesis using the author's epistemology, the intentions of the original authors may not have been entirely fulfilled. This decision avoided disregarding valuable material, but should be considered by the reader throughout the following article.

Most studies employed the procedure of identifying a relevant sample and interviewing them with a loosely structured schedule. Transcripts were analysed through a process of coding data from small sections of the transcripts up to more general themes or categories, presenting a framework for understanding the meaning within the participants' accounts. There were examples of other techniques, such as analysis of written materials (Lobban & Barrowclough, 2005; Geanellos, 2005), and use of focus groups (e.g. Lloyd et al., 2005). Such differences in methodologies will often create a different kind of data by nature of their approach or recruitment strategy. For example, Geanellos studied first person accounts published within a professional journal. Such participants might be assumed to be well functioning in order to coherently write and submit such accounts; therefore, elements of *fragmentation* and *disintegration* described in the study (and discussed below) would most likely have been recall, rather than descriptions of currently lived experience. It also suggests that the representativeness of these accounts to individuals who have not been able to approach this level of functioning might be lower. However, a benefit of such methodology is that participant accounts were unstructured by research aims, as they had not been produced with this purpose in mind. Such issues need consideration in comparing the following studies, and were also the grounds for exclusion of some studies. For example, *ethnographic* studies, which draw their analyses from an author's immersion in the context of the study, and are less reliant on direct inductive analysis of first-hand accounts, were considered too different from the other studies to be included, though they have a different value in their own right. Similarly, case studies were excluded where they were presented primarily as a clinician's considerations rather than a rigorously analysed data source.

1.3. Quality Control

Whilst guidelines for assessing quality in qualitative research do exist (e.g. Dixon-Woods et al., 2004; Yardley, 2000), there will never be a definitive gold standard of a perfectly valid study, because the nature of the concepts underlying the processes deny the option of being able to measure an objective truth. Nevertheless, studies can be subject to quality control by assessing whether techniques used increase the trustworthiness of the analysis, leaving the reader confident that the analysis presented represents the thoughts of the participants that would have been present in the original data sources.

Good examples of these quality control methods exist within some of the papers reviewed. There was the use of member checking (respondent validation), in which the analysis is shared back with the participants to ensure that the interpretations being made by the researchers adequately represent the meanings of the participants (e.g. Drinnan & Lavender, 2006; El-Mallakh, 2006). A similar technique is professional validation. Here the researchers take their analysis outside of the immediate research team to other professionals with knowledge of either the methodology or the literature and clinical issues in the field, using this resource to check whether the route of the analysis seems understandable and genuine (e.g. Lobban & Barrowclough, 2005; Rice, 2006).

The process of taking the idiographic findings from individuals into a more general account of the sample is sometimes seen to depend upon the concept of homogeneity within the sample. Kinderman et al. (2006) showed how to put this concept into practice, noticing differences at the early stages of analysis between inpatients and outpatients in their sample, and responding by choosing to treat them as two separate homogenous samples for the sake of data validity. Responsiveness in this manner is to be encouraged.

A key tool for a qualitative researcher is the process of reflexivity. This is the way in which the researcher critically appraises the approach they are taking (often through peer supervision) in order to notice and adjust to problems such as bias in analysis. This aspect is frequently mentioned in papers but rarely seen in action; Kilkku et al. (2003) are therefore to be commended for reporting on difficulties they recognised within their inductive reasoning in the first few interviews, and adjusting as a result.

There are other examples of places where quality control could have been improved. One example, perhaps particularly within the field of psychosis and not specific to qualitative research, is sampling methodology that creates barriers to individuals taking part whose experiences may be as valid. Examples include recruitment solely through mental health professionals, or through individuals accessing particular services (e.g. Drinnan & Lavender, 2006). Such processes (with the obvious exceptions, such as discussing the experience of being in mental health services) might only allow people access to the project when their professional worker deems it appropriate. They might also inadvertently insist that the participant has a level of acceptance of the need for treatment or a medicalised label. This can skew samples in ways that are inconsistent with the inclusive and democratic philosophies often cited in qualitative literature.

Another example of a procedure that raises questions about quality is when interview techniques described do not appear best suited to allowing participants' accounts to be freely given. Whilst open-ended questioning is widely employed, an interview described simply as "unstructured" is likely to be subject to some implicit interviewer direction when it is located within a research project that has specific aims (e.g. McCann & Clark, 2004). In such cases, examples are needed of how interviewers do not unduly direct participants.

A limitation that can exist in qualitative research, as discussed below with regards to MacDonald et al.'s (2005) study, is that it often requires individuals to have a high enough level of verbal ability to provide data "rich" enough for analysis; this can be contrasted with quantitative studies which, for all the comparative limitations of forced choice questionnaires or observation-based studies, could be more user-friendly for participants with less verbal ability. As a result, there is some doubt about the extent to which many of the studies reviewed reflect the spectrum of experiences of people who have experienced psychosis. This is due to the difficulty in avoiding recruitment biases towards 1) verbally able people who are able to coherently share their narrative, and 2) people who would not necessarily be considered to represent a state of large-scale current distress from their experiences (e.g. Drinnan & Lavender, 2006, who excluded people who were currently experiencing acute difficulties). However, it should be noted that Smith (2004) advocates IPA in particular as an approach that can be adapted for use with a groups with varied language skills. Nevertheless, readers of qualitative research with psychosis should remain aware of these potential limits.

The difficulties of trying to condense the salient points from transcripts of anything up to 50 participants means that no author can ever fully demonstrate the genuine extent to which their article reflects inductive analysis grounded in the data. However, even with this in mind, it is this author’s opinion that some of the studies examined for this review left too many doubts about the process to be fully considered as genuine reflections, and were so excluded. One example is Spaniol, Wewiorski, Gagne and Anthony (2002), which did present itself as a reflective inductive study. However, the details of analysis process did not suggest that analysis represented an element of participants’ understandings (e.g. interview overviews of “key information” were apparently analysed rather than direct transcriptions). Instead, the themes reported appeared to represent clinical opinions rather than a reflection of the meanings attributed by participants (one example was the reporting of a theme of timescale that was not taken from accounts at all, but rather the self-help literature). Similar exclusions were made of papers which did not have an audit trail that included the first-hand accounts that were being analysed. For example, Navon and Ozer (2003) relied on comprehensive interviewer notes, which would depend on the ability to faithfully represent an interview in this manner, a difficult task without automatically beginning a level of filtering about what interests the interviewer personally has. Similarly difficult, Stanghellini and Ballerini, (2006) had their main data source as therapeutic notes; the likelihood of those notes, written in a non-research context and for different ethical and legal reasons, being as accurate and untainted a representation of the participants' accounts from which the researcher can faithfully inductively analyse as interview transcripts is low, and so this paper could not be included. However, the author accepts that these three exclusion decisions represent a quality barrier that is individual to their own concepts.

1.4. Article Aims

This article has two intentions with regard to recent peer-reviewed inductive qualitative studies with people who have experienced psychotic episodes. The literature is both reviewed, by assessing and discussing the detail and quality of papers and relating them to other literature in the field, and also synthesised, by presenting a framework for understanding the papers that represents this author's understanding of commonalities between the findings, whilst recognising hermeneutic difficulties discussed above.

Adopting the position of Division of Clinical Psychology (BPS, 2000), literature is included which has sought to understand psychotic experiences without necessarily applying specific psychiatric diagnostic criteria; studies which have recruited based on diagnosis included schizophrenia, bipolar disorder, and similar conditions. The use of inductive techniques with this population has increased in recent years; this article therefore focussed on the recent burst of literature within a five year time frame.

The selection of inductive qualitative studies that fit with the author's epistemology as described above is not intended to suggest a superiority of these studies over other qualitative studies or positivist quantitative research; this synthesis is simply intended to provide an understanding of a specific section of literature that has a unique, but not comprehensive, contribution to make to the understanding of psychosis and how individuals relate their experiences.

1.5. Methods

Papers were identified by a search of the databases Medline and Psychinfo. Search terms within titles, abstracts, and keywords used a combination of schizophreni* OR psychotic* OR psychosis* OR psychoses* OR schizotypy* with understand* OR concept* OR framework* OR attribution* OR illness belief* OR health belief*. This search was limited by English language, journal articles, and publication from 2002 to 2006[1] inclusive. Prompts for appraising qualitative research suggested by both Dixon-Woods, Shaw, Agarwal and Smith (2004) and Yardley (2000) were used to inform the review and inclusion of papers, followed by a hermeneutic decision that the papers' methods and findings corresponded to the reviewer's research epistemology about inductive analysis.

Papers identified had varied aims, but all reported an aspect of the participants' unusual experiences. Studies with aims related primarily to treatment (e.g. experience of

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[1] The review focussed on this five year period as it captures a recent "burst" of qualitative literature in the field, which was identified by a paucity of references using the same criteria for earlier time-frames.

therapy) were reviewed to ascertain whether experience-related phenomenology was included, but themes directly relating to treatment and services were not included.

The suggestions of Walsh and Downe (2005) have been followed in the process of this synthesis. Separate themes from each paper are categorised below according to the author’s perception of relationships between them; where different themes from one paper are included in more than one category, readers are directed to the earlier reference for details of study methodology.

2. Themes Reported

The themes discussed below are the primary themes reported by the authors of the selected papers, as the minutiae of detail reported in papers could not be fully integrated in this review.

2.1. Identity Development and Negotiation

A number of analyses discussed aspects of the participants’ sense of identity (ways in which the person defined themselves), and ways in which it was affected by or related to psychotic experiences.

Geanellos (2005) found that psychotic experiences appeared to disrupt the individual’s pre-psychosis identity. The analysis of first person accounts published within *Schizophrenia Bulletin* over 13 years derived four themes, all apparently related to the individuals’ identity; *fragmentation*, *disintegration*, *reintegration*, and *reconstruction*. Although a thorough reflexive process was described, Geanellos did not indicate having shared analysis with others as part of this process, which can improve the perceived trustworthiness of analyses.

Change in identity was also discussed by Robertson and Lyons (2003). They interviewed ten women with a diagnosis of puerperal psychosis, asking about the effects on social relationships, understanding and explanation of what caused the illness, experiences of treatment, and decisions about further children. A higher order concept identified was that women had to determine how to negotiate through *regaining and changing self*. A common description used was “life-changing experience”. They also identified a major category as *loss*, including losses related to control, motherhood, mother/child relationship, and further pregnancies - these could all relate to the participants’ sense of identity. Unfortunately, this paper also failed to explicitly describe reflexive approaches. Koivisto, Janhonen and Vaisanen (2002) also discussed identity change, reporting on an analysis of nine interviews with individuals recovering from psychosis on acute psychiatric wards. They reported *feelings of changing one’s self* as one of the main themes derived by analysis - unfortunately, as this article was written more for the purpose of illustrating qualitative techniques to nursing colleagues, the meanings of the analysis were not well specified, (e.g. no examples of data were included).

Wagner and King’s (2004) study suggests that psychotic experiences could leave individuals feeling their opportunities for growth are limited. They conducted focus groups with 24 individuals with defined psychiatric diagnoses related to psychosis. One of the key themes emerging from their investigation of the existential needs and experiences of this sample was *need for personal development*, participants often having felt “moored” by their experiences. They also described the *need for integrity of the self* having been shaken by their experiences. By separately analysing transcripts before discussing differences between their findings, the reliability of this study is enhanced.

Beyond feeling held back, Lloyd, Sullivan and Williams’ (2005) findings suggest that people feel that psychotic experiences take away elements of their identity. They conducted a focus group with six young men with a diagnosis of a psychotic disorder, who had participated in a social skills training program. The group were asked about the experience of mental illness and aspects of social relationships associated with the condition. The *change in self-perception* described by this group related partly to changing their goals (for example no longer expecting similar standards when forming relationships), and also a decreased sense of self-worth; notably this analysis was discussed back with the original participants, which suggests an analysis that captured participants' meaning well.

Identity can also be affected in terms of people's future expectations. Rice (2006) and a research team of mixed professions analysed interviews with nine women who reported a diagnosis of schizophrenia and a history of violence. The sample all related *foreclosing a future of possibilities* to schizophrenia. The use of mixed professions is reflected to have reduced the level of assumptions within the analysis. McCann and Clark (2004) reported similar findings from their "unstructured" (p.786) interviews with nine individuals with a diagnosis of schizophrenia, asking what it was like to be a young adult living with schizophrenia. A primary theme, *embodied temporality: illness as a catastrophic experience,* related to effects on them presently and their uncertainty about future effects. Although the analysis was apparently reflexive, the lack of structure to the interviews raises questions about how inadvertent bias was avoided.

Werbart and Levander (2005) suggest that psychosis can leave some individuals feeling a sense of loss to their identity, but others with opportunities for change. They conducted three interviews every four months with 12 dyads of therapists and clients who had experienced either their first episode or long-term psychosis. Analysis was carried out by three psychoanalytically trained researchers. Participants presented *two patterns of recovery from psychosis*; one set responded to the psychotic experiences as a "hole" in meaning that required either bridging or sealing over. A second set conceptualised the experience as something that needed integration into the participant's existing context of meaning. This pattern of change over time is a less usual, but welcome, method in qualitative research.

Kinderman, Setzu, Lobban and Salmon's (2006) analysis discusses *the inseparability of illness from patients' identity* in the immediacy of psychosis. They interviewed 20 individuals with a diagnosis of schizophrenia from inpatient and outpatient sources, exploring participants' beliefs about entering psychiatric care and various other aspects of their experience. The inpatient sample of 10 described their illness and identity as inseparable, which contrasted with the outpatient sample's *separation of current self from past experiences*. However, the outpatients were more likely to have adopted an expectation of *hopelessness and resignation*. This study described a comprehensive reflexive cycle, part of which included testing ideas from early analyses in later interviews.

The relationship of experiences and identity conceptualised the entire findings of Drinnan and Lavender (2006). In their analysis of interviews with individuals who had experienced religious delusions, they suggested that all of their three major themes could be described in terms of *negotiating identity*. A major theme of *personal identity development* was not expanded upon due to study aims. The interaction between experiences and beliefs suggested that the formation of the individual's *religious identity development* was an interactive process. Whilst strengths of this study included participant corroboration of analyses, the recruitment strategy (community team clients not currently experiencing acute difficulties) was not inclusive enough of the potential sample relevant to their aims.

2.2 Attributions and Explanations for Experiences

Clinicians and researcher working within the field of psychosis often consider *insight* as part of their work; although the complexity of the concept is recognised in some forums (e.g. Dam, 2006), the concept is sometimes considered simply to relate to the awareness that one is ill and in need of treatment (e.g. Goodman, Knoll, Isakov & Silver, 2005). Concentration on people's acceptance of such medical explanations could miss the importance of people's own explanations. The following papers discussed such attributions and explanatory models.

There is evidence in this literature that people who have experienced psychosis are often well able to develop explanations for their experience. Within *finding meaning in symptoms*, Rice's (2006, see above) sample of women who had a history of violence and a schizophrenia diagnosis all related the psychosis as closely aligned to their history of violence. This included reliving the experience, or as a contextual meaning to their identity (e.g. feeling that the psychosis was telling her that she was taken advantage of).

Explanations can have flexibility, such as in Kinderman et al. (2006, see above). When interviewing individuals with a diagnosis of schizophrenia, they reported that within the inpatient sample, there appeared to be both *flexibility and uncertainty of beliefs* about the causes of their experiences, one individual able to hold a number of explanations simultaneously. Werbart and Levander (2005, see above) also noted that each of the clients in their therapist-client dyads held multiple theories to explain their problems. Messari and Hallam (2003) interviewed five participants', all diagnosed with paranoid schizophrenia, regarding the use of CBT. Two themes noted were the potentially contradictory positions of *this is truly happening* versus *I am ill*. The authors described this as representing a double awareness of their beliefs, illustrating the complexity with which individuals can explain their experiences. This study also described comprehensive reflexive processes that included discussion of analysis with peers.

Another main theme that Kinderman et al. (2006) found within the inpatient sample was the *social dimensions of illness labels*. When labels were used by the professional interviewer they were apparently perceived as more pejorative than when used by participants themselves. There was apparent sophistication in the attributions made by the outpatient sample, including discussion of a link between *the social and psychological elements of illness labels*. The relationship between individual and service explanatory frameworks was also described by Duggins and Shaw (2006). They interviewed 10 people with a diagnosis of schizophrenia with a schedule that was primarily interested in the participants' experiences and satisfaction with a ward stay. The theme of *internal factors* suggested that satisfaction with treatment was partly determined by the level of concordance between the service's explanations for their experiences and the participants' explanatory framework. This study addressed validity primarily through shared analysis within a research team.

The complexity of explanatory frameworks might increase when cultural factors are also considered. Hsiao, Klimidis, Minas and Tan (2006) interviewed 28 Chinese-Australian (immigrant or first generation) participants diagnosed with a mental disorder, asking them about their problems and the attributions made. Themes reported included a *coexistence of traditional Chinese and Western categories of psychosis*, such as convergence of the two areas (e.g. the idea that Schizophrenia is a basic imbalance of Yin and Yang). However, because some Chinese concepts apparently recognise only a limited number of conditions as mental illness, *modified traditional Chinese categories of psychosis* meant description of some psychotic experiences as "psychological problems" rather than "illness". Attributions were also apparently affected by the extent to which participants were *accepting western medical categories of non-psychotic illness*.

The explanations above include biological elements, and it appears that sometimes the biomedical model is the preferred attribution. For example, when Robertson and Lyons (2003, see above) interviewed ten women with a diagnosis of puerperal psychosis, they identified a major category as the concept of puerperal psychosis as a *separate form of mental illness*, partly because all women made biological attributions of causality (i.e. childbirth).

The phenomenology of psychotic experiences may inform the choice of explanation. Garret and Silva (2003) investigated phenomenology and attributions using a mixed methods approach to understand how 41 acute inpatient participants described and explained their experiences of hearing voices. Responses were categorised according to both their association with a Source Monitoring Framework and inductively derived descriptors. Most participants considered the voices to represent individual entities, and the majority of the ten inductively derived items were described by participants in terms that explained why the voices were real to them (e.g. the fact that the voices predicted the future proved their reality and independence).

Related to the attributions made by people for their experiences, Lobban and Barrowclough (2005) investigated the extent to which participant perceptions of schizophrenia could be mapped onto a pre-existing model of illness perceptions. In a mixed-methods approach, a group of individuals who had been given a schizophrenia diagnosis wrote responses to the question “What do you understand by the term Schizophrenia?” Statements within the responses were categorised using an a priori coding system derived from the Illness Perception Questionnaire. Three dimensions appeared most relevant to this sample in understanding the term, being Symptoms (37%

of the statements), Consequences (19%) and Labels (16%). The question format means that responses were made to the understanding of a label in general, rather than more an understanding of the participant's own experiences, although one might expect that at least some of the participants would have responded in this manner.

In a similar manner, studies can find people's accounts of their experiences as embodied within the options for treatment available. For McCann and Clark (2004, see above), one of the primary themes was *embodied treatment: medication side effects as burdensome*.

2.3. Social Context

Given that people can experience psychosis as a challenge to the nature of their identity, it is perhaps unsurprising that some studies have discussed the way in which psychotic experiences affect the social context in which the people lived.

The analyses within a couple of papers appeared to show how participants' sense of identity could be closely tied to their social context. For Wagner and King (2004, see above) a number of the key themes emerging from their investigation of the existential needs and experiences of this sample appeared related to social context - *need to win respect and avoid shame*, *need for autonomy*, *need for love*, and *need for acceptance and understanding*.

An example of how participants relate their social lives was Macdonald, Sauer, Howie and Albiston (2005), whose research aims were exclusively related to social matters. They interviewed six people aged 19-26 who were participating in a recovery program and had experienced their first episode of psychosis, with an interview schedule that discussed their social relationships since the episode. Five themes were identified in the accounts; *hanging out with people I like and who understand me*, *valuing families and other supports*, *spending less time with old friends*, *something* *happened to me - being different now*, and *building new relationships*. Across these themes, a crucial ingredient in socialising appeared to be being understood by people, which often meant being with people who had similar experiences and drifting away from old friends. It is interesting to note that there were a number of positively appraised elements recorded from this analysis, although selection of individuals who were actively engaged in a group activity around recovery may have influenced the likelihood of such findings. Similarly, participants were purposively selected for their articulacy and ability to give detailed descriptions, which may have meant selection of participants more likely to be able to successfully negotiate social circumstances anyway. This study described a comprehensive reflexive process, but made the questionable decision to avoid member checking of analysis; the rationale, that changes in participants' live and mental states may have introduced new data rather than allowing the interpretations to stand, is questionable.

Being understood as a relevant factor was also found in the Robertson and Lyons (2003, see above) study of interviews with ten women who had received a diagnosis of puerperal psychosis. They identified a major category as the effect of the psychosis on *relationships and social roles*, including husbands and friends. The level of understanding apparently affected the amount to which friends were able to cope with the participants' experiences.

There are also examples of how participants appear to have experienced the negatives effects on their relationships in the context of their psychotic experiences. Drinnan and Lavender (2006, see above) reported on a primary social theme related to the *social context and triggers for psychological difficulties*. Their participants described family difficulties, generally negative social relationships, and drew links between these difficulties and their experiences. A factor in participant's accounts of negative relationships appeared to sometimes include the role of stigma. Rice’s (2006, see above) study with women who reported schizophrenia and violence described a major theme related to the women’s experiences of *being stigmatized.* All participants used the term without prompting from the interviewer, and related stigma to both negative aspects of the schizophrenia label and the history of violence. Lloyd et al. (2005, see above) reported that their group described how *stigma* affected their relationships, making many of them more superficial. They also described having less to say within the family due to their diagnosis.

The concept of stigma for this group appears to be multi-dimensional. Schulze and Angermeyer (2003) conducted focus groups with 25 individuals with a diagnosis of schizophrenia, asking about their experiences of stigma. One dimension of stigma identified was in terms of *interpersonal interaction*, and finding that previously good relationships were now broken due, in their view, to the lack of understanding of what the diagnosis meant. They related this to their awareness of discrimination in *public images of mental illness*. They also described stigma in relation to imbalances and injustices suggestive of social *structural discrimination*, and their perception of reduced their *access to of social roles*. This analysis came from a rigorously reflexive process involving repeated peer supervision to corroborate the analysis.

A balance of positive and negative social contexts is found in the analysis of McCann and Clark (2004, see above). A primary theme is labelled *embodied relationality: illness as a mediator of social relationships*. The young adults interviewed discussed the issues around revealing their diagnosis to others, living with unsupportive family, and the supportive nature of a network of friends. Similarly, there appear to be differences between participants; Forchuk, Jewell, Tweedell and Steinnagel (2003) interviewed 15 individuals who had experienced psychosis, and had started a new course of atypical antipsychotic medication. Major themes identified included participants' *relationship with staff* at hospital, and *relationship with family*. Within these themes, a number of participants apparently reported superficial or limited relationships, whilst others reported an improvement in relationships as they experienced an improvement in their experiences. The briefly described methodology does suggest that inductive processes were followed in this analysis. The process described of testing analysis by seeking to achieve saturation in data through testing themes with new participants also suggests that validity checks were in hand. However, there is no explicit discussion of corroboration of the analysis by other individuals.

A final element to the social context was the effect that this can have on the process of accessing services. Boydell, Gladstone and Volpe (2006) performed a secondary analysis (on data that had been gathered for the purposes of studying motivation in Schizophrenia) for interviews with 8 young people who had recently had their first episode of psychosis. The analysis was directed towards looking for evidence of how participants discussed help-seeking behaviours. One main theme was *help-seeking: the role of significant others*, suggesting the importance of family and friends in starting the process. This study reported rigorous analysis and cross-checking of analysis for validation

2.4 Emotional Reaction

Some studies found that participants related their psychotic experiences to emotional responses. This was explicit in Koivisto et al. (2002, see above) who reported *emotional feelings*, all implicit of negative distress, as one of the main themes derived by their (minimistically described) analysis. Similarly, when Robertson and Lyons (2003, see above) interviewed ten women who had received a diagnosis of puerperal psychosis, they identified a higher order concept of learning about *living with emotions*.

These emotions included guilt, fear, and anger. Anticipatory fear was described by Marland and Cash (2005), whose study sought to understand the medicine-taking decisions of 16 individuals with a schizophrenia diagnosis. They found that psychotic experiences were often followed by *fear* of the experiences returning. However, their comparison with individuals with diagnoses of asthma and epilepsy suggested that this experience was not an unusual to psychosis. Their Grounded Theory approach saw interviews and analysis carried out contemporaneously, so that analytic ideas could be checked against later participants. However, there was little discussion made of attempts to ensure analytic validity.

2.5. Timescale

Some papers suggested that participants' conceptualise their experiences in terms of the passage of time in relation to the experiences. This can include the different experiences or tasks that face them at each of those stages. Kilkku, Munnukka and Lehtinen (2003) investigated this with relation to the early stages of the experiences. They interviewed seven people who had recently experienced a first psychotic episode and were in contact with health services, but were not currently in the acute stages. The authors presented *the experience of psychosis* according to their participants as a move from a long lasting, exhausting situation in life, to extinction of their own resources, to the frightening psychotic experiences to admission for services. The process of analysis was comprehensively described in this study, and an example of how the researchers reflexivity informed the redression of bias in their process was reported. However, no checks from other interested parties appear to have been systematically sought for the analysis.

Ko, Yeh, Hsu, Chung and Yen (2006) described how participants relate the temporality of their experiences to moving beyond the frightening experiences of the acute stages. They were interested in the process of insight formation, and interviewed 50 individuals from an outpatient clinic in Taiwan with a diagnosis of schizophrenia, asking about their experiences and whether they viewed their problems as an illness. Narrative analysis was used to investigate the transcripts. They reported participants as describing a process which involved going through the stages of firstly *feeling that symptoms are unbearable or a loss of control,* secondly making *comparison of experiences with references* to others, thirdly, the *perception that medication works through trial and error experiments,* and finally *awareness of illness after medication relieves symptoms*. Issues of quality control by standard narrative analysis criteria were addresses, and peers audited the analysis. However, it should be noted that the authors were primarily concerned with insight as a major aim, and measured insight using the Schedule of Assessment of Insight as part of the research procedure. This evidences the presence of a significant a priori concept, but no bracketing procedures were described to monitor the effect this might have had on the analysis.

Another example of how moving through stages involved a change in their relationship to the experiences was El-Mallakh (2006). Repeated interviews were conducted with eleven individuals with co morbid diagnoses of schizophrenia or schizoaffective disorder and diabetes. El-Mallakh developed a model which explained participants' accounts in terms of an evolution of self care. The first stage of this model was described as *mastering mental illness*, which involved *acknowledging vulnerability to mental illness* and then *maintaining stability*. It was only following this stage that participants could begin *accommodating diabetes,* part of which included *applying acquired knowledge of mental illness to diabetes care.*; upon accommodating diabetes, they could then begin *striving for health*, and discussed *taking responsibility, hoping* and *doing my best* as main themes within that. A comprehensive reflexive and inductive process was reported, and trustworthiness of findings was ascertained through checking back with respondents.

2.6. Coping Strategies

This category is reported more because of the limited extent to which concepts that were thought of as coping strategies were reported; this contrasts with what might be expected from the general literature in the field of psychosis. Elements that might be thought of as coping strategies were found in Boydell et al. (2006, see above), who described a main theme of reactions to *first signs of psychosis: ignoring, denying, lack of understanding*. A similar example of participants describing a way that they tried to deal with their experiences was in Wagner and King (2004, see above), who reported how a few individuals discussed their faith that God would help doctors to find a cure for their disorder.

2.7. Control

One of the phenomenological aspects that was touched on in a few papers was the way in which participants sometimes related their experiences to a loss of control. Lloyd et al. (2005, see above) found that one main theme was *loss of control*, which was related to both the amount of say that they had in treatment, and their general control over their lives. Koivisto et al. (2002, see above) also reported *feelings of a loss of control* as one of the main themes derived by their (minimistically described) analysis.

3. Summary, Conclusions and Implications

This interpretation of the recent burst of published inductive analysis in the field of psychosis suggests that there could be seven categories within which the findings could be organised: identity, attributions, social context, emotional reaction, timescale, coping strategies, and control.

Regarding identity, psychotic experiences may mean that the individual goes through a process of fragmentation and rebuilding of the pre-psychosis identity. Individuals can feel their identity changes as a result of the experience, but might also feel that their opportunities for growth within their identity have been stifled, or perhaps even that they have somehow lost aspects of their identity or that their expectations for the future are limited. It can be hard for individuals in the early stages of a particularly strong psychotic experience to separate themselves from these experiences. These findings from analysis of the accounts of such individuals corresponds closely to recent theoretical articles which have related the phenomenology of psychosis as representing a collapse in the internal and external dialogue that creates the sense of self (Lysaker and Lysaker, 2001 & 2004), and suggest that the process of recovery in therapy is dependent upon a rebuilding of such dialogue. The way in which psychosis can appear to affect the very core of personhood in these ways should be a solemn reminder to the professional that they should neither underestimate the potential fragility of the individual following these experiences, nor the importance of its meaning to them. These findings may also point to useful avenues of therapeutic enquiry for the practising therapist.

Regarding attributions for the experiences, there is evidence that the methods used by individuals can be coherent, complex, flexible, culturally informed, and drawn from a variety of types of explanation including the biological framework. Accepting psychiatric labels might still feel different when used by the individual rather than a professional, but can be organised into understandings based on similar models to other medical conditions, the most salient perhaps being symptoms, consequences, and labels. There is also evidence that the attributions can be marked by a level of self-responsibility. These examples of the ways in which individuals develop and hold different attributions about their experiences is particularly relevant in light of the increasing use of cognitive therapies with this population; for example, Birchwood and Spencer (2001) in their review of early intervention strategies describe a cognitive model for which the attributions play an important role. Such ideas inform therapeutic models, such as Addington and Haarmans (2006), who describe a second stage to therapy that includes considering personal explanatory models of psychosis. There is also relevance to the insight literature which, although often recognising insight as a complex concept, does still tend to suggest that patient attributions can be considered to either show insight into the biomedical nature or lack it (Dam, 2006). The inductive findings described above suggest that people's explanatory frameworks need to be treated with respect and utilised within psychotherapy, as they can represent advanced psychological reasoning rather than the assumed misunderstanding that could be implied by terminology such as "lack of insight".

Regarding the social context, there is evidence in these analyses that many of the needs of relationships are similar for this group as they might intuitively be for many others (e.g. winning respect and avoiding shame, need for autonomy, need for love, need for acceptance and understanding), although a particular emphasis might be on the need to be understood within their relationships. Some people are also aware of the stigma there might be around their experiences, and hold a multi-dimensional understanding of how this affects their relationships and wider social issues. There is evidence of people discussing positive as well as negative aspects of relationships within the context of psychotic experiences, and some people also recognise the role that family members had within their process of seeking help for their experiences. These findings are relevant to the literature that discusses how social difficulties are frequently part of the clinical picture for individuals experiencing psychosis, perhaps as a result of neurodevelopmental factors (Cornblatt et al, 2003), suggesting that intervening with social issues, particularly at an early stage, could be an important clinical task (Cornblatt et al, 2007). Similarly, the apparent importance of social context within this sample suggests that a systemic approach, which includes consideration of how the individual can relate and operate within their wider social network, would be a useful philosophy to adopt. The findings related to the individuals' sense of stigma also reinforce the current drivers to improve public knowledge and understanding of such experiences.

Emotional reactions to the psychotic experiences appear to mostly fall into the more negatively appraised type. Analyses have suggested that distress, guilt, fear, anger, and anticipatory fear might all be present for within this group of people. Such findings might imply that therapeutic goals could prioritise addressing emotional distress over developing a coherent understanding for the individuals, although naturally there are many ways in which the two concepts would overlap. Such issues have been discussed recently by Kuipers et al (2006), who suggest that emotional changes within psychosis are an under-recognised element within treatment models but have a strong impact upon the phenomenology of the experiences, and so should form a core part of cognitive therapy with this population.

Regarding timescale, it appears that some people conceptualise their experiences in a way that illustrates changes over time, or movement through stages. As well as some of the changes in sense of identity over time described above, accounts include descriptions of the initial journey moving from long lasting exhaustion through loss of resources to fear in the experience. There is also evidence that when investigated using a medical approach, the period leading up to acceptance of medication can involve movement through stages – unbearable symptoms, making reference to others, trial and error with medication, and recognition of an illness. For individuals managing a physical health condition alongside their psychotic experiences, there may also be a stage process of first, mastering their experiences, second, accommodating the physical health condition, and finally, striving for health. One implication of this sense that a change over time is relevant to individuals is that the services working with them should ensure that they are aware of the different issues that might be relevant for the individual as time passes. This information that people can reach a sense of mastery following the experiences could also be a positive story to share with people who are in the earlier stages of the experiences. This also fits with models of therapy described for psychosis (e.g. Cornblatt et al, 2007) which describe a staged model of therapy that recognises the different stages at which individuals might be functioning.

Coping strategies are not widely reported within these analyses; however, some people reported a reaction to their experiences that suggested they first sought to ignore, deny, or hide their experience, whilst others discussed trusting in God that the doctors would find a cure for them. The limited extent to which these have been found in these accounts may represent a higher importance of understanding the experiences over actively dealing with them; however, it may also be that participants in these studies had not been sufficiently aided in finding coping strategies, or perhaps that some of the methodology was not developed in a way that would necessarily allow such issues to be discussed. It would certainly seem a surprise that the topic did not arise more given other evidence that nearly all individuals with psychosis apparently have a certain level of natural coping (see Farhall, Greenwood, and Jackson, 2007, for a review). Given that certain avenues of psychotherapy with this population actively focus on coping strategies (e.g. Tarrier, 2002), this might be an area where a focussed qualitative study could be an appropriate avenue.

The issue of control is also not widely discussed in the papers reviewed, but it is suggested that people feel that loss of control can be an important consideration, relating it to both their say in treatment and general control in their life. As with coping, it might be a surprise that control was not discussed more given the link between locus of control and symptomatology found in other literature (e.g. Jones & Ferynough, 2007), and further focussed qualitative research might therefore be appropriate. The possibility that this is a salient issue for this group might suggest that the service providers should reflect on how much their service offers people a sense of control, and seek to amplify the parts that could encourage this sense within individuals.

The range of studies reported have all in some sense sought to understand and report on aspects of the psychotic experiences that are salient to those who experience them. The findings suggest that the mental health clinician seeking to share in or develop an understanding of the lived experience of those who they seek to help should be constantly aware that the experience is multi-faceted.

The value of the findings from studies such as these also point to the importance of conductive qualitative research with people who have experienced psychosis. It is suggested that despite discussions about avoiding reductive categories of psychiatric diagnosis, the current literature remains focussed on such populations as a result of the recruitment strategies employed. Further research might therefore seek to investigate the issues which have been raised within limited populations in the wider population of individuals who have had psychotic experiences, but remained outside of psychiatric services. Qualitative explorations might also continue to examine the factors that determine how individuals make certain attributions for their experiences. A limitation of this review is that by focussing on the recent literature, there may be other themes of relevance in the earlier literature that could provide additional ideas about the lived experience of individuals who have experienced psychosis; further review of this literature may therefore be valuable.

References

Addington, J., & Haarmans, M. (2006). Cognitive-Behavioral Therapy for individuals recovering from a first episode of psychosis. *Journal of Contemporary Psychotherapy, 36,* 43-49.

Birchwood, M., & Spencer, E. (2001). Early intervention in psychotic relapse. *Clinical Psychology Review, 21,* 1211-1266.

Boydell, K. M., Gladstone, B. M., & Volpe, T. (2006). Understanding help seeking delay in the prodrome to first episode psychosis: A secondary analysis of the perspectives of young people. *Psychiatric Rehabilitation Journal, 30,* 54-60.

British Psychological Society (2000). Recent Advances In Understanding Mental Illness And Psychotic Experiences: A Report By The British Psychological Society, Division Of Clinical Psychology. Leicester: BPS.

Cornblatt, B. A., Auther, A. M., Niendam T., Smith, C. W., Zinberg, J., Bearden, C. E., & Cannon, T. D. (2007). Preliminary findings for two new measures of social and role functioning in the prodromal phase of schizophrenia. *Schizophrenia Bulletin, 33,* 688–702.

Cornblatt, B. A., Lencz, T., Smith, C. W., Correl, C. U., Auther, A. M., & Nakayama, E. (2003). The schizophrenia prodrome revisited: A neurodevelopmental perspective. *Schizophrenia Bulletin, 29,* 633-351

Dixon-Woods, M., Shaw, R. L., Agarwal, S., & Smith, J. A. (2004). The problem of appraising qualitative research. *Quality and Safety in Health Care, 13,* 223–225.

Dam, J. (2006) Insight in schizophrenia: A review. *Nordic Journal of Psychiatry, 60,* 114-120.

Drinnan, A., & Lavender, T. (2006). Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions. *Mental Health, Religion and Culture, 9,* 317-331.

Duggins, R., & Shaw, I. (2006). Examining the concept of patient satisfaction in patients with a diagnosis of schizophrenia: A qualitative study. *Psychiatric Bulletin, 30,* 142-145.

El-Mallakh, P. (2006). Evolving self-care in individuals with schizophrenia and diabetes mellitus. *Archives of Psychiatric Nursing, 20,* 55-64.

Farhall, J., Greenwood, K. M., & Jackson, H. J. (2007). Coping with hallucinated voices in schizophrenia: A review of self-initiated strategies and therapeutic interventions. *Clinical Psychology Review, 27,* 476–493

Forchuk, C., Jewell, J., Tweedell, D., & Steinnagel, L. (2003). Reconnecting: The client experience of recovery from psychosis. *Perspectives in Psychiatric Care, 39,* 141-150.

Garrett, M., & Silva, R. (2003). Auditory hallucinations, source monitoring, and the belief that "voices" are real. *Schizophrenia Bulletin, 29,* 445-457.

Geanellos, R. (2005). Adversity as opportunity: Living with schizophrenia and developing a resilient self. *International Journal of Mental Health Nursing, 14,* 7-15.

Goodman, C., Knoll, G., Isakov, V., & Silver, H. (2005). Insight into illness in schizophrenia. *Comprehensive Psychiatry, 46,* 284-290.

Hsiao, F. H., Klimidis, S., Minas, H. I., & Tan E. S. (2006). Folk concepts of mental disorders among Chinese-Australian patients and their caregivers. *Journal of Advanced Nursing, 55,* 58-67.

Jones, S. R., & Fernyhough, C. (2007). The roles of locus of control and self-esteem in hallucination- and delusion-proneness in a non-clinical sample. *Personality and Individual Differences, 43,* 1087–1097.

Kilkku, N., Munnukka, T., & Lehtinen, K. (2003). From information to knowledge: the meaning of information-giving to patients who had experienced first-episode psychosis. *Journal of Psychiatric and Mental Health Nursing, 10,* 57-64.

Kinderman, P., Setzu, E., Lobban, F., & Salmon, P. (2006). Illness beliefs in schizophrenia. Social Science & Medicine, 63, 1900-11.

Kuipers, E., Garety, P., Fowler, D., Freeman, D., Dunn, G., & Bebbington, P. (2006). Cognitive, emotional, and social processes in psychosis: refining cognitive behavioral therapy for persistent positive symptoms. *Schizophrenia Bulletin, 32,* S24–S31.

Ko, N. Y., Yeh, M. L., Hsu, S. T., Chung, H. H., & Yen, C. F. (2006). Investigation of insight formation using narrative analyses of people with schizophrenia in remission. *Journal of Nervous and Mental Disease, 194,* 124-127.

Koivisto, K., Janhonen, S., & Vaisanen, L. (2002). Applying a phenomenological method of analysis derived from Giorgi to a psychiatric nursing study. *Journal of Advanced Nursing, 39,* 258-65.

Larsen, J. A. (2004). Finding meaning in first episode psychosis: experience, agency, and the cultural repertoire. *Medical Anthropology Quarterly, 18,* 447-71.

Lloyd, C., Sullivan, D., & Williams, P. L. (2005). Perceptions of social stigma and its effect on interpersonal relationships of young males who experience a psychotic disorder. *Australian Occupational Therapy Journal, 52,* 243-250.

Lobban, F., & Barrowclough, C. (2005). Common sense representations of schizophrenia in patients and their relatives. *Clinical Psychology and Psychotherapy, 12,* 134-141.

Lysaker, P. H., & Lysaker, J. T. (2001). Psychosis and the disintegration of dialogical self-structure: Problems posed by schizophrenia for the maintenance of dialogue. *British Journal of Medical Psychology, 74,* 23–33

Lysaker, P. H., & Lysaker, J. T. (2004). Schizophrenia as dialogue at the ends of its tether: The relationship of disruptions in identity with positive and negative symptoms. *Journal of Constructivist Psychology, 17,* 105-119.

Macdonald, E., Sauer, K., Howie, L., & Albiston, D. (2005). What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *Journal of Mental Health, 14,* 129-143.

Marland, G. R., & Cash, K. (2005). Medicine taking decisions: Schizophrenia in comparison to asthma and epilepsy. *Journal of Psychiatric and Mental Health Nursing, 12,* 163-172.

McCann, T. V., & Clark, E. (2004). Embodiment of severe and enduring mental illness: finding meaning in schizophrenia. *Issues in Mental Health Nursing, 25,* 783-798.

Messari, S., & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences. *British Journal of Clinical Psychology, 42,* 171-188.

Naudin, J., Azorin, J. M., Mishara, A. L., Wiggins, O. P., & Schwartz, M. A. (2000). Schizophrenia and common sense: Study of 3 single cases. *Psychopathology, 33,* 275-282.

Navon, L., & Ozer, N. (2003). Ordinary logic in unordinary lay theories: A key to understanding proneness to medication nonadherence in schizophrenia. *Archives of Psychiatric Nursing, 17,* 108-116.

National Institute for Clinical Excellence (2002). Schizophrenia: Core Interventions In The Treatment And Management Of Schizophrenia In Primary And Secondary Care (Clinical Guideline 1). London: NICE.

Rice, E. (2006). Schizophrenia and violence: The perspective of women. *Issues in Mental Health Nursing, 27,* 961-983.

Robertson, E., & Lyons, A. (2003). Living with puerperal psychosis: A qualitative analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 76,* 411-431.

Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma: A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social Science and Medicine, 56,* 299-312.

Smith, J. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1,* 39-54.

Smith, J. & Dunworth, F. (2003). Qualitative Methodology. In J. Valsiner & K. J. Connolly (eds), *Handbook of Developmental Psychology,* 603-621. London: Sage.

Spaniol, L., Wewiorski, N. J., Gagne, C., & Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry, 14,* 327-336.

Stanghellini, G., & Ballerini, M. (2007). Values in persons with schizophrenia. *Schizophrenia Bulletin, 33,* 131-41.

Tarrier, N. (2002). The use of coping strategies and self-regulation in the treatment of psychosis. In A. Morrison (Ed), *Casebook of Cognitive Therapy for Psychosis*, Routledge: London.

Wagner, L. C., & King, M. (2005). Existential needs of people with psychotic disorders in porto alegre, brazil. *British Journal of Psychiatry, 186,* 141-145.

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: A literature review. *Journal Of Advanced Nursing, 50,* 204–211

Werbart, A., & Levander, S. (2005). Understanding the incomprehensible: private theories of first-episode psychotic patients and their therapists. *Bulletin of the Menninger Clinic, 69,* 103-136.

Wilce, J. (2004). Madness, fear, and control in Bangladesh: clashing bodies of power/knowledge. *Medical Anthropology Quarterly, 18,* 357-75.

Yardley, L. (2000). Dilemmas in Qualitative Research. *Psychology and Health, 15,* 215-228.

A Qualitative Investigation of the Relationship between Psychosis, Positive Discontinuous Experiences, and Spiritual or Religious Beliefs

Abstract

Background

Individuals’ explanations for psychotic experiences are important, and these explanations might be related to spiritual/religious beliefs.

Aims

To explore the relationship between people’s psychotic experiences, their explanations, and their spiritual/religious beliefs.

Method

Qualitative methodology was used to analyse the transcripts of semi-structured interviews with 8 participants who could be described as having experienced psychosis.

Results

The phenomenology of psychotic-type experiences seemed related to people’s sense of self and their explanations for the world and their experiences. Spiritual explanations for experiences beyond consensual normality were often used for both positively and negatively appraised experiences. All types of explanation were characterised by sophisticated reasoning, including testing of explanations and biological alternatives. Individuals are concerned with hiding both their experiences and their explanations.

Conclusions

Clinicians and services should encourage sharing and acceptance of individual’s explanations for their experiences that might draw on religious frameworks and positive experiences.

Declaration of interest

None

Individuals who have experienced psychosis can hold multiple and flexible explanations for their experiences (e.g. Navon and Ozer, 2003). It is accepted that seeking to understand how these individuals explain their experiences, and helping them to develop their own understanding, is an important part of the service that mental health care should be providing (NICE, 2002). Such provision would benefit from a literature base discussing the ways that people do explain their experiences. Spiritual/religious beliefs inform the attributions lay people make for mental illness (Hartog & Gow, 2005), and spirituality/religiousness is known to affect the way individuals react to psychotic experiences (Drinnan & Lavender, 2006; Mohr *et al*, 2006). This study therefore sought, through qualitative investigation, to explore whether spiritual/religious beliefs affected participants' understanding of their psychotic experiences, whether psychotic experiences affected participants' spiritual/religious beliefs, and whether experiences labelled as either psychotic or spiritual were considered phenomenologically different by participants.

Method

Theoretical Framework

The study generally follows the writings and theories of Interpretative Phenomenological Analysis (IPA; Smith, 2004), an inductive qualitative methodology. IPA seeks to understand the experiences of people through the sense they have made of them, whilst simultaneously recognising that the researcher has an unavoidable influence on the way that these descriptions are interpreted.

The author adopts the position advocated by the Division of Clinical Psychology (DCP; BPS, 2000) by concentrating specifically on psychotic experiences rather than limiting the study to individuals who had fulfilled the diagnostic criteria of specific conditions that might involve psychotic experiences. Psychotic experiences are defined as any mental experiences that are perceived as substantially discontinuous from the individual's normal or preferred spectrum of mental experience, and which negatively affect the individual’s mental well-being and level of functioning within social functioning, work functioning, or self-care. This maps closely to the description of psychosis described in the DSM-IV-TR (APA, 2000). Also following the DCP, the author accepts that a single true explanation of such experiences is currently unavailable and unlikely to be found; this informed the process of conducting the study, as the author sought to therefore maintain an open-mind about potential truth in every participant’s explanatory framework.

No closed definition of spiritual/religious beliefs was used. It was noted that a recent UK project relating spirituality and psychiatry (Gilbert, 2006), coordinated by the National Institute for Mental Health and the Mental Health Foundation, recognises the highly individual nature of such concepts, and the fact that individual spirituality does not necessarily relate to societal concepts of organised religion. The recruitment strategy therefore sought to simply allow that individuals had a concept of what terms such as “spiritual” and “religious” meant to them, and that they identified themselves with these concepts in one manner or another.

Participants and Recruitment

Participants were recruited using an advert (see Appendix 4.a) asking for people with experience of “hearing voices, having strong beliefs, or any similar experience that has affected your mental wellbeing and general functioning in life”, and also whose “religious or spiritual beliefs or experiences [have] ever been important to you?”; a freepost address was supplied inviting them to contact the researcher if they were interested in participating in a research project to discuss these experiences and beliefs. Posters were sent out to the managers of various locations – mostly selected by choosing services listed within a city’s guide to mental health services – where individuals who had experienced psychosis might notice them; these included voluntary sector services, residential homes, day centres, trust chaplaincy, and all GP surgeries within four primary care trusts. Adverts were also sent to the city’s NHS teams providing services to people with psychotic experiences (continuing needs, early intervention, rehab and recovery). Clinicians within those teams were requested to give the adverts to any of their service-users that they deemed appropriate (i.e. their mental health or engagement with the service would not be adversely affected by the process of the professional giving them the advert). These two forms of recruitment were intended to reach as many people as possible, whilst avoiding the creation of a participation barrier through entire selection by clinicians.

Upon responding to the advert, participants were sent a full information sheet (see Appendix 4.b) and an opt-in/screening form (see Appendix 3.a). This form requested demographic details, asked for a brief description of their experiences, and then provided four Likert scaled statements. These asked them to rate agreement at four levels for statements about firstly, the effect this experience had on their mental well-being, and secondly, the disruption it caused them on the three elements described in the DSM-IV-TR description of psychosis (social functioning, work functioning, and self-care).

Participants were deemed eligible on the basis of the two criteria of 1) having held spiritual/religious beliefs that were subjectively important to them at some point in their lives, and 2) having experienced psychosis. The first criterion was fulfilled by self-selection, as participants were primed by the question on the advert. To ascertain the second criterion, two members of the research team assessed whether the experience described on the screening form would appear to represent a mental experience that was discontinuous from the individual's normal or preferred spectrum of mental experience. If so, participants were included who also rated that either

a) their mental well-being had been affected at least *quite a lot* by the experience or

b) that their mental well-being had been affected at least *a little*, and that either

  i) two of the three categories of disruption had been affected *a little*, or

  ii) one category had been affected *quite a lot*.

Due to the analytic methodology employed, participants had to be fluent in use of English. Once determined as eligible, participants were phoned to arrange an interview; these mostly took place at the research unit, though one took place in the participant’s place of work. Participants were required to sign a consent form before the interview began (see Appendix 4.c), and received £10 remuneration for time and expenses incurred - two participants declined to accept this remuneration.

16 individuals responded to the adverts asking for more information. Of these, 9 returned their opt-in form; all were deemed to fulfil the research criteria, and were approached to arrange interviews. Of these, 8 interviews were eventually conducted (see Table 1); the remaining person withdrew from the opportunity to take part in the interview, citing life circumstances that made it impossible for them to feel they could take part at that time. It should be noted that in the course of the interviews, Gordon, who had recorded Church of England on the form, actually described a different set of beliefs, feeling that he had not yet made up his mind. Furthermore, David, who recorded “--” on the form, reported a strong belief in God but no identification with any one organised religious framework. Due to the lower than expected number of individuals who responded to the adverts, a focus group planned for later discussion of analysis was not conducted.

[Table 1 about here]

Measures

The interviews were guided by a semi-structured schedule (see Appendix 3.b), developed through a process of peer and academic supervisory discussion, including the views of a collaborator who had experienced psychosis themselves. The recommendations of Smith (1995) were followed in devising the schedule, creating a selection of open and neutral questions with prompts. The schedule focussed on three areas: 1) people’s experiences of psychosis, and the ways in which these have affected their life, self-perception, and coping style; 2) their spiritual/religious beliefs, the history of how these beliefs were derived, involvement in spiritual/religious communities, the way spiritual/religious beliefs affect their self-perception, and any experiences they have had that they would describe as spiritual; and 3) any ways in which the two elements of spiritual/religious beliefs and experiences of psychosis interact. The end part of the schedule also contained questions about the participants’ experiences (course, hospitalisation, and so on). The interview schedule was first practised with a peer who did not fulfil the research criteria, and then piloted with the first respondent to the advert. As the schedule appeared to fulfil the aims and was not experienced as negative by the participant, no further amendments were made; data from this pilot was therefore included in the analysis.

Interviews were all conducted by the author, and ranged in length from 60-120 minutes. Although the schedule was used in all interviews, it was treated as a prompt sheet to ensure that all participants had been given opportunity to cover the relevant areas, rather than a rigid order for the questions. All interviews eventually covered the various areas on the schedule, but always in a different order to that specified. When content that appeared to answer a specific question had already been discussed, the interviewer would summarise that content and check whether the participant also felt that it had answered the question that would have been asked. Clarifications, reflections, and further prompts were used as deemed appropriate within the interview, and discussions that did not directly fit with an answer to one of the questions were encouraged, provided that the opportunity to discuss the intended interview content was not compromised.

Interviews were recorded and transcribed verbatim with the removal of identifying information (names, locations, and so on). The transcriber for all but one interview was external to the research team, agreed to a confidentiality agreement (see Appendix 4.d), and followed the guidelines set in Appendix 4.e.

Analysis

Transcripts were analysed according to the tenets of IPA (Smith, 1995). Each transcript was read alongside the original recording, and then re-read. At the first level of analysis, the author then went through the transcript, noting on one side general points of interest (e.g. specific phrases that seemed key, initial thoughts about what meaning might be, reflexive notes such as particular thought processes or interests of the researcher at the time). The author then returned to the beginning of the interview, and on the other side of the text listed initial descriptive themes that appeared to be present in the participant’s account (themes were not limited to those fitting directly with the research aims). These titles were then listed into a word processing document, along with page or line references to allow easy reference back to the original source. This process was conducted for all eight participants individually before the clustering stage took place.

The lists of themes for each participant were then clustered into groups that appeared relevant to each other as representing a similarity in the way that the participant was making sense of their experiences; although the emergent clusters that were developed in the first transcripts analysed informed the clustering of subsequent transcripts, there was always reflexive room for differences to be recognised and reflected in the different clusters. The eight sets of clusters were then amalgamated into one master table, where differences in clustering patterns were made apparent. Further clustering then took place to group the theme clusters identified in individual transcripts into associated groups, with reliability checked by ensuring that the initial themes of each participant still reflected each new framework, and with the opportunity for new clusters to be created.

An example of these initial stages of analysis can be seen in Appendix 4.f.

Quality Control

Whilst there is recognition in using IPA that the process involves a researcher making sense of accounts within their own constructed framework, it remains incumbent on the researcher to ensure that their analysis remains adequately reflective of the original data. To support the trustworthiness of this analysis, a reflexive log was kept, recording field notes from interviews, and the development of any ideas or process of thought throughout the project process; academic supervision was used similarly throughout the project to ensure that the author monitored the extent to which they brought their own issues to the research process.

Six of the eight transcripts were audited at the second stage of analysis (development of initial themes) by peers with experience of at least either the methodology, knowledge about the academic and clinical fields of psychosis, or the experience of psychosis themselves. These audits verified the processes of the interviews, sought to ensure that the researcher was using analyses that were grounded in data, and highlighted aspects of the data that the auditor considered relevant and that was not reflected in the initial analysis. This process informed the subsequent analyses by highlighting occasions where participants might have been unreasonably led by the interview and questioning the development of themes from those occasions, and also by highlighting the initial tendency to use thematic titles that were more abstract than the words used by the participants. Analyses were re-read with these comments in mind, and amended accordingly.

The clustering process was also audited by discussing the initial processes of clustering for one participant in a supervisory context, and discussing any discrepancies between how the members of this discussion thought that the initial themes could be clustered. The final table of analysis was also shared and discussed in this manner. A focus group with individuals who fulfilled the same participation criteria had been intended to be conducted in order to gain further thoughts on the validity of the final theme cluster; unfortunately, recruitment levels meant that this group did not take place.

Results

Participant accounts were organised into three primary themes, each with a selection of secondary themes and further areas of categorisation, and also with recognition of substantial overlap between some areas and themes; Figure 1 suggests roughly how these themes reflect the author’s understanding of the participants’ accounts.

The first primary theme was *Unusual Experiences*, where sections of the account related to experiences that were essentially different from the normal continuum of reality, either within their experience or in comparison to the people around them. As part of this theme, participants had *descriptions* of the experiences, spoke about the *consequences and reactions*, and described *context narratives.* The second primary theme was *Explanations, Understandings, and Beliefs*, related to the ways in which the person is communicating the sense they make of aspects of the world and their experiences. Within this theme, participants described their explanations for their *unusual experiences*, which included spiritual and biological frameworks, a discussion of all the alternatives, and described the origin of the beliefs - their explanations were often the same whether the experience had been perceived as positive or negative. Participants also described their explanations for *life and the world* (their ontology), including beliefs about divine or spiritual intervention, having a relationship with God, how their framework related to organised religions, the moral standards in life that their framework gave them, and as with explanations of the unusual experiences, they described the origins of these beliefs. The final secondary theme of the *Explanations* theme was *testing and proof*, which related to the way that participants described how and why they believed in the frameworks they had given for both their unusual experience and for life and the world. The final primary theme was *Self in the World*, where participants described aspects of how they negotiated their way through life. This included *growth and learning* through both their unusual experiences and life in general, *social considerations* such as comparisons with other people, hiding aspects of their life from others, and their role in a spiritual community and family, and finally *general narratives* about aspects of their life other than their spiritual beliefs and unusual experiences.

[Figure 1 about here]

All identified themes are reported here, with the themes most relevant to project aims focussed on within the discussion. Example quotes which most clearly represent the theme being discussed are provided. These quotes exclude conversational punctuations from the researcher and participant originally recorded in transcription.

Unusual Experiences

This strand of the participants' accounts related to experiences that were essentially different from the normal continuum of reality, either within their experience or in comparison to the people around them. The term "unusual experience" is used rather than "psychosis" because the theme included discontinuous experiences that did not affect their functioning in the way described by DSM-IV-TR as well as those that did; regardless, they were generally all discussed by participants as conceptually similar.

Descriptions

These sections of the participants' accounts were concerned with communicating the nature of the experiences, the phenomenology as it were. The descriptions included labels of voices, visions, paranoia, and delusions, and there were a few occasions when the participant would describe a somatic sensation associated with the experience. However, it is important to note that nearly every participant reported hearing voices in a different to normal context, whilst the presence in the accounts of recognised delusions and paranoia were more limited.

The recruitment strategy required that individuals had experienced some negative consequence as a result of an unusual experience, and so it was inevitable that all participants would report *negative appraisals* of some such experiences, with typical adjectives including frightening and horrible.

> Harry, p15: I want to be dead because I don't want to suffer from this mental illness anymore because it's torturous it's like being tortured tortured

Harry was describing the paranoia that he felt on a daily basis about bad things happening to him, and how he frequently believed he heard people talking badly about him. He continued this discussion by illustrating that it was his Christian beliefs that meant he would not kill himself, despite the torturous experiences.

However, the majority of participants also reported a number of *positive appraisals* of experiences, for example a sense of reassurance, or awe and joy.

> Gordon, p9: It was like this intense feeling of, of, of peace and erm, calm, and erm, like everything's going to be alright because absolutely nothing to be frightened about, nothing to be worried about, don't be frightened of death, just you know, everything's going to be fine

Gordon was in hospital at the time of this experience, having been in a car accident; he had found himself increasingly paranoid about death and other's intentions towards him, when this experience gave him the reassurance that he would be OK. Although currently undecided about his spiritual beliefs, the intensity and positive feelings from this experience were something that he hoped were spiritual in origin, and could therefore potentially be accessed again.

Commonly, the *power* of the experience was discussed, either in terms of its intensity or in terms of being controlled by it; negative appraisals were not necessarily made of this fact, though often they were as below, where Harry was discussing the times he felt forced into self-harm by hallucinations when in prison and on secure psychiatric units.

> Harry, p9: I've got five cuts where I've cut my neck erm, because I was honestly I was I was overpowered by these voices, seven voices, one after each other and the voices like, were like coming from the ceiling into my head it felt like they were coming from the

> ceiling into my head and I couldn't stop them, no way could I stop them

It was also frequently noted that the experiences included a level of *conflict*, such as in the sense of two voices giving contradictory commands or between two sets of beliefs about the world at that point. For example, Ethel described the cognitive dissonance she had when she was experience paranoid guilt about actions she had taken towards a tenant, despite rational knowledge that she had been fair to him.

> Ethel, p4: I started feeling, it's because I've taken this man to court I was feeling guilty, I was feeling absolutely terrible and I could feel the change in him and I got well, I'm doing nothing wrong here because we'd tried, we told him he can move out and not, erm not pay

Within their descriptions, there were examples of participants seeking to emphasise the sense of *reality* in their experience. For example, Chloe compared having heard the voice of a spirit with having heard a voice from objectively real and observable people as a way of emphasising that the spirits were real entities.

> Chloe, p7: I actually heard a voice, erm, I'd gone up to see my mum and, erm the voice, I didn't, wh- whether it be good or bad I've never heard a voice so close and it were just, it, it could have been you or my brother or, you know, somebody whispering in my ear, it were that close, like if it had blown they'd have blown my hair and I've never felt anybody that close from spirit

Consequences & Reactions

This section of the accounts related the things that happened directly as a result of the experiences. Typically, this included the *controlled reactions*; the behaviours that the person took, or considered taking, in conscious response to the experience, including spiritual and secular ideas. In some sense, many of these examples could have been considered as coping strategies within the wider psychology literature, but this terminology was rarely used by the participants despite the direct use of the word by the interviewer at times. The participants also described the importance of generally taking control of the experiences. Barbara described how, despite the fact that religious beliefs had at times contributed to her distress in her earlier life, she now found faith was an active ingredient in her psychological well-being.

> Barbara, p61: my faith now, actually helps it keeps me calm and I have a laugh

Some of the accounts made reference to consequences over which they had a limited sense of control or ownership, generally categorised here as *uncontrolled reactions* - On the whole, such things were examples of negatively appraised experiences, but there were some positive or neutrally appraised experiences. Felicity's first unusual experience came at a time of domestic stress with her husband's drug use, and also a time when she was questioning spiritual meanings herself, having experienced some abusive uses of religious ideas and practices in her early life; the religiously toned experience was particularly distressing for her.

> Felicity, p2: I kind of got this, erm, experience of scripture verses just coming into my head, erm, I was frightened and I was very perplexed by it erm and like I get, all these addresses and stuff coming in and, and I were that scared I kind of responded to it

> immediately, got outside, er, wheeling the kids around in the pram, running around like a blue arsed fly in *-park-*, not knowing what to do with all this that were going off

A final selection of the accounts regarding the consequences of the unusual experiences, labelled *external and others*, was about the way in which they perceived reactions in the world around them that weren't directly related to their own state. For example, Gordon was aware that his wife was upset by having observed his behaviours whilst in the detached state of awe described above.

> Gordon, p12: she came to the ward, and she said that she saw me thrashing about and, you know, which really sort of scared her

It should be noted that there was an extent to which the consequences of the unusual experiences was linked with parts of the *Explanations, Understandings and Beliefs* theme described below, in the sense of the experiences informing the explanations made.

Context Narratives

In describing their experiences, the majority of participants sought to thicken their accounts with details of what was happening in their lives and the world around them at these times. Compared with the *Descriptions* and *Consequences and Reactions*, these sections of the accounts sought to describe the reality as it might have been seen objectively, as opposed to the participants' direct experience or their actions in relation to the experiences or the sense of meaning to the participant. A number of participants sought to describe the *build up*, most describing busy lives or examples of typical stressors such as accidents or illness, although these were not necessarily attributed as causal by the participants themselves. Ethel felt that her life had been too busy before she her powerful sensory experience (attributed to a yogic spiritual framework), and that she had been in circumstances with little control over what was happening to her.

> Ethel, p2: when I look back I see everything slotted into place actually now er, I was, erm, I'd got, was running three businesses at the time and, er, erm, I couldn't do anything

Narratives also included a sense of the context within which the experiences continued *at the time*. This was often related to the experience of being in hospital and the people around them, such as Harry, who had a particularly bad experience as he was in prison prior to a court appearance.

> Harry, p4: I was due in, they up in erm *-City-* crown court that, that morning and they opened the door and they said *-name-*, you've had a rough night haven't you? and I said yeah I have, and, erm, they said go and get a shower go and get, go and clean yourself up mate so I went and got a shower

There were a few narratives which continued beyond the initial phases of the experience, which appeared to represent a separate category of narrative labelled here as *following*. For example, Chloe discussed how she withdrew from her spiritual church in the period after her frightening experiences.

> Chloe, p32: I'd been going but not as regularly as I did afterwards but it was, erm, af- after the breakdown it was erm quite a while before I went back

Although the presence of these narratives within the context of the study aims is not especially relevant, their presence is worth noting in the sense that (as is also the case with many elements of the *Self in the World* theme, particularly the *General*

Narratives) they were not directly prompted for by the interviewer. Their presence therefore perhaps represents something important about the way in which individuals who have experienced psychosis locate these experiences within their general life story.

Explanations, Understanding, & Beliefs

This second primary theme derived from the participants' accounts related to the ways in which the person is communicating the sense they make of aspects of the world. Whilst the presence of this theme is perhaps unsurprising in the context of participants having been asked to describe their religious beliefs, the details within the theme represent an analysis that has responded to the separate issues identified by participants - in particular, participants' explanations of their unusual experiences were not directly prompted for within the interview schedule (although within individual interviews, further clarification of an explanation was sought when it had been independently volunteered by the participant), and just as the *context narratives* of the *Unusual Experiences* above arose independently, so the way in which participants sought to explain their experiences rather than just describe the phenomenology would appear to represent an important element of how this group felt it was important to communicate around such experiences.

For Unusual Experiences

No participant described their unusual experience without providing some kind of explanation for what it was. Every participant had at least some idea that there could have been a *spiritual* element to the experience, including direct conversations with God, experience of God in the cosmos, and spirit embodiments. Abdul described how some of his problems were related to *djin*, a type of spiritual being that were apparently found within his Muslim beliefs.

> Abdul, p15: I used to have a djin it used to cause me problems sometimes this, this led, er whenever it come to Christmas like it would stress me out like

However, a number of participants also suggested a *biological* explanation for the unusual experience, including adoption of medical labels for their experiences - looking again at Abdul, he used medical terminology as well as spiritual explanations, perhaps having been closely involved in psychiatric services for a number of years.

> Abdul, p2: three years ago I experienced some problems problems but I didn't realise I was getting ill and more I was heading towards that way I just thought I could I started experiencing symptoms like I was getting followed

The potential disagreement between these two types of explanation was recognised by almost all participants in whom the two options were described, which appeared to be grouped within an important category of *alternatives*. These represented times when the participant discussed the fact that there were alternative explanations, describing the reasons why they might accept one over the other, discussing the uncertainty about either option, or in Barbara's case, fully accepting both possible explanations as able to mutually coexist. She believed that both a virus she had when younger and a recent stroke meant that her brain was more susceptible to having unusual experiences; however, she also believed that these were genuine spiritual experiences, representing protection from her grandmother and the Virgin Mary. She expressed disappointment that, although she was able to see how the two factors could both be true, the majority of people she spoke to about it focussed solely on the biological side rather than the spiritual.

> Barbara, p25: I’ve been told by my GP actually that, er with me having chickenpox as a child as well the virus can lay dormant which to me, erm, as well as religious beliefs it also, I believed very strongly they were proper visions but also having that virus lay dormant in me that, er, there is a medical side to it as well which to me is now, at long last been recognised … people are actually listening to me understanding me and believing me because it’s the medical side and they’re switching off to the spiritual side which to me is sad because there is the spiritual part there there is a definite spiritual connection there

Each participant was also able to explain the *origins* of their explanations, showing what had led them to hold these explanations; sometimes this was through read material, contact with others, or a result of the framework for life and the world that they already held. At other times the reality of the experience seemed enough to explain the origin spiritually. Felicity felt that God’s voice, which she heard most times that she prayed, was completely different from things she recognised as her own internal thoughts and dialogue; this was enough justification for her to be sure that it was genuinely God’s voice.

> Felicity, p27: I do have a little God voice that I know is God [R: Can you tell me a bit more about, erm, the God voice then, what, what's God’s voice like?] It’s gentle, it’s loving, it’s, erm it’s deeper than my own thoughts erm it’s authoritative, erm it’s truthful, erm it’s warm and welcoming erm and away from my own thought processes.

With regards to participants’ explanations for their unusual experiences, the way in which they recognised alternatives, could highlight the origins of the explanations, and (as discussed below) looked at how they could prove the truth of any given explanation suggested a process of rationalising that was reasonable and coherent.

In understanding the ways in which participants’ explained their experiences, reference should be made back to the fact that the majority of the participants’ experienced voice hearing, which is often reported in literature to be mostly experienced as an entity independent from the participant - the processes of explaining the origin of something experienced as separate may be more conducive to coherent explanations.

It should also be noted here that in proffering explanations for their unusual experiences, the explanations were often the same regardless of the negative or positive appraisals, and participants rarely made a distinction between them. One notable exception was David, whose unusual experiences were primarily related to conversations he had with God, which had started at a particularly low period in his life when he was in a psychiatric institution following a suicide attempt, but which had continued virtually on demand and had helped him to develop a perspective on the world which he felt more comfortable with. David used the difference between a positive and negative feeling to decide whether a spiritual explanation was correct or not for that particular experience; however, he remained convinced throughout that the positive experiences were divine in origin.

> David, p.37: when you begin to distrust God erm, you know that what you’re talking to isn’t God (laughs) and there are times when I could only talk to this thing I distrusted which was me I knew it was but luckily, since then I’ve been talking to, I’ve talked to God quite frequently.

Chloe also found that negatively appraised unusual experiences made her doubt the spiritualist explanation she held for them; however, this doubt applied to the unusual experiences as a whole, and not just the bad experiences.

For life & the world

The second secondary theme within the *Explanations, Understandings and Beliefs* theme addressed the ways in which the participant believes, or has believed, the world works, referred to herein as their ontology (again, readers are alerted to the prompt question about understanding religious beliefs). Of all the themes, the separate areas discussed below as part of this theme illustrated perhaps the most examples of overlap.

A recurrent area within this theme was examples of belief in *divine or spiritual intervention*, in other words the times in which the person makes reference to a spiritual entity actively affecting material circumstances. This included both positive ways in which spiritual beings could effect change and negative counter-examples.

> Chloe, p16: if you ask the universe and you ask the spirit world then I believe that they can help to shape things

It was also noted in a number of accounts that participants believed in the existence of a direct *relationship with God*, which ranged from a practical level, in that they would hold conversations with God, to a more abstract level, in that they believed God would notice what they did as an individual, and directly reward or punish them. In the majority of cases, this relationship was seen as a positive thing which gave the individual reassurance, particularly when paired with an understanding of divine intervention that God could make things better for them. For Felicity, the individual relationship with God, which included conversations directly with him as described above, was one of the things that helped her to reconcile difficulties she had with religious ideas in general, feeling that it all became more relevant to her individually.

> Felicity, p13: I was then able to seek God on my own terms. It was like because I felt that part of it was, er, conditioning. The conditioning as a child, erm how would I know if God existed, if I'd not been taught about it, would I you know all this kind of stuff were going on, erm but I really felt I wanted to access God for my own er, on my own volition rather than what was expected

As seen in this quotation, the relationship with God was often something that bore relevance to the next category in which participants related the ontology they expressed in the context of frameworks suggested by *organised religion*. Whilst for some, the framework of beliefs suggested by organised religions directly informed their ontology, others discussed their own beliefs by making reference to the difference between them and those of organised religions, often undermining the latter. There was often a sense of resentment about the ways in which organised religion or its perceived representatives would use their frameworks, and where the participant believed in a more direct relationship with God, they valued the beliefs that came through that relationship more than the ideas that came from organised religion. David described a number of ways in which he no longer trusted or valued the organised religions, which seemed related to his negative experiences as a child of what he saw as hypocrisy in his church-going parents. His conversations with God had proven to him that the major religious figures, such as Jesus and Mohammed, had not actually had any more divine authority than he did, and so ideologies related to these frameworks were not acceptable to him.

> David, p16: what I find is, is they're people who have their own sort of visions if you like of heaven and hell and as soon as those categories come into it I realise that they're not talking any kind of truth that I want or you know that I can understand if you like it seems such a, a sort of, you know law of the jungle kind of thing you know, you break the rules you go to hell

For some individuals, their ontology included a link towards *standards & directives* about the ways in which they should live their lives or be in the world. This included references both to beliefs derived from an organised religious framework, or more individualistic ideas. These standards were sometimes spoken about with reference to the participant's identity within a particular spiritual label. Felicity felt that there were an implicit set of standards that Christians should live by, and which she did not entirely fulfil, although she did use Christian ideas to inform the way she lived in relation to other people.

> Felicity, p3: I'm not a perfect Christian by any means, I don't read the bible, way like I should do

> Felicity, p16: that doesn't stop me being working towards the gospels which is love, mercy, forgiveness and that kind of stuff

Each individual (sometimes as prompted) discussed the *origins & changes* in their beliefs, giving context to where they first came across the concepts, and describing periods in their life where they changed concepts. Often, this represented a discussion of beliefs to which they were exposed in childhood, and though Abdul related his current ontology directly to his childhood beliefs, the majority spoke about them as examples of how they have changed since then. Chloe described how being exposed to psychiatric explanations for her experiences was a difficult challenge because of the value she placed on her spiritualist beliefs; ultimately, she retained the spiritualist explanations.

> Chloe, p32: it were quite upsetting to think that you know, perhaps everything I believed in weren't true that's you know, because that's a big belief that I'd had all them years, had carried with me and then to suddenly think, oh perhaps I'm just clinically sick is distressing

As with explanations for the unusual experiences, the nature of some of these themes illustrates how the discussions around individual's ontology often represented what seemed to be a fairly coherent approach to making sense of the world, and one that included knowledge and evaluation of alternative sets of belief.

Testing & Proof

This final secondary theme within *Explanations, Understandings and Beliefs* represents part of the rationale-giving process that was engaged with for each of the other two secondary themes. Frequently, participants would (unprompted) use examples of things that had happened which illustrated why their account was true; sometimes these examples would be circumstances which had arisen as a direct result of the participant challenging or testing the beliefs themselves - this could mean being told something by God which they couldn't possibly have known, and was later proven correct. Often, it also related to prayers being answered; Barbara had been praying for a son for ten years, and took his birth as evidence that prayers had been answered and so God must exist..

> Barbara, p69: I was saying "Jesus give me this" I saw, I my grandmother, my grandmother came to me, "I need my little boy I need my little -*husband's name*-" so I finally got him

The presence of this theme within the accounts more directly illustrates how the participants were most often describing a process of engagement with the debate around their beliefs, and had developed their beliefs in a way which at least in part relied upon typical rational processes. Reflexive notes from the interviews and analysis suggests that, when approached with an open mind, the explanations provided by participants often felt coherent and convincing to the researcher, despite the mutual exclusivity of some of the explanations offered between different participants.

Self in the World

This final primary theme referred to the parts of the accounts in which participants described aspects of how they negotiated their way through life; again, there was overlap with areas of the previous primary themes, but this theme was distinct in that material seemed to belong to a more general sense of how people beyond just their unusual experiences or their explanations for the world.

Growth, Learning, and Personal Changes

Discussions within this secondary theme were concerned with the things that had led participants to feel a substantial change in some aspect of their identity or sense of place within their world. In some cases, the unusual experiences were the triggers to this process; sometimes, this was because the nature of the experience led them to feel differently, and in these cases it was often a negative reappraisal of their circumstances, but an alternative was the way in which the content of the experience (i.e. the content of discussions with God) would lead to a more positive reappraisal. For Gordon, the realisation that his perception of normal experiences and comfort in them was not stable

> Gordon, p21: I definitely feel more vulnerable, erm and whereas before, probably felt reasonably safe … it’s kind of shattered a lot of the kind of illusions that I probably had that I was reasonably safe

Growth and change was also related to the experiences when it formed part of the individual's explanatory framework for the experience, such as Ethel's description of a Kundalini experience (in which the participant's sense of the world was entirely overwhelmed by an experience of energy and light).

> Ethel, p9: there's a lot of people in mental health hospitals who are sectioned, who's had these experiences and they just, a way, this is the way they evolve this is the way they evolve

However, growth and change was related to more than just the consequences of unusual experiences. It was also used by participants in relation to their sense of self having accepted a particular religious framework from a previously non-religious stance. For Harry, becoming a Christian after his release from prison and psychiatric care led to both behavioural changes, including renunciating criminality, and an attitude that he considered to be more pro-social.

> Harry, p32: I used to do a lot of masturbation and I've given that up just recently and it's another stage, you know it's another stage, erm erm humble that it's made me humble it's made me caring because I I care for people a lot more, you know I respect people a lot more than stealing off them

Other areas in which change and learning were discussed included the experiences of nearly dying, and the effect of social relationships, as illustrated here by Abdul when he was describing a relationship which had been part of the precursors to his first unusual experiences..

> Abdul, p7: It was a student who I knew it was a student what I knew and she was very causing problems with me, oh I've learnt, I've learnt a lot from that one

Relationships & Social Considerations

Participants frequently made reference to how their position in the world was determined by their understandings about other people. *Comparison* was often used to illustrate their sense of self, either by agreement with how other people were, or by illustration of how they were not. This included both comparisons with people in their immediate environment, including other people who had also been through the unusual experiences, and comparisons with religious figures. Barbara described how, sat at a party, she became sad at the differences she perceived between herself and her peers, wishing that the distress she experienced from her unusual experiences was not there.

> Barbara, p62: I'd been sat down one minute, going out for fresh air, looking out, looking around "why can't I be more like these people here, why can't I have a nice home why can't everything be fine, why can't every they just carry on with their lives happily, no problems why can't I be like that?"

Participants also frequently discussed how they had to use *hiding, denial, and pretence* within their relationships. This often included the times that they had to hide their unusual experience from other people, but for some participants it also related to the times that they had to keep an aspect of their ontology from the people around them due to the likelihood of it not being sanctioned. It also sometimes meant that they felt they had to hide their explanations for their experiences from professionals around them, knowing that it would not be sanctioned. Gordon, knowing that his wife had practical stresses, particularly as a result of his accident, did not want to share with her the paranoid feelings he was having, despite his partial awareness of the irrationality of them.

> Gordon, p17: I just thought I don’t want to add to any of the kind of anxieties and worries, er, so it just didn’t feel as though I could, as though I could tell anyone. And also I was like I was scared of telling people because I thought, I, I was frightened of them diagnosing the fact that I might be going mad, you know, so it scared me you know, so I did, yeah, I was just trying to deal with it myself, you know, sort of make sense of it myself.

As part of the process of describing their identity within relationships, there were two common contexts in which the descriptions were made, one of which was their *spiritual community* (although spiritual community was included as a prompt within the interview, much of these discussions arose unprompted). Whilst some individuals were easily able to name their spiritual community as having been helpful at times in dealing with either life’s problems or their unusual experiences, there was also often also a feeling of ambivalence or non-acceptance described, suggesting that the community was not always the resource that was wanted or expected. Often, this related to the issue described above in which the participant contrasted their ontology with that they perceived of organised religion or the people who were part of it. For Ethel, joining the various communities that might have an acceptance of a spiritual explanation for her experience was an important part of the search for meaning she was engaged with, reinforcing a positive appraisal to the experience.

> Ethel, p8: I’d had the Kundalini gradually I was getting information and I realised I was on this spiritual path I joined the churches fellowship for psychic and spiritual studies and everything was positive

The second likely context in which social identity was discussed was *family*. This included discussion of the effects that participants knew they had on their family when going through their unusual experiences, and description of the nature of their family relationships. For some participants, family was the most likely context in which hiding and pretence would take place; others described the extent to which they felt torn between their family and their spiritual community or spiritual beliefs. Abdul noted that his family, in sharing his spiritual explanation for his unusual experiences, became scared of the consequences that he was possessed by this evil spiritual entity; it was his family who sought psychiatric help for him as a result of these fears.

> Abdul, p38: He was quite scared because the, whole family was scared, “he’s got a djin, he’s got a djin”

General Narratives

This secondary theme related to the parts of the participants’ accounts where they sought to describe things that had happened to them outside the immediate context of their unusual experiences, most often including things remembered from their childhood, such as David remembering the abusive background of his upbringing, but not necessarily in the context of trying to explain why he had the unusual experiences or why he believed what they were.

> David, p21: I mean I just had no erm there was no-one in my life whom I gave a shit about basically and I that was the situation for a very long period er, very violent background, family life, abusive

As noted above, the presence of these narratives was unprompted.

Identity Descriptions

The final secondary theme located within *Self in the World* was about the times that participants made direct reference to an element of their personal sense of identity, either currently or past. Failure/achievement, strength and independence, dangerousness, and relationship to moral standards set by religious frameworks were all included within this theme. Harry remembered how, before accepting Christianity, he was anti-social, a label that he accepted for himself as much as it was apparently placed upon him. In contrast, Chloe remembered how, upon realising that she could access spirits more directly, she felt an enhanced self-esteem because of the positive appraisal she made of this experience, and what it meant about her abilities.

> Harry, p3: because I was a menace to society you know that's what one judge called me a menace to society because I kept burgling people's homes which I were at that time I needed, I needed being locked up for my safety and for other people's safety

> Chloe, p7: it were nice because it were like, oh you've got the gift, as they call it which is a nice feeling when we've always had that belief yourself

Discussion

The discussion here focuses on the areas of analysis considered most relevant to the research aims by the author, and recognises that some of the material provided by participants is therefore overlooked at this time.

Flexibility and Reasoning in Explanations

Participants invoked a sophisticated level of reasoning during the process of explaining both their ontology and their attributions for their experiences. Given the sampling, it was unsurprising that participants used spiritual/religious references in their explanations for both their experiences and their ontology; however, it was the nature of these explanations that was notable. There is literature published which suggests that, within a social cognitive perspective, religion can be seen as providing simple heuristics that help the individual “form rapid judgements rather than engage in extended inquiry” (Carone & Barone, 2001, p.990). The cognitive reasoning evidenced by these participants did not support this suggestion. Participants evidenced engagement in consideration of both their preferred or dominant explanatory frameworks and alternatives to these frameworks. They weighed up the reasons for their preference of one over the other, and often engaged in a process of testing their explanations. The arguments presented, whilst not necessarily rationally watertight, did lead to conclusions that seemed understandable in the face of the evidence, and not clearly less rational than the average belief system of individuals who have not experienced psychosis (although it is recognised that this claim is made without having engaged in detailed conversational analysis).

It was also interesting to note that the majority of the participants were aware of biological explanations for their experiences, exhibited varying levels of acceptance for these models, and were in some cases able to accept the validity of these explanations alongside a spiritual explanation. These findings are relevant in relation to the literature around “insight” into psychotic experiences; although the complexity of the concept is recognised in some forums (e.g. Dam, 2006), there are also recent examples in which the concept is considered to related simply to the awareness that one is ill and in need of treatment (e.g. Goodman *et al*, 2005). This simplistic position might be considered inappropriate in light of the appearance that individuals can have a level of acceptance of biological frameworks that does not mutually exclude their alternative explanations to them; this would suggest that insight research may need to conceptualise the term as a balance between biological and other explanations. Furthermore, the evidence of these participants suggests that they are not necessarily lacking the necessary information when they decide to reject a complete acceptance of the biological framework; rather, they appear to have engaged with the information and decided against the complete acceptance. This process could be compared with the position adopted by the Division of Clinical Psychology (BPS, 2000), in which a group of academics and clinicians who have access to all available literature reach a consensus that no one explanation might be found for psychotic experiences. In this light, the reasoned decision by individuals who have these experiences to accept alternative attributions, particularly alongside a biological attribution, should perhaps be given more credence.

The analysis of these accounts could be considered to be part of a growing body of evidence from other qualitative studies with this population (e.g. Kinderman *et al*, 2006; Werbart & Levander, 2005). Elements of these studies also suggest that the reasoning behind, and nature of, individual’s explanations for their experiences are frequently flexible, complex, and objectively reasonable. These findings may need to inform the approach that services and clinicians take in working with such individuals, developing an acceptance that individuals who have psychotic experiences may have a good rationale behind their attributions and their ontology. This might be more difficult for clinicians who are faced with the kinds of explicitly metaphysical discussions found within this sample; in particular, ideas such as divine/spiritual intervention affecting our lives might be the types of content that would put off many clinicians from engaging in reasoned discussion. For example, in a qualitative study of clinical psychologists’ approach to spiritual beliefs, Crossley and Slater (2005) found that some participants were reluctant to engage in spiritual discussions, or actively avoided the topic with clients; this was apparently due partly to the difference between spiritual beliefs and their own value systems. However, the findings of this study support the suggestion that spiritual/religious beliefs can heavily inform individuals' understandings of the experiences that might be causing them distress. It could be suggested that a therapeutic intervention that does not seek to understand these aspects of a person's values and beliefs might struggle to engage with important issues.

This study also relates to findings by McCabe *et al* (2004). Their study sought to investigate whether the Theory of Mind deficits suggested by empirical literature (e.g. Harrington *et al*, 2005) were supported by conversational analysis of clinical interactions with individuals diagnosed with schizophrenia. Their findings suggested that participants were able to understand others' perspectives, even if the disagreement between their own perspective on delusional ideas and the anticipated other's perception did not lead to modification of their belief. Although the accounts described in this study were not analysed in the same manner, the process of holding and understanding that other perspectives were available formed a key part of this section on explanations and understandings. This study therefore supports McCabe *et al*'s suggestion that the proposed Theory of Mind deficit may need some reconsideration that takes account of such examples of perspective-taking by individuals.

Individualism of Explanations and Religious Activities

In describing their (usually spiritual/religious) ontology, it was notable that nearly all participants explained them in terms of ways that they had independently made sense of life as an autonomous individual. Even the participants who identified themselves with a particular organised religion or spiritual community discussed ways in which their sets of beliefs differed from the consensus opinions within those groups. Much of the discussion about this seemed to imply that the primary concern for many participants was their relationship, or potential relationship, with God (or in one case spirits) directly. This was often informed by the experiences the participants had of being somehow connected with the divine, either in a concrete sense of engaging in conversations (as was the case for two participants), or in a more ethereal sense of a phenomenology that implied strong but undefined emotional experiences, typically euphoric. The primacy of this direct relationship seemed to give participants a sense of permission to be less engaged with the perceived belief and activity structures of the spiritual/religious communities.

There implication of this tendency within this sample relates to how services and clinicians might approach issues of culturally and religiously appropriate activity, in particular in terms of training activities. Training commissioners might typically arrange awareness raising training, in which particular religious groups may talk about the specific belief systems of their denomination, and think about how these might affect mental health issues. Religiously aware services might also arrange for contact between their clients and members of the relevant spiritual/religious community - again, one of Crossley and Slater's (2005) clinical psychologist participants described recommending that clients go and see their minister. Whilst both of these approaches are commendable in their own right, there is a potential danger of missing the individual nature and importance of the client's framework by assuming its relationship with generalised religious frameworks. Appropriate training may involve the development of clinicians' ability to explore these issues with the clients.

An important part of this ability would be in communicating the clinician's openness to discuss such matters to their clients. This is notable in the light of the finding that concerns with hiding, denial and pretence were salient to this sample. The finding that some were concerned with hiding aspects of their unusual experiences from either clinicians or family members is similar to Boydell *et al* (2006), who also found that their sample were concerned with hiding their experiences in the early stages. The finding that this sample were at times similarly concerned with needing to hide their own belief systems from both family and services is perhaps a concern. This might suggest that they have not experienced professional or personal relationships that were conducive to sharing two important aspects of their lives. This could clearly limit the amount of help that they are able to receive for dealing with the sometimes “dreadful” experiences using their own resources of values and beliefs. This study does not to suggest ways that clinicians could demonstrate their openness to such individuals, but merely points to this as an area that could need development and further research.

Effect of Religious/Spiritual Explanations

The contribution that spiritual/religious beliefs made in dealing with the experiences was not straightforward. There were some clear examples of how reactions with a spiritual/religious context were appraised as under the participants’ control and useful - for example, the experience of praying or meditation leading to a reduction in voices or difficult thoughts was repeated in a number of accounts. There were also examples of how the spiritual beliefs that arose as a consequence of the experience helped to give participants a more positive sense of meaning; for example, developing a reassuring sense of the microscopic nature of human existence in comparison to God, or hoping that such wonderful experiences are related to God and could potentially be experienced again. Sometimes, the standards and directives suggested by spiritual/religious beliefs were important factors in participants’ outcome; this included the belief that suicide would not have been acceptable because it would be against God’s wishes, or various examples of individuals seeking a pro-social way of living as it corresponded to their spiritual/religious framework.

However, there were also examples of the spiritual/religious beliefs negatively affecting the participants' experiences. This included beliefs that God would seek to punish a childhood crime, a belief that re-emerged at each example of a negative experience, and apparently exacerbated the associated fear. The expectations created by involvement with spiritual communities were also at times experienced punitively, which corresponds to the findings of Redko (2003), whose ethnographic study in Brazil also suggested that the pressure of spiritual communities could cause individuals experiencing their first episode of psychosis difficulties.

This mixed picture can be related to the findings in Drinnan and Lavender's (2007) qualitative study investigating religious beliefs and religious delusions; within their finding that participants described a religious-identity development, they noted discussion of positive and negative aspects of religion. However, in assessing the likelihood of each of these aspects, reference can be made to Mohr *et al* (2006), who interviewed 115 outpatients with psychotic illness. They found that religion had a positive effect on 71% of their sample in dealing with their experiences, whilst it had a negative effect on 14%. Once again, these findings point to the importance of clinicians being able to discuss a clients' spiritual/religious beliefs without inhibition: in some circumstances, they can represent a valuable resource from which therapeutic options might be drawn; in other circumstances, they may be presenting focal points of distress, that could be invaluable for sensitive exploration of the kind described by one participant in Crossley and Slater (2005).

Spiritual vs. Psychotic Experiences and Explanations

There is a discussion about the extent to which experiences labelled as psychotic and those labelled as spiritual can be distinguished. The suggestion is that the underlying psychological correlates of either experience would be similar, with the only difference being in the manner in which they affect the individual’s life (Jackson, 2001; Jackson & Fulford, 1997). Jackson describes both as experiences that are beyond the mundane consensual reality and similar on a number of factors that typically describe psychosis (e.g. true vs. pseudo hallucination, control, duration), but spiritual experiences are experienced as a source of help in times of crisis, whilst diagnosed psychotic experiences are those that impair life functioning.

The accounts of participants in this sample also suggest a discriminatory difficulty. For most of the individuals, their reports of experiences that were beyond the normal spectrum of experience included both negatively and positively appraised examples. Beyond just the participants’ appraisal, these were likewise seen interpretatively as an outsider to have both positive and negative effects on the areas of functioning described within diagnostic criteria such as DSM-IV-TR (APA, 2000). However, there was rarely distinction in the type of attribution made between the positive and negative experiences. The exception was the one person who suggested that the time they stopped trusting in God’s voice was the time that this voice was a construction of their own imagination; however, this still appeared to be a difference in their reaction to it rather than a difference in the core phenomenology. Differences in attribution that were seen suggested more that negative experiences could be related to a different aspect of the spiritual framework (e.g. good spirits vs. bad spirits); this is despite the fact that, in the clinical opinion of the research team, all of the negatively appraised experiences would have suited the application of a label of psychosis, even for the participants who had never accessed mental health services or received a psychiatric diagnosis. The fact that individuals do not appear to discriminate between their experiences in this manner might support the suggestion that some of the underlying psychological and neurological correlates of such experiences are shared.

Growth and Learning

Many participants related their accounts in a way which implied that they used both the unusual experiences and other parts of their life as an opportunity for personal development. This fits both with literature about recovery in psychosis (e.g. Kelly & Gamble, 2005), and also other qualitative literature about the changing and challenging effect of psychotic experiences on identity (e.g. Geanellos, 2005). The presence of this thread can perhaps inspire hope within clinicians that therapeutic intentions around ideas such as self-actualisation would appear to be congruent with the way that some of these individuals conceptualise their own states of both current being and potential futures.

Extraneous Material

This analysis sought to be inclusive of all material brought by participants without focussing solely on the material relevant to research aims. As a result, there is a large selection of material which does not relate directly to the understanding of the relationship between religious/spiritual beliefs and psychotic experiences. This includes the themes and areas reported such as the general narratives, the identity descriptions, and even the context narratives of the unusual experiences that were not directly elicited by the interview schedule. However, these areas were reported and are worthy of comment because of the potential relevance to understanding experiences for this population. It could be suggested that in seeking to so explicitly share wider elements of their life in describing their unusual experiences and spiritual/religious beliefs, these participants were demonstrating a perception that the understanding of these elements can only be achieved when the listener (researcher) is provided with the wider context that they exist in. Potentially, this can be referenced to the numerous examples of qualitative research with individuals who have experienced psychosis which have found that elements of the person's sense of identity are closely linked to their psychotic experiences (e.g. Geanellos, 2005); in other words, the breadth of participants' accounts found in this study may reflect the importance of these issues to their core sense of identity.

It is accepted that the wider range of issues brought by the participants might have reflected over-inclusive interviews that could have been made more focussed; however, it should be noted that four individuals beyond the author had opportunity to comment on the process of the interviews, and found them to be acceptable.

Limitations

A limitation of this study lies within the characteristics of the sample. The methodology was conceived to be inclusive of any range of types of experiences, sets of beliefs, levels of functioning, and many elements of demographic status. Unfortunately, the sample recruited did not entirely reflect these intentions. The sample included only one non-white participant, which does reflect the study's catchment area with a population that is 91% white (National Statistics, 2007). Although the themes identified were as relevant to this individual as the other participants, it is conceivable that there are issues to do with descriptions and explanatory frameworks that might be culturally bound and more different in individuals from non-white ethnic origins. These potential elements were missed in this study, and may reflect an avenue for further investigation of this type.

Although no formal assessment of current general functioning was sought, the participants who did take part might all have been considered to be in the relatively well-functioning spectrum of people who have experienced psychosis. Geanellos (2005) described how his qualitative analysis of 1st person accounts of people with a diagnosis of schizophrenia found that people described stages of *fragmentation* followed by *disintegration* followed by *reintegration* followed by *reconstruction.* Within this kind of framework, none of the participants would probably have identified with currently being in either of the first two less functioning states (which could be considered comparable with terminology such as “acute phase” in other literature). This suggests that the accounts obtained might be considered only of relevance to people who have reached some sense of consolidation of the self following the experiences, which does not entirely reflect the research aims.

The intention of the author had been that any individuals whose psychotic experiences had led to a loss of spiritual/religious beliefs would be able to take part within the recruitment criteria and methodology. No such individuals responded, and so no discussion can be made of any such causal link. It is conceivable that there are few such people around in comparison with people whose pre-psychosis beliefs were maintained or increased through the experiences; however, it its more likely that the recruitment strategy failed to evoke the necessary resonance for such individuals to contact the research team, and perhaps a more explicit strategy would be needed to access such individuals, assuming they do exist.

Although the author undertook various elements of quality control, it is accepted that this could have been improved upon. In particular, a form of respondent validation would have been a useful tool in assessing the analysis. It is unfortunate that the intended process of a focus group could not be employed. As original participants had not consented to be contacted regarding the analysis of their interviews, this process could unfortunately not be ethically approved following the discarding of the focus group from the research protocol. IPA studies should ideally seek to ensure that some level of such validation will occur.

Further Research

The aims of the study were intended to understand religious/spiritual beliefs in general, and therefore the recruitment method did not distinguish between individuals who identified themselves with any particular denomination of organised religion. However, there may be different areas of shared phenomenology and conceptualisation between individuals who do identify with particular groups, which could form the basis of further qualitative investigation.

The implications for clinical practice are discussed, with recommendations including a more tolerant approach to individuals' attributions for psychotic experiences and encouragement of services to provide a more open forum for individuals to be able to discuss their individually derived spiritual/religious frameworks. Following on from these recommendations, further research could well aim to assess the impact that such changes in approach have on both satisfaction and outcome.

A number of the limitations discussed above represent examples of invisible barriers inadvertently created within the recruitment strategy. Readers proposing further research, either within this field specifically or with individuals who have experienced psychosis generally, are advised to consider how they can avoid creating similar barriers for their participants.

Conclusions

The use of qualitative methods to develop an understanding of this group of people has revealed some interesting results. There is evidence here that individuals who provide spiritual explanations for their experiences often do so on the basis of a sophisticated reasoning approach that has made due consideration of alternatives, including engagement in testing of their explanations. There would appear to be some value in these explanations for the ways in which they fit with individual's general beliefs and their sense of self in the world. Spiritual explanations need not be mutually exclusive of biological explanations according to these individuals.

When considering spiritual attributions for such experiences, clinicians should remain aware of the individualism of these explanatory frameworks. Regardless of whether individuals identify with a particular organised religion, the evidence from this sample is that they will engage with spiritual beliefs with a level of autonomy. In particular, the importance of a perceived relationship with a divine element such as God can provide more meaning to individuals than the constructs of a religious consensus. Given the likelihood that individuals will feel compelled to hide either their experiences or their beliefs, the nature of these discussions would need a careful and open-minded approach, to avoid diminishing opportunities for personal growth.

The experiences of individuals who hold spiritual/religious beliefs and who ascribe spiritual/religious explanations to their discontinuous experiences suggest that the typical distinction of psychosis, that it has negative effects on an individual’s function, may not be represented in any essentially different phenomenology for these people. This finding could inform the discussions about the use of such classifications, and the theories about their pathology.

References

American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, Text Revision)*. Washington DC: APA.

Boydell, K. M., Gladstone, B. M., & Volpe, T. (2006) Understanding help seeking delay in the prodrome to first episode psychosis: A secondary analysis of the perspectives of young people. *Psychiatric Rehabilitation Journal,* **30,** 54-60.

British Psychological Society (2000) *Recent Advances In Understanding Mental Illness And Psychotic Experiences: A Report By The British Psychological Society Division Of Clinical Psychology.* Leicester: BPS.

Carone, D. A., & Barone, D. F. (2001) A social cognitive perspective on religious beliefs: Their functions and impact on coping and psychotherapy. *Clinical Psychology Review,* **21,** 989-1003.

Crossley, J. P., & Salter, D. P. (2005) A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research and Practice,* **78,** 295-313.

Dam, J. (2006) Insight in schizophrenia: A review. *Nordic Journal of Psychiatry,* **60**, 114-120.

Drinnan, A., & Lavender, T. (2006) Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions. *Mental Health, Religion and Culture,* **9**, 317-331.

Geanellos, R. (2005) Adversity as opportunity: Living with schizophrenia and developing a resilient self. *International Journal of Mental Health Nursing,* **14,** 7-15.

Gilbert, P. (2006) Breathing Space. *Community Care,* **19-25 January 2006,** 36-37. Accessed from on 29th July 2007 fromwww.nimhe.csip.org.uk/our-work/spirituality-in-mental-health/spirituality-resources.html

Goodman, C., Knoll, G., Isakov, V. *et al* (2005) Insight into illness in schizophrenia. *Comprehensive Psychiatry,* **46,** 284-290.

Harrington, L., Siegert, R. J., & McClure, J. (2005) Theory of mind in schizophrenia: A critical review. *Cognitive Neuropsychiatry,* **10,** 249-286

Hartog, K., & Gow, K. M. (2005) Religious attributions pertaining to the causes and cures of mental illness. *Mental Health, Religion and Culture,* **8,** 263-276.

Jackson, M. 2001) Psychotic and spiritual experience: A case study comparison. In I. Clarke (Ed), Psychosis and Spirituality: Exploring the New Frontier. London: Whurr, 165-190.

Jackson, M., & Fulford, K. W. M. (1997) Spiritual experience and psychopathology. *Philosophy, Psychiatry, and Psychology,* **4,** 41-65.

Kelly, M., & Gamble, C. (2005) Exploring the concept of recovery in schizophrenia *Journal of Psychiatric and Mental Health Nursing,* **12,** 245–251.

Kinderman, P., Setzu, E., Lobban, F. *et al* (2006) Illness beliefs in schizophrenia. *Social Science & Medicine,* **63,** 1900-11.

McCabe, R., & Priebe, S. (2004) Assessing the stability of schizophrenia patients' explanatory models of illness over time. Journal of Mental Health, **13,** 163-169.

Mohr, S., Brandt, P. Y., Borras, L. et al (2006) Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. *American Journal of Psychiatry,* **163,** 1952-1959.

National Statistics (2007) Neighbourhood Statistics: Area, Sheffield (Local Authority) Site accessed on 29th July, 2007. http://neighbourhood.statistics.gov.uk/dissemination/LeadTableView.do?a=3&b=276794&c=sheffield&d=13&e=13&g=365736&i=1001x1003x1004&m=0&enc=1&dsFamilyId=890

Navon, L., & Ozer, N. (2003) Ordinary logic in unordinary lay theories: A key to understanding proneness to medication nonadherence in schizophrenia. *Archives of Psychiatric Nursing,* **17,** 108-116.

National Institute for Clinical Excellence (2002) *Schizophrenia: Core Interventions In The Treatment And Management Of Schizophrenia In Primary And Secondary Care (Clinical Guideline 1)* London: NICE.

Redko, C. (2003) Religious construction of a first episode of psychosis in urban Brazil. *Transcultural Psychiatry,* **40,** 507-530.

Smith, J. A. (1995) Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre, L. V. Langenhove (eds), Rethinking Methods in Psychology. London: Sage, 9-26

Smith, J. (2004) Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology,* **1,** 39-54.

Werbart, A., & Levander, S. (2005) Understanding the incomprehensible: private theories of first-episode psychotic patients and their therapists. *Bulletin of the Menninger Clinic,* **69,** 103-136.

Tables

Pseudonym	Gender	Age	Ethnicity	Religious Denomination
Abdul	M	24	Bangladeshi	Islam
Barbara	F	54	White-British	Roman Catholic
Chloe	F	41	White-British	Spiritualism
David	M	59	White-British	--
Ethel	F	75	White-British	I see my truth in them all
Felicity	F	45	White-British	Church of England
Gordon	M	51	White-British	Christian
Harry	M	35	White-British	Christian (EVJ)

Figures

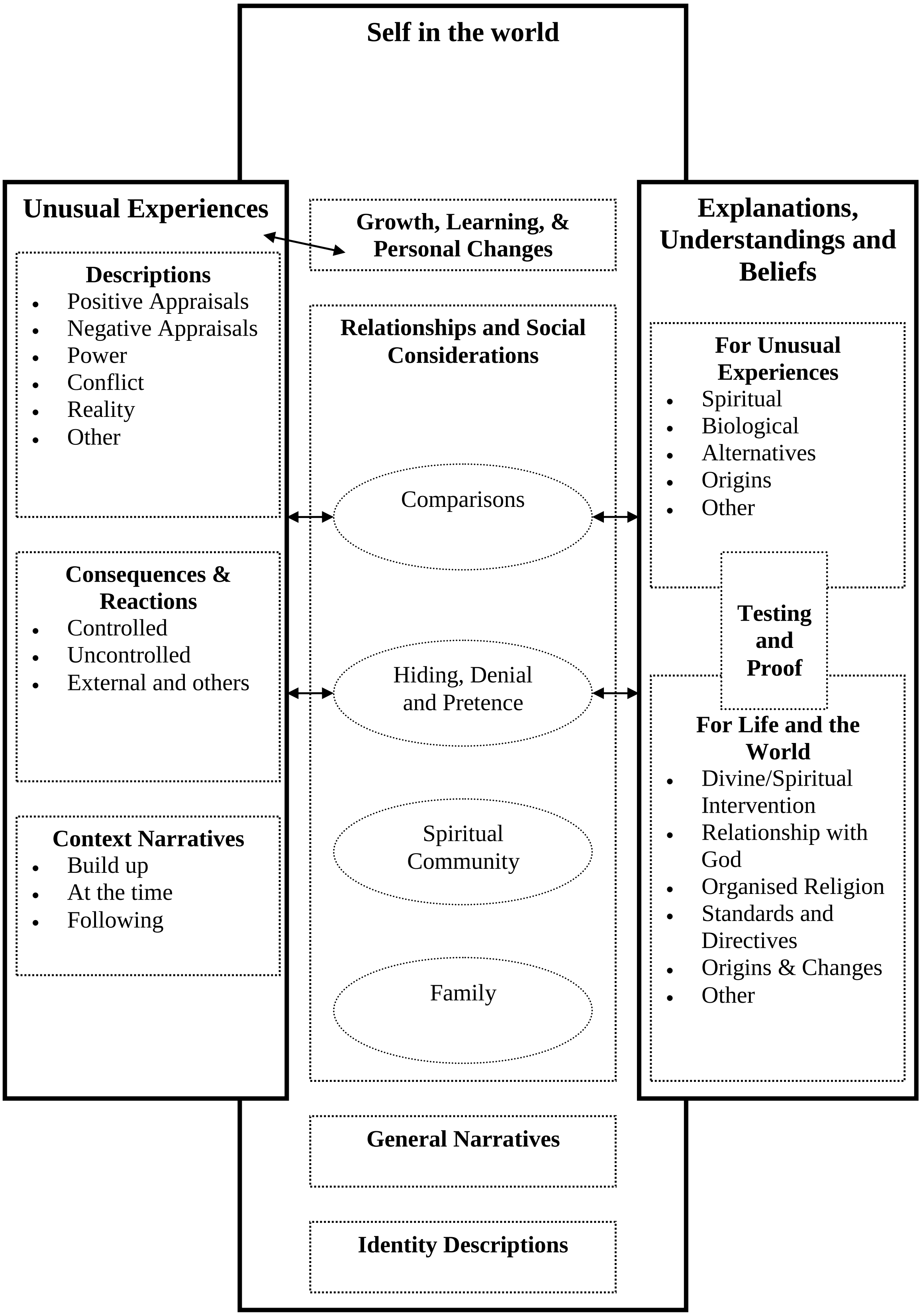


Figure 1: Diagrammatic representation of general theme structure

A Qualitative Investigation of the Relationship between Psychosis, Positive Discontinuous Experiences, and Spiritual or Religious Beliefs

A Critical Reflection on the Research Process

Project Conception

The origins of this topic can be drawn back to my undergraduate studies over five years ago. Coming from a background of personal religious and spiritual practise, I was confronted within the learning environment with what I perceived to be a general cynicism or dismissal towards matters of faith and spirituality. In attempting to reconcile what I felt to be a disparity between my personal beliefs and my academic pursuits, I spent some time investigating and critiquing some of the psychological literature regarding the area. In particular, I assessed the general tone of psychological research as considering this as an area of personal belief that could be explained in reductive terms - heuristics, coping strategies, social theories, and neuropsychological curiosities. There did not appear to be openness to adopting a position of the possibility of truth in what is described in spiritual/religions texts and communities (e.g. Carone & Barone, 2001). I personally felt that this was a short-sighted view resulting from the drive within psychological professions to be considered *scientific*, but which actually operated without actually fully investigating with an open mind in the manner that would be expected of a scientist. It was these initial thoughts that originally inspired me to believe that this was an area in which further psychological research would be valuable.

My specialisation into considering the experiences of psychosis specifically with spirituality came then from my clinical practise as an assistant psychologist. Working on an inpatient setting within severe and enduring mental services, I observed a system which I believe failed to adequately address its users' spiritual and religious needs and beliefs, at either an organisational level or an individual care-planning and formulation level. This was all the more apparent when religious content appeared within a service user's supposedly delusional framework. Again, I was motivated by what I perceived to be a lack of understanding to develop the knowledge base within this area.

The catalyst to convert these initial motivations into a useful project then came following the research fair at which my supervisor presented her ideas for a research topic in which psychosis and spirituality were considered. Our initial meetings suggested that we were approaching the topic from different stances. Her thoughts had been primarily around the similarities in experience and conceptualisation between people with more atypical religious views (such as New Religious Movements) who had also experienced psychosis. This contrasted with my ideas about understanding the experiences of what I was calling "standard" religious beliefs. Our discussions soon led to more usefully operationalised ideas which allowed the development of the design.

The origins of this process have made a difference to how the project continued. My initial passion for the area has essentially fuelled my motivation to continue with the work during some of the more difficult times, and in particular the times when the bureaucracy and administration side of research was consuming all of the time and energy that could be put into it. In future, I will try to use this as a self-check before embarking upon any research, as I think that without the interest in the work, the process runs the risk of progressing far too slowly to be of use.

The initial discussions also highlighted two important learning points. Firstly, the utility of discussion at the conception stages should not be undervalued. The process of conversation about ideas highlights disparities and inconsistencies, and opens up new avenues, in a way that personal reflection and rumination cannot. As an NHS researcher, I might be likely to find myself in situations where I could be the only worker directly involved with a project, but my experience here would ensure that I endeavour to always seek peers for sounding about ideas, if not collaborators.

Secondly, the discussions illustrated to me how it can be useful to find a collaborator who has some differences of opinion, particularly if I feel as passionately about a topic as I did here. My supervisor described herself as agnostic/atheist, which provided an important counterpoint to my personal investment in spiritual beliefs. These differences encouraged me to be more focussed on the grounding of the research within the context that it would be perceived in the academic literature, and I would hope to find again collaborators who were prepared, implicitly or explicitly, to challenge any of my own lines of enquiry or discourse that might hamper the validity of my research.

Project Design

Methodology

The initial stages of design included selection of methodology for the research question. My first priority was that the methodology should be driven by understanding the complexities of both individuals' spiritual or religious beliefs and their experiences of psychosis. In light of the scarcity of academic literature covering this area, I felt that there was no quantitative scale or methodology available that could adequately capture the breadth of the area without overly condensing potentially important areas of experience. I was therefore drawn towards using a qualitative methodology. This was also biased by my experiences at undergraduate level using a quantitative interview schedule, where I frequently found myself frustrated by having to condense a lot of information described by participants into a single number on a scale; I personally felt that this time, I wanted to be able to let people talk more and make use of the times that they did.

I find myself wondering how common this is within research processes; I can imagine that a lot of time, the research methodology chosen is not based solely on an area of research independently identified then defined in terms of the best methodology so suit the question, but does often have to necessarily incorporate an element of what the researcher is personally interested in and feels comfortable in doing. This reiterates my earlier point regarding being interested in the subject matter, as being interested in the methodology probably also keeps the individual researcher engaged.

In electing to use qualitative research, I then had to decide on the specific methodology to use. Faced with a number of options, I was drawn to IPA for two reasons; firstly, I felt that the grounding in phenomenology fitted closely with my research question about understanding what the experiences of participants are, contrasting with approaches concerned more with language used (such as discourse analysis or narrative analysis), or approaches concerned with wider contexts and using phenomenology as only part of the evidence (such as grounded theory). Secondly, there were pragmatics involved, in that the methodology was one in which I could find a lot of support from within my institution (which is important for using a novel technique), and which fitted with the rest of the processes that I would have to be involved in. For example, I could not envisage the definite point at which I could stop my recruitment having achieved saturation in a grounded theory approach; I was concerned that this would feel unethical in that I would ultimately have to stop at some point in order to submit the project for the deadline. I was also concerned about my capability to be continually circular and responsive within the analysis to data collection cycle, as would be expected in grounded theory, in the context of my limited time available. Again, I take from this the learning point that one must acknowledge the practicalities of conducting research when selecting methodology.

Terminology

The nature of my philosophy towards both psychosis and spirituality affected the design of the project. I was keen that the project be inclusive and non-labelling as far as possible. As is becoming increasingly common within psychology and further afield, I have some disagreement with the way the “psychiatric disorders” are classified and diagnosed (e.g. BPS, 2000), and do not consider the diagnoses such as schizophrenia and bipolar disorder to be entirely valid as descriptions of individuals’ direct experiences.

However, in making the research useful to services and the individuals who use them, I had to recognise that these services commonly do use diagnostic categories; I would also be naïve in ignoring a level of shared experience between users within these services. I also had to consider that IPA does seek a level of homogeneity within its sampling. The term *psychosis* was therefore selected to try and describe a common set of experiences that could be understood non-pejoratively by both services and most of those who had these experiences. My collaborator from the service-user forum did say that even this term might not be accepted or understood by all participants. Therefore I settled on deciding that I could honestly use this term at a theoretical level when planning and describing the project, and not hide it from participants (for example, mentioning the word as a potential descriptor in the information sheet); however, I would also ensure that my interactions with participants were primarily around the nature of the experiences that they had on their terms, without forcing the term on them in any sense. It was important for me to be clear in my head about what I meant by psychosis, and to regularly reflect on ensuring that I didn’t find myself in a pejorative labelling process.

This left certain difficulties in operationalising my sample, running the risk of falling too close to potentially including the entire population, and I eventually had to use a method which did, to some extent, impose my subjective categorisation and acceptance onto another’s experience. Ultimately, I feel the chosen strategy did strike the right balance, and has allowed recruitment of a sample whose experiences would be meaningful to many of the people whom this research is aimed at either helping or influencing. I would like to ensure that I do not shy away from the potentially controversial understandings of psychology, but that I approach future research with a more pragmatic style from the start, and I would expect to be able to find a way of combining these two elements if necessary.

Clinical Implications and Rooting

At the initial stages of design, I was readily prepared to consider the general theoretical issues that were present within this area, and focussed on the philosophy of what might result from the research. However, I needed a level of direction within supervision to ensure that I remained aware of the importance of bringing clinical implications from the project. This was a useful reminder to keep me focussed throughout the project on where I hoped the research would have an effect, and what kind of things would be most useful to that audience. It also meant that I was reminded to consider where the current clinical psychology literature was. Whilst I wanted to think primarily about experiences of psychosis and beliefs about spirituality, I would have been ignoring the fact that there is an area that is looking at how spiritual and psychotic experiences are related (Clarke, 2001). My initial reluctance to follow this path was related to my own thoughts that this could be seen as part of the literature that suggests a scientific dismissal of the possibility of truth in spiritual conceptualisations. However, supervision helped me to understand firstly, that by not covering this within my research I would potentially be denying participants their opportunity to contribute to the debate, and secondly, that engaging with the debate through research was a more effective way of impacting positively in the manner I desired. Ultimately, I came to realise at a later point that the implications of Clarke’s work in particular does not necessarily subscribe to the point of view that I was reacting against, and I hope that this project can contribute to that movement.

Interview Schedule

As the main interface between the thoughts I was having about the research question and the process of eliciting participants' experiences was going to be the interview, it was important to design a schedule that adequately addressed both elements. There were four phases to the life of the schedule:

1. Producing a schedule following my initial reading and discussion with my supervisor; this had four general areas of the experiences of psychosis, the nature of their spiritual or religious beliefs, the interaction between them, and their identity or how they would describe themselves. There was some difficulty at this stage in trying to develop a useful set of prompts within these areas; in particular, we were reading around Smith's writings on funnelling (Smith & Osborn, 2003) and finding ourselves resistant to putting anything at the lower end of the funnel.
2. Discussing the schedule with my collaborator from the service user forum and an IPA-informed peer. At this point we discarded the separate section about the personal identity as seeming somewhat artificial. I had originally included it as an open question so that if participants responded to it with spirituality or psychosis language, it would represent their own perception rather than having been led into it. However, we discussed how this would in fact be untrue, as the nature of the project and questioning beforehand would arguably have primed participants into this anyway. The questions were therefore integrated into the other sections as prompts. The prompts were firmed up somewhat - it seemed that the decisiveness of the

individuals in this discussion moved us beyond worrying too much about the funnelling side and recognised that to ethically make use of mine and participants time, there had to be a sense of direction for myself and the participants within the interview.

3. The pilot interviews, which were firstly a practise session with a peer and then the first participant recruited, gave me the opportunity to check how the questions seemed to be received. The direct feedback of my peer practise suggested that the questions did not feel offensive in that context, and the relative engagement of my first participant also gave me the confidence to proceed with the schedule as planned.
4. The continued use of the schedule throughout the interviews was itself a part of the design process. I found that the schedule was essentially a guide, but not one interview followed the process which would be suggested on the schedule. This was as expected from the IPA readings and writings; as discussed further below, I think that my experience of interviewing skills within the context of a therapeutic clinician helped me to allow this process in a relaxed fashion. This meant using the schedule as primarily a checklist that areas had been covered, and reflecting where I thought previous answers had already covered a question on the sheet and checking if there was more to add.

I take from this experience the reassurance that schedules can be creatively designed and are useful in focussing the researcher at the outset, but must also be approached with an open mindedness that ensures that allows the participant to follow the leads that they think are more appropriate to their experience.

Project Conduction

Time Balancing

My main learning point on conducting this project from conception to completion regards the length of time required for processes not directly related to the data collection and analysis. From allocation of supervisor and initial agreement of project area in Summer 2005, it was nearly 15 months before I met with my first research participant, followed by 8 months before I had to hand in the completed thesis. This nearly 2:1 time ratio reflects the amount of time that the administration of the project required; writing and amending protocols, submitting and amending ethics and governance applications, then contacting services and arranging recruitment.

Throughout this time, I wanted to make a start on the process of actually finding out what I wanted to, but felt frustrated in not having the freedom to do so. Whilst some of the time was useful in the sense of contributing to a more solid project conception, there was a lot of time that ultimately was entirely necessary but not stimulating. As already said, I would take from this the importance of being interested in the research to make the effort of these times feel less onerous. However, my main learning would be about personal expectations of the progress of the project, and having a sense of realism about the time that it may take. I also feel that I would benefit from maintaining a close watch on the timescale, and set reasonable deadlines that could keep me on task with these less stimulating research requirements. This is particularly important in the context of organisations (such as ethics and governance) which have their own timescales and deadlines that can have their own moderating effect on the process.

Reliability and Validity

The reliability checks used in this project were audit and comparative analysis by peers with experience in the use of IPA; four different individuals looked through at least one transcript (different for each peer), commented on the processes observed, gave at least their initial impressions of themes that were emergent (in some cases having produced a list of their own themes for sections of the text), and commented on the initial lists of themes I produced alongside the textual excerpts from which they were derived. This seems to meet an average level of reliability audit. There are IPA studies in which only one transcript from a selection might be audited, and only one individual is used for this peer review. However, this was not the highest level of audit to which I aspired initially, having planned to hold a focus group with a theoretically similar sample of participants to the interviewees; this would have been a novel approach within IPA to my knowledge. Recruitment issues meant that this was not possible, and although one of the project team is a representative of the service user forum, he also has an academic and clinical background meaning that the final set of themes has not faced any form of evaluation by lay individuals or participants. I believe this to be one of the biggest limitations of the project.

In future, I will plan projects more carefully with a back-up plan to ensure that such validity checks do occur. I would hope that this be easier within time-frames that I hope to be operating under in the future; the deadline set for this project meant that, having realised that the group would not be able to occur, I was not in a position to arrange alternative forms of validation. Having seen how a peer of mine, also conducting an IPA project, summarised each of their participant’s themes in a letter and used this as validation, I would consider this approach as my first choice in the future, and allow for it during the project design stage.

Interview Process

In conducting the interviews, I was intrigued to note the importance of my own reactions to participants. The individuals were from diverse backgrounds, and I took it as a challenge to ensure that each interview was as valid as the others in terms of giving participants the correct kinds of opportunity. I think that part of the reason this was achieved related to my intention to always maintain a genuine openness to the potential truth in what they were saying, and accept that their spiritual framework might be closer to the truth than my own. I feel this was reflected in their responses to the interview, where some participants described how they had spoken more about here than they had in therapy. Of course, this partly reflects the entirely different contexts of the situations; however, it still indicates that they felt comfortable in this setting, and I take some credit for that.

Analysis

Time Intensity

This was my first attempt at conducting IPA, and so I was not entirely prepared for how long the process might take. Although warned about this within teaching, supervision, and reading within the IPA literature, I still found that the whole process took longer than I had envisaged in every aspect. To start, despite having had the interviews transcribed externally, and despite what I would consider a fairly high quality of transcription, I still found that just listening through the recordings again whilst checking the script took up to four hours per hour of tape. I had then expected that the process of initial analysis would take around five hours per hour of interview from blank transcript to having completed both columns; again, this was an underestimation, and I would think that it probably took on average twice this amount.

Part of the reason that this level of time intensity felt difficult was due to the nature of conducting this research whilst on clinical training. I found that having only a single study day a week made it difficult to maintain my focus on the task from one week to the next, particularly when there were always a number of administration tasks or meetings to fit in. Having underestimated the time required for auditing the transcripts, I also found myself with less time on the study blocks I had arranged, which had also been set up in smaller blocks in order to minimise disruption to my clinical placements.

Whilst I do take from this the learning point that I should not underestimate the time needed for these kinds of research processes, I think that a useful part of this experience is that it did reflect the kind of context that I would most likely experience in conducting research as a clinician in the future. In this sense, I can take a sense of the achievable from the process; despite not being able to arrange time being purely focussed on my research, I have been able to come through at the end with a project that fulfils in a large part what I had wanted it to do. I can now believe that this would be possible in future settings provided that I can be disciplined in protecting at least a little time for the process.

Clinician vs. Academic

There are a number of instances in the process of analysis that have led me to question the potential differences that might occur in research processes when the interviewer or analyst is a clinician rather than a pure academic. Firstly, I realised in the process of interview that I was very geared towards allowing the participant to tell their initial narrative for a substantial period at the start of the interview, without much orientation towards specifics of the project; this could have been closer to the process that I would typically find in a clinical assessment than might necessarily be used in a typical academic semi-structured interview. Secondly, reflecting on an interview process with my supervisor in an audit session, we noted that I was tending to speculate about the participant’s motive for responding in a particular way, rather than just observing it. Finally, I noticed in my analysis that I was finding myself drawn towards similar processes of formulation that would be used clinically, and in particular that I often felt frustrated by not having the full information to comprehensively formulate - of course, not having all the information is not different from what would necessarily be expected in an initial clinical assessment.

In my position as a clinician-researcher, I am not able to know whether these three factors are peculiar to clinicians. I believe from my reading of IPA writings and discourse that the three observations are not discordant with the underlying theory, and I may be misjudging the likely experience of researchers who are not used to clinical interviews in suggesting that they would not also necessarily observe these factors. Part of the difficulty in knowing whether there would be a difference in approach is that IPA has typically been adopted primarily within Health and Clinical Psychology, and so perhaps the majority of publications are from clinician-researchers; a discussion about whether there is, or would be, a difference in process or analysis between projects conducted by pure academics as opposed to clinician-researchers might be a valid topic within the debates around IPA.

What I am sure of is that this part of the process was clearly informed by my four years of clinical experience of listening to and exploring people’s beliefs about themselves and their experiences; similarly, I think that being able to hold participants’ engagement and trust within interviews (as corroborated by the four individuals who audited transcripts) was helped by my previous experience of active listening within therapy.

For future research using this methodology, I think I would try to find a means of audit which did not involve just individuals who had some experience of providing a clinical interview themselves, so that I could be informed by the discussion around whether my own position as a clinician influenced any part of the process. This is one level of audit that was missing from this project, as all four individuals who looked at my transcripts work regularly as clinicians themselves and so would not be able to offer the alternative position (if indeed there is a difference).

Intellectualisation

In the process of audit of my analysis, a discussion arose about the level to which I abstracted themes from the participant's text. My supervisor noted that my wording tended to be at a fairly high readability level, and wondered whether this was appropriate.

IPA is intended to draw interpretative findings that represent more abstract concepts than might be explicitly stated by participants. In this sense, there was justification to this process. However, in reflection I realised that my focus was very firmly on how the findings would be perceived in the journal for which I was writing. I believe that, knowing this journal has a relatively strong academic focus and publishes less qualitative studies than others, I was trying to present an image of intellectual capability that would be respected by the editorial board and readers of the publication. I am also aware that using complex words and intellectualising debates is typical of my personal style of interaction; it is interesting that this should be my tendency when the initial project conception involved a reaction against over-intellectualisation.

Through the discussion, we recognised that the level of interpretation I was taking went further than was justified. It was noted that part of my initial motivation for the project had also been about giving participants a voice, and providing a framework which other people in their position could relate to. The extent to which I was intellectualising my findings moved beyond words that my participants would use, but furthermore beyond words that a number of them would probably be able to understand; the phrase of "where have <u>they</u> gone - this is only <u>me</u> speaking" was developed from this observation. I recognised the need to make the thematic labelling more rooted in the text and more user-friendly; a process that I will hopefully be more aware of within future work.

Plans for Dissemination

1. August 2007: Present findings to Trent Psychosis SIG.
2. By October 2007: Disseminate a brief summary of the project to all who have been involved in the process, including participants both interviewed and not interviewed (unless requested otherwise), local services that were approached to advertise the project, a national spirituality and mental health research group, and all other individuals and groups networked over the course of the process.
3. November 2007: Submit abstract to present findings at Sheffield Health and Social Research Consortium conference.
4. By March 2008: Submit final manuscript of literature review and research report to nominated journals.
5. By March 2008: Offer presentation to service-user forum
6. By March 2008: Offer presentation to Sheffield Interfaith.
7. By March 2008: Offer presentation to Sheffield Care Trust’s Spirituality Project Group.
8. By September 2008: Submit abstract for presentation at a qualitative research conference (e.g. IPA conference, July 2008).
9. By September 2008: Submit abstract for presentation at a psychological or psychiatric conference (e.g. BPS conference, 2-4 April 2008).

Informing Future Practise

As discussed above, the following points are reminders for me of what can help in planning future research projects:

1. Be interested in the research.
2. Ensure projects are comprehensively discussed in the early stage, in particular ensuring that abstract or unclear ideas are better operationalised.
3. Recognise and work within the balance of methodologies that answer the question, are of interest to the researcher, and are practically achievable
4. Be prepared to approach issues of academic/philosophical difference with methods that practically address the concerns, and do not underestimate these.
5. Always ensure that research projects have relevance to current thinking in the literature.
6. Design interview schedules through open discussions, and be responsive in the use of the schedules within the interviews themselves.
7. Be prepared to allow a substantial amount of time for the administrative stages of research.
8. Be disciplined in preparation of deadlines for the initial stages of research.
9. Ensure that lay-validation will definitely be involved in the research process.
10. Be open and prepared for differences in process within interviews.
11. Do not underestimate the time required for good analysis.
12. Remember that I have already been able to produce a good piece of research within the context of working as a clinician.
13. Seek non-clinicians for audit of analytic processes.

14. Avoid over intellectualising or interpreting the material

References

British Psychological Society (2000). Recent Advances In Understanding Mental Illness And Psychotic Experiences: A Report By The British Psychological Society, Division Of Clinical Psychology. Leicester: BPS.

Clarke, I (2001). *Psychosis and Spirituality: Exploring the New Frontier*. London: Whurr.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed), *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage, 51-80.

Appendices

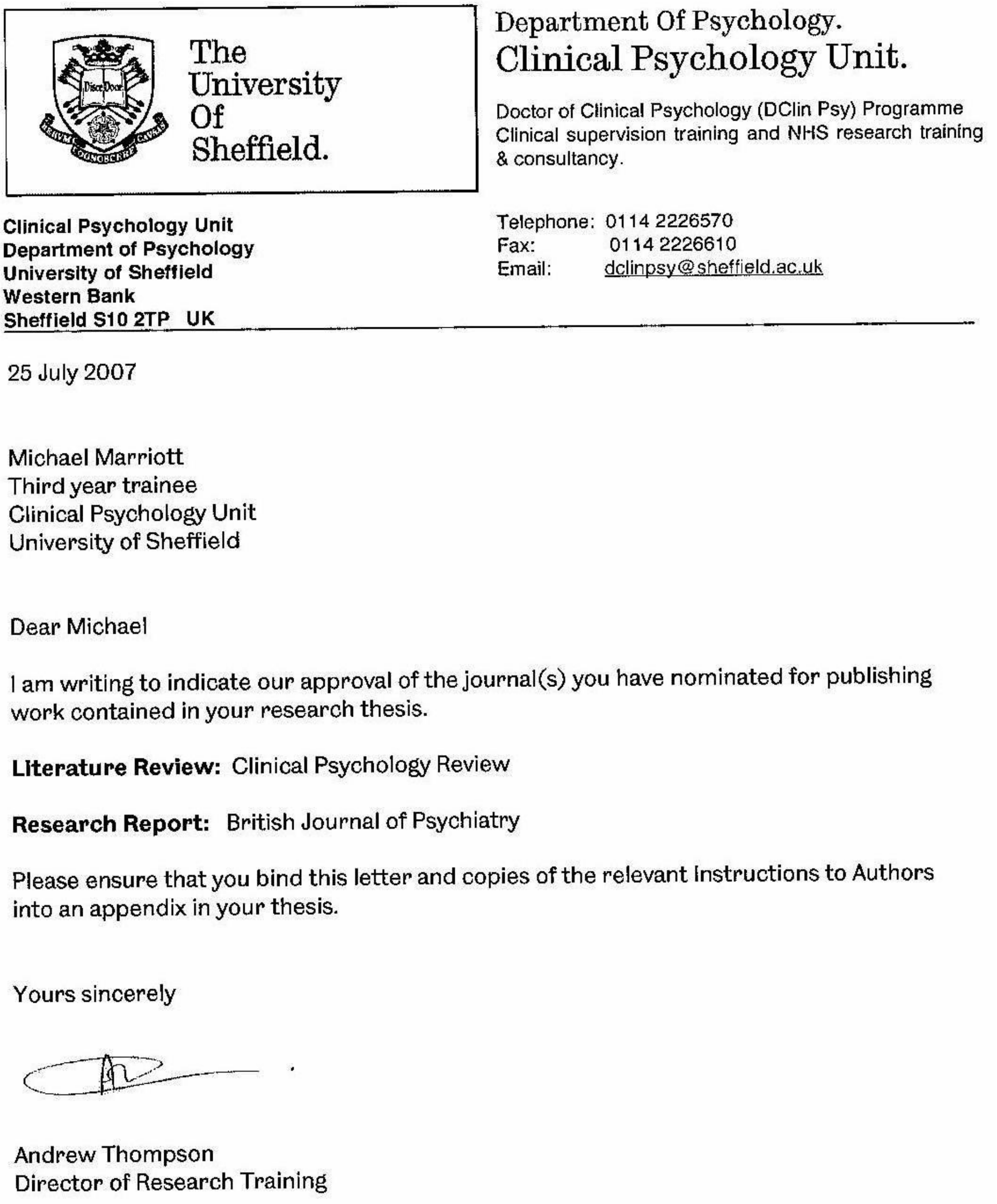
Appendix 1

Appendix 2

Appendix 3

Appendix 4

Appendix 1.a Approval of Specified Journals



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25 July 2007

Michael Marriott
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Michael

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: Clinical Psychology Review

Research Report: British Journal of Psychiatry

Please ensure that you bind this letter and copies of the relevant Instructions to Authors into an appendix in your thesis.

Yours sincerely

Andrew Thompson
Director of Research Training

Appendix 1.b: Clinical Psychology Review Instructions for Authors

Downloaded on 29th July 2007 from http://www.elsevier.com/wps/find/journaldescription.cws_home/652/authorinstructions

SUBMISSION REQUIREMENTS: Authors should submit their articles electronically via the Elsevier Editorial System (EES) page of this journal (http://ees.elsevier.com/cpr). The system automatically converts source files to a single Adobe Acrobat PDF version of the article, which is used in the peer-review process. Please note that even though manuscript source files are converted to PDF at submission for the review process, these source files are needed for further processing after acceptance. All correspondence, including notification of the Editor's decision and requests for revision, takes place by e-mail and via the Author's homepage, removing the need for a hard-copy paper trail. Questions about the appropriateness of a manuscript should be directed (prior to submission) to the Editorial Office, details at URL above. Papers should not exceed 50 pages (including references).

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

FORMAT: We accept most wordprocessing formats, but Word, WordPerfect or LaTeX are preferred. Always keep a backup copy of the electronic file for reference and safety. Save your files using the default extension of the program used.

Please provide the following data on the title page (in the order given).

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract. A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

STYLE AND REFERENCES: Manuscripts should be carefully prepared using the Publication Manual of the American Psychological Association, 5th ed., 1994, for style. The reference section must be double spaced, and all works cited must be listed. Please note that journal names are not to be abbreviated.

Reference Style for Journals: Cook, J. M., Orvaschel, H., Simco, E., Hersen, M., and Joiner, Jr., T. E. (2004). A test of the tripartite model of depression and anxiety in older adult psychiatric outpatients, Psychology and Aging, 19, 444-45.

For Books: Hersen, M. (Ed.). (2005). Comprehensive handbook of behavioral assessment (2 Volumes). New York: Academic Press (Elsevier Scientific).

TABLES AND FIGURES: Present these, in order, at the end of the article. High-resolution graphics files must always be provided separate from the main text file (see http://ees.elsevier.com/cpr for full instructions, including other supplementary files such as high-resolution images, movies, animation sequences, background datasets, sound clips and more).

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Appendix 1.c: British Journal of Psychiatry Instructions for Authors

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Introduction

The *British Journal of Psychiatry* is published monthly by The Royal College of Psychiatrists. The *Journal* publishes original work in all fields of psychiatry. Manuscripts for publication should be submitted online via http://submit-bjp.rcpsych.org.

All published articles are peer reviewed. Contributions are accepted for publication on the condition that their substance has not been published or submitted for publication elsewhere. Authors submitting papers to the *Journal* (serially or otherwise) with a common theme or using data derived from the same sample (or a subset thereof) must send details of all relevant previous publications and simultaneous submissions.

The *Journal* is not responsible for statements made by contributors. Material in the *Journal* does not necessarily reflect the views of the Editor or of The Royal College of Psychiatrists.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style.

Online submission

Manuscripts for publication must be submitted online at http://submit-bjp.rcpsych.org. A unique account will be created for each contributor using his or her email address as identification. (Note for contributors with more than on email account: please ensure you use the same email address whenever logging on to the manuscript submission website.) Contributors may track the progress of their submissions at any time via this website. For assistance with online submission, please email bjp@rcpsych.ac.uk or telephone +44 (0)20 7235 8857. A cover letter should be included with the submission explaining why you consider the submitted article suitable for publication in the *Journal*.

To submit a letter to the Editor, see below.

Fast-track assessment

Authors have the option of submitting articles for fast-track assessment. Those wishing to take this route should state this in the first or second sentence of their cover letter, together with the reasons for rapid assessment. A decision whether to approve the fast-track route will be made within 10 days of submission; those papers that are not selected for this route will be assessed in the normal way unless the authors state specifically that they want fast-track assessment only. All papers approved for the fast-track route will be assessed within 4 weeks of submission. Review articles will not be considered for fast-track assessment.

Title and authors

The title should be brief and relevant. If necessary, a subtitle may be used to clarify the main title. Titles should not announce the results of articles and, except in editorials, they should not be phrased as questions.

All authors must sign the copyright transfer and publication agreement, which can be downloaded from http://submit-bjp.rcpsych.org once a manuscript has been accepted. One of the authors should be designated to receive correspondence and proofs, and the appropriate address indicated. This author must take responsibility for keeping all other named authors informed of the paper's progress. The contribution of each author to the paper must be stated at the end of the article. Authorship credit should be based only on substantial contribution to:

conception and design, or analysis and interpretation of data

drafting the article or revising it critically for important intellectual content and final approval of the version to be published.

All these conditions must be met. Participation solely in the acquisition of funding or the collection of data does not justify authorship. In addition, the corresponding author must ensure that there is no one else who fulfils the criteria but has not been included as an author.

The *Journal* does not consider people thanked in the Acknowledgements or listed as members of a study group on whose behalf a paper is submitted to be authors. Only those listed as authors on the title page of the manuscript and (on acceptance for publication) whose signed copyright agreement has been obtained, qualify as authors. It is the responsibility of the corresponding author to ensure that authorship is agreed among the study's workers, contributors of additional data and other interested parties, before submission of the manuscript.

The names of the authors should appear on the title page in the form that is wished for publication, and the names, degrees, affiliations and full addresses at the time the work described in the paper was carried out should be given at the end of the paper.

Declaration of interest

All submissions to the *Journal* (including editorials and letters to the Editor) require a declaration of interest. This should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, an organisation whose interests, financial or otherwise, may by affected by the publication of the paper. This pertains to all the authors of the study.

Structure of manuscripts

Papers

A structured summary not exceeding 150 words should be given at the beginning of the article, incorporating the following headings: Background; Aims; Method; Results; Conclusions; Declaration of interest. The summary is a crucial part of the paper and authors are urged to devote some care to ensuring that all the important findings are within the word limit.

Introductions should normally be no more than one paragraph (up to 150 words). This should be followed by Method, Results and Discussion sections. The Discussion should always include limitations of the paper to ensure balance. Use of subheadings is encouraged, particularly in Discussion sections. A separate Conclusions section is not required.

The article should normally be between 3000 and 5000 words in length (excluding references, tables and figure legends) and include no more than 25 essential references beyond those describing statistical procedues, psychometric instruments and diagnostic guidelines used in the study. References exceeding 25 essential ones may be reduced in number. Use of the option of including additional material in the online version of the *Journal* is encouraged; this in particular applies to large tables of data that may be of value to future researchers (see Online data supplements, below).

Review articles

Review articles should be structured in the same way as regular papers, but the restriction on the number of references does not apply. The procedure for the publication of systematic reviews is the preferred format

Short reports

Short reports require an unstructured summary of one paragraph, not exceeding 100 words. The report should not exceed 1200 words (excluding references, tables and figure legends) and contain no more than one figure or table and up to 10 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study. Short reports will not exceed two printed pages of the *Journal* and authors may be required to edit their report at proof stage to conform to this requirement. This may be necessary even if the report does not exceed 1200 words if the figure or table is unduly large.

Editorials

Editorials require an unstructured summary of one paragraph, not exceeding 50 words. Editorials should not exceed 1500 words and may contain no more than one figure or table and up to 10 essential references. Editorials may only exceed two printed pages in length at the Editor's discretion.

Reappraisal

This is a section following the structure of Editorials but with up to 15 essential references, provided that the total length does not exceed two printed pages. These articles are mainly commissioned by the Editor and are concerned with well-known subjects in psychiatry which are going through a period of controversy or re-evaluation. Reappraisals are intended to give a long-term balanced perspective on the subject based on the latest evidence.

References

References should be listed alphabetically at the end of the paper, the titles of journals being given in full. Reference lists not in the correct style will be returned to the author for correction.

Authors should check that the text references and list are in agreement as regards dates and spelling of names. The text reference should be in the form `(Smith *et al*, 1991)' or `Smith *et al* (1991) showed that . . .'. The reference list should follow the style example below (note that *et al* is used after three authors have been listed for a work by four or more). Documents published on the internet should be treated in the same way as printed documents but with the full URL included at the end of the reference. If a DOI exists, this should be included.

Abraham, H. D. (1974) Do psychostimulants kindle panic disorder? *American Journal of Psychiatry*, **143**, 1627-1628.

American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (DSM-III). APA.

Aylard, P. R., Gooding, J. H., McKenna, P. S., *et al* (1987) A validation study of three anxiety and depression self assessment scales. *Psychosomatic Research*, **1**, 261-268.

De Rougemont, D. (1950) *Passion and Society* (trans. M. Belgion). Faber and Faber.

Fisher, M. (1990) *Personal Love*. Duckworth.

Flynn, C. H. (1987) Defoe's idea of conduct: ideological fictions and fictional reality. In *Ideology of Conduct* (eds N. Armstrong & L. Tennehouse), pp. 73-95. Methuen.

Jones, E. (1937) Jealousy. In *Papers on Psychoanalysis*, pp. 469-485. Bailliere Tindall.

Mayor, S. (2003) Value of prescribing heroin is uncertain. *BMJ*, **327**, 638, doi: 10.1136/bmj.327.7416.638-b

Mullen, P. E. (1990*a*) Morbid jealousy and the delusion of infidelity. In *Principles and Practice of Forensic Psychiatry* (eds R. Bluglass & P. Bowden), pp. 823-834. Churchill Livingstone.

Mullen, P. E. (1990*b*) A phenomenology of jealousy. *Australian and New Zealand Journal of Psychiatry*, **24**, 17-28.

Pharmaceutical Research and Manufacturers of America (PhRMA) (2005) *PhRMA Guiding Principles on Direct to Consumer Advertisements About Prescription Medications*. PhRMA. http://www.phrma.org/publications/policy//2005-08-02.1194.pdf

Personal communications need written authorisation (email is acceptable); they should not be included in the reference list. No other citation of unpublished work, including unpublished conference presentations, is permissible.

Tables

Each table should be submitted on a separate sheet. Tables should be numbered and have an appropriate heading. The tables should be mentioned in the text but must not duplicate information in the text. The heading of the table, together with any footnotes or comments, should be self-explanatory. The desired position of the table in the manuscript should be indicated. Do not tabulate lists, which should be incorporated into the text, where, if necessary, they may be displayed.

Authors must obtain permission from the original publisher if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table.

Figures

Figures should be clearly numbered and include an explanatory legend. Avoid cluttering figures with explanatory text, which is better incorporated succinctly in the legend. 3-D effects should be avoided. Lettering should be parallel to the axes. Units must be clearly indicated and should be presented in the form quantity (unit) (note: `litre' should be spelled out in full unless modified to ml, dl, etc.). All figures should be mentioned in the text and the desired position of the figure in the manuscript should be indicated.

Authors must obtain permission from the original publisher if they intend to use figures from other sources, and due acknowledgement should be made in the legend.

Colour figures may be reproduced if authors are able to cover the costs.

Statistics

Methods of statistical analysis should be described in language that is comprehensible to the numerate psychiatrist as well as the medical statistician. Particular attention should be paid to clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected and full explanations given for any *post hoc* analyses carried out. The value of test statistics used (e.g. *t*, *F*-ratio) should be given as well as their significance levels so that their derivation can be understood. Standard deviations and errors should not be reported as ± but should be specified and referred to in parentheses.

Trends should not be reported unless they have been supported by appropriate statistical analyses for trends.

The use of percentages to report results from small samples is discouraged, other than where this facilitates comparisons. The number of decimal places to which numbers are given should reflect the accuracy of the determination, and estimates of error should be given for statistics.

A brief and useful introduction to the place of confidence intervals is given by Gardner & Altman (1990, *British Journal of Psychiatry*, 156, 472-474). Use of these is encouraged but not mandatory.

Authors are encouraged to include estimates of statistical power where appropriate. To report a difference as being statistically significant is generally insufficient, and comment should be made about the magnitude and direction of change.

Randomised controlled trials

The *Journal* recommends to authors the CONSORT guidelines (1996, *Journal of the American Medical Association*, 276, 637-639) and their basis (2001, *Annals of Internal Medicine*, 134, 663-694) in relation to the reporting of randomised controlled clinical trials; also recommended is their extension to cluster randomised controlled trials (2004, *BMJ*, 328, 702-708). In particular, a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) must be included.

Qualitative research

The *Journal* welcomes submissions of reports of studies that have used qualitative research methods. These may, for example, be based on fieldwork notes, interview transcripts, recordings or documentary analysis. Such studies may be judged using criteria that differ from those used to judge reports based on statistical evidence. The following checklist (adapted, with permission, from the *BMJ*'s guidelines) shoulds serve as a useful guide.

Is the research question clearly defined?

Are the theoretical framework andmethods used at every stage of the research made explicit?

Is the context clearly described?

Is the sampling strategy clearly described and justified?

Is the sampling strategy theoretically comprehensive to ensure the generalisabilityof the conceptual analysis (diverse range of individuals and settings, for example)?

How was the fieldwork undertaken? Is it described in detail?

Could the evidence (fieldwork notes, interview transcripts, recordings, documentary analysis, etc.) be inspected independently by others? If relevant, could the process of transcription be independently inspected?

Are the procedures for data analysis clearly described and theoretically justified? Do they relate to the original research questions?

How were themes and concepts identified from the data?

Was the analysis repeated by more than one researcher to ensure reliability?

Is quantitative evidence used to test qualitative conclusions where appropriate?

Have observations that might have contradicted or modified the analysis been sought out and reported?

Is sufficient of the original evidence presented systematically in the written account to satisfy the sceptical reader of the relation between the interpretation and the evidence (for example, were quotations numbered and sources given)?

General

Access to data

If the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Registration of clinical trials

The *Journal* recommends that all clinical trials are registered in a public trials registry. Further details of criteria for acceptable registries and of the information to be registered are available at http://www.icmje.org/index.html#clin_trials. For reports supported by industry funds, this is a requirement for the paper to be considered for publication in the *Journal*.

Case reports and consent

If an individual is described, his or her consent must be obtained and submitted with the manuscript. Our consent form can be downloaded here. The individual should read the report before submission. Where the individual is not able to give informed consent, it should be obtained from a legal representative or other authorised person. If it is not possible for informed consent to be obtained, the report can be published only if all details that would enable any reader (including the individual or anyone else) to identify the person are omitted. Merely altering some details, such as age and location, is not sufficient to ensure that a person's confidentiality is maintained. Contributors should be aware of the risk of complaint by individuals in respect of defamation and breach of confidentiality, and where concerned should seek advice. In general, case studies are published in the *Journal* only if the authors can present evidence that the case report is of fundamental significance and it is unlikely that the scientific value of the communication could be achieved using any other methodology.

Online data supplements

Material related to a paper but unsuitable for publication in the printed journal (e.g. very large tables) may be published as a data supplement to the online *Journal* at the Editor's discretion. For large volumes of material, charges may apply.

Abbreviations, units and footnotes

All abbreviations must be spelt out on first usage and only widely recognised abbreviations will be permitted.

The generic names of drugs should be used.

Generally, SI units should be used; where they are not, the SI equivalent should be included in parentheses. Units should not use indices: i.e. report g/ml, not gml^{-1}.

The use of notes separate to the text should generally be avoided, whether they be footnotes or a separate section at the end of a paper. A footnote to the first page may, however, be included to give some general information concerning the paper.

Materials, equipment and software

The source of any compounds not yet available on general prescription should be indicated. The version number (or release date) and manufacturer of software used, and the platform on which it is operated (PC, Mac, UNIX etc.), should be stated. The manufacturer, manufacturer's location and product identification should be included when describing equipment central to a study (e.g. scanning equipment used in an imaging study).

Proofs

A proof will be sent to the corresponding author of an article. Offprints, which are prepared at the same time as the *Journal* is printed, should be ordered when the proof is returned to the Editor. Offprints are despatched up to 6 weeks after publication.

Copyright

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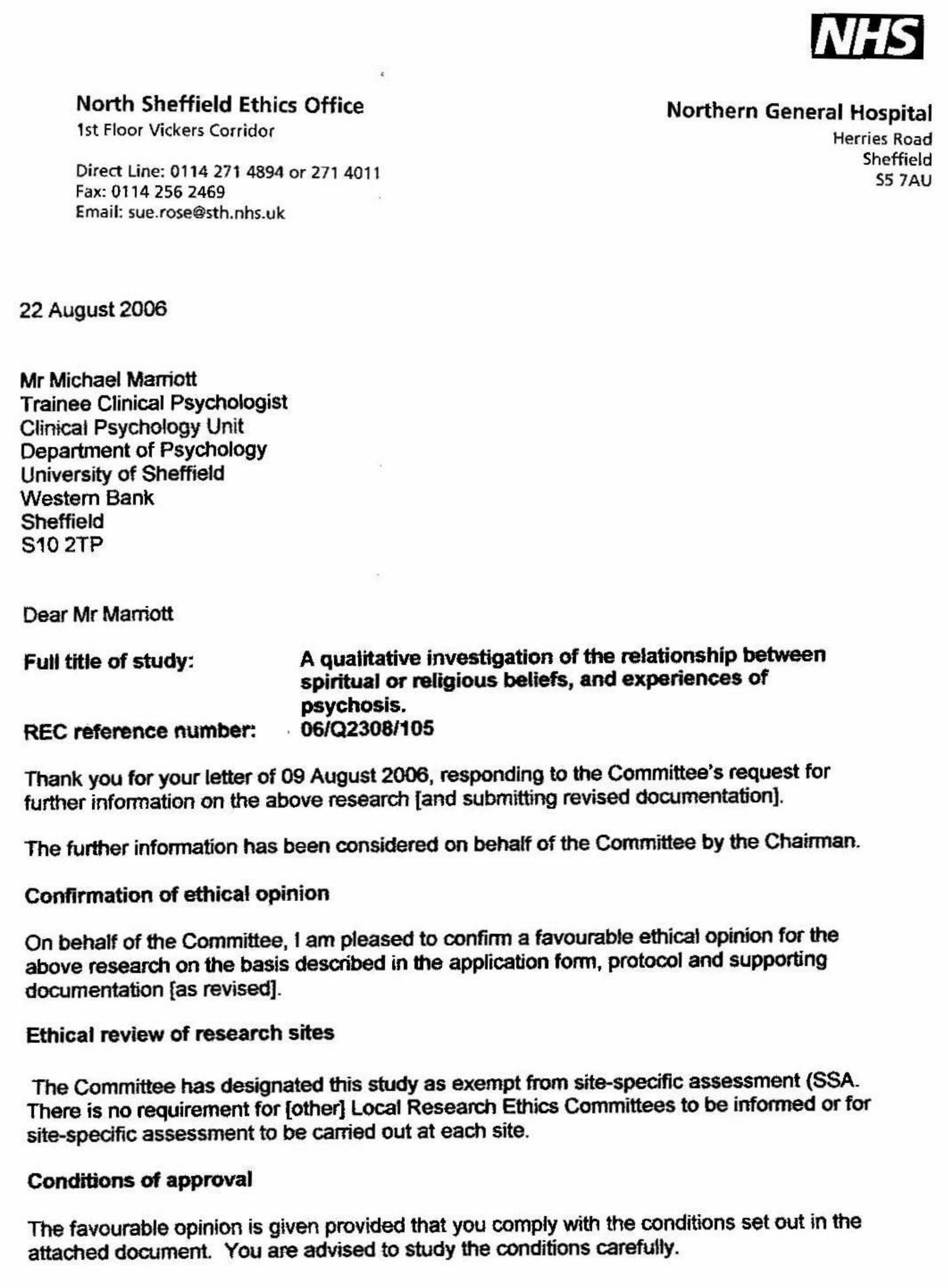
Letters to the Editor

All letters must be submitted online either as responses to published articles (follow the link 'submit a response' when viewing an article online) or as general letters to the Editor (from the general eLetter submission page). A selection from these eLetters will subsequently be included in the printed *Journal*.

Open access

There is no submission or publication fee for papers published in the *Journal* in the usual way. All papers published in the *Journal* become freely available online 12 months after publication. In a new initiative to maximise access to original research, authors now have the option to make their papers freely available from the time of publication, on payment of an open access charge. This charge is currently £2500 (or US$4500) per article plus VAT where applicable. If you wish to take up this option, contact the BJP Editorial Assistant once your paper has been accepted for publication. For such papers the requirement for a 12-month delay before release of the manuscript in a public archive is waived, and the final published version may be deposited.

Appendix 2.a (Ethical Approval



NHS

North Sheffield Ethics Office
1st Floor Vickers Corridor

Direct Line: 0114 271 4894 or 271 4011
Fax: 0114 256 2469
Email: sue.rose@sth.nhs.uk

Northern General Hospital
Herries Road
Sheffield
S5 7AU

22 August 2006

Mr Michael Marriott
Trainee Clinical Psychologist
Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield
S10 2TP

Dear Mr Marriott

Full title of study: **A qualitative investigation of the relationship between spiritual or religious beliefs, and experiences of psychosis.**

REC reference number: **06/Q2308/105**

Thank you for your letter of 09 August 2006, responding to the Committee's request for further information on the above research [and submitting revised documentation].

The further information has been considered on behalf of the Committee by the Chairman.

Confirmation of ethical opinion

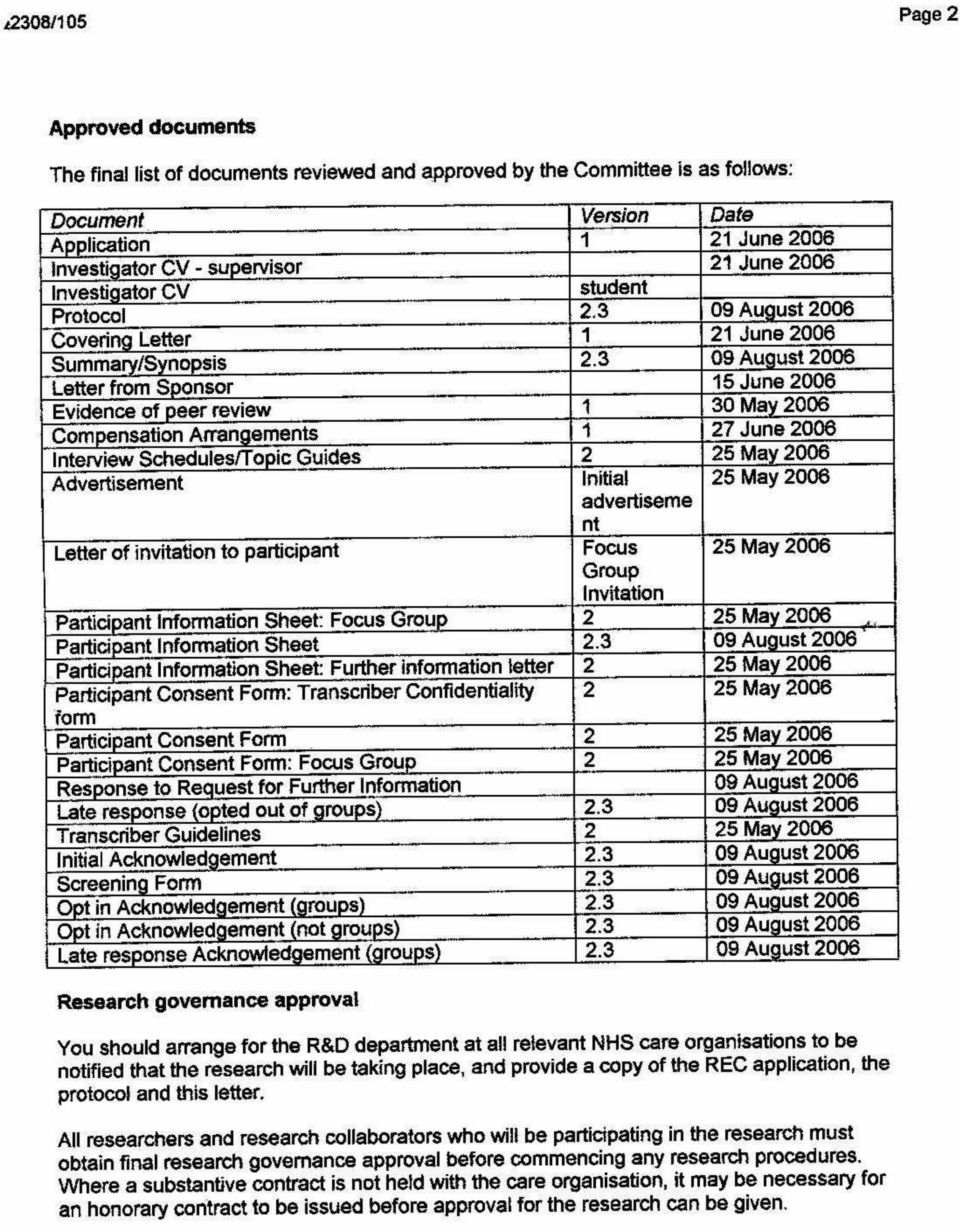
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised].

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.



Approved documents

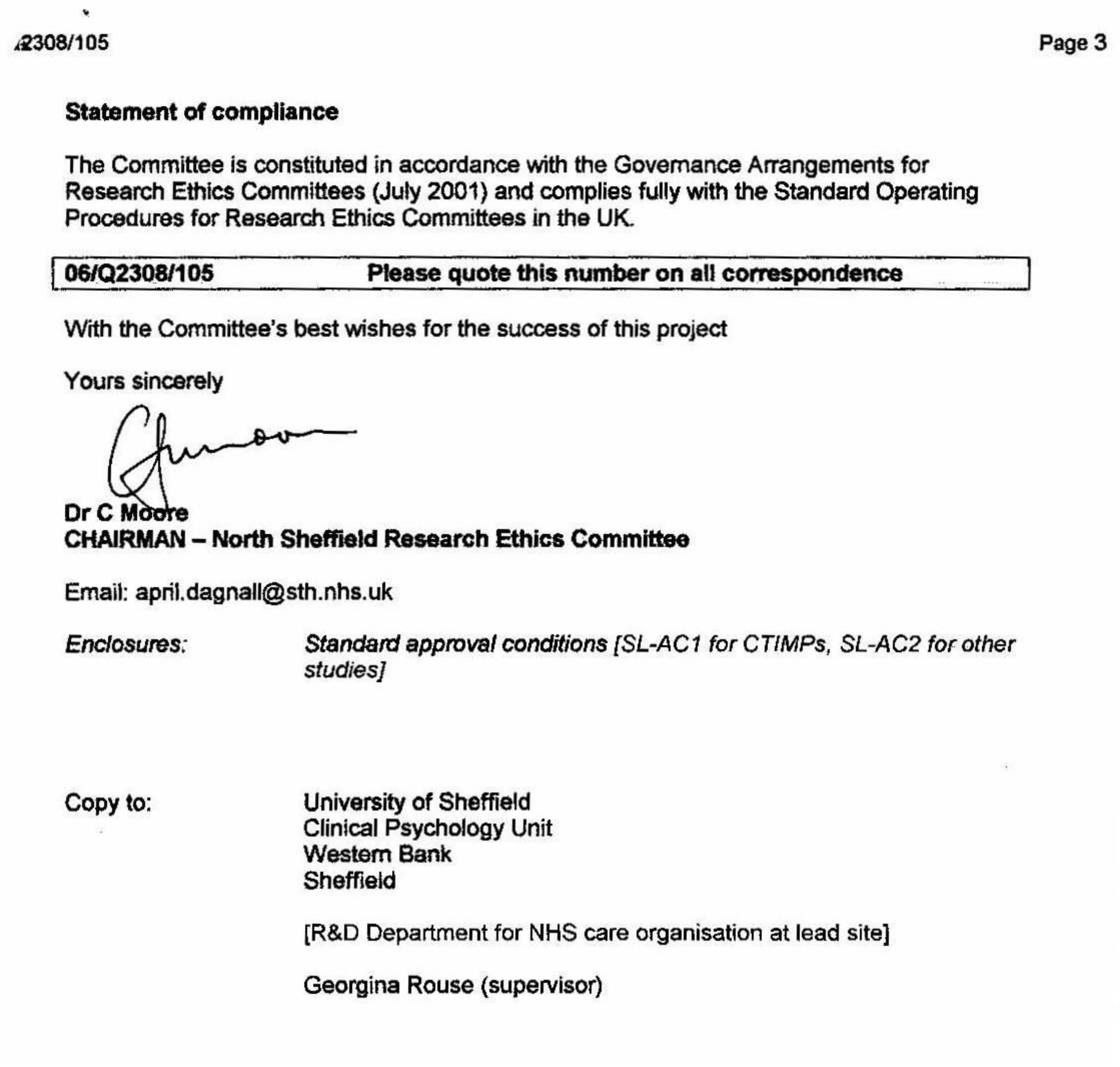
The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	1	21 June 2006
Investigator CV - supervisor		21 June 2006
Investigator CV	student	
Protocol	2.3	09 August 2006
Covering Letter	1	21 June 2006
Summary/Synopsis	2.3	09 August 2006
Letter from Sponsor		15 June 2006
Evidence of peer review	1	30 May 2006
Compensation Arrangements	1	27 June 2006
Interview Schedules/Topic Guides	2	25 May 2006
Advertisement	Initial advertisement	25 May 2006
Letter of invitation to participant	Focus Group Invitation	25 May 2006
Participant Information Sheet: Focus Group	2	25 May 2006
Participant Information Sheet	2.3	09 August 2006
Participant Information Sheet: Further information letter	2	25 May 2006
Participant Consent Form: Transcriber Confidentiality form	2	25 May 2006
Participant Consent Form	2	25 May 2006
Participant Consent Form: Focus Group	2	25 May 2006
Response to Request for Further Information		09 August 2006
Late response (opted out of groups)	2.3	09 August 2006
Transcriber Guidelines	2	25 May 2006
Initial Acknowledgement	2.3	09 August 2006
Screening Form	2.3	09 August 2006
Opt in Acknowledgement (groups)	2.3	09 August 2006
Opt in Acknowledgement (not groups)	2.3	09 August 2006
Late response Acknowledgement (groups)	2.3	09 August 2006

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.



Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q2308/105 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr C Moore
CHAIRMAN – North Sheffield Research Ethics Committee

Email: april.dagnall@sth.nhs.uk

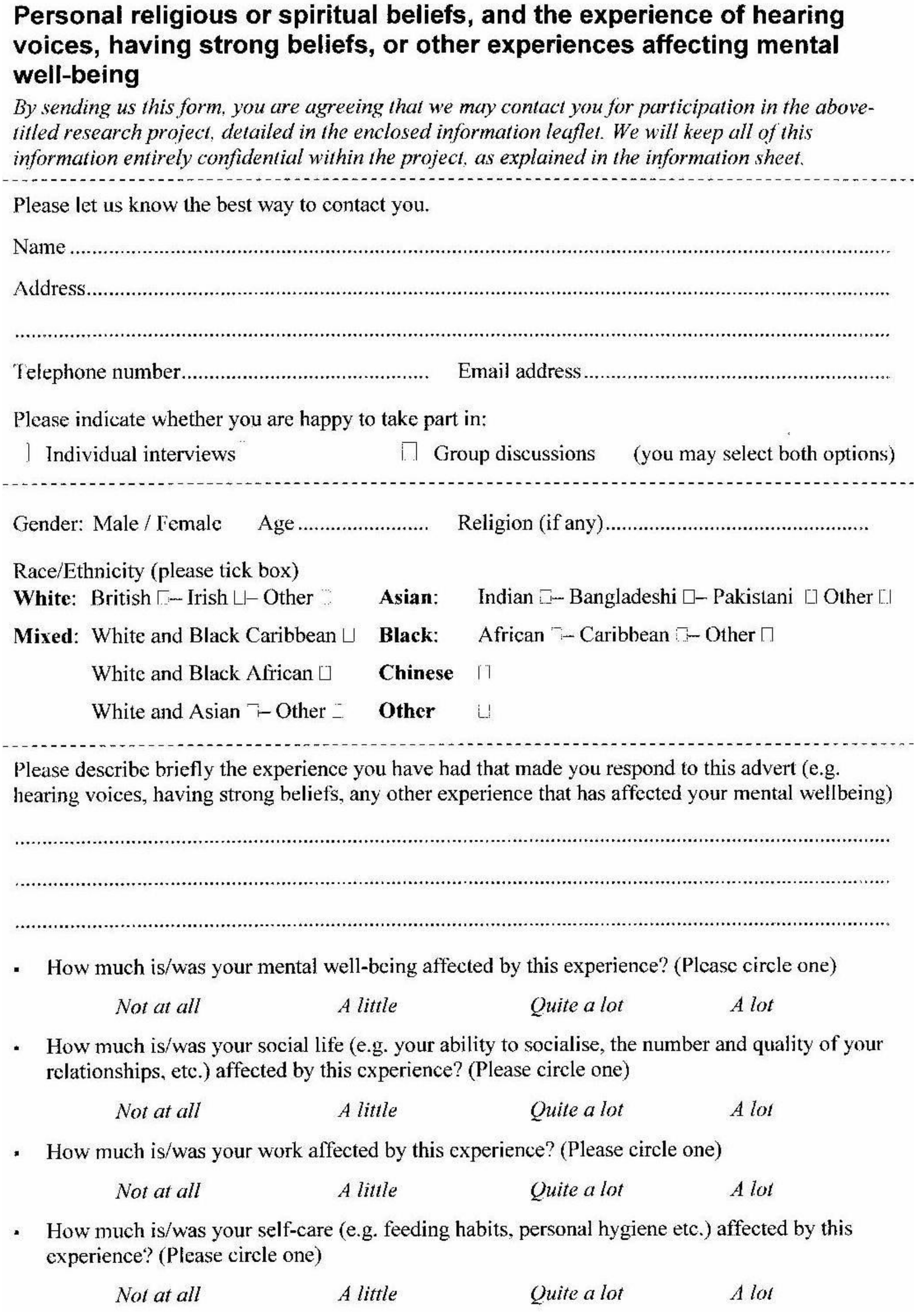
Enclosures: *Standard approval conditions [SL-AC1 for CTIMPs, SL-AC2 for other studies]*

Copy to:
University of Sheffield
Clinical Psychology Unit
Western Bank
Sheffield

[R&D Department for NHS care organisation at lead site]

Georgina Rouse (supervisor)

Appendix 3.a: Opt-in/Screening Form



Personal religious or spiritual beliefs, and the experience of hearing voices, having strong beliefs, or other experiences affecting mental well-being

By sending us this form, you are agreeing that we may contact you for participation in the above-titled research project, detailed in the enclosed information leaflet. We will keep all of this information entirely confidential within the project, as explained in the information sheet.

Please let us know the best way to contact you.

Name ....

Address..

....

Telephone number.. Email address ....

Please indicate whether you are happy to take part in:

☐ Individual interviews ☐ Group discussions (you may select both options)

Gender: Male / Female Age .... Religion (if any) ....

Race/Ethnicity (please tick box)

White: British ☐ – Irish ☐ – Other ☐ **Asian:** Indian ☐ – Bangladeshi ☐ – Pakistani ☐ Other ☐

Mixed: White and Black Caribbean ☐ **Black:** African ☐ – Caribbean ☐ – Other ☐

White and Black African ☐ **Chinese** ☐

White and Asian ☐ – Other ☐ **Other** ☐

Please describe briefly the experience you have had that made you respond to this advert (e.g. hearing voices, having strong beliefs, any other experience that has affected your mental wellbeing)

....

....

....

- How much is/was your mental well-being affected by this experience? (Please circle one)

  Not at all *A little* *Quite a lot* *A lot*

- How much is/was your social life (e.g. your ability to socialise, the number and quality of your relationships, etc.) affected by this experience? (Please circle one)

  Not at all *A little* *Quite a lot* *A lot*

- How much is/was your work affected by this experience? (Please circle one)

  Not at all *A little* *Quite a lot* *A lot*

- How much is/was your self-care (e.g. feeding habits, personal hygiene etc.) affected by this experience? (Please circle one)

  Not at all *A little* *Quite a lot* *A lot*

Appendix 3.b: Interview Schedule

As you know from the information sheet, I am hoping to talk with you today about your experiences of having heard voices, held strong beliefs, or whatever other experience has affected your mental wellbeing. I would also like to talk about your religious or spiritual beliefs and experiences. I have a selection of questions that I would like to ask you about these topics. For all of these questions, there are no right or wrong answers; I am just interested in what your experiences have been. If you would rather not answer any of the questions, please do say and we can move on to something else. You should also feel free to stop the interview at any time, or take a break if needed. Remember that anything we discuss in this interview will remain confidential as described in the information sheet and the consent form.

- To make a start, would you mind telling me briefly about your experiences? (Prompt: You answered the advert because I asked about hearing voices, strong beliefs, and similar experiences that can affect people’s mental wellbeing and general functioning. Tell me about these experiences)
    - What word or words do you use to describe your experiences?
    - How, if at all, has this affected you?
    - How, if at all, has this made a difference to your life?
    - Have your experiences made a difference to how you feel about yourself, or see yourself?
    - What ways, if any, have you found to cope with your experiences?
- (Optional prompt) Would you like to take a break now?
- Could you tell me a little about your spiritual or religious beliefs?

  - What are[2] the most important parts of your beliefs?
  - Where do your beliefs come from?
  - When did you first begin to hold these kinds of beliefs?
  - Are you involved with any spiritual or religious community or group as part of these beliefs?
  - Have your spiritual or religious beliefs made a difference to how you see yourself?
  - Have you ever had any religious or spiritual experiences?
- (Optional prompt) Would you like to take a break now?
- You have told me about […summarise psychosis experiences…][3] and about […summarise spiritual/religious beliefs and experiences…]. How, if at all, do you think these relate to each other?
  - Are there any similarities or differences between your spiritual/religious experiences and your […psychosis…]?
  - Have your spiritual or religious beliefs affected your […psychosis…]?
  - Has your […psychosis…] affected your spiritual or religious beliefs at all?
  - Have you had any involvement with your religious community/group during your […psychosis…]? (Prompt: Different people find things

---

[2] The use of past tense may be more appropriate throughout the interview depending on participants' initial responses

[3] To avoid the use of the word "Psychosis", I shall refer directly to the participant's experiences or their chosen word or phrase throughout the interview.

helpful and unhelpful; what would you say about your involvement with the community/group?)

- Is there anything else important about these issues that you would like to tell me?

(If not covered in the initial questions about the experiences, ask the following series…) I would just like to know a few practical details about how your experiences affected you

- Did you ever seek professional help following your experiences?
- Were you ever given a diagnosis by a health professional?
- Have you ever had to go into hospital because of your experiences? How many times if so?
- About how many “episodes” have you had where you were affected by these kinds of experiences?
- When was the first time you had one of these episodes?
- When was the last time you had one of these episodes?
- Do you have any questions for me?

Thank you very much for your time. This interview will now be transcribed, and I will spend some time looking at what we have discussed today, before using the discussion to help me write up some of the issues that are relevant in both my project and for a research paper. [Unless otherwise stated…] You can be assured that everything we have done today will remain confidential and anonymous, just as it says in the information sheet. Neither your name nor any names mentioned today will be transcribed in the interview.

- Would you like me to send you a copy of the transcript of the interview?
- Would you like a copy of a summary of the results from this project?

If you have any further questions about the project, please do contact me using the details on the information sheet. If you feel the need to discuss further any of the issues that we have discussed today, please do contact either of the people on the information sheet.

Many thanks again.

Appendix 4.a: Recruitment Advert

Have religious or spiritual beliefs or experiences ever been important to you?

Have you ever experienced hearing voices, having strong beliefs, or any similar experience that has affected your mental wellbeing and general functioning in life?

Do you want to take part in research?

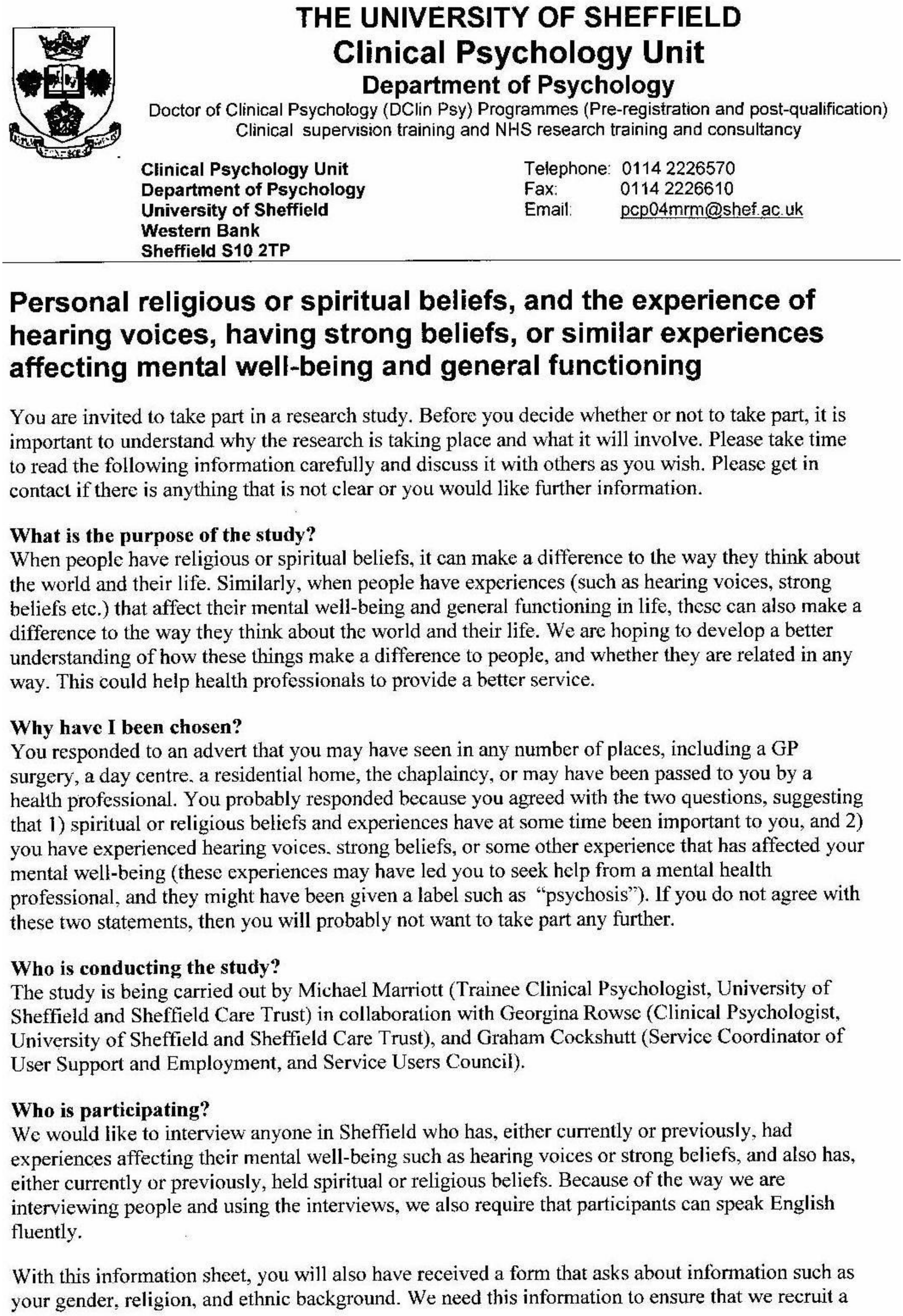
If you can answer "Yes" to these questions, then we would like to hear from you. We are carrying out a research project about these experiences and beliefs, and will be interviewing people like yourself to try and understand your experiences. If you think you might be interested and would like more information, please send your name and address FREE (no stamp required) to the following address:

Michael Marriott
Clinical Psychology Unit
Dept of Psychology
University of Sheffield
FREEPOST NEA4492
SHEFFIELD S10 1BQ

Alternatively, you can phone Michael Marriott or Georgina Rowse on:
0114 222 6570
or email Michael on:
pcp04mrm@shef.ac.uk

We will send you more information on the project, and offer you the opportunity to take part. If you choose to write to us, your details will remain confidential within the project, and will not be passed to any other services. This will not affect any services that you currently receive.

Appendix 4.b: Information Sheet



THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology
Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP

Telephone: 0114 2226570
Fax: 0114 2226610
Email: pcp04mrm@shef.ac.uk

Personal religious or spiritual beliefs, and the experience of hearing voices, having strong beliefs, or similar experiences affecting mental well-being and general functioning

You are invited to take part in a research study. Before you decide whether or not to take part, it is important to understand why the research is taking place and what it will involve. Please take time to read the following information carefully and discuss it with others as you wish. Please get in contact if there is anything that is not clear or you would like further information.

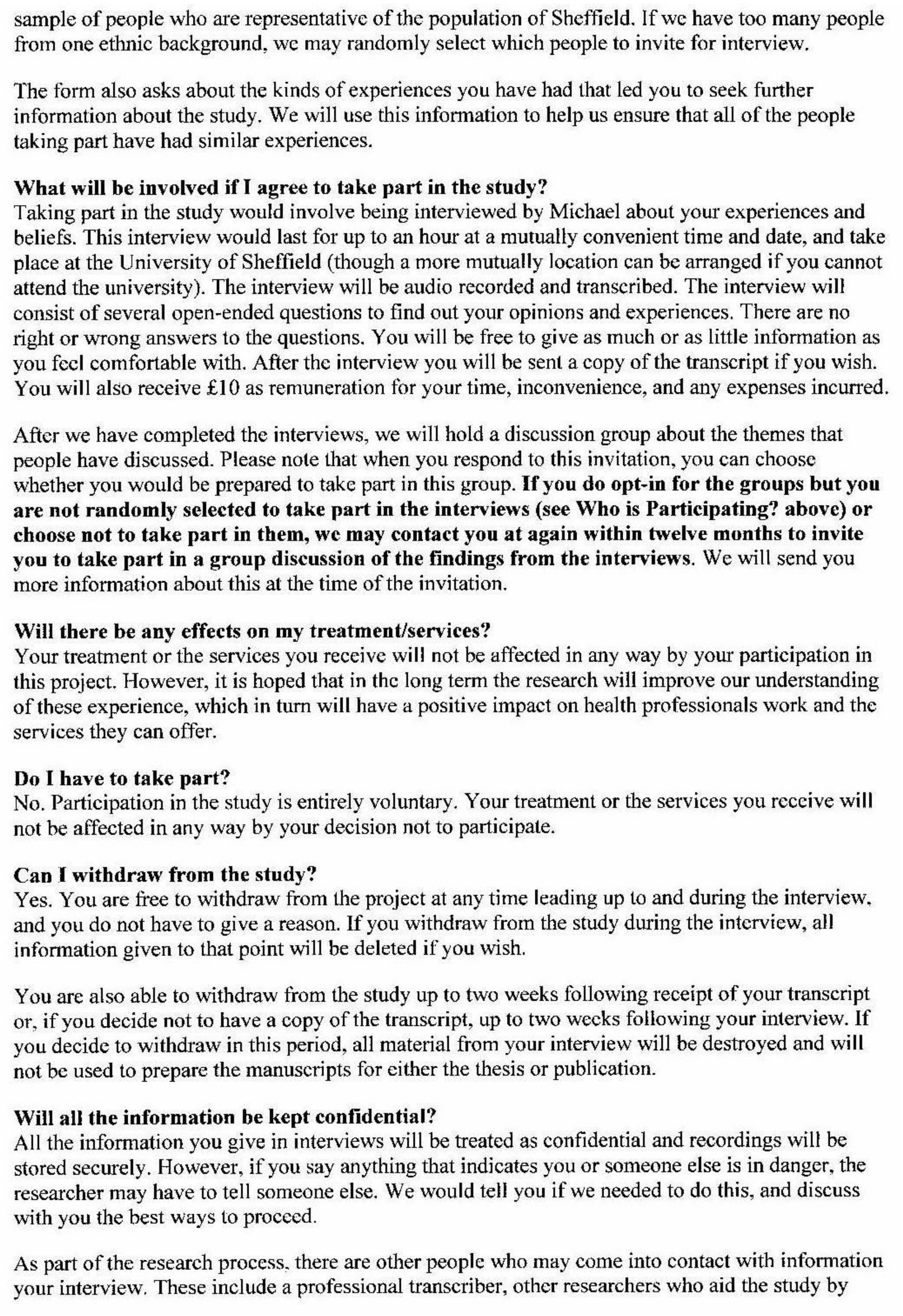
What is the purpose of the study?
When people have religious or spiritual beliefs, it can make a difference to the way they think about the world and their life. Similarly, when people have experiences (such as hearing voices, strong beliefs etc.) that affect their mental well-being and general functioning in life, these can also make a difference to the way they think about the world and their life. We are hoping to develop a better understanding of how these things make a difference to people, and whether they are related in any way. This could help health professionals to provide a better service.

Why have I been chosen?
You responded to an advert that you may have seen in any number of places, including a GP surgery, a day centre, a residential home, the chaplaincy, or may have been passed to you by a health professional. You probably responded because you agreed with the two questions, suggesting that 1) spiritual or religious beliefs and experiences have at some time been important to you, and 2) you have experienced hearing voices, strong beliefs, or some other experience that has affected your mental well-being (these experiences may have led you to seek help from a mental health professional, and they might have been given a label such as "psychosis"). If you do not agree with these two statements, then you will probably not want to take part any further.

Who is conducting the study?
The study is being carried out by Michael Marriott (Trainee Clinical Psychologist, University of Sheffield and Sheffield Care Trust) in collaboration with Georgina Rowse (Clinical Psychologist, University of Sheffield and Sheffield Care Trust), and Graham Cockshutt (Service Coordinator of User Support and Employment, and Service Users Council).

Who is participating?
We would like to interview anyone in Sheffield who has, either currently or previously, had experiences affecting their mental well-being such as hearing voices or strong beliefs, and also has, either currently or previously, held spiritual or religious beliefs. Because of the way we are interviewing people and using the interviews, we also require that participants can speak English fluently.

With this information sheet, you will also have received a form that asks about information such as your gender, religion, and ethnic background. We need this information to ensure that we recruit a



sample of people who are representative of the population of Sheffield. If we have too many people from one ethnic background, we may randomly select which people to invite for interview.

The form also asks about the kinds of experiences you have had that led you to seek further information about the study. We will use this information to help us ensure that all of the people taking part have had similar experiences.

What will be involved if I agree to take part in the study?
Taking part in the study would involve being interviewed by Michael about your experiences and beliefs. This interview would last for up to an hour at a mutually convenient time and date, and take place at the University of Sheffield (though a more mutually location can be arranged if you cannot attend the university). The interview will be audio recorded and transcribed. The interview will consist of several open-ended questions to find out your opinions and experiences. There are no right or wrong answers to the questions. You will be free to give as much or as little information as you feel comfortable with. After the interview you will be sent a copy of the transcript if you wish. You will also receive £10 as remuneration for your time, inconvenience, and any expenses incurred.

After we have completed the interviews, we will hold a discussion group about the themes that people have discussed. Please note that when you respond to this invitation, you can choose whether you would be prepared to take part in this group. **If you do opt-in for the groups but you are not randomly selected to take part in the interviews (see Who is Participating? above) or choose not to take part in them, we may contact you at again within twelve months to invite you to take part in a group discussion of the findings from the interviews**. We will send you more information about this at the time of the invitation.

Will there be any effects on my treatment/services?
Your treatment or the services you receive will not be affected in any way by your participation in this project. However, it is hoped that in the long term the research will improve our understanding of these experience, which in turn will have a positive impact on health professionals work and the services they can offer.

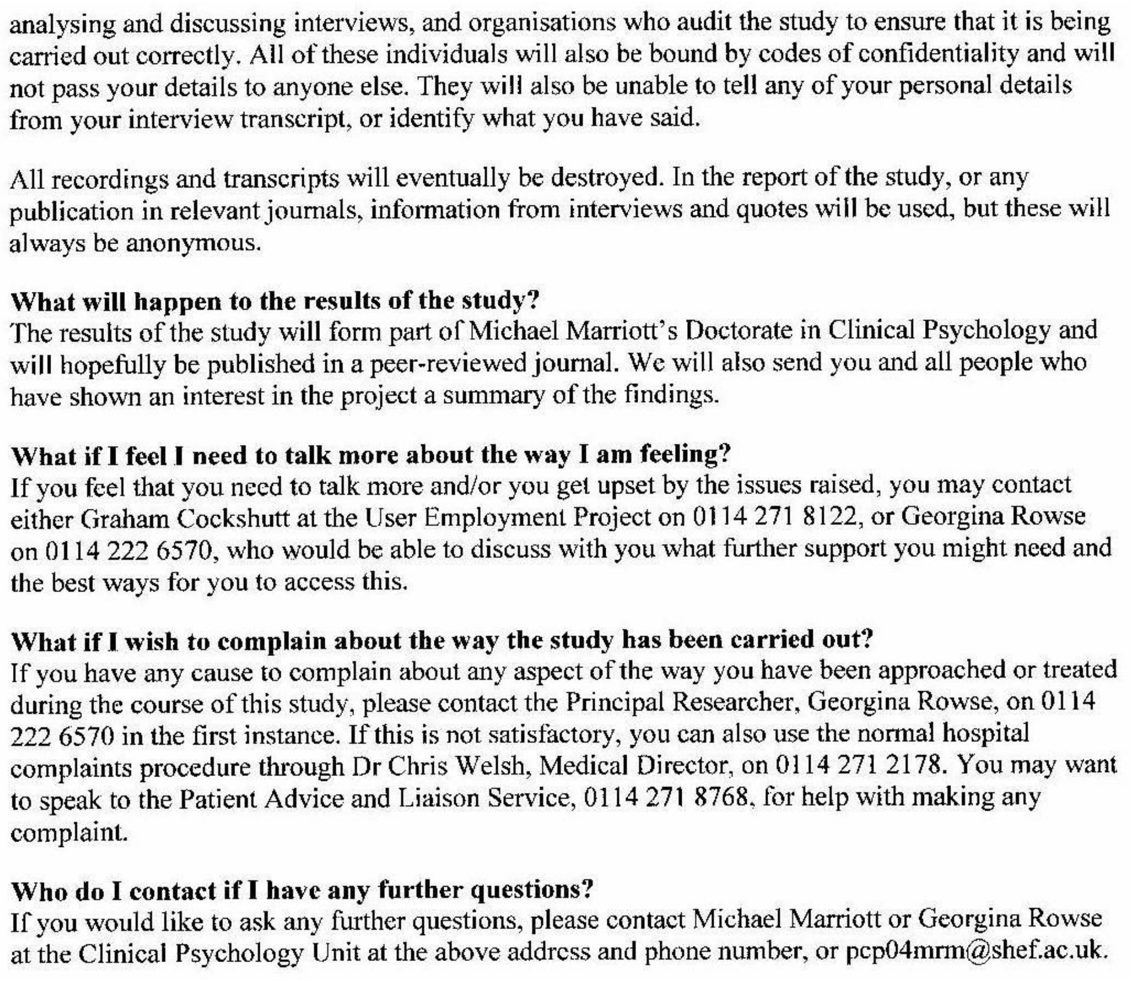
Do I have to take part?
No. Participation in the study is entirely voluntary. Your treatment or the services you receive will not be affected in any way by your decision not to participate.

Can I withdraw from the study?
Yes. You are free to withdraw from the project at any time leading up to and during the interview, and you do not have to give a reason. If you withdraw from the study during the interview, all information given to that point will be deleted if you wish.

You are also able to withdraw from the study up to two weeks following receipt of your transcript or, if you decide not to have a copy of the transcript, up to two weeks following your interview. If you decide to withdraw in this period, all material from your interview will be destroyed and will not be used to prepare the manuscripts for either the thesis or publication.

Will all the information be kept confidential?
All the information you give in interviews will be treated as confidential and recordings will be stored securely. However, if you say anything that indicates you or someone else is in danger, the researcher may have to tell someone else. We would tell you if we needed to do this, and discuss with you the best ways to proceed.

As part of the research process, there are other people who may come into contact with information your interview. These include a professional transcriber, other researchers who aid the study by



analysing and discussing interviews, and organisations who audit the study to ensure that it is being carried out correctly. All of these individuals will also be bound by codes of confidentiality and will not pass your details to anyone else. They will also be unable to tell any of your personal details from your interview transcript, or identify what you have said.

All recordings and transcripts will eventually be destroyed. In the report of the study, or any publication in relevant journals, information from interviews and quotes will be used, but these will always be anonymous.

What will happen to the results of the study?

The results of the study will form part of Michael Marriott's Doctorate in Clinical Psychology and will hopefully be published in a peer-reviewed journal. We will also send you and all people who have shown an interest in the project a summary of the findings.

What if I feel I need to talk more about the way I am feeling?

If you feel that you need to talk more and/or you get upset by the issues raised, you may contact either Graham Cockshutt at the User Employment Project on 0114 271 8122, or Georgina Rowse on 0114 222 6570, who would be able to discuss with you what further support you might need and the best ways for you to access this.

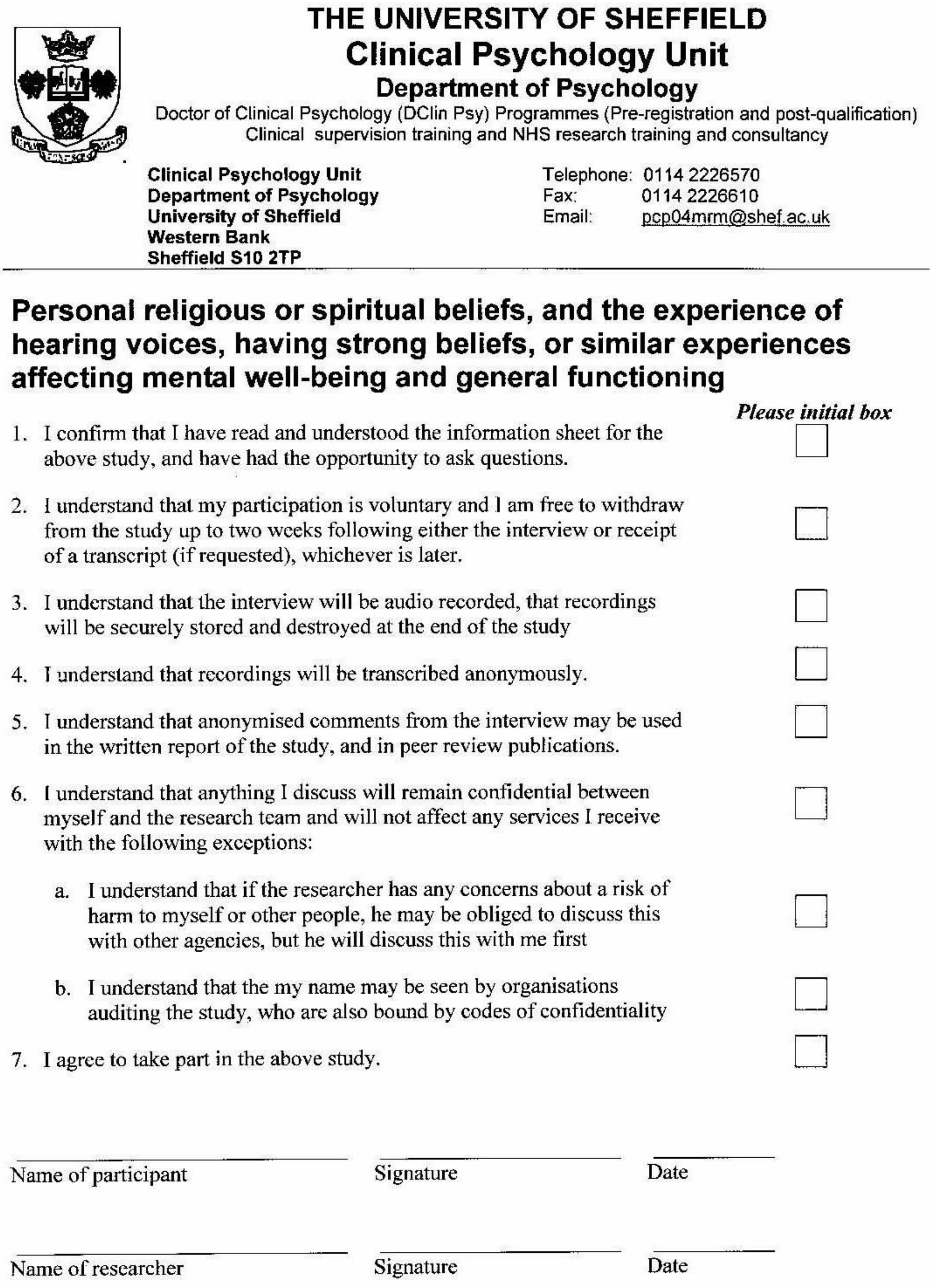
What if I wish to complain about the way the study has been carried out?

If you have any cause to complain about any aspect of the way you have been approached or treated during the course of this study, please contact the Principal Researcher, Georgina Rowse, on 0114 222 6570 in the first instance. If this is not satisfactory, you can also use the normal hospital complaints procedure through Dr Chris Welsh, Medical Director, on 0114 271 2178. You may want to speak to the Patient Advice and Liaison Service, 0114 271 8768, for help with making any complaint.

Who do I contact if I have any further questions?

If you would like to ask any further questions, please contact Michael Marriott or Georgina Rowse at the Clinical Psychology Unit at the above address and phone number, or pcp04mrm@shef.ac.uk.

Appendix 4.c: Consent Form



THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology
Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Western Bank
Sheffield S10 2TP

Telephone: 0114 2226570
Fax: 0114 2226610
Email: pcp04mrm@shef.ac.uk

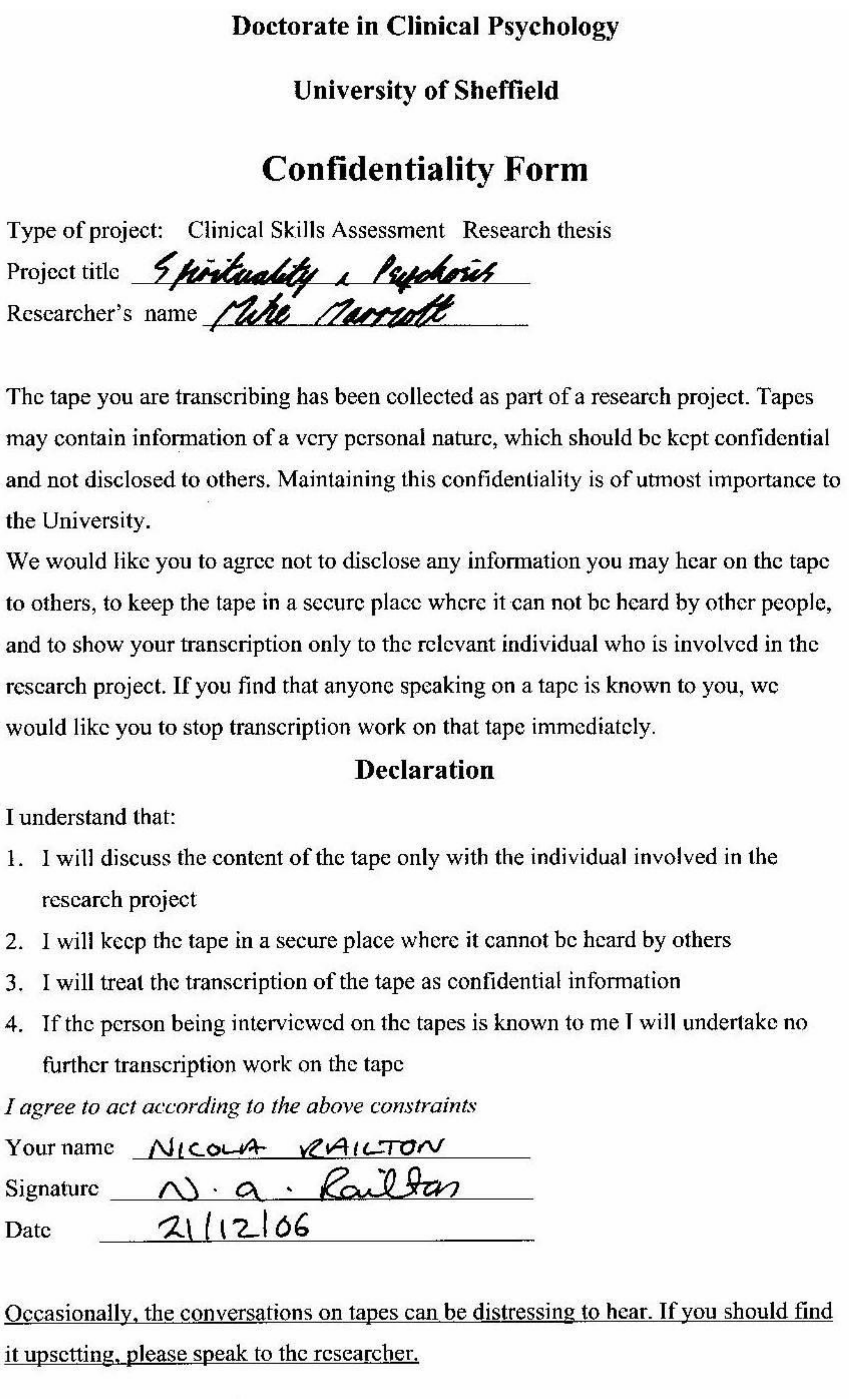
Personal religious or spiritual beliefs, and the experience of hearing voices, having strong beliefs, or similar experiences affecting mental well-being and general functioning

Please initial box

1. I confirm that I have read and understood the information sheet for the above study, and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and I am free to withdraw from the study up to two weeks following either the interview or receipt of a transcript (if requested), whichever is later. ☐
3. I understand that the interview will be audio recorded, that recordings will be securely stored and destroyed at the end of the study ☐
4. I understand that recordings will be transcribed anonymously. ☐
5. I understand that anonymised comments from the interview may be used in the written report of the study, and in peer review publications. ☐
6. I understand that anything I discuss will remain confidential between myself and the research team and will not affect any services I receive with the following exceptions: ☐
    a. I understand that if the researcher has any concerns about a risk of harm to myself or other people, he may be obliged to discuss this with other agencies, but he will discuss this with me first ☐
    b. I understand that the my name may be seen by organisations auditing the study, who are also bound by codes of confidentiality ☐
7. I agree to take part in the above study. ☐

______________________	______________________	____________
Name of participant	Signature	Date
______________________	______________________	____________
Name of researcher	Signature	Date

Appendix 4.d: Transcriber Confidentiality



Doctorate in Clinical Psychology

University of Sheffield

Confidentiality Form

Type of project: Clinical Skills Assessment Research thesis

Project title Spirituality & Psychosis

Researcher's name Mike Marriott

The tape you are transcribing has been collected as part of a research project. Tapes may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining this confidentiality is of utmost importance to the University.

We would like you to agree not to disclose any information you may hear on the tape to others, to keep the tape in a secure place where it can not be heard by other people, and to show your transcription only to the relevant individual who is involved in the research project. If you find that anyone speaking on a tape is known to you, we would like you to stop transcription work on that tape immediately.

Declaration

I understand that:

1. I will discuss the content of the tape only with the individual involved in the research project
2. I will keep the tape in a secure place where it cannot be heard by others
3. I will treat the transcription of the tape as confidential information
4. If the person being interviewed on the tapes is known to me I will undertake no further transcription work on the tape

I agree to act according to the above constraints

Your name NICOLA RAILTON

Signature N · a · Railton

Date 21/12/06

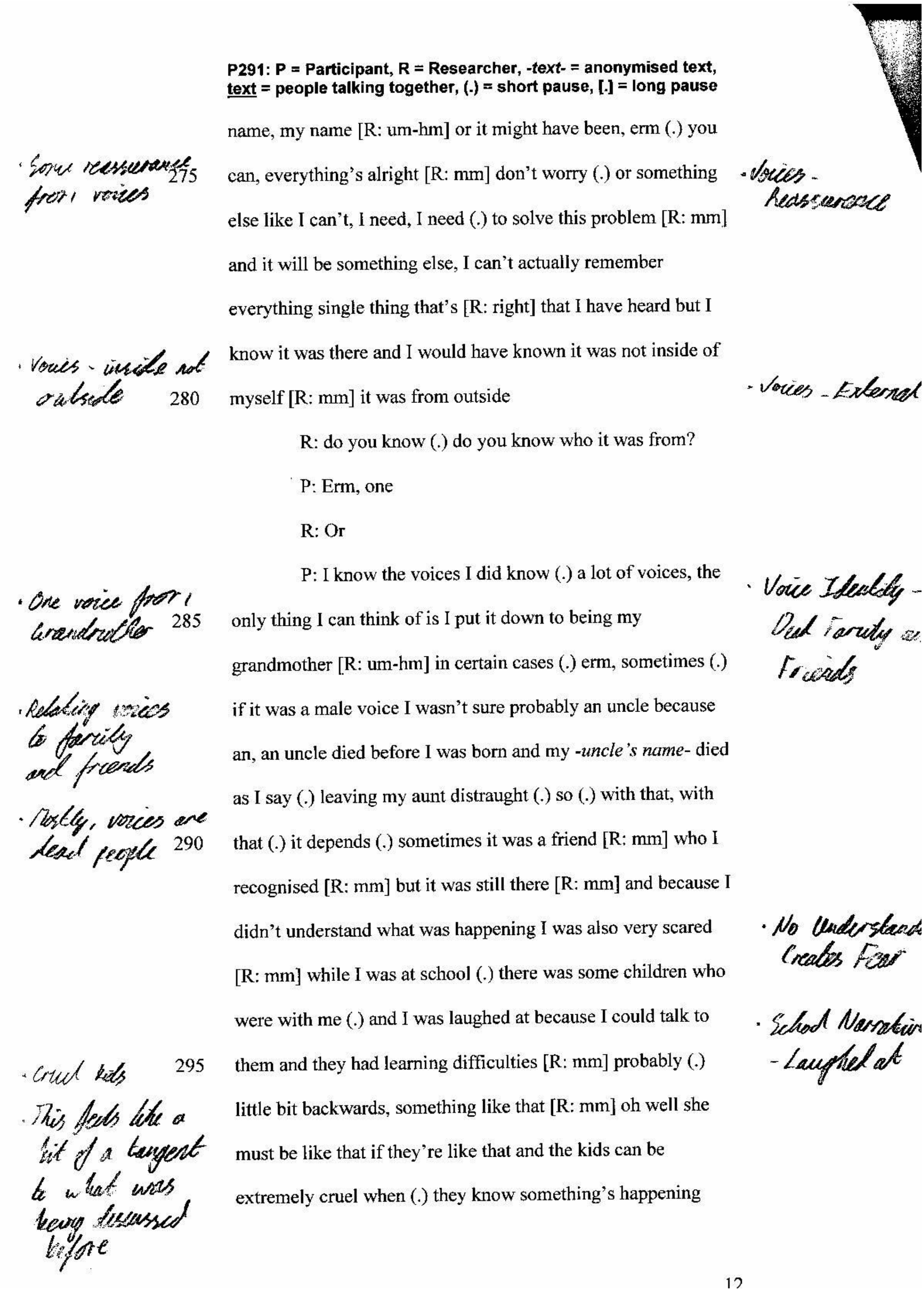
Occasionally, the conversations on tapes can be distressing to hear. If you should find it upsetting, please speak to the researcher.

Appendix 4.e: Transcription Instructions

- Use double-spacing.
- Use margins of 5cms on either side of the page to allow for notes to be made.
- Number each line.
- Number each page.
- Mark when the tape is not audible.
- Indicate when the researcher (R) is talking and when the participant (P) is talking.
- Use a new line when a different person starts speaking.
- Indicate when people are talking at the same time.
- Remove all names used in the interview. Therefore, the researcher is known as R; the participant is known as P; any other names can be referred to as person A, person B etc. as appropriate.
- Use appropriate punctuation; i.e. a question mark when a question has been asked, a full stop if the conversation topic changes.
- Record any pauses (less than one second) in conversation using (.)
- Record gaps (of more than one second) with [.]
- Record exactly what is said by each person as they say it. This includes any hesitations (e.g. erm, err), recurring phrases (e.g. you know, I mean, like, etc.), and pauses as they occur in the conversation.
- Do not record anything that has not been said, even if this makes the meaning of what is said difficult to understand.

Appendix 4.f: Example Analysis

Notes on the left hand column of the original transcript represent the first stage of analysis (notes) and the right hand column represents the second stage (themes).



P291: P = Participant, R = Researcher, *-text-* = anonymised text, text = people talking together, (.) = short pause, [.] = long pause

· Some reassurance from voices

· Voices - Reassurance

name, my name [R: um-hm] or it might have been, erm (.) you can, everything's alright [R: mm] don't worry (.) or something else like I can't, I need, I need (.) to solve this problem [R: mm] and it will be something else, I can't actually remember everything single thing that's [R: right] that I have heard but I know it was there and I would have known it was not inside of myself [R: mm] it was from outside

· Voices - inside not outside

- Voices - External

R: do you know (.) do you know who it was from?

P: Erm, one

R: Or

P: I know the voices I did know (.) a lot of voices, the only thing I can think of is I put it down to being my grandmother [R: um-hm] in certain cases (.) erm, sometimes (.) if it was a male voice I wasn't sure probably an uncle because an, an uncle died before I was born and my *-uncle's name-* died as I say (.) leaving my aunt distraught (.) so (.) with that, with that (.) it depends (.) sometimes it was a friend [R: mm] who I recognised [R: mm] but it was still there [R: mm] and because I didn't understand what was happening I was also very scared [R: mm] while I was at school (.) there was some children who were with me (.) and I was laughed at because I could talk to them and they had learning difficulties [R: mm] probably (.) little bit backwards, something like that [R: mm] oh well she must be like that if they're like that and the kids can be extremely cruel when (.) they know something's happening

· One voice from grandmother

· Relating voices to family and friends

· Mostly, voices are dead people

· Cruel kids

· This feels like a bit of a tangent to what was being discussed before

· Voice Identity - Dead Family a

Friends

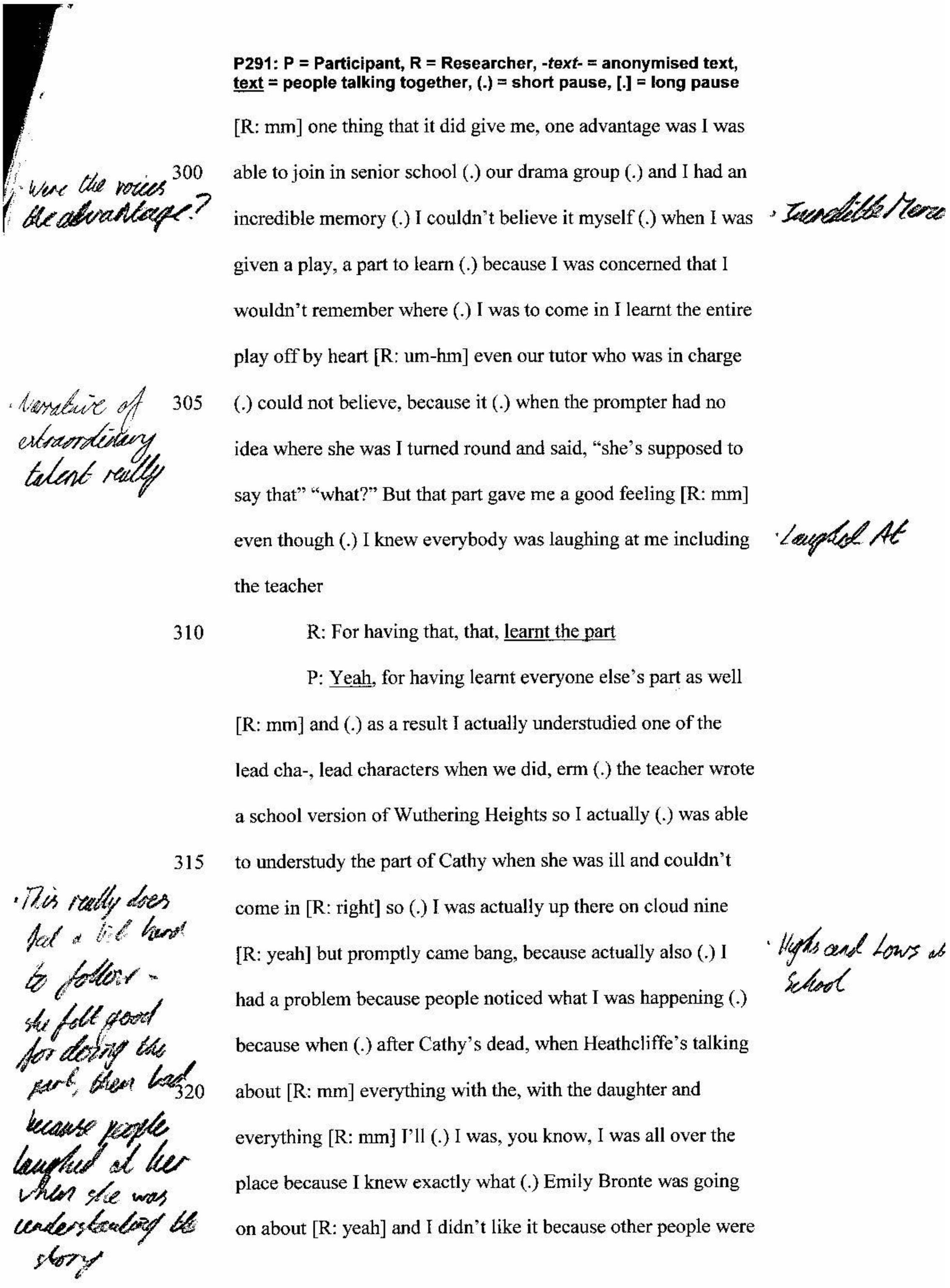
· No Understand

Creates Fear

· School Narrativ

- Laughed at

12



P291: P = Participant, R = Researcher, *-text-* = anonymised text, <u>text</u> = people talking together, (.) = short pause, [.] = long pause

[R: mm] one thing that it did give me, one advantage was I was able to join in senior school (.) our drama group (.) and I had an incredible memory (.) I couldn't believe it myself (.) when I was given a play, a part to learn (.) because I was concerned that I wouldn't remember where (.) I was to come in I learnt the entire play off by heart [R: um-hm] even our tutor who was in charge (.) could not believe, because it (.) when the prompter had no idea where she was I turned round and said, "she's supposed to say that" "what?" But that part gave me a good feeling [R: mm] even though (.) I knew everybody was laughing at me including the teacher

· Were the voices the advantage?

· Narrative of extraordinary talent really

· Incredible Mem

· Laughed At

R: For having that, that, <u>learnt the part</u>

P: <u>Yeah</u>, for having learnt everyone else's part as well [R: mm] and (.) as a result I actually understudied one of the lead cha-, lead characters when we did, erm (.) the teacher wrote a school version of Wuthering Heights so I actually (.) was able to understudy the part of Cathy when she was ill and couldn't come in [R: right] so (.) I was actually up there on cloud nine [R: yeah] but promptly came bang, because actually also (.) I had a problem because people noticed what I was happening (.) because when (.) after Cathy's dead, when Heathcliffe's talking about [R: mm] everything with the, with the daughter and everything [R: mm] I'll (.) I was, you know, I was all over the place because I knew exactly what (.) Emily Bronte was going on about [R: yeah] and I didn't like it because other people were

· This really does feel a bit hard to follow – she felt good for doing the part, then bad because people laughed at her when she was understanding the story

· Highs and Lows at School

13

Following these levels of analysis, the themes derived on the right hand side were listed and referenced. Reflecting the dynamic nature of the analysis, there were times when theme titles would be changed in the process of writing the list if more appropriate terminology was thought of. 214 themes were derived from this transcript, a selection of which follows, along with page references.

(1): Seen Shapes
(1): Heard Voices
(1): Stroke - Opened Head
(1): Episodes More Frequent Post-Stroke
(1): Be Understood
(2): Fear To Acceptance
(2): Methodism - Strict And Puritanical
(2): Childhood Fear Of Punishment In Hell
(3): Religious Teachings Create Fear Of Experiences
(3): Mental Health Problems Are Bad
(3): Parents' Death And Illness
(3): Family Dynamics Narrative
(3): Family Lack Of Understanding Of Anxiety
(3): Empathy
(4): Family Disapproval Of Mental Health Problems
(4): Scared To Share Experiences With Family
(4): Major Experience - Context Narrative
(4): Fright
(5): Experience Context - Uncertainty Of Physical Health
(5): Experience Context - Poor Physical Health
(5): Illness - Scared Of Having Done Wrong
(6): Physical Illness As A Punishment
(6): Wrongdoing Narrative
(6): Parental Response Narrative
(6): Fear Of Police And God
(7): Long Term Beliefs Of Punishment
(7): Deserving More Punishment
(7): Asking Questions, Refused Answers
(7): Religious Control Over Knowledge
(8): Desire For Mary - Kind, Unpunishing
(8): Better Memory Than Most
(8): Childhood - Delayed Development
(8): Link Of Virus To Fear

(9): Childhood - Reduced	Communication	(9): Betrayal And No Forgiveness

The entire list of themes was then arranged into clusters that seemed to represent shared meaning for the participant.

Primary Theme	**Secondary Theme**	
Explanations & Understanding	For experiences	(1): Stroke - Opened Head (1): Episodes More Frequent Post-Stroke (and so on)
	For life & the world	(2): Methodism - Strict And Puritanical (2): Childhood Fear Of Punishment In Hell (and so on)
	Testing & Proof	(17): Proof Of Vision's Truth (27): Proof Of Spiritual Explanation (and so on)
Growth, Learning, and Personal Changes		(2): Fear To Acceptance (11): Using Experience To Inform Parenting (and so on)
Relationships & Social Considerations	General	(3): Family Dynamics Narrative (3): Empathy (and so on)
	Hiding and Denial	(4): Scared To Share Experiences With Family (16): Family Narrative - Hiding Upsetting Things (and so on)

Primary Theme	**Secondary Theme**	
Life Story & Identity	Events, Circumstances, and Behaviours	(3): Parents' Death And Illness (6): Wrongdoing Narrative (and so on)
	Comparison	(8): Better Memory Than Most (62): Social Comparison
	Descriptive	(7): Deserving More Punishment (11): Rebelliousness As A Child (and so on)
Experiences of Voices, Visions, Fears, and Mood Difficulties		(1): Seen Shapes (1): Heard Voices (and so on)
	Premonition	(15): Spiritualist Premonition (55): Dream - Premonition Proved True (and so on)
Coping & Reaction	General	(38): Statue Of Jesus - Brilliant (38): No Coping (and so on)
	Control	(38): Cracking Up - No Control (47): In Control (and so on)
Process		(1): Be Understood

After these tables were produced for each individual, a master table was produced representing the theme structure described in the results. In the process of creating this master table, each of the individual tables were compared for similarities that could inform the final structure. Themes which appeared to be less common across the group were examined for the potential inclusion within a different theme. For each change associated with this master table, every participant's analysis was rearranged so that the original themes remained related to the new structure, and a process of checking the references to ensure that no essential meaning had been lost was performed repeatedly. This resulted in a column for each participant where the original themes that related to the final master structure were referenced.

Major Theme	**Secondary Theme**	**Areas**	**Barbara**
Unusual Experiences	Experience Descriptions	Positive Appraisals	(12): Voices - Reassurance (16): Voice - Reassurance (and so on)
Unusual Experiences	Experience Descriptions	Negative Appraisals	(4): Fright (9): Fear Of Wrong Punishment (and so on)
Unusual Experiences	Experience Descriptions	Power	(48): Voice - Commanding (and so on)
Unusual Experiences	Experience Descriptions	Conflict	(38): Contradictory Voices (and so on)
Unusual Experiences	Experience Descriptions	Reality	
Unusual Experiences	Experience Descriptions	Other	(1): Heard Voices (54): Conversation With Mary And God - Submissal (and so on)

Major Theme	**Secondary Theme**	**Areas**	**Barbara**
Unusual Experiences	Consequences & Reactions	Controlled	(38): Statue Of Jesus - Brilliant (49): Faith Is A Comfort (and so on)
Unusual Experiences	Consequences & Reactions	Uncontrolled	(38): No Coping (61): Vision - Stopped Ability To Function (and so on)
Unusual Experiences	Consequences & Reactions	External and others	(63): Safety Control By Husband (39): Priest Trying To Help (and so on)
Unusual Experiences	Context Narratives	Build Up	(4): Major Experience - Context Narrative (5): Experience Context - Uncertainty Of Physical Health (and so on)
Unusual Experiences	Context Narratives	At the time	
Unusual Experiences	Context Narratives	Following	

Major Theme	**Secondary Theme**	**Areas**	**Barbara**
Explanations, Understanding, & Beliefs	For Unusual Experiences	Spiritual	(12): Voice Identity - Dead Family And Friends (23): Vision Identity - Friends (and so on)
Explanations, Understanding, & Beliefs	For Unusual Experiences	Biological	(1): Stroke - Opened Head (1): Episodes More Frequent Post-Stroke (and so on)
Explanations, Understanding, & Beliefs	For Unusual Experiences	Alternatives	(26): Truth Of Medical And Spiritual Explanations (26): Others Acceptance Of Medical Over Spiritual (and so on)
Explanations, Understanding, & Beliefs	For Unusual Experiences	Origins	(3): Religious Teachings Create Fear Of Experiences (12): No Understanding Creates Fear (and so on)
Explanations, Understanding, & Beliefs	For Unusual Experiences	Other	(3): Mental Health Problems Are Bad (42): Nervous Breakdown (and so on)

Major Theme	**Secondary Theme**	**Areas**	**Barbara**
Explanations, Understanding, & Beliefs	For Life and the World	Divine/Spiritual Intervention	(34): Mary Did Something (6): Physical Illness As A Punishment (and so on)
Explanations, Understanding, & Beliefs	For Life and the World	Relationship with God	(8): Desire For Mary - Kind, Unpunishing (10): Pleading With God (and so on)
Explanations, Understanding, & Beliefs	For Life and the World	Organised Religion	(2): Methodism - Strict And Puritanical (14): Methodism Denies Spirituality (and so on)
Explanations, Understanding, & Beliefs	For Life and the World	Standards & Directives	(36): Hell If Not Punished Enough (27): Wrong Relationship With God (and so on)
Explanations, Understanding, & Beliefs	For Life and the World	Origins & Changes	(19): Esoteric Grandfather (28): Quick Identification With Catholicism (and so on)

Major Theme	**Secondary Theme**	**Areas**	**Barbara**
Explanations, Understanding, & Beliefs	For Life and the World	Other	(6): Fear Of Police And God (50): Others' Difficult Circumstances (and so on)
Explanations, Understanding, & Beliefs	Testing & Proof		(17): Proof Of Vision's Truth (27): Proof Of Spiritual Explanation (and so on)
Self in the world	General Narratives		(3): Parents' Death And Illness (6): Wrongdoing Narrative (and so on)
Self in the world	Identity Descriptions		(7): Deserving More Punishment (11): Rebelliousness As A Child (and so on)
Self in the world	Growth, Learning, and Personal Changes		(2): Fear To Acceptance (11): Using Experience To Inform Parenting (and so on)

Major Theme	**Secondary Theme**	**Areas**	**Barbara**
Self in the world	Relationships & Social Considerations	Comparison	(8): Better Memory Than Most (62): Social Comparison (and so on)
Self in the world	Relationships & Social Considerations	Hiding, Denial, & Pretence	(4): Scared To Share Experiences With Family (16): Family Narrative - Hiding Upsetting Things (and so on)
Self in the world	Relationships & Social Considerations	Spiritual Community	(35): Caution Of Priest In Acceptance (39): Priest Trying To Help (and so on)
Self in the world	Relationships & Social Considerations	Family	(3): Family Dynamics Narrative (62): Husbands Threats Of Institutionalisation (and so on)
Self in the world	Relationships & Social Considerations	Other	(28): Understanding By Others (59): Worries About Psychiatrist Friend's Reaction (and so on)