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DOCTOR OF PHILOSOPHY

Mental health professionals' perspectives on spirituality and psychosis

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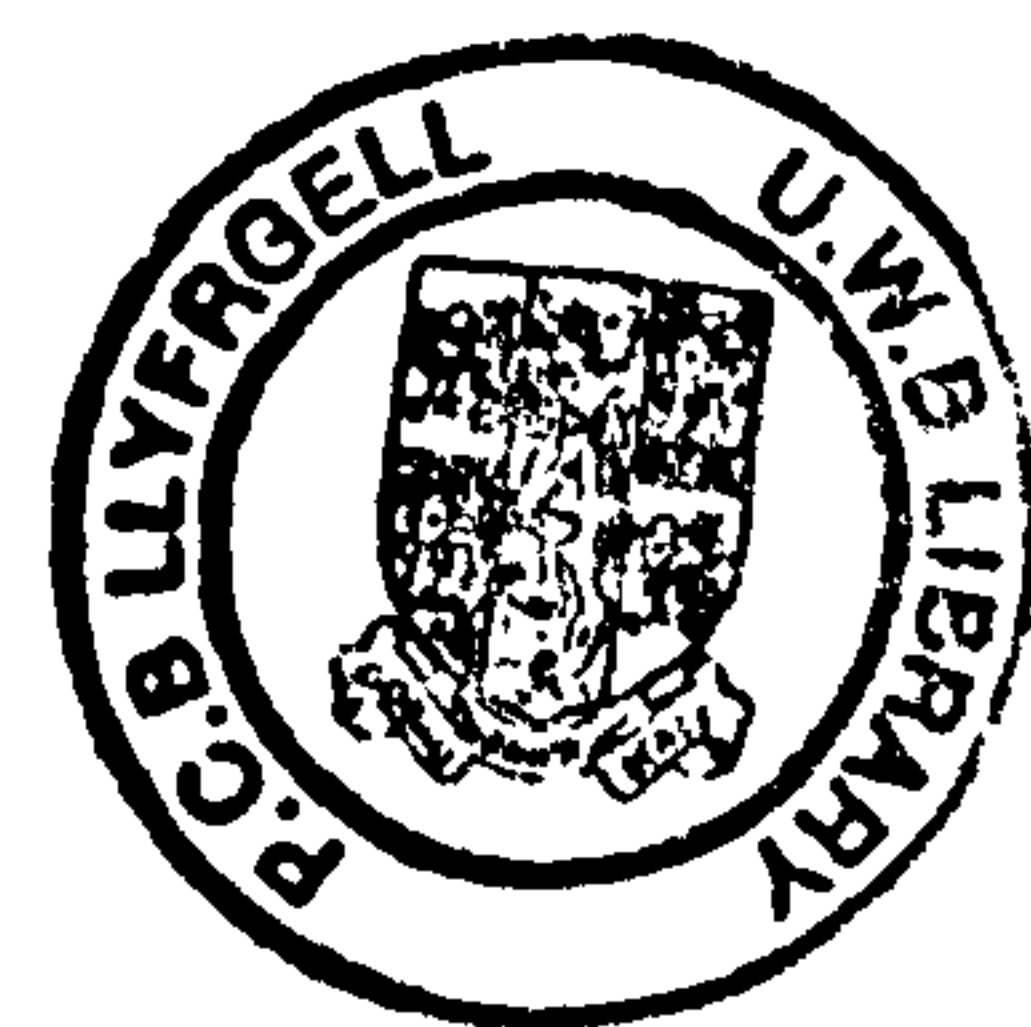
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**MENTAL HEALTH PROFESSIONALS' PERSPECTIVES ON
SPIRITUALITY AND PSYCHOSIS**

FIONA RANDALL, BSc Hons

UNIVERSITY OF WALES, BANGOR

JUNE 2006



Acknowledgements

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I would like to thank everyone who kindly took part in this research. I was particularly heartened with the high response rate and the many supportive comments from clinical psychologists.

Finally, I would like to thank my family, my husband, for his patience, my mother for her time and supportive ear, my father for his quiet confidence in my ability, Keith, Carole and Barbara for their support, and of course my son, Noah, who has been waiting for mummy to “stop working all the time”. Well, I think it’s time!

Mental health professionals' perspectives on spirituality and psychosis

This large-scale research project examined mental health professionals' perspectives of their own, and service users' spirituality and mental health difficulties. Recent research has shown a relationship between mental health professionals' own beliefs around spirituality and that of service users. The initial part of the thesis reviews: the area of spirituality in mental health care, from both view point of the mental health professional and service user; models attempting to make a distinction between spirituality and psychosis; treatment incorporating a spiritual perspective and current and future training of clinical psychologists. The main focus of the review is clinical psychology and more serious mental illness, psychosis.

The aim of the empirical paper was to investigate mental health professionals' perspectives of spirituality and psychosis. The study employed a postal questionnaire across three groups of mental health professionals: psychiatrists; nurses; and clinical psychologists. The main findings of the study were in line with the original hypotheses. Qualitative analysis was performed to enhance and enrich the quantitative data.

LARGE SCALE RESEARCH PROJECT

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SECTION ONE – ETHICS PROPOSAL

NHS Research Ethics Committee

APPLICATION FORM

This form should be completed by the Chief Investigator, after reading the Guidance Notes.
See Glossary for clarification of different terms in the application form.

Short Title and version number: (maximum 70 characters – this will be inserted as header on all forms)

Attitudes about spirituality and psychosis 1

Name of NHS Research Ethics Committee to which application for ethical review is being made:

North Wales Central LREC

Project Reference number from above REC: 05/WNo02/30

Submission Date: 23/06/2005

PART A: Introduction

A1. Title of Research

Full title: Exploring mental health professionals' attitudes about spirituality and psychosis

Key words: mental health professionals'; spirituality; psychosis

A2. Chief Investigator

Title: Mrs
Forename/Initials: Fiona
Surname: Randall
Post: Trainee Clinical Psychologist
Qualifications: BSc
Organisation: North Wales Clinical Psychology Programme, University of Wales
Address: School of Psychology
University of Wales – Bangor
Post Code: LL57 2DG
E-mail: work@fionarandall.co.uk
Telephone: 07880 593032
Fax:

A copy of a current CV, (maximum 2 pages of A4) for the Chief Investigator must be submitted with application

A3. Proposed Study Dates and Duration

Start Date: 06/05/2005
End Date: 03/05/2006
Duration: Months: 0 ; Years: 1

A4. Primary purpose of the research: (Tick as appropriate)

- Commercial product development and/or licensing
 Publicly funded trial or scientific investigation
 Educational qualification
 Establishing a database/data storage facility
 Other

A5. Tick the box if your research:

- Involves testing a medicinal product
 Involves investigating a medical device
 Involves additional radiation above that required for clinical care
 Involves using stored samples of human biological material (e.g. blood, tissue)
 Involves taking new samples of human biological material
 Involves only patient records or data, with no other direct patient contact
 Involves prisoners or others in custodial care
 Involves adults unable to consent for themselves through physical or mental incapacity
 Has the primary aim of being educational (e.g. a student project, or a project or research necessary for a postgraduate degree or diploma)

A6. Do you consider that this research falls within the category where there is no need to appoint a Principal Investigator at each site?

Yes No

If Yes, please justify:

In our opinion, this project falls into the 'no local investigator' category, as it is a postal questionnaire study.

Advice can be found in the Guidance Notes on this topic. Some studies do not require further consideration of site-specific issues by local research ethics committees, but will still require approval to proceed from the host organisation(s).

PART A: Section 1

A7. What is the principal research question/objective? *(Must be in language comprehensible to a lay person.)*

The principle research objectives are to:

1. explore how much of an issue spirituality/religion is for mental health professionals
2. explore any relationship between mental health professionals (psychiatrists/psychologists/nurses) expressions of their own spiritual experience and their judgements about others' experiences.

Mental health professionals will be asked to answer two questionnaires. One which taps into their own experiences of spirituality and the other which taps into the experiences of their clients spiritual/psychotic experiences.

A8. What are the secondary research questions/objectives? *(If applicable, must be in language comprehensible to a lay person.)***A9. What is the scientific justification for the research? What is the background? Why is this an area of importance?** *(Must be in language comprehensible to a lay person.)*

Recently Eeles, Lowe & Wellman (2003) conducted a qualitative study exploring the criteria that nurses use to evaluate spiritual-type experiences reported by clients and nurses own experiences of spirituality. In conclusion they reported that a 'reduction of personal bias is desirable to ensure beneficial treatment for patients, determining that sometimes dramatic and personally significant but essentially harmless spiritual-type experiences are not mistaken for the symptoms of mental illness.'

From previous research it is clear that a person's belief system (including their spirituality) has a large impact on their experience and therefore their health (Clarke, 2001). This coupled with the proposition that some forms of psychosis and spirituality have much in common (Jackson, 1991; Jackson & Fulford, 1997) indicates that to understand the attitudes towards spirituality/psychosis of mental health professionals that are responsible for the care of people with a diagnosis of psychosis, is crucial for their future rehabilitation.

Based on the Eeles et al (2003) study, this present study aims to investigate further the criteria that mental health professionals (including nurses, psychiatrists and psychologists), use to evaluate the spiritual-type experience of their clients and their own experiences of spirituality.

A10. Give a brief synopsis/summary of methods and overview of the planned research, including a brief explanation of the theoretical framework which informs it. It should include a brief description of how prospective research participants and concerned communities (not necessarily geographical) from which they are drawn have been consulted over the design and details of the research.

(Where appropriate a flow chart or diagram should be submitted separately. It should be clear exactly what will happen to the research participant, how many times and in what order).

This section **MUST** be completed in language comprehensible to the lay person. Do **NOT** simply reproduce the protocol.

Jackson (1991) proposed the term p-s experiences to describe accounts involving similarities in descriptions of experience between people diagnosed as psychotic and those experiencing benign spiritual experiences. In this and later research (Jackson & Fulford 1997) they found these p-s experiences could not be reliably distinguished using the Present State Examination, a psychiatric measure of hallucinations and delusions. This was because spiritual and psychotic-type phenomena were often qualitatively identical. This led to the tentative conclusion that it was not the form and content of the experience that determines the label it receives but more likely the context in which it is experienced and the amount of distress it causes.

More recently, Eeles, Lowe & Wellman (2003) conducted a qualitative study exploring the criteria that 14 nurses used to evaluate spiritual-type experiences reported by patients, and their own experiences of spirituality. In conclusion they reported that a 'reduction of personal bias is desirable to ensure beneficial treatment for patients, determining that sometimes dramatic and personally significant but essentially harmless spiritual-type experiences are not mistaken for the symptoms of mental illness.'

To expand on this work, 700 mental health professionals (psychiatrists, psychologists and nurses) will be asked to fill in two postal questionnaires:

1. The Expressions of Spirituality Questionnaire, Macdonald (2000), which incorporates five dimensions of spirituality and has been described as encompassing the core descriptive elements of spirituality as currently represented in available paper & pencil measures. The questionnaire has good internal reliability (.80-.89) for all of the five dimensions and good validity correlating highly with a number of similar measures.

2. A questionnaire which incorporates Eeles et al (2003) semi structured interview, including vignettes detailing real life accounts of psychotic/spiritual experiences, questions about participants own spiritual/religious practices and open ended questions about their experience of their clients' spirituality.

The questionnaires will take approximately 20 minutes to complete. The second questionnaire includes both closed and open ended questions to enable quantitative and qualitative analysis to be performed.

The aim of the study is to:

1. Investigate the psychometric properties (internal reliability) of the vignette questionnaire;
2. Explore the impact of spirituality/religion on mental health professionals day to day lives;
3. Explore any relationship between mental health professionals (psychiatrists/ psychologists/nurses) expressions of their own spiritual experience and their judgements about others' experiences.

It is hypothesised that:

1. Participants that express an openness to spiritual issues/spirituality(as rated on the Expressions of Spirituality Inventory) will be more likely to rate the vignettes as common spiritual experiences;
2. There will be a difference between professional groups in the way they rate the questionnaires;
3. Participants' rating the vignettes which describe distressing experiences are more likely to rate the individual as having a mental health problem.

The final deadline for the project is June 2006. There are two progress reports planned, October 2005 and February 2006.

A11. Will any intervention or procedure, which would normally be considered a part of routine care, be withheld from the research participants?

Yes No

A12. Will the research participants receive any clinical intervention(s) or procedure(s) including taking samples of human biological material over and above that which would normally be considered a part of routine clinical care?

Yes No

A13. Will the research participant be subject to any non-clinical research-related intervention(s) or procedure(s)?
(These include interviews, non-clinical observations and use of questionnaires.)

Yes No

Additional Intervention	Average number per patient	Average time taken (mins/hours/days)	Details of additional intervention or procedure, who will undertake it, and what training they have received.
Postal questionnaire to home	2	20mins	

A14. Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during interviews/group discussions, or use of screening tests for drugs)?

Question A14 below is not applicable if No is selected in question A13.

Yes No

If Yes, give details of procedures in place to deal with these issues

An information sheet will be provided with contact details of Investigators should any difficulties arise.

The Information Sheet should make it clear under what circumstances action may be taken

A15. What is the expected total duration of participation in the study for each participant?

The expected total duration of the participation in the study is approximately 20 minutes (based on the mean time taken for a selection of colleagues to fill in the questionnaire).

A16. What are the potential adverse effects, risks or hazards for research participants either from giving or withholding medications, devices, ionising radiation, or from other interventions (including non-clinical)?

N/A

A17. What is the potential for pain, discomfort, distress, inconvenience or changes to lifestyle for research participants?

Very little. The participants are encouraged to contact the researcher should any difficulties arise for them.

A18. What is the potential for benefit to research participants?

Increase awareness of the impact that spirituality, their own and their clients' may have on their work and their lives.

A19. What is the potential for adverse effects, risks or hazards, pain, discomfort, distress, or inconvenience to the researchers themselves? (if any)

No obvious risks have been identified for researcher involved.

A20. How will potential participants in the study be (i) identified, (ii) approached and (iii) recruited?

Give details for cases and controls separately if appropriate:

Based on information gathered from the Mental Health Directorate Information Manager there are an estimated 660 mental health professionals across the three trusts in North Wales. Using the internal mental health network communication system these mental health professionals will be identified. They will then be approached and recruited via postal questionnaire, to their work address, which will be returnable via a pre-paid postal business reply service.

A21. Where research participants will be recruited via advertisement, give specific details.

Not Applicable

If applicable, enclose a copy of the advertisement/radio script/website/video for television (with a version number and date).

A22. What are the principal inclusion criteria? (Please justify)

All clinicians, psychologists, nurses, psychiatrists will be recruited. This is to expand on the Eeles (2003) study, who only recruited nurses for a small scale qualitative study.

A23. What are the principal exclusion criteria? (Please justify)

Anyone who is not a mental health clinician.

A24. Will the participants be from any of the following groups? (Tick as appropriate)

- Children under 16
- Adults with learning disabilities
- Adults who are unconscious or very severely ill
- Adults who have a terminal illness
- Adults in emergency situations
- Adults with mental illness (particularly if detained under Mental Health Legislation)
- Adults suffering from dementia
- Prisoners
- Young Offenders
- Adults in Scotland who are unable to consent for themselves
- Healthy Volunteers
- Those who could be considered to have a particularly dependent relationship with the investigator, e.g. those in care homes, medical students
- Other vulnerable groups

Justify their inclusion.

Mental Health staff are healthy volunteers

A25. Will any research participants be recruited who are involved in existing research or have recently been involved in any research prior to recruitment?

- Yes No Not Known

If Yes, give details and justify their inclusion. If Not Known, what steps will you take to find out?

There is a question on the information sheet regarding previous research.

A26. Will informed consent be obtained from the research participants?

- Yes No

If Yes, give details of who will take consent and how it will be done. Give details of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material.

If participants are to be recruited from any of the potentially vulnerable groups listed in A24, give details of extra steps taken to assure their protection. Describe the arrangements to be made for obtaining consent from a legal representative.

If consent is not to be obtained, please explain why not.

A consent form and information sheet detailing the study and answering any questions will be included with the questionnaires. Participants will be required to sign and return the consent form along with the questionnaires.

Copies of the written information and all other explanatory material should accompany this application.

A27. Will a signed record of consent be obtained?

Yes No

If Yes, attach a copy of the information sheet to be used, with a version number and date.

A28. How long will the participant have to decide whether to take part in the research?

Participants will be asked to return the questionnaire via post within 14 days of receipt.

A29. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters etc.)

The information sheet will be produced in both Welsh and English. Questionnaires will be produced in English as there are not any properly valid translations into Welsh.

A30. What arrangements are in place to ensure participants receive any information that becomes available during the course of the research that may be relevant to their continued participation?

If any individual participant reported experiencing extreme distress the research, for that participant, would obviously be stopped.

A31. Does this study have or require approval of the Patient Information Advisory Group (PIAG) or other bodies with a similar remit? (see Guidance Notes)

Yes No

A32a. Will the research participants' General Practitioner be informed that they are taking part in the study?

Yes No

If Yes, enclose a copy of the information sheet/letter for the GP with a version number and date.

A32b. Will permission be sought from the research participants to inform their GP before this is done?

Yes No

If No to either question, explain why not
Not necessary

It should be made clear in the patient information sheet if the research participants' GP will be informed.

A33. Will individual research participants receive any payments for taking part in this research?

Yes No

A34. Will individual research participants receive *reimbursement of expenses* or any other *incentives or benefits* for taking part in this research?

- Yes No

A35. What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for negligent harm?

The research is covered by University of Wales–Bangor indemnity insurance.

Please forward copies of the relevant documents.

A36. What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for non-negligent harm?

The research is covered by University of Wales–Bangor indemnity insurance.

Please forward copies of the relevant documents.

A37. How is it intended the results of the study will be reported and disseminated? (Tick as appropriate)

- Peer reviewed scientific journals
 Internal report
 Conference presentation
 Other publication
 Submission to regulatory authorities
 Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
 Written feedback to research participants
 Presentation to participants or relevant community groups
 Other/none e.g. Cochrane Review, University Library

A38. How will the results of research be made available to research participants and communities from which they are drawn?

Copies of the research report will be available on request.

A39. Will the research involve any of the following activities at any stage (including identification of potential research participants)? (Tick as appropriate)

- Examination of medical records by those outside the NHS, or within the NHS by those who would not normally have access
- Electronic transfer by magnetic or optical media, e-mail or computer networks
- Sharing of data with other organisations
- Export of data outside the European Union
- Use of personal addresses, postcodes, faxes, e-mails or telephone numbers
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals
- Use of audio/visual recording devices
- Storage of personal data on any of the following:
 - Manual files including X-rays
 - NHS computers
 - Home or other personal computers
 - University computers
 - Private company computers
 - Laptop computers

Further details:

A40. What measures have been put in place to ensure confidentiality of personal data? Give details of whether any encryption or other anonymisation procedures have been used and at what stage:

All data will be kept confidential with all identifiers being kept separate from the data on the computer.

A41. Where will the analysis of the data from the study take place and by whom will it be undertaken?

On the University owned Laptop by the Principle Investigator. The supervisor, Dr. Mike Jackson will have access to the database.

A42. Who will have control of and act as the custodian for the data generated by the study?

Dr. Mike Jackson

A43. Who will have access to the data generated by the study?

The Principle Investigator, the supervisor, Dr. Mike Jackson and Dr. Dave Daley Research Director of NWCPP will have access to an electronic and anonymised version of the data so that they can provide support and advice on statistical analysis.

A44. For how long will data from the study be stored?

5 Years Months

Give details of where they will be stored, who will have access and the custodial arrangements for the data:
Data will be stored in a locked cabinet at the Supervisor's office. The Principle Investigator and the Supervisor will have access to this. All computer files will also be kept on disc in this cabinet.

A45. How has the scientific quality of the research been assessed? (Tick as appropriate)

- Independent external review
 Review within a company
 Review within a multi-centre research group
 Internal review (e.g. involving colleagues, academic supervisor)
 None external to the investigator
 Other, e.g. methodological guidelines

If you are not in possession of any referees or other scientific critique reports relevant to your proposed study, justify and describe the review process and outcome. If review has been undertaken but not seen by the researcher, give the details of the body which has undertaken the review:

A copy of any referees' comments or other scientific critique reports relevant to the proposed research must be enclosed with the application form.

A46. Has similar research on this topic been done before?

- Yes No

If Yes, why should it be repeated?

Previous research was carried out with a small number of nurses using a qualitative approach. This research plans to access a greater number of nurses plus recruit psychiatrists and psychologists as well using quantitative analysis and therefore widen the sample to enable a clearer understanding of the issues around clinician's experiences of spirituality within themselves and in their clients.

A47. Have all existing sources of evidence, especially systematic reviews, been fully considered?

- Yes No

If Yes, please give details of search strategy used. If No, explain why not.

Full literature search was conducted using psycinfo, medline and web of science with the search terms: psychosis; spirituality; mental health professionals; nurses; psychiatrists; psychologists.

A48. What is the primary outcome measure for the study?

Primary outcome for the study is the response to both questionnaires: ESI and vignettes questionnaire.

A49. What are the secondary outcome measures? (if any)**A50. How many participants will be recruited? How many of these participants will be in a control group?**

In order to recruit a sample of 200 + participants to the study, 700 questionnaires will have to be sent out. There is no control group.

A51. Has the size of the study been informed by a formal statistical power calculation?

- Yes No

If Yes, indicate the basis upon which this was done, giving sufficient information to allow the replication of the calculation: A power calculation using Cohens a power primer indicated that with a medium effect size and an alpha level of 0.05 200 participants would yield sufficient power greater than 0.8 to determine effects. In case the results are not statistically significant measures of effect size will be used to determine any differences between groups.

A52. Has a statistician given an opinion about the statistical aspects of the research?

Yes No

If Yes, enclose a copy of comments. If the comments are not available then please enclose a summary of the opinion.

A53. Describe the statistical methods and/or other relevant methodological approaches (e.g. for qualitative research) to be used in the analysis of the results. Give details of the methods of randomisation process to be used if applicable:

Initial analysis will explore the internal consistency between the items on the vignette questionnaire, and any items which are found to have low internal consistency will be treated with extreme caution in any analysis. Both quantitative and qualitative analysis will be conducted on the data. Depending on whether the data is parametric or not (as tested by the Kolmogorov–Smirnov test), a t-test (or equivalent) will be performed on any differences between expressions of spirituality (which will be determined by using dichotomous variables of high v low spirituality on all five expressions) and response to the vignettes. A between groups, 2 (distressing v non-distressing vignettes) x 2 (high v low expressions of spirituality) x gender (male v female) analysis of variance or equivalent will then be performed to look at any differences between ratings on vignettes portraying distressing experiences versus positive experiences, professionals expressions of spirituality and gender. Further analysis might include any differences between the professions of the respondents and any others that become clear at the time, based on the number of questionnaires returned. Simple qualitative analysis will investigate the open-ended questions, highlighting any emerging themes.

A54. Where will the research take place? (Tick as appropriate)

- UK
 Other states in European Union
 Other countries in European Economic Area
 Other

Give details:
North Wales

A55. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK, the European Union or the European Economic Area?

Yes No

A56. In how many and what type of host organisations (NHS or other) in the UK is it intended the proposed study will take place?

Indicate the type of organisation by ticking the box and give approximate numbers if known:

- | | Number of organisations |
|--|-------------------------|
| <input type="checkbox"/> Acute teaching NHS Trusts | |
| <input type="checkbox"/> Acute NHS Trusts | |

- NHS Community and/or Primary Care Trusts
 NHS Trusts providing Mental Healthcare 3+
 NHS Care Trusts
 Social Care Organisations
 Prisons
 Independent hospitals
 Educational establishments
 Independent research units
 Other (give details)

Other:

A57. What arrangements are in place for monitoring and auditing the conduct of the research?

Day to day monitoring of the research will be the responsibility of the research supervisor. Additionally, North Wales Clinical Psychology Programme require regular written progress reports.

Will a data monitoring committee be convened?

Yes No

If Yes, details of membership of the data monitoring committee (DMC), its standard operating procedures and summaries of reports of interim analyses to the DMC must be forwarded to the NHS Research Ethics Committee which gives a favourable opinion of the study.

What are the criteria for electively stopping the trial or other research prematurely?

If it became clear that the questionnaires were in any way distressing participants.

A58. Has funding for research been secured?

Yes No

If Yes, give details of funding organisation(s) and amount secured and duration:

Organisation: North Wales Clinical Psychology Programme
 Address: School of Psychology, University of Wales
 Bangor, Gwynedd
 Post Code: LL57 2PX
 UK contact: lynn moran
 Telephone: 01248 382205 Fax: 01248 387718
 E-mail: l.moran@bangor.ac.uk
 Amount (£): 566.00 Duration: 12 Months

A59. Has the funder of the research agreed to act as sponsor as set out in the Research Governance Framework?

Yes No Not Known

Has the employer of the Chief Investigator agreed to act as sponsor of the research?

Yes No Not Known

Give details of the organisation which will act as the sponsor of the research:

UK contact:

Title: Ms

Forename/Initials: Lynn

Surname: Moran

Organisation: University of Wales Bangor

Address: North Wales Clinical Psychology Programme

Telephone: 01248 382205

Fax: 01248 383718

Postcode: LL57 2DG

E-mail: l.moran@bangor.ac.uk

A copy of documentation indicating that the organisation has accepted the role of sponsor should be enclosed if the sponsor is not the main funder, the Chief Investigator's employer, or an NHS body hosting the research.

A60. Has any responsibility for the research been delegated to a subcontractor?

Yes No

A61. Will individual researchers receive any personal payment over and above normal salary for undertaking this research?

Yes No

A62. Will individual researchers receive any other benefits or incentives for taking part in this research?

Yes No

A63. Will the host organisation or the researcher's department(s) or institution(s) receive any payment or benefits in excess of the costs of undertaking the research?

Yes No

A64. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share-holding, personal relationship etc.) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

Yes No

A65. Other relevant reference numbers if known(give details and version numbers as appropriate):

Applicant's/organisation's own reference number, e.g. RD(if available):

Sponsor's/protocol number:

Funder's reference number:

International Standard Randomised Controlled Trial Number (ISRCTN):

European Clinical Trials Database (EudraCT) number:

Project website:

A66. Other key investigators/collaborators(all grant co-applicants should be listed)

Title:	Dr.	
	Forename/Initials: Mike	Surname: Jackson
Post:	Consultant Clinical Psychologist	
Qualifications:	DClinPsy., DPhil., C Psychol.	
Organisation:	North West Wales Trust	
Address:	Bodfaen	
	Craig y don Road, Bangor	Telephone: 01248 360490
	Gwynedd	Fax: 01248 364496
Postcode:	LL572BG	
E-mail:	Mike.Jackson@nww-tr.wales.nhs.uk	

If further collaborators are required, please enter at end of section or attach a further sheet.

A67. If the research involves a specific intervention, (e.g. a drug, medical device, dietary manipulation, lifestyle change etc.), what arrangements are being made for continued provision of this for the participant (if appropriate) once the research has finished?
 Not Applicable
PART A: Summary of Ethical Issues**A68. What do you consider to be the main ethical issues or problems which may arise with the proposed study and what steps will be taken to address these?**

There may be difficulties recruiting the proposed number of participants as postal surveys often yeild small numbers. However, recruitment at various local psychosis interest groups should overcome this difficulty

With regards to any difficulties that participants may have with the questionnaires –The information sheet requests that participants contact the researcher who will direct them to appropriate support if necessary.

A69. Do you need to add further information about certain questions in Part A?

This question is not applicable for the online version of COREC form.

PART A: Student Page

A70. Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/degree:

Doctor of Clinical Psychology

Name of educational establishment:

North Wales Clinical Psychology Programme

School of Psychology

University of Wales – Bangor

Bangor

Gwynedd

LL57 2DG

Name and contact details of educational supervisor:

Dr. Mike Jackson

Bodfaen

Craig y Don Road

Bangor

Gwynedd

LL57 2BG

A71. Declaration of Supervisor

I have read and approved both the research proposal and this application for the ethical review. I undertake to fulfil the responsibilities of a supervisor as set out in the Research Governance Framework for Health and Social Care. I can confirm on behalf of my academic institution that any necessary indemnity or insurance arrangements are in place.

Signature:

Date: (dd/mm/yyyy)

Print Name:

A one-page summary of the supervisor's CV should be submitted with the application

PART B: Section 7 – Declaration

- The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I undertake to abide by the ethical principals underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
- If the research is approved I undertake to adhere without unagreed deviation to the study protocol, the terms of the full application of which the main REC has given a favourable and any conditions set out by the main REC in giving its favourable opinion.
- I undertake to inform the main REC of any changes in the protocol, and to submit annual reports setting out the progress of the research.
- I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer.
- I understand that research records/data may be subject to inspection for audit purposes if required in future.
- I understand that personal data about me as a researcher in this application will be held by the relevant RECs and their operational managers and that this will be managed according to the principles established in the Data Protection Act.

Signature:

Date: (dd/mm/yyyy)

Print Name:

1. Do you need to add further information about certain questions in part B?*This question is not applicable for the online version of COREC form.***ENSURE THAT YOU COMPLETE AND SIGN THE FORM, AND ENCLOSE ANY RELEVANT ADDITIONAL DOCUMENTS.**

APPENDIX 1.1: FULL RESEARCH PROTOCOL

Title of study	Exploring mental health professionals' attitudes about spirituality and psychosis
Principle Investigator	Fiona Randall – Trainee Clinical Psychologist
Supervisor	<p>Dr Mike Jackson Bodfaen Craig y Don Road Bangor, Gwynedd, LL57 2BG</p> <p>The supervisor will be providing supervision on all aspects of the project- including data analysis.</p>
Background	<p>At the turn of the ^{last} century William James (1902) made the connection between spiritual experience and psychotic experience, coining the term 'diabolical mysticism' (James 1902: 426). Until recently, however, there had been a noticeable lack of research investigating this relationship. A recently published book edited by Clarke (2001) called 'Psychosis and Spirituality: Exploring a New Frontier', a project currently underway by the National Institute for Mental Health in England and the Mental Health Foundation investigating 'Spirituality and Mental Health' and research carried out by authors such as Jackson and colleagues (1991, 1997) and Claridge (1997) are all indications that this is changing.</p> <p>Clarke (2001) stated that it is 'the subtle use of language, and other means, whereby the spiritual and the psychotic have hitherto been kept in essentially separate compartments'. She proposed that the 'New Frontier' referred to in the title of the book represented a challenge in 'linking the highest realms of human consciousness and the depths of madness'.</p>

Between 1% and 3% of the population experience a diagnosed psychotic episode at some point in their lives (APA 1994). The psychosis spectrum disorders (DSM-IV: APA 1994) include: schizophrenia (delusions, hallucinations, thought disorder, affective flattening and catatonic disorder over at least 6 months involving a significant deterioration in life functioning); schizophreniform disorder (same presentation as schizophrenia, but shorter in duration); brief reactive psychosis (lasting for a maximum of 1 month); delusional disorder (a single fixed delusion); bipolar affective disorder (cycles of mania and depression); schizoaffective disorder (features of both schizophrenia and bipolar affective disorder); and schizotypal personality disorder (less overt psychotic experience). The continuity/dimensionality of psychotic characteristics, which are recognised as extreme expressions of traits that manifest within the general population, are now firmly established among psychologists (Claridge 1997) and increasingly among psychiatrists (Van Os et al 1999).

Jackson (1991) defines spiritual experience in terms of three categories: 'psychic' experiences characterised by extra-sensory perception, apparitions, out of body experiences; 'numinous' experiences involving a sense of the presence of an external agent, sometimes interpreted in explicitly religious terms; and 'mystical' experiences characterised by feelings of unity with a larger whole. He also makes the distinction between the spiritual experiences referred to in much research of the 'great mystics' and the everyday spiritual experiences of people. These experiences may occur as a result of specific spiritual practices, through life crises such as bereavement, under the influence of drugs and in some cases simply from out of nowhere. In a study by Hay (1987) who found that 30-60% of the population had experienced some kind of spiritual experience (as defined above), a large majority of these the experiences were viewed as life enhancing and changing.

Jackson (1991) proposed the term p-s experiences to describe the accounts involving similarities in descriptions of experience between people diagnosed as psychotic and those experiencing benign spiritual experiences. These experiences are very different from the unambiguous symptoms of psychosis

such as delusions of persecution, thought broadcasting, catatonia, emotional blunting, poor pre-morbid adjustment, the factors associated with negative symptoms of schizophrenia and the most widely reported forms of spiritual experience like experiencing brief moments of unity with the whole. In this and later research (Jackson & Fulford 1997) found these accounts could not be reliably distinguished using the Present State Examination, leading to the tentative conclusion that it is not the form and content of the experience that determines the label it receives but more likely the context in which it is experienced and the amount of distress it causes. Jackson proposed a 'problem-solving' model to account for the benign effect of intense spiritual experiences, as opposed to the deterioration found in psychosis. He suggested that both are experienced in emotional crises and are accompanied by extreme emotional intensity. However, in the case of a spiritual experience, a 'negative feedback' loop increases spiritual insight, reduces arousal, leading to increased coping behaviour. In psychosis, a 'positive feedback' loop increases the state of arousal, which then precipitates increasingly florid experiences. This links into a recent cognitive model of persecutory delusions (Freeman & Garety, 2002). They state that it is against a backdrop of possible trauma, anxiety (anxiety is thought to be a central emotion in the formation of persecutory delusions) and depression which feed into the individual's persecutory threat beliefs causing arousal and these in turn are exacerbated through lack of sleep. Their model clearly highlights the importance of difficulties in affect being the main precipitator in the formation of a persecutory delusion.

In line with the above models, Clarke's discontinuity model which draws on two models: Kelly's personal construct theory (Bannister & Fransella 1971); and Teasdale's interacting subsystems (Teasdale & Barnard 1993), proposes that a functioning individual operates within constructs or between two levels of representation that balance the logical and emotional aspects of the self. Clarke proposes that in psychosis/spirituality these balanced systems are 'disjointed' and it is this discontinuity that creates the space for either a mystical or psychotic experience.

The preferred treatment of individuals who have received a diagnosis of

psychosis is neuroleptic medication. Interestingly, Beck (1952) and Ellis's (1955) initial case studies were based on people with psychosis, and yet it has only been more recently that Cognitive Behavioural Therapy (CBT) has been incorporated into treatment for psychosis. Kingdon (2001) proposed the development of 'normalising rationales' as a way of working therapeutically with clients diagnosed with psychosis. Proposing that 'since mental health professionals are a group seemingly less religious than their patients, caution is needed in separating normal religious beliefs from religious delusion'. Research has supported the argument that psychotherapists are less religious than the general public (Worthington, Kuru, McCullough & Sandage, 1996).

Jackson (1991) proposed that one of the most important implications for his research on the relationship between psychotic and spiritual experience was the impact on the treatment of psychoses. He concluded with 'more generally, greater openness towards the taboo area of spiritual experience, on the part of psychiatric workers, psychologists, religious professionals and other may help sufferers, 'normals' and society alike to reap the positive benefits of this most mystical of human faculties'. However, until recently, there has been little research investigating this area. There has been some research looking at the relationship between mental health professionals and the clergy (Weaver, Samford, Kline, Lucas, Larson & Koenig, 1997) and more specifically psychologists collaborating with clergy (McMinn et al (2003). McMinn et al (2003) have also developed a questionnaire to investigate this relationship.

Recently Eeles, Lowe & Wellman (2003) conducted a qualitative study exploring the criteria that nurses use to evaluate spiritual-type experiences reported by patients and nurses own experiences of spirituality. In conclusion they reported that a 'reduction of personal bias is desirable to ensure beneficial treatment for patients, determining that sometimes dramatic and personally significant but essentially harmless spiritual-type experiences are not mistaken for the symptoms of mental illness.'

From previous research it is clear that a person's belief system (including their spirituality) has a large impact on their experience and therefore their health (Clarke, 2001). This coupled with the proposition that some forms of

psychosis and spirituality have much in common (Jackson, 1991; Jackson & Fulford, 1997) indicates that to understand the attitudes towards spirituality/psychosis of mental health professionals that are responsible for the care of people with a diagnosis of psychosis, is crucial for their future rehabilitation.

Drawing on the above research, the proposed project will investigate mental health professionals' own expressions of spirituality and their judgements of p-s experiences which are either positive or negative in outcome.

Research Question

The aim of the study is to:

1. investigate the psychometric properties (internal reliability) of the vignette questionnaire;
2. explore how much of an issue spirituality/religion is for mental health professionals
3. explore any relationship between mental health professionals (psychiatrists/psychologists/nurses) expressions of their own spiritual experience and their judgements about others' experiences. It is hypothesised that:
 - participants that express an openness to spiritual issues/spirituality (as rated on the Expressions of Spirituality Inventory) will be more likely to rate the vignettes as common spiritual experiences
 - there will be a difference between professional groups in the way they rate the questionnaires
 - participants' rating the vignettes which describe distressing experiences are more likely to rate the individual as having a mental health problem.

Participant recruitment

700 Mental Health Professionals, predominantly psychiatrists, psychologists and nurses will be approached. The questionnaires (See Appendix 1.4) will be sent out to local clinicians via the post. If needed, opportunity sampling will be gathered at local and national conferences.

Design & Procedure

700 mental health professionals (psychologists/psychiatrists/nurses) across North Wales will be asked to:

1. complete the Expressions of Spirituality Questionnaire (See Appendix 3) (MacDonald, 2000);
2. complete a questionnaire based on Eeles et al (2003) semi structured interview, which includes vignettes detailing real life accounts of psychotic/spiritual experiences (See Appendix 3);
3. expand on their answers in a open ended response section

Measures

1. *Expressions of Spirituality Inventory (ESI)*: MacDonald, D.A., Spirituality: Description, measurement, and relation to the Five Factor Model of personality, *Journal of Personality*. Vol 68(1), Feb 2000, pp. 153-197. A 30 item revised version of this scale will be used, which was devised from the original 98-item instrument using a five point response scale. 938, 17-55 yr olds were administered the ESI. The instrument was designed to operationalize a five-dimensional model of spirituality that was developed through factor analyses of 18 extant measures of the construct. These five dimensions have been described as encompassing the core descriptive elements of spirituality as currently represented in available paper & pencil measures. The five factors include: Cognitive Orientation Towards Spirituality (e.g. beliefs about the existence of spirituality and its relevance to personal functioning); Experiential/Phenomenological Dimension (e.g. spiritual experience), Existential Well-Being (e.g. positive sense of purpose and meaning in life, sense of self-directedness, self satisfaction and inner strength), Paranormal Beliefs e.g. belief in para-psychological phenomena, spiritualism and witchcraft), and Religiousness (e.g. traditional religious beliefs and practices, mostly of a Judeo-Christian nature). The measure has good internal reliability (.80-.89) for all of the five dimensions and good validity correlating highly with a number of similar measures. Means are supplied for each dimension and anyone scoring above the mean will be classified as high on that dimension, conversely, anyone scoring below will be classified as low on that dimension (See Appendix 3)

Vignettes: questionnaire with a series of vignettes depicting both positive and distressing experiences (See Appendix 3)

Data management and analysis Based on previous research into postal questionnaires (Shaw, 1975), the return rate is likely to be in the region of 10-15%. This will generate a sample size of between 70 and 105 participants, with 50 participants recruited at a conference.

Initial analysis will explore the internal consistency between the items on the vignette questionnaire, and any items which are found to have low internal consistency will be treated with extreme caution in any analysis. Both quantitative and qualitative analysis will be conducted on the data. Depending on whether the data is parametric or not (as tested by the Kolmogorov-Smirnoff test), a t-test (or equivalent) will be performed on any differences between expressions of spirituality and response to the vignettes. A between groups, 2 (distressing v non-distressing vignettes) x 2 (high v low expressions of spirituality) x gender (male v female) analysis of variance or equivalent will than be performed to look at any differences between ratings on vignettes portraying distressing experiences versus positive experiences, professionals expressions of spirituality and gender. Further analysis might include any differences between the professions of the respondents and any others that become clear at the time, based on the number of questionnaires returned. Simple qualitative analysis will be investigate the open-ended questions, highlighting any emerging themes. These themes will feed into the separate larger scale qualitative research as already mentioned.

Proposed journals Philosophy, Psychiatry & Psychology for the review and the research paper. (See Appendix 2.1)

Ethical/Registration issues As NHS staff will be recruited for the study, registration and ethical approval will be sought from the three LREC committees in North Wales. (Appendix 1.2)

Feedback Participants will be given the opportunity to access the findings of the research by contacting the investigator. This will be explicitly stated on the information sheet (Appendix 1.5).

Risk Assessment

There are no obvious risks to participants. See information sheet, which will be attached to the questionnaire (Appendix 1.5).

Data Storage

The data collected for the study will be electronically stored and there will be no identifying information collected with this data, so participants' anonymity will be honoured.

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APPENDIX 1.2 – APPROVAL LETTERS

- **NHS RESEARCH ETHICS COMMITTEE**
- **SCHOOL OF PSYCHOLOGY**

Pwyllgor Moeseg Ymchwil Canolog Gogledd Cymru
North Wales Central Research Ethics Committee

Mrs. Julie Whitmore,
Gweinyddwraig Etheg/
Ethics Administrator,
Ystafell 1038 / Room 1038,
Ysbyty Glan Clwyd,
Rhyl, Denbighshire
LL18 5UJ

Ffon/Tel: 01745 - 534132 (Llanelli uniongyrchol / direct line)
Ffacs/Fax: (01745) 583143
Llyth-el/E-mail: Julie.Whitmore@cd-tr.wales.nhs.uk

02 June 2006

Mrs Fiona Randall
Trainee Clinical Psychologist
North Wales Clinical Psychology Programme,
School of Psychology
University of Wales - Bangor
LL57 2DG

Dear Mrs. Randall,

Full title of study: Exploring mental health professional's attitudes about spirituality and psychosis
REC reference number: 05/WNo02/30

Thank you for your email of 2nd August 2005, responding to the Committee's request for further information on the above research and for submitting revised documentation.

The further information has on this occasion been considered on behalf of the Committee by the Vice 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). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Research Ethics Committees to be informed or SSA's 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	2	21 July 2005
Investigator CV		(None Specified)
Protocol	1	28 June 2005
Peer Review		28 June 2005
Compensation Arrangements		01 August 2004

Copy of Questionnaire Validated		(None Specified)
Copy of Questionnaire Invalidated	3	23 July 2005-08-10
Letters of Invitation to Participants	1	28 June 2005
Participant Information Sheet	4	02 August 2005
Participant Consent Form	2	29 July 2005
Supervisors CV		(None Specified)
University letter of support		09 May 2005

Research governance approval

You should arrange for 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 research governance approval from the relevant care organisation 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.

[REC reference number] 05/WNo02/30 Please quote this number on all correspondence

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

Yours sincerely

Mr. Roger Hebden,
Vice Chairman

E-mail: Julie.Whitmore@cd-tr.wales.nhs.uk

Enclosures Standard approval conditions SL-AC2

Copy to: Ms. L. Moran, North Wales Clinical Psychology Programme, School of
Psychology, University of Wales, Bangor, Gwynedd. LL57 2PX
R & D Manager, H. M. Stanley Hospital

Dear Colleagues

Exploring mental health professionals' attitudes about spirituality and psychosis

Your research proposal, referred to above, has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines. This approval is provisional upon the amendments highlighted in the attached information sheet being incorporated into the final version. In addition, one of our reviewers also points out that on the questionnaire with vignettes, page 9, the subject of the vignette is called Evelyn, then later Ms. E and it was suggested that there be consistency here.

If you wish to make any substantial modifications to the research project please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if research participants experience any unanticipated harm as a result of participating in your research.

Once these amendments are made, you should forward the application to COREC and to the appropriate NHS Research Ethics Committee. They expect one of the investigators to make an oral presentation in support of the proposal at their meeting. You will be contacted by their committee with details as to the date and place of the meeting at which your proposal will be considered.

You may not proceed with the research project until you are notified of the approval of the NHS Research Ethics Committee.

Yours sincerely

Kath Chitty

Coordinator - School of Psychology Research Ethics Committee

APPENDIX 1.3 – AMENDMENT TO ETHICS PROPOSAL

Fiona

From: Work [Work@FionaRandall.co.uk]
Sent: 19 August 2005 13:35
To: 'Whitmore, Julie'
Cc: Mike.Jackson@nww-tr.wales.nhs.uk; D.M.Daley
Subject: Ethics
Attachments: Invitation to participants.doc; The questionnaire.doc

Hi Julie,

Mike and I had a meeting today and as a result we have slightly amended both the letter to participants and the questionnaire (demographic data). I have underlined where the changes are. I would be grateful if you could take chair's action on these.

Additionally, in the letter confirming ethical approval it states that I 'should arrange for all relevant NHS care organisations to be notified that the research will be taking place'. I am aware that the two other LREC's have received details about my study so I'm wondering, should I send them the information you stated in the letter? And do I need to send the information anywhere else?

Thanks, I look forward to hearing from you.

Fiona

Re: Exploring mental health professionals' attitudes about spirituality and psychosis

As part of my Clinical Psychology doctoral training I am researching mental health professionals' attitudes about spirituality and psychosis.

Rationale:

1. **Service users often comment that the spiritual aspect of their experience is overlooked by mental health professionals;**
2. **At the same time, mental health professionals sometimes feel uncertain about how to deal with spirituality issues.**

This study aims to develop our understanding of this area and I hope you will find the time to participate.

As a mental health professional, I am inviting you to take part in this research by filling in the enclosed questionnaire, which should not take more than 20 minutes. Also enclosed is an information sheet detailing the study and a consent form, which you will be required to complete, prior to sending back the questionnaire in the attached pre-paid envelope.

I hope you are able to be part of this study.

Thank you in advance.

Yours faithfully,

Fiona Randall

Mental Health Professionals' perspectives on spiritual/psychotic experiences

This questionnaire is designed to assess Mental Health professionals' perspectives on spiritual/psychotic experiences. Our interest is in how you evaluate spiritual experiences in your day to day working life.

- Section 1 asks for demographic data
- Section 2 ask for your own religious and spiritual background and includes a questionnaire designed to measure expressions of spirituality (ESI)
- Section 3 asks you to answer some general questions about clients' experiences and more specifically about vignettes, which portray different peoples' (both clients' and lay peoples') experiences

Completion of the questionnaire assumes that you have read, understood and agreed to the statements outlined at the bottom of the information sheet. The information sheet is attached to the front of this questionnaire.

If you have any further questions, please do not hesitate to contact the researcher Fiona Randall (work@fionarandall.co.uk) c/o. North Wales Clinical Psychology Programme, School of Psychology, University of Wales, Bangor, Gwynedd LL57 2DG.

Section 1 Demographic Details

Please circle

- | | | | | | |
|----|-------------------------|-------------------------------|--------|-----------------------|-----|
| 1. | Gender | Male | Female | | |
| 2. | Age | 20-30 | 30-40 | 40-50 | 50+ |
| 3. | Occupation | Psychiatrist | Nurse | Clinical Psychologist | |
| | | <u>Occupational Therapist</u> | | <u>Social Worker</u> | |
| | | <u>Other (please specify)</u> | | | |
| 4. | Years experience | 0-5 | 5-10 | 10-15 | 15+ |

Pwyllgor Moeseg Ymchwil Canolog Gogledd Cymru
North Wales Central Research Ethics Committee

Mrs. Julie Whitmore,
Gweinyddwraig Etheg/
Ethics Administrator,
Ystafell 1038 / Room 1038,
Ysbyty Glan Clwyd,
Rhyl, Denbighshire
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Ffacs/Fax: (01745) 583143

Llyth-el/E-mail: Julie.Whitmore@cd-tr.wales.nhs.uk

02 June 2006

Miss. Fiona Randall,
[REDACTED]
[REDACTED]
[REDACTED]

Dear Miss. Randall,

Full title of study: Exploring mental health professional's attitudes about spirituality and psychosis
REC reference number: 05/WNo02/30

Amendment number: [1] **Amendment date:** [19/08/2005]

Thank you for your letter of 19th August 2005 notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require ethical review by the Committee and may be implemented immediately, provided that it does not affect the research governance approval for the research given by the R&D Department for the relevant NHS care organisation.

Documents received

The documents received were as follows:

Copy of Questionnaire Invalidated	4	19 August 2005
Letters of Invitation to Participants	2	19 August 2005

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.

[REC reference number]: 05/WNo02/30 Please quote this number on all correspondence

Yours sincerely

Mrs. Julie Whitmore, *Ethics Co-ordinator*
E-mail: Julie.Whitmore@cd-tr.wales.nhs.uk

Copy to: Ms. L. Moran, North Wales Clinical Psychology Programme, School of Psychology,
University of Wales, Bangor, Gwynedd. LL57 2PX
R & D Manager, H. M. Stanley Hospital

**Pwyllgor Moeseg Ymchwil Canolog Gogledd Cymru
North Wales Central Research Ethics Committee**

**Mrs. Julie Whitmore,
Gweinyddwraig Ethege/
Ethics Administrator,
Ystafell 1038 / Room 1038,
Ysbyty Glan Clwyd,
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**Ffon/Tel: 01745 - 534132 (Llanelli uniongyrchol / direct line)
Ffacs/Fax: (01745) 583143**

Llyth-el/E-mail: Julie.Whitmore@cd-tr.wales.nhs.uk

02 June 2006

Fiona

From: Work [Work@FionaRandall.co.uk]
Sent: 26 September 2005 17:59
To: 'Whitmore, Julie'
Cc: Mike.Jackson@nww-tr.wales.nhs.uk; D.M.Daley
Subject: Ethics
Attachments: questionnaire email.doc; Fiona Randall Information sheet V4email.doc

Hi Julie,

I have started to send out my questionnaires and I have had a query about the consent form because the participant is asked to put their name on it and the study is meant to be anonymous. I think this compromise confidentiality somewhat. Additionally, psychiatrists have requested that they receive the questionnaire via email. As a result I request that:

1. I am able to send the questionnaires out via email (see attached form which has been amended for this purpose)
2. Filling in the questionnaire indicates consent and therefore a consent form will not be required (I have attached an information sheet which has been amended for this purpose).

I look forward to hearing from you.

Kind regards,

Fiona

Pwyllgor Moseg Ymchwil Canolog Gogledd Cymru
North Wales Central Research Ethics Committee

Mrs. Julie Whitmore,
Gweinyddwraig Etheg /
Ethics Administrator,
Ystafell 1038 / Room 1038,
Ysbyty Glan Clwyd,
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Llyth-el/E-mail: Julie.Whitmore@cd-tr.wales.nhs.uk

02 June 2006

Mrs Fiona Randall
Trainee Clinical Psychologist
North Wales Clinical Psychology Programme,
School of Psychology
University of Wales - Bangor
LL57 2DG

Dear Mrs Randall

Full title of study: Exploring mental health professional's attitudes about
spirituality and psychosis
REC reference number: 05/WNo02/30

Amendment number: [2]
Amendment date: [26/09/2005]

Thank you for your email dated 26th September 2005 notifying the Committee of the above amendment which was originally approved on 10th August 2005.

The amendment has on this occasion been considered by the Chairman

The Chairman does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require ethical review by the Committee and may be implemented immediately, provided that it does not affect the research governance approval for the research given by the R&D Department for the relevant NHS care organisation.

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copy of Questionnaire Validated (Electronic Copy)	4	19 August 2005
Participant Information Sheet	4	02 August 2005

The concerns expressed in regard to participants being requested to include their name on the Consent Form have been noted. However, on referring to Version 2 of the "Letter to participants" which was submitted on 19th August '05 and subsequently reviewed by the Chairman as per our letter of 22nd August '05 you do however clearly state that " an Information Sheet and completed Consent Form will be required, **prior** to sending back the questionnaire", which would not have compromised participants confidentiality as no names were to be requested on the actual questionnaire which was to be sent back under separate cover.

I note your comments on the email - bullet point 2 – relating to your request that the return of the questionnaire should act as Consent to participate and can confirm that this method is acceptable to my Chairman.

Whilst I can acknowledge receipt of the revised Participant Information Sheet (Version 4 - 02/08/2005) I should point out a couple of points for your attention:

- a) Bullet point 5 – Do I have to take part? Second line text "signed the consent form" has not been amended to reflect the changes identified previously.
- b) Version No and Date should be amended to read – Version 5 - 27/09/2005 as the previously amended P.I.S. was marked by myself as Version 4 – 02/08/05

With regard to your request to be able to send the Questionnaire(s) – electronic version provided - via Email to Psychiatrists, my Chairman, Mr. Penfold has confirmed that he cannot see a problem with this provided that it is stipulated that the responses are sent via the postal services to avoid possible identification.

I look forward to receiving the revised Participant Information Sheet as mentioned above, on headed paper with the relevant version number and date added.

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.

REC Ref: 05/WNo02/30 Please quote this number on all correspondence
--

Yours sincerely

Mrs Julie Whitmore
Ethics Coordinator

Email: julie.whitmore@cd-tr.wales.nhs.uk

| Cc [Lona Tudor Jones, R & D Manager, H.M.Stanley Hospital](#)

APPENDIX 1.4 – MEASURES USED IN PROPOSED STUDY

Mental Health Professionals' perspectives on spiritual/psychotic experiences

This questionnaire is designed to assess Mental Health professionals' perspectives on spiritual/psychotic experiences. Our interest is in how you evaluate spiritual experiences in your day to day working life.

- Section 1 asks for demographic data
- Section 2 ask for your own religious and spiritual background and includes a questionnaire designed to measure expressions of spirituality (ESI)
- Section 3 asks you to answer some general questions about clients' experiences and more specifically about vignettes, which portray different peoples' (both clients' and lay peoples') experiences

Completion of the questionnaire assumes that you have read, understood and agreed to the statements outlined at the bottom of the information sheet. The information sheet is attached to the front of this questionnaire.

If you have any further questions, please do not hesitate to contact the researcher Fiona Randall (work@fionarandall.co.uk) c/o. North Wales Clinical Psychology Programme, School of Psychology, University of Wales, Bangor, Gwynedd LL57 2DG.

Section 1 Demographic Details

Please circle

- | | | | | | |
|----|-------------------------|------------------------|--------|-----------------------|-----|
| 1. | Gender | Male | Female | | |
| 2. | Age | 21-30 | 31-40 | 41-50 | 51+ |
| 3. | Occupation | Psychiatrist | Nurse | Clinical Psychologist | |
| | | Occupational Therapist | | Social Worker | |
| | | Other (please specify) | | | |
| 4. | Years experience | 0-5 | 6-10 | 11-15 | 16+ |

Section 2 Religious and spiritual background and Expressions of Spirituality Inventory (ESI) (please circle)

5. Do you consider yourself to have, or ever have had, a particular religious or spiritual affiliation or belief?

- No
- Yes (please specify)

6. Were you brought up to have a particular religious affiliation or belief by a parent or carer?

- No
- Yes (please specify)

7a. Do you attend any religious services or meetings? Do not include weddings, funerals, baptism's and the like.

No /Yes - If yes then is this:

- More than once a week
- Once a week
- A few times a month
- Once a month
- Less than once a month

b. When was the last time you attended a religious service or meeting? Do not include weddings, funerals, baptisms and the like.

Do you agree/disagree with the following statements:

8. Spiritual experience is pathological (comes from illness)

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

9. I am able to tell the difference between spiritual experiences and psychotic symptoms.

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

Expressions of Spirituality Inventory- Revised
 © Douglas A. MacDonald 2000

This is a questionnaire which concerns your experiences, attitudes, beliefs and lifestyle practices pertaining to spirituality. Below are several statements. Read each statement carefully. Using the five point scale described below, rate the extent to which you agree with each statement as it applies to you and put your response in the space provided. There are no right or wrong answers. Please respond to every statement and respond as honestly as possible.

0-----1-----2-----3-----4
 Strongly Disagree Disagree Neutral Agree Strongly Agree

- | | |
|--|---|
| <p>_____ 1. Spirituality is an important part of who I am as a person</p> <p>_____ 2. I have had an experience in which I seemed to be deeply connected to everything</p> <p>_____ 3. It always seems that I am doing things wrong</p> <p>_____ 4. It is possible to communicate with the dead</p> <p>_____ 5. I believe that going to religious services is important</p> <p>_____ 6. Spirituality is an essential part of human existence</p> <p>_____ 7. I have had an experience in which I seemed to transcend space and time</p> <p>_____ 8. I am not comfortable with myself</p> <p>_____ 9. I believe witchcraft is real</p> <p>_____ 10. I feel a sense of closeness to a higher power</p> <p>_____ 11. I am more aware of my lifestyle choices because of my spirituality</p> <p>_____ 12. I have had a mystical experience</p> <p>_____ 13. Much of what I do in life seems strained</p> <p>_____ 14. It is possible to predict the future</p> <p>_____ 15. I see myself as a religiously oriented person</p> | <p>_____ 16. I try to consider all elements of a problem, including its spiritual aspects, before I make a decision</p> <p>_____ 17. I have had an experience in which I seemed to merge with a power or force greater than myself</p> <p>_____ 18. My life is often troublesome</p> <p>_____ 19. I do not believe in spirits or ghosts</p> <p>_____ 20. I see God or a Higher Power present in all the things I do</p> <p>_____ 21. My life has benefited from my spirituality</p> <p>_____ 22. I have had an experience in which all things seemed divine</p> <p>_____ 23. I often feel tense</p> <p>_____ 24. I think psychokinesis, or moving objects with one's mind, is possible</p> <p>_____ 25. I practice some form of prayer</p> <p>_____ 26. I believe that attention to one's spiritual growth is important</p> <p>_____ 27. I have had an experience in which I seemed to go beyond my normal everyday sense of self</p> <p>_____ 28. I am an unhappy person</p> <p>_____ 29. It is possible to leave your body</p> <p>_____ 30. I believe that God or a Higher Power is responsible for my existence</p> <p>_____ 31. This questionnaire appears to be measuring spirituality</p> <p>_____ 32. I responded to all statements honestly</p> |
|--|---|

Section 3

Do you work with people with psychosis/serious mental illness no/yes

If yes please state the number of hours a week you work with these clients

With reference to clients you have encountered who have described spiritual experiences and the ways in which you made an evaluation of their experience and mental health:

10a Have you worked with clients who report having distinct spiritual experiences (e.g. reporting physically feeling the presence of a spirit or hearing a voice from God)?

Yes/No (if no turn to next page, question 14)

b **If yes** Without identifying individual clients, could you describe the person and their experiences?

11. What was your interpretation of the experiences that the client was describing?

12. Can you identify any specific features of the client's experience, which helped you in your evaluation?

13. Can you think of any other considerations you made in your evaluation?

Vignettes

This is a selection of real life descriptions, some written, some spoken, describing various peoples' experiences. Some have been diagnosed and treated for psychotic mental illnesses, others have not.

Anne

Anne is an atheist. She was invited to join an anti-nuclear demonstration by a friend, to which she reluctantly went.

Whilst at the demonstration the women present joined hands and began to sing and move around in a circle. Anne joined the circle. She describes that although the women were still singing everything became silent, everything seemed to stand still. She felt her head being lifted upwards and her body begin to float above the ground, she describes feeling overwhelming spiritual love. At this point she looked up and saw an enormous female figure, who she described as having jet black hair which was also multicoloured.

As a result of the vision Anne describes a realisation that the peace movement was supported by spiritual beings and that each individual must do their part. She says how she began to understand the Oneness of all things, which she used as a focus for a Masters in theology. Anne continued to receive enlightenment about the Oneness of everything and had several other similar experiences.

14a The experience described is a common spiritual experience

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

b The individual described here has a mental health problem

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

c the individual described would benefit from being hospitalized

Yes/No

d the individual described would benefit from an intervention (medication/psychological therapy)

Yes/No

e is there any other information you would want to know about the individual or their experience to help you to evaluate their mental health?

Carl

Carl is a doctor. He had been a member of the Baptist church all his life. He was having legal action taken against him at work and had recently ended his marriage after discovering his new wife was “demonic”

Carl was praying for guidance at a makeshift altar at home. He describes how the next morning he discovered that a candle had melted onto a piece of paper forming shapes. At the sight of the wax he felt that God was intervening in his life and that he was chosen by God to bring a message of unifying Christianity. He continued to get revelations from the wax (forming pictures of guardians, weapons and other images which convinced him that God was protecting him). Carl began to take photographs of the wax which he showed to others.

Carl was subsequently convicted in court. He continues to believe he has been chosen by God for a special purpose and has had further spiritual experiences, including God speaking to him through the TV. He has recently experienced difficulties in his career.

15a The experience described is a common spiritual experience

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

b The individual described here has a mental health problem

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

c the individual described would benefit from being hospitalized

Yes/No

d the individual described would benefit from an intervention
(medication/psychological therapy)

Yes/No

e is there any other information you would want to know about the individual or their experience to help you to evaluate their mental health?

Diane

Diane was brought up in a strongly religious home. She has recently been widowed.

Diane reports having mystical experiences as a child and a strong feeling of her husband's presence after his death. She reports feeling a very strong sense that she was going to die, that she was definitely going to die on a certain day. She felt compelled toward a sacrifice of some sort and that that sacrifice was to be her. She began to feel that she was part of a drama performing the role of Mary the mother of God and then felt she was in fact God.

Diane has since taken up transcendental meditation and become a Bahai (Bahai is a religious faith which centres around the unity of mankind and its different faiths, those who are part of the faith believe strongly in world peace). She is now at peace with herself and sees her experiences as taking her to a higher level of spiritual awareness.

16a The experience described is a common spiritual experience

- Definitely agree
 Probably agree
 Neutral
 Probably disagree
 Definitely disagree

b The individual described here has a mental health problem

- Definitely agree
 Probably agree
 Neutral
 Probably disagree
 Definitely disagree

c the individual described would benefit from being hospitalized

Yes/No

d the individual described would benefit from an intervention
(medication/psychological therapy)

Yes/No

e is there any other information you would want to know about the individual or their experience to help you to evaluate their mental health?

Tony

Tony is unemployed and spends much of his time alone in his bed-sit.

He explained 'I laid quietly and tried to think of nothing, and ... thoughts came into me, in, in, in, flashing all at once ... one after the other, and so I said "Will you stop because there's too many thoughts. Will you put it into words?" and they put it into words ... and that's how I came to have sort of voices in my head, although they're not voices; they are thoughts, but I can tell that they're not my thoughts - there's something sort of different about them. They were comforting, trying to settle me down and comfort me. Its a relative of mine, an ancestor of mine, who was talking to me - he's talked about all sorts of things, he even once explained to me, why there is all the misery and suffering and torture and wars and famines etc, and it was as clear as day to me.

There are many things that I've been told about my family that I haven't known about...it's come to me and I've known things that have happened hundreds of years ago, and I've proved it later ... so I'm obviously getting help from my family to - go back. There are many things that I don't know but I wish I did know and they don't seem to tell me, but they certainly have been telling me things to get me back and back and back. I don't know who the other voices are, they sometimes comfort me, but mainly I get angry and upset by them'.

17a The experience described is a common spiritual experience

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

b The individual described here has a mental health problem

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

c the individual described would benefit from being hospitalized

Yes/No

d the individual described would benefit from an intervention (medication/psychological therapy)

Yes/No

e is there any other information you would want to know about the individual or their experience to help you to evaluate their mental health?

Beryl

Beryl is closely involved with the Church of England. She had discovered some time ago she was unable to have children, and had become very successful in her career. She was considering what to do next.

Beryl was driving in her car when she heard a clear external voice saying “when are you coming to work for me?” She interpreted this voice as that of Jesus.

Six weeks after hearing this voice Beryl gave up her job and began to work in her local parish, becoming a well respected spiritual advisor. She continues to hear a voice (which she feels she now has a choice to hear) and reports being able to understand things about other people through feelings and pictures.

18a The experience described is a common spiritual experience

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

b The individual described here has a mental health problem

- Definitely agree
- Probably agree
- Neutral
- Probably disagree
- Definitely disagree

c the individual described would benefit from being hospitalized

Yes/No

d the individual described would benefit from an intervention (medication/psychological therapy)

Yes/No

e is there any other information you would want to know about the individual or their experience to help you to evaluate their mental health?

Evelyn

Evelyn is Jewish. She is training to be a spiritual healer.

Evelyn describes how during a healing session she picked up a strange sense from the person being healed. She felt the sensation go in through her feet and began to feel very hot. As the day progressed she felt a "heartbeat" in her stomach and realised that there was something alien inside her. She went back to the place where it had started and prayed for it to be taken away. However Evelyn was still aware of the being inside of her. She describes being woken up early one morning by the heartbeat and prayed once again for it to leave. At this point Evelyn describes waves of energy flowing through her and a great force holding her down. The heartbeat subsequently stopped.

As a result of this and other similar experiences Evelyn converted to Christianity.

19a The experience described is a common spiritual experience

- | | |
|---------------------|--------------------------|
| Definitely agree | <input type="checkbox"/> |
| Probably agree | <input type="checkbox"/> |
| Neutral | <input type="checkbox"/> |
| Probably disagree | <input type="checkbox"/> |
| Definitely disagree | <input type="checkbox"/> |

b The individual described here has a mental health problem

- | | |
|---------------------|--------------------------|
| Definitely agree | <input type="checkbox"/> |
| Probably agree | <input type="checkbox"/> |
| Neutral | <input type="checkbox"/> |
| Probably disagree | <input type="checkbox"/> |
| Definitely disagree | <input type="checkbox"/> |

c the individual described would benefit from being hospitalized

Yes/No

d the individual described would benefit from an intervention
(medication/psychological therapy)

Yes/No

e. is there any other information you would want to know about the individual or their experience to help you to evaluate their mental health?

Below are a number of specific features, which might affect your interpretation of spiritual experiences described by clients. How do you think the following would affect your evaluation:

20 a amount of religious involvement

b outcome of the experience

c content of the experience

d context of the experiences

21 Is there anything else you consider to be important for evaluating the spiritual experiences described by clients?

22 Were any of the above issues covered in your training?

Yes (if yes please clarify)

No

23 Space below for any other comments

APPENDIX 1.5: INFORMATION SHEET AND CONSENT FORM

Exploring mental health professionals' attitudes about spirituality and psychosis **Information Sheet**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

- **Study title**

Exploring mental health professionals' attitudes about spirituality and psychosis.

- **Who is conducting the study?**

The study is being conducted by Fiona Randall, a trainee clinical psychologist on the North Wales Doctorate in Clinical Psychology Course.

- **What is the purpose of the study?**

The aim of this research is to explore mental health professionals' attitudes about spirituality and psychosis. The study will run until June 2006.

- **Why have I been chosen?**

You are being approached because of your position as a mental health professional. Permission has been sought and received to approach you by the North Wales Central Research Ethics Committee. It is expected that 200 participants will take part in this study.

- **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part, it will be presumed that you have read this information sheet. Even if you decide to take part now you are still free to withdraw at any time by contacting the researcher (details below) and without giving a reason.

- **Consent**

If you do decide to take part in the study returning the questionnaire will act as consent. The questionnaires will take approximately 20 minutes to complete. The study will be complete by June 2006.

- **What do I have to do?**

Simply complete the questionnaires and return them to: Fiona Randall, FREEPOST CS221A, School of Psychology, University of Wales, Bangor, Gwynedd, LL57 2AS.

- What are the possible disadvantages and risks of taking part?

In the unlikely event that you feel upset while taking part in this study, you are free to contact the researcher who will put you in touch with appropriate support. You are also free to withdraw from the research at anytime without reason.

- What are the possible advantages of taking part?

Carrying out this research will enable a clearer understanding of clinicians' attitudes to spirituality and psychosis.

- Will my taking part in this study be kept confidential?

The questionnaires are anonymous although some demographic information is being gathered. All data will be kept confidential and stored securely in locked filing cabinets.

- What do I do if I wish to make a complaint?

If you have a complaint about the conduct or the content of this research then you may contact Dr. Mike Jackson (Mike.Jackson@nww-tr.wales.nhs.uk), Bodfaen, Craig y Don Road, Bangor, Gwynedd, LL57 2BG. As this research has also been passed by a NHS regional ethics committee you may also make a complaint through the NHS.

- What will happen to the results of the research study?

The results of the study will be analysed and written up as part of a major research project for the North Wales Doctorate in Clinical Psychology. Publication will also be sought in a relevant journal. If you wish to access the results please contact the researcher (see below).

- Contact for Further Information.

If you have any questions about the study that you would like to ask either now or later please contact the researcher: Fiona Randall, email: work@fionarandall.co.uk, c/o. North Wales Clinical Psychology Programme, School of Psychology, University of Wales, Bangor, Gwynedd LL57 2DG.

Participation in this study assumes the following:

- That you have read and understood the information sheet about the above study.
- That you understand that if you have any questions about the research you have the opportunity to address these to the researcher before, during or after taking part in the research.
- That you understand that your participation is voluntary and that you are free to withdraw at any time, without giving any reason

Thank you for your time.

Archwilio agweddau staff proffesiynol iechyd meddwl tuag at ysbrydolrwydd a gorffwylledd

Taflen Wybodaeth

Fe'ch gwahoddir i gymryd rhan mewn astudiaeth ymchwil. Cyn i chi benderfynu, mae'n bwysig i chi ddeall pam rydym yn gwneud yr ymchwil hwn a'r hyn a fydd yn digwydd. Cymerwch eich amser i ddarllen y wybodaeth ganlynol yn ofalus a thrafodwch gydag eraill os ydych yn dymuno. Gofynnwch os bydd rhywbeth yn aneglur neu os hoffech wybodaeth bellach. Cymerwch eich amser i benderfynu a ydych yn dymuno cymryd rhan neu beidio. Diolch i chi am ddarllen hwn.

- **Teitl yr Astudiaeth**

Archwilio agweddau staff proffesiynol iechyd meddwl tuag at ysbrydolrwydd a gorffwylledd

- **Pwy sy'n arwain yr astudiaeth?**

Fiona Randall sy'n arwain yr astudiaeth, seicolegydd clinigol dan hyfforddiant ar Gwrs Doethuriaeth Seicoleg Clinigol Gogledd Cymru.

- **Beth yw pwrpas yr astudiaeth?**

Nod yr ymchwil hwn yw archwilio agweddau staff proffesiynol iechyd meddwl tuag at ysbrydolrwydd a gorffwylledd. Bydd yr astudiaeth yn parhau hyd Mehefin 2006.

- **Pam rydw i wedi cael fy newis?**

Gofynnwyd i chi gymryd rhan oherwydd eich swydd fel staff proffesiynol iechyd meddwl. Gofynnwyd am a derbyniwyd caniatâd i ofyn i chi gan Bwyllgor Moesau Ymchwil Canol Gogledd Cymru. Rydym yn disgwyl i 200 o bobl gymryd rhan yn yr astudiaeth hon.

- **Oes raid i mi gymryd rhan?**

Eich penderfyniad chi yn unig yw a ydych am gymryd rhan neu beidio. Os byddwch yn penderfynu cymryd rhan, byddwn yn cymryd yn ganiataol eich bod wedi darllen y daflen wybodaeth hon a llofnodi'r ffurflen gydsynio. Er eich bod wedi penderfynu cymryd rhan nawr, mae'r hawl gennych i dynnu'n ôl unrhyw amser drwy gysylltu â'r ymchwilydd (manyllion isod) heb roi unrhyw reswm.

- **Cydsynio**

Os byddwch yn penderfynu cymryd rhan yn yr astudiaeth, bydd dychwelyd yr holiadur atom yn gweithredu fel cydsyniad. Bydd yr holiaduron yn cymryd oddeutu 20 munud i'w cwblhau. Byddwn wedi cwblhau'r astudiaeth erbyn Mehefin 2006.

- **Beth y mae'n rhaid i mi ei wneud?**

Yn syml, cwblhau'r holiaduron a'u dychwelyd yn yr amlen Rhadbost a'u dychwelyd at Fiona Randall, RHADBOST CS221A, Ysgol Seicoleg, Prifysgol Cymru Bangor, Gwynedd LL57 2AS.

- Beth yw'r anfanteision a'r risgiau o gymryd rhan?

Os byddwch, yn annhebygol iawn, yn teimlo'n ofidus wrth gymryd rhan yn yr astudiaeth hon, mae croeso i chi gysylltu â'r ymchwilydd a fydd yn eich rhoi mewn cysylltiad â chefnogaeth briodol. Mae'r hawl gennych i dynnu'n ôl o'r astudiaeth unrhyw amser heb roi rheswm.

- Beth yw'r manteision posibl o gymryd rhan?

Bydd yr ymchwil hwn yn rhoi dealltwriaeth eglurach i ni o agweddau clinigwyr tuag ysbrydolrwydd a gorffwylledd.

- A fydd fy rhan yn yr astudiaeth hon yn cael ei chadw'n gyfrinachol?

Mae'r holiaduron yn ddiennw, ond bydd rhywfaint o wybodaeth ddemograffig yn cael ei chasglu. Bydd yr holl ddata yn cael ei gadw'n gyfrinachol a'i gadw mewn cwpwrdd ffeilio dan glo.

- Beth ddylwn i ei wneud os byddaf yn dymuno cwyno?

Os bydd gennych gwyn ynghylch sut mae'r astudiaeth wedi'i chynnal neu ei chynnwys, gellir cysylltu â Dr Mike Jackson (Mike.Jackson@nww-tr.wales.nhs.uk), Bodfaen, Ffordd Craig y Don, Bangor, Gwynedd, LL57 2BG. Gan fod yr ymchwil hwn hefyd wedi derbyn cymeradwyaeth pwyllgor moesau rhanbarthol GIG, gellir hefyd cwyno drwy'r GIG.

- Beth fydd yn digwydd o ganlyniad i'r astudiaeth ymchwil?

Bydd canlyniadau'r astudiaeth yn cael eu dadansoddi a'u hysgrifennu fel rhan o brosiect ymchwil mawr gan Ddoethuriaeth Seicoleg Clinigol Gogledd Cymru. Byddwn yn gobeithio cael cyhoeddi mewn cylchgrawn priodol hefyd. Os byddwch yn dymuno cael mynediad at y canlyniadau, cysylltwch â'r ymchwilydd (gweler isod).

- Cysylltwch am Fanylion Pellach

Os bydd gennych unrhyw gwestiynau ynghylch yr astudiaeth yr hoffech ofyn nawr neu'n hwyrach ymlaen, cysylltwch â'r ymchwilydd: Fiona Randall, e-bost: work@fionarandall.co.uk, d/o Rhaglen Seicoleg Clinigol Gogledd Cymru, Coleg Seicoleg, Prifysgol Cymru, Bangor, Gwynedd LL57 2DG.

Byddwn yn cymryd y canlynol yn ganiataol os byddwch yn cymryd rhan:

- Eich bod wedi darllen a deall y daflen wybodaeth ynghylch yr astudiaeth uchod.
- Eich bod yn deall os bydd gennych unrhyw gwestiynau ynghylch yr astudiaeth, eich bod yn cael y cyfle i ofyn y rhain i'r ymchwilydd cyn, yn ystod neu ar ôl cymryd rhan yn yr ymchwil.
- Eich bod yn deall bod cymryd rhan yn wirfoddol a'ch bod â'r hawl i dynnu'n ôl unrhyw amser heb roi unrhyw reswm

Diolch yn fawr am eich amser

CONSENT FORM

Title of research: Exploring Mental Health Professionals' attitudes about spirituality and psychosis

Name of Researcher: Fiona Randall

Please initial box

1. I confirm that I have read and understand the information sheet for
the above study.

2. I understand that my participation is voluntary and that I am free to withdraw at any time,
without giving any reason, without my medical care or legal rights being affected.

4. I agree to take part in the above study.

Name (optional)

Date

Signature

Researcher

Date

Signature

1 for participant; 1 for researcher

FFURFLEN GYDSYNIO

Teitl yr Ymchwil: Archwilio agweddau staff proffesiynol iechyd meddwl tuag at ysbrydolrwydd a gorffwylledd

Enw'r Ymchwilydd : Fiona Randall

Blaenlythrennwch y blwch

1. Cadarnhaf fy mod wedi darllen a deall y daflen wybodaeth ar gyfer yr astudiaeth uchod.

2. Rwy'n deall bod fy rhan yn wirfoddol ac mae gen i hawl i dynnu'n ôl unrhyw amser, heb roi rheswm, heb effeithio ar fy ngofal meddygol a fy hawliau cyfreithiol

3. Rwy'n cytuno cymryd rhan yn yr astudiaeth uchod.

Enw

Dyddiad

Llofnod

Ymchwilydd

Dyddiad

Llofnod

1 i'r un sy'n cymryd rhan; 1 i'r ymchwilydd

SECTION TWO – LITERATURE REVIEW

**Spirituality in clinical psychology: service users and mental health professionals’
perspectives, treatment and training – a conceptual and empirical review.**

**Fiona Randall*, Mike Jackson
University of Wales, Bangor, UK**

***Address for correspondence and requests for reprints: NWCPP, School of Psychology,
University of Wales, Bangor, Gwynedd LL57 2DG**

***Biography: Academic interests: psychosis, mindfulness.**

Recent publications:

**Randall, F., Corcoran, R., Day, J.C. and Bentall, R.P. (2003) “Attention, theory
of mind and causal attributions in people with persecutory delusions”, *Cognitive
Neuropsychiatry* 8(4), 287-294**

**Day, J.C., Bentall, R.P, Roberts, C., Randall, F., Rogers, A., Cattell, D., Healy,
D., Rae, P., Power, C. (2005). Attitudes toward Antipsychotic Medication: The Impact
of Clinical Variables and Relationships with Health professionals, *Archives of General
Psychiatry*, 62(7), 717-724**

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Abstract

Research shows both service users and mental health professionals believe that integrating spiritual perspectives into therapy, and therefore having this dimension in training would be beneficial. The following review covers the wide and fragmented literature around spirituality and clinical psychology, with a particular focus on psychosis. Drawing on historical perspectives and current policies the aim of the review is to present current research into mental health professionals and service users perspectives on spirituality. The review then briefly considers current cognitive models from clinical psychology and the impact of the new wave of therapies, culminating in a discussion around the training of clinical psychologists.

Key words: spiritual perspectives, service users, training, clinical psychology

Spirituality in clinical psychology: service users and mental health professionals' perspectives, treatment and training – a conceptual and empirical review.

Introduction

A small amount of research from clinical psychology (Miller, 2001; Martinez, 2005) shows both service users and mental health professionals believe that integrating spiritual perspectives into therapy, and therefore having this dimension in training clinical psychologists would be beneficial. Other aspects of diversity training; sexuality; race and culture are all incorporated to varying degrees (Nezu, 2005; Young & Olavarria, 2004). Recently, the relationship between spirituality and psychosis has been investigated with some surprising findings (Jackson & Fulford, 1997; Clarke, 2001), that there was no qualitative difference between some of these experiences. Furthermore, evidence from several major organisations: the World Health Organisation (WHO) (Culliford, 2002); the National Institute of Mental Health Executive (NIMHE) (Gilbert & Nichols, 2003); Rethink (Martyn, 2005); and the National Schizophrenia Fellowship (Turner, 2001) regard spirituality and religion not only as an important area of functioning in service users' lives, but as a contributory factor in self-management and recovery from severe mental health problems.

Aim of the review

Much of the research has been exploratory to date, with qualitative, survey and quasi-experimental designs. The United Kingdom Central Council (UKCC, 2000) for nurse training declared the following levels of competency be achieved for professional

registration: 'comprehensive, systematic and accurate nursing assessment of ...spiritual needs of patients, clients and communities' (McSherry, Cash & Ross, 2004). However, outside of the general ethical guidelines of the British Psychological Society (BPS, 1994), there appears little evidence of the same requirement when searching the literature for examples of assessment of spirituality in clinical psychology. However, upon widening the search to spirituality in therapy there is a body of research investigating spiritual practices within therapy (Kabat-Zinn, 1990; Segal, Williams & Teasdale, 2002; Hayes, Follette & Linehan, 2004; Gilbert, 2005; Linehan, 1993a, 1993b), which although not the main focus of this review will be discussed. There is also a plethora of research into the psychology of religion, not covered by this review (Koenig, McCullough & Larson, 2001).

This review will investigate spirituality in clinical psychology and the difficulties encountered in attempting to make a vague concept explicit. Drawing on previous research this paper aims: to investigate the attitudes around spirituality and religion of both service users and mental health professionals; recent models that attempt to explain the difference between mental health problems and spiritual experiences; and the integration of spiritual concepts into therapy and training in clinical psychology, with a specific focus on severe mental illness. The databases 'Medline' and 'Psychinfo' were searched from the present day back to the year 2000 using the search terms 'spirituality' or 'religion', 'training' or 'therapy', 'clinical psychology', 'psychiatry' or 'nursing' and 'service user' or 'patient' or 'client'. The predominant focus of this review is clinical psychology however, due to the very small number of studies; others have been based on the more general term 'psychotherapies'.

This review has attempted to answer five questions: What are service users' perspectives of spirituality? What are mental health professionals' perspectives of spirituality? What can recent models, which attempt to explain the difference between mental health problems and spiritual experience, tell us? What therapies are available which incorporate a spiritual perspective? And finally, is there any evidence that incorporating spirituality into clinical psychology training is required?

Historical background and definition

At the turn of the century a number of books were published exploring spirituality and mental health care (Miller, 2001; Swinton, 2001; King-Spooner, 2001; West, 2000, 2004). In the introduction to Miller's book he states that:

“It would be difficult to find another topic that has been more taboo for therapists. We ask clients about their emotional, physical, mental, sexual, financial, family, vocational, legal and social lives, but we so often remain silent when it comes to spirituality”

Spirituality within mental health care has been “taboo” historically through psychologists bringing a scientific world view of psychotherapy. Some have written extensively about religion and attacked it as regressive, superstitious, exploitative and antithetical to psychological health (Ellis, 1980, 1981, 1987; Freud, 1963). This negative view is evidence of the uncertainty engendered in dealing with such an intangible subject from an empirical perspective. Hay & Nye (1998) even discovered that children as young as six had already learnt that their spirituality was regarded as odd and mad by peers and adults. However, others have viewed religion and spirituality

as a source of morality, a potent agent of psychological transformation and integration, and an expression of that which is best and most creative in humanity (Allport, 1950; James, 1901; Jung, 1933; Maslow, 1970; Rogers, 1980).

King & Dein (1998) proposed that the reason why religious research in psychiatry remains neglected, problematical and unpopular is because:

“Mental health professionals have associated religion with superstition, intolerance and persecution. Kung (1990) refers to this phenomenon as the ‘repression’ of religion in psychiatric practice. While general psychiatrists look the other way at the mention of religion, their academic colleagues take flight. Researchers who try to address the issue risk being branded as fanatically religious or as purveyors of soft science in which each variable correlates in some vague way with every other. Journal editors have reacted to poor research methods by demanding higher standards of scientific rigour than pertain in other areas of psychiatric research. Young researchers avoid the area for fear of negative repercussions on their career advancement (Sherrill & Larson, 1994 pp.149-177). American psychiatrists have described this phenomenon as the ‘anti-tenure factor’ of religious research.”

There is a distinct difference between the terms religion and spirituality. Miller (2001) defines religion by social entity, prescribed beliefs, rituals and practices. He describes spirituality as a complex multi-dimensional construct, like personality or health, which is not adequately defined by any single continuum or dichotomous classification (Larson, Swyers, & McCullough, 1998). This construct, in which every individual can be located, avoids the misleading classification of a person being

“spiritual” or “not spiritual”. Other authors have defined spirituality in terms of the content of the experiences people report (James, 1901; Jackson 1991; Elkins, Hedstorm, Hughes, Leaf & Saunders, 1998). Jackson (1991) divided spiritual experience into three categories: “psychic” experiences characterised by extra-sensory perception, apparitions, out of body experiences; “numinous” experiences involving a sense of the presence of an external agent, sometimes interpreted in explicitly religious terms; and “mystical” experiences characterised by feelings of unity with a larger whole. He also makes a distinction between the spiritual experiences referred to in previous research of the “great mystics” (Wapnick, 1969; Underhill, 1922; James, 1901) and the everyday spiritual experiences of contemporary people in the general population (Hay, 1987).

Policies and perspectives

Recently, there have been a number of developments from different professional disciplines that indicate spirituality is being taken more seriously within mental health care. In 1995 the DSM-IV introduced the code of “Religious or Spiritual Problem” to be used when service users experience distress focused around loss or questioned faith, psycho-emotional issues surrounding conversion to a new faith, or questions involving spiritual values which may or may not arise in the context of an organised religion. Scott, Garver, Richards, & Hathaway (2003) examined the clinical use of this code and concluded that it provides a useful tool in some clinical situations but does not provide incentive for mental health professionals to routinely assess a service user’s religion.

According to the World Health Organisation (1998), health is a:

“state of complete physical, mental and social well-being, not merely the absence of disease...the health professions have largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith - in healing, in the physician and in the doctor-patient relationship. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process”

In 2001, the Handbook of Religion and Health (Koenig et al 2001) was published, documenting more than 1200 studies and 400 research reviews which showed a 60 to 80% correlation between religion or spirituality and better health. In September of the same year, NIMHE embarked on a project entitled “Spirituality and Mental Health”. This project was partly in recognition that the tragic events of September 11th 2001 would have a profound impact across communities both locally and worldwide. Secondly, the Chief Executive of NIMHE felt very strongly that mental health should encompass a wider agenda than mental illness, recognising the “whole person” within the context of their life and community. Appleby, (2002) stated that the views of service users will start to influence therapies of all kinds from April 2003 and the impact of those views on treatment are discussed in more detail below.

In 1999 the British Psychological Society (BPS) set up the Transpersonal Psychology group. In the same year the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists was founded with the express aim of influencing the training curriculum for psychiatry in the United Kingdom. The BPS

Code of conduct (1994, 2005), does not explicitly state spirituality or religiosity as diversity issues to be taken into consideration.

Different perspectives

Research into the area of spirituality and mental health highlights the following: Service users often comment that the spiritual aspect of their experience is overlooked by mental health professionals (Carey, 1997; Macmin & Foskett, 2004; Breakey, 2001); mental health professionals sometimes feel uncertain about how to deal with spirituality issues (Foskett, Marriott & Wilson-Rudd, 2004; Crossley & Salter, 2005.).

Service users' perspectives

As already stated, only recently has spirituality been regarded as a subject for study within mental health and even more recently that service users' contributions have been seen as important (D'Souza, 2002; 2004; Knox, Caitlin, Casper, Schlosser & Lewis 2005; Perez, 2005, Macmin & Foskett, 2004).

D'Souza (2002) carried out a pilot study surveying the spiritual attitudes and needs of 79 hospitalised service users with psychiatric illness in New South Wales, Australia. 79% rated spirituality as very important, 82% thought mental health professionals should be aware of their spiritual beliefs and needs, 69% reported that their spiritual needs should be considered in treating their psychological illness and 67% said that their spirituality helped them cope with their psychological pain. The questionnaire had good reliability, 0.83. However, criticisms of this research include the difficulty generalising the results to other cultures, this was further complicated due

to little demographic information. Furthermore it was not clear what psychological problems the service users' experienced, the questions they were asked, or what type of scale was used.

Knox et al (2005) interviewed 12 adult service users about the role of religion and spirituality in their lives, in psychotherapy and their experiences of discussing their beliefs with non-religious mental health professionals. The results were analysed qualitatively and they indicated service users were regularly involved in spiritual activities, and found their therapists open to discussions around spirituality. However, unhelpful discussions made service users feel judged by the therapist.

Perez (2005) used a case study of three service users with a diagnosis of schizophrenia and explored the role of spirituality in the recovery process. The findings of this multiple case study, which included information from questionnaires, qualitative interviews, and the views of caretakers and mental health professionals was that both spirituality and religion play a significant, if not critical role in the recovery process. In-depth information gathered regarding the service users care was very helpful, however, these findings are only based on three service users so further research would have to be carried out. Furthermore, the service users were out-patients and it would be interesting to find out how inpatients would respond.

In a paper entitled "Don't be afraid to tell" (Macmin & Foskett, 2004) explored the spiritual and religious experiences of service users in Somerset. This paper was unique in that service users were both interviewees and interviewers, enabling them to focus on what they believed was relevant. A qualitative design was used and interviews were analysed using a grounded theory approach, which was chosen for its potential in

describing psycho-social processes (Cheritz & Swanson, 1986). The conceptual labels produced a number of categories, with a central core concept “the search for meaning” (See Figure 1).

Insert Figure 1 here

This was then illustrated by a model of what happens when the search to “find meaning in “madness” goes well and where it is frustrated or aborted.” (See Figure 2). The left hand side of the model illustrates a beneficial process and the right hand side shows service users becoming frustrated in their search, ignored by staff, with their beliefs treated as a product of their illness. Because the study was exploratory there was little generalisability to other groups, however, this has the effect of richness, depth and good ecological validity as it has real meaning for the service users themselves.

Insert Figure 2 here

This study concluded that the “research indicated how important it is to service users that their spirituality is taken as seriously as their mental and psychological states and their social situations. Too often they have experienced professionals ignoring or rejecting their religious and spiritual concerns.” Relating to this conclusion, Louis Appleby (2002) proposed the need for “a system where we measure things that are relevant to the lives of people with mental health problems”. This has been strongly endorsed by Townend & Brathwaite (2002) who proposed that in order to ensure the

future integrity of research, mental health service users' should be actively and equitably involved in every aspect of the research process

In summary, the research to date shows that service users' spirituality appears to be important in the recovery process, and their values and beliefs need to be taken into consideration.

Mental health professionals' perspectives

There have been a small number of studies looking at mental health professionals' perspectives on spirituality and mental health care relating to their own spiritual/religious experience, assessment and therapy (Bilgrave & Deluty, 2002; Smith & Orlinsky, 2004; Panning, 2005; Hathaway, Scott & Garver, 2004; Habermann, 2005; Crossley & Salter, 2005; Foskett, Marriott & Wilson-Rudd, 2004).

In a sample of 237 American clinical and counselling psychologists Bilgrave & Deluty (2002) used a questionnaire comprised of 122 items. 66% of the sample believed in the transcendent, 72% stated that their religious beliefs influenced their practice of therapy and 66% stated that their practice of therapy influenced their religious beliefs. The psychologists with Christian beliefs tended to practice from a more cognitive-behavioural perspective, whereas those who had more Eastern and mystical beliefs, tended to practice more humanistic and existential orientations. Furthermore, 67% of the sample disagreed with the statement 'science provides the only truths about the world', indicating that many psychologists, who have been trained to base their work on science, draw on epistemologies other than science to help them judge what is true. The authors' proposed that depending on what perspective they

draw from, this divergence from the scientist-practitioner model is either a cause for concern or is beneficial to the process of therapy. One criticism of the research was no reference was made to the 57% that did not respond.

Using a survey method Smith and Orlinsky (2004) investigated religious and spiritual experience among 975 international psychotherapists from New Zealand, Canada and the United States. The results of the survey showed that 51% of therapists exhibited a pattern definable as personal spirituality, 27% as religious spirituality and 21% as secular morality. The outcome of the survey indicated a multifaceted, complex relationship between psychotherapists and spirituality and therefore a qualitative element would have enabled more exploration.

Panning (2005) conducted an email survey of 275 doctoral level clinical and counselling psychologists investigating their religious and spiritual beliefs. The results showed that under half of the participants 40% stated they were religious, and 75% endorsed a religious preference, generally ascribing to more personal spiritual beliefs. This group believed that religion was an appropriate topic for psychotherapy; however, when asked about using spiritual techniques in therapy, they displayed a theoretical understanding, but rarely used such techniques themselves. However, psychologists that endorsed spiritual beliefs viewed the religious beliefs of service users as more positive.

Hathaway, Scott and Garver (2004), conducted two studies investigating four clinics and 1,000 clinical psychologists nationally across America. Their findings showed that psychologists believe that service users' spirituality was an important factor in functioning. The authors' concluded that assessment of religiousness and spirituality

should become more widely used in clinical practice, “Anything less would be a failure to take religion and spirituality seriously as a diversity domain”.

Habermann (2005) investigated the spirituality of 20 psychologists and 50 service users using a variety of standardised and non-standardised spirituality measurements including the Spiritual Well-Being Scale (SWBS; Ellison, 1983). The results indicated that compared to service users, proportionally fewer psychologists identified themselves as “religious”. However, psychologists had higher scores on the standardised measurements of spirituality, with psychologists showing greater existential well being than clients. The author concluded that: psychologists may view “religion” as more pejorative than service users, despite potentially higher levels of religious and spiritual well-being among psychologists; psychotherapy and spirituality overlap, particularly in the area of existential well-being; service users with higher levels of spirituality are more likely to report positive changes in spirituality as a result of therapy; psychotherapy does not decrease service users spirituality; service users with higher levels of spirituality are more likely to have a stronger working alliance with the psychologists, than those scoring lower on spirituality measures. Additionally, the SWBS was not recommended for use in future studies due to its bias towards Eurocentric groups.

Crossley & Salter (2005) developed an account of the way clinical psychologists understand and address spirituality within therapy in the United Kingdom. Analysing the semi-structured interviews of eight clinical psychologists they developed two core categories: spirituality as an elusive concept; and finding harmony with spiritual beliefs. In the category, “spirituality as an elusive concept” there was a need for explicit

clarification of terms, which related to psychologists difficulty with the language that is already available and feeling that they were often forced to use clichés or words they considered inadequate when expressing their ideas. Much value was placed on a reflexive approach, which incorporates the psychologist's openness to explore their personal perspectives on spirituality, in turn opening up discussion within therapy. This followed from the general feeling of discomfort and embarrassment that some psychologists felt about discussing ideas around the meaning and purpose of life. It was felt that religion was a particularly sensitive subject, making it all the more awkward yet important to discuss.

In the category, "finding harmony with spiritual beliefs" there were two perspectives, understanding beliefs and respecting them. In order to understand the service users' beliefs, some psychologists referred directly to these beliefs, without service users making prior reference to them. Others were less explicit, allowing the service user to mention their beliefs in the course of therapy, believing that if they had a significant positive or negative impact on their experience, then they would naturally be brought up without the need for prompting. Psychologists found respecting service users' beliefs difficult when they contributed to their distress, and discussed ways to manage these difficulties. Due to the nature of the research design, small numbers were interviewed, which limits the generalisability of the study.

Foskett, Marriott & Wilson-Rudd (2004) reviewed the relationship between mental health, religion and spirituality over the last 20 years and presented data from two questionnaire studies. The focus of the paper was not specifically psychologists but mental health professionals in general. Questionnaires were administered to mental

health professionals and religious leaders in Somerset, and the outcome showed that generally neither profession had any doubts about the significance of the links between people's mental health and spirituality. However, what was less clear was whether they believed the relationship to be positive or negative. Leading to the conclusion "given the current lack of professional expertise and knowledge there is no consensus about when and how the relationship will contribute to a person's well being or their problems. And no one can be confident to make an accurate prognosis of how any persons' religious and spiritual beliefs will affect their mental health and vice versa" (Koenig et al., 2001).

It is clear from the above research that mental health professionals are confused and cautious about integrating spirituality into therapy. This conclusion is understandable, particularly when considering research into the area of malignant spirituality and cults (Galanter, 1989) and the difficulties that can arise when spirituality goes 'wrong' and becomes fundamentalist, rather than supportive.

Models

Recently models have emerged from the cognitive perspective which attempt to explain the difference between psychotic and spiritual experiences (Jackson 2001; Clarke, 2001).

The above model of Macmin and Foskett, 2004 (See Figure 2) is similar to the 'problem-solving process' model proposed by Jackson (2001), applied more specifically to psychosis. Drawing from theoretical concepts in depth psychology and his experience of in-depth interviews, psychotic experience is seen as a "solution" to

existential concerns, which gives the sense of authority needed to override and alter existing cognitive structures. Jackson proposed that in the case of benign spiritual experience, this problem-solving process is homeostatic or self-limiting. Stress or “cognitive tension” generated by unresolved existential concerns (e.g. bereavement), triggers a psychotic/spiritual ‘insight’ experience, which leads to a substantial shift in the cognitive framework (‘paradigm shift’) therefore resolving the underlying concern, reducing the level of tension, and thus completing a negative feedback loop. For example, bereavement grief triggers an experience of the continued presence of the deceased in the form of a vision or a voice, and this leads to a shift towards belief in survival after death, thus reducing the grief.

In psychosis however, where the initial “insights” do not resolve the triggering emotional crisis, stress increases, either due to the resulting beliefs as in persecutory delusion, or because of the adverse consequences on the individual’s life and relationships, and one could argue the impact of mental health professionals. Jackson describes these situations as fulfilling a positive feedback loop, the initial experience results in increased emotional stress and a spiral into either florid psychosis, or a withdrawal from society in order to avoid dissonant social feedback.

He then states that clinical interventions may increase stress, either by invalidating the individual’s experience or through sometimes unavoidable compulsory hospitalisation. He proposes the use of cognitive behavioural therapy and similar approaches, where anomalous experiences are ‘normalised’ and an attempt is made to understand these beliefs within the context of the individual’s values, goals and needs. Suggesting that religious traditions may provide a language and conceptual framework

which sometimes helps individuals who have experienced psychosis to make sense of and integrate their experiences in a constructive way.

In line with Jackson's model, Clarke's (2001) Discontinuity Model, proposes that a functioning individual operates within constructs or between two levels of representation that balance the logical and emotional aspects of the self. In psychosis and spirituality these balanced systems are 'disjointed' and it is this that creates the space for either a spiritual or psychotic experience. Clarke (2006) proposed that the 'new wave' (Hayes, Follete & Linehan, 2004) of therapies which incorporate mindfulness as a core component may help individuals in distress to bridge the discontinuity gap by becoming an observer to their experience as opposed to an unwilling participant. Chadwick, Newman-Taylor & Abba (2005) recently conducted a trial investigating the effectiveness of mindfulness-based therapy for people with a diagnosis of psychosis with encouraging results.

Swinton's (2001) integrative model that spirituality needs to be viewed as more than just over-reductive psychological or social function places more emphasis on meaning, purpose, hope, value, connectedness and transcendence. However, there have been many criticisms of the above models, Berrios, (1991) proposed a biomedical perspective whereby psychotic symptoms, are inherently meaningless.

There are a variety of models from purely medical (Berrios, 1991), which view psychosis (and one could argue spirituality) as meaningless, to cognitive (Jackson, 2001; Clark, 2001), which view spirituality as a solution to stress and integrative, which views spirituality as a "basic human need, which manifests itself in various ways according to culture and context" (Swinton, 2001: 132).

Therapies incorporating a spiritual perspective

As stated in the introduction, a full account of this area is beyond the scope of this review and therefore a general overview is presented. There is a distinction between therapies that incorporate spiritual practices, predominantly mindfulness practice, as a way of enabling people to manage their difficulties, for example, Dialectical Behaviour Therapy (Linehan, 1993a & b), Mindfulness Based Cognitive Therapy (Segal, Williams and Teasdale, 2002), Acceptance and Commitment Therapy (Hayes, Stroschal & Wilson, 1999), and Compassion and Shame (Gilbert, 2005) and therapies which focus on the individual spirituality, beliefs and values of the person for example Psychosynthesis (Assagioli, 1980), Spiritual Emergency (Grof & Grof, 1989) and Logotherapy (Frankl, 1978). The former are based on bringing spiritual practices into the therapy setting, and incorporating them into a model of therapy, predominantly cognitive behavioural. These 'new wave' therapies have evolved from cognitive behaviour and behaviour therapies. The latter focus more on what an individual brings to the therapy their own spiritual practice or spiritual emergency.

Recently, D'Souza (2004) developed Spiritual Augmented Cognitive Behavioural Therapy (SACBT). The main focus of the therapy is self-therapy, utilising practices like prayer and meditation with exploration of different types of meaning: experiential values (experiencing something or someone we value); creative values (doing a deed, providing oneself with meaning by becoming involved in the project of one's own life) and attitudinal values (including such virtues as compassion, bravery, a good sense of humour, even achieving meaning, as Frankl (1978) suggested, on one's

suffering). To date there have been no studies investigating the effectiveness of this type of intervention.

In America, Pargament et al (2005) has recently presented an empirically-based rationale for spiritually integrated psychotherapy which they claim is 'capable of integration into virtually any form of psychotherapy'. Based on the premise that: spirituality can be a part of the solution to psychological problems; spirituality can be a source of problems in and of itself; people want spiritually sensitive help; and spirituality cannot be separated from psychotherapy, they have defined the characteristics of such a therapy. The therapy would need to be based on a theory of spirituality; be empirically oriented; and will transform the nature of psychotherapy. They do not suggest that this added dimension to psychotherapy is a new, stand alone, form of treatment, which competes with or replaces other forms of help. It is, as they state, integrated, "it weaves greater sensitivity and explicit attention to the spiritual dimension into a process of psychotherapy".

Pargament, Murray-Swank & Tarakeshwar (2005) also discuss in detail the dangers of a spiritually-integrated psychotherapy which include the risk of trivializing spirituality, turning it into one "among many tools that can be selectively applied by cool dispassionate therapists interested in returning their clients to normalcy"; that there may be spiritual reductionism whereby mental health professionals begin to explain spirituality in terms of psychological, social or physiological processes; that there is a danger of the mental health professional imposing their views on the service user and finally, that there is a danger of over emphasising the importance of spirituality and reducing all aspects of living into purely spiritual concerns.

Callanan (2005) developed an approach called PIERS analysis (Physical including context; biology; gender; health; Intellectual, including education, beliefs, world-view; Emotional; Relational including loved ones, friends, pets, colleagues; Spiritual including beaches, churches, forests, and safety), which she describes as dimensions to reflect on in therapy.

Finally, Shafranke (2000) proposed that the process and outcome of psychological treatment is influenced by many factors including objective (i.e. sex, ethnicity) and subjective (i.e. emotional well being, values and attitudes and beliefs) therapists variables. Furthermore, there is a cultural distinction, between America and Britain, whereby American's are generally more explicitly religious than the British secular society. Additionally, more globally, there is a cultural distinction between spiritual beliefs.

Training

In both the United States and the United Kingdom reports indicate that discussions of religious or spiritual issues are either absent or rare in clinical psychology training courses (Yarhouse & Fisher, 2002; Lukoff & Lu Francis, 1998; Shafranske & Malony, 1990). Shafranske (2000) proposed that the relationship of religion and spirituality on mental and physical health requires attention within graduate education and clinical psychology training in light of the value-based nature of psychological intervention, the high salience of religion for most individuals and the need for sensitivity towards diversity.

More generally Hertsprung & Dobson (2000) surveyed the Directors of Clinical Training (DCTs) at all Canadian clinical psychology programs. They were asked which

aspects of diversity training they deemed important or essential to their program, which training activities were required and how effective different training methods were viewed. The results showed that DCTs varied widely in terms of the importance placed on diversity issues and the methods of training.

Baich (1999) based his dissertation on developing a workshop for training psychologists in the area of religion and spirituality in clinical practice. 40 doctoral students participated in both didactic and interactive learning experiences. The results indicated that: the workshop was effective in increasing the students' awareness of and sensitivity to religious and spiritual issues in clinical practice; participants were encouraged to examine their personal and professional attitudes toward religious and spiritual attitudes and practices in an effort to minimize the possibility of bias and counter transference problems; participants awareness of the deficits in training were increased. The author proposed the workshop would be a valuable addition to the educational curriculum of psychologists.

Miller (2001) proposed some recommendations for clinical psychology training including: encouraging open discussion and exploration of spiritual and religious issues during training and supervision and spiritual and religious issues should be addressed in professional supervision as part of the training of clinical psychologists (see appendix * for further recommendations).

At a recent Psychosis and Spirituality conference (2006) attended by mental health professionals, the issue of training was raised. The consensus appeared to confirm the work of Pargament (2005), indicating that the raising of mental health professionals awareness is more important than formal training. Isabel Clarke (2006)

has recently begun running awareness training for mental health professionals, which incorporates spirituality, hope and meaning into the concept of a recovery model, encouraging accessible language and the need for fearlessness when exploring this area. (See Appendix 4.1)

Discussion

The review began by posing five questions: What are service users' perspectives of spirituality? What are mental health professionals' perspectives of spirituality? What can recent models, which attempt to explain the difference between mental health problems and spiritual experience, tell us? What therapies are available which incorporate a spiritual perspective? And finally, is there any evidence that incorporating spirituality into clinical psychology training is required?

Service users' propose that spirituality needs to be more explicit in therapy (Macmin & Foster, 2004). Mental health professionals' experiences of spirituality were varied, there seems to be both an acknowledgement of the need for new language to discuss service users spirituality and religion, but also that this engenders fear and anxiety in mental health professionals (Foskett, Marriott & Wilson-Rudd; 2004) and more specifically, clinical psychologists (Crossley & Salter, 2005).

Recently Jackson (2001) and Clarke (2001) have attempted to incorporate spirituality and psychosis into models. Jackson's problem solving model describes the differences between spirituality and psychosis, based on the perspectives (values and beliefs) of the individual and their environment. Clarke's discontinuity model of spirituality and psychosis is based on the dissonance between two levels of

representation that balance the logical and emotional aspects of the self. These models propose, in varying degrees that the distress of psychosis and in some cases spiritual experience (Grof & Grof, 1989) is within the individual's perceptual framework. Other perspectives incorporate the idea of the 'mystery' and of an outside force as being helpful in explaining both psychosis and spirituality (Grof & Grof, 1989).

If a therapeutic language was developed (or borrowed) and explored, the likelihood is that there would be more understanding between mental health professionals and service users about the impact of spirituality on an individual's well being, and a respect for the 'grey area' that appears to exist between spirituality and psychosis. Additionally, integrating spirituality into the training (Miller, 2000) of clinical psychologists in a similar way that race, culture and sexuality have been integrated, would open up these areas for discussion.

The main conclusions of this review of a large and disjointed area of research are that mental health professionals and service users' experiences of spirituality are not that dissimilar and that if the individuals' spiritual beliefs and practices are sustaining then surely they are to be encouraged. If, however, they are damaging, they must be gently challenged.

To date, there is little mainstream research being carried out and as is usual at the end of any review paper, the recommendation is that more research is necessary into this area as it is particularly rich and challenging. As a starting point the following may be carried out: research evaluating training clinical psychologists from a service user's perspective; evaluating joint training between clinical psychologists and spiritual leaders; exploring the recent cognitive models in more detail; and evaluating clinical

psychologists and other mental health professionals' perspectives on spirituality and psychosis.

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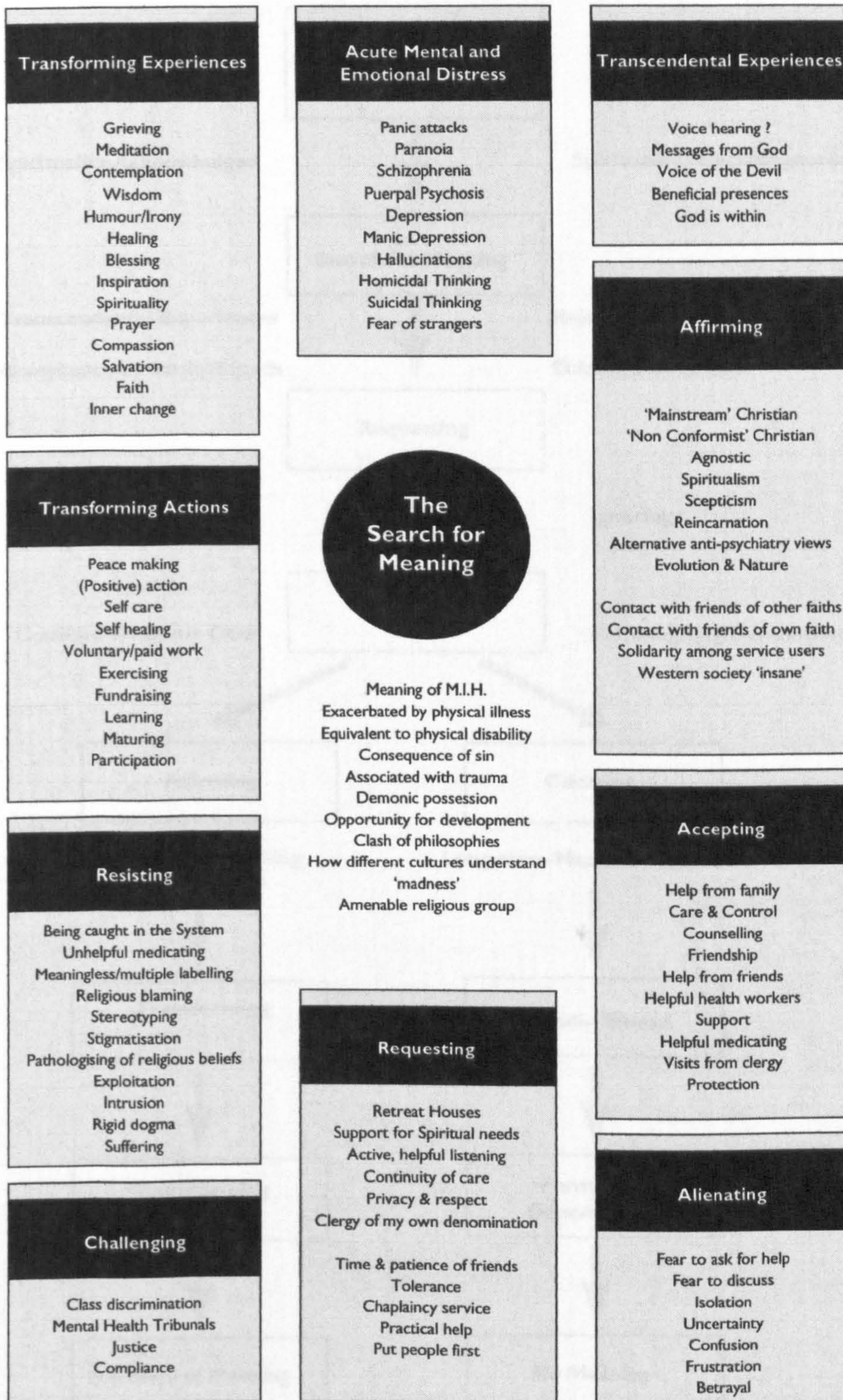


FIGURE 1. *The search for Meaning.*

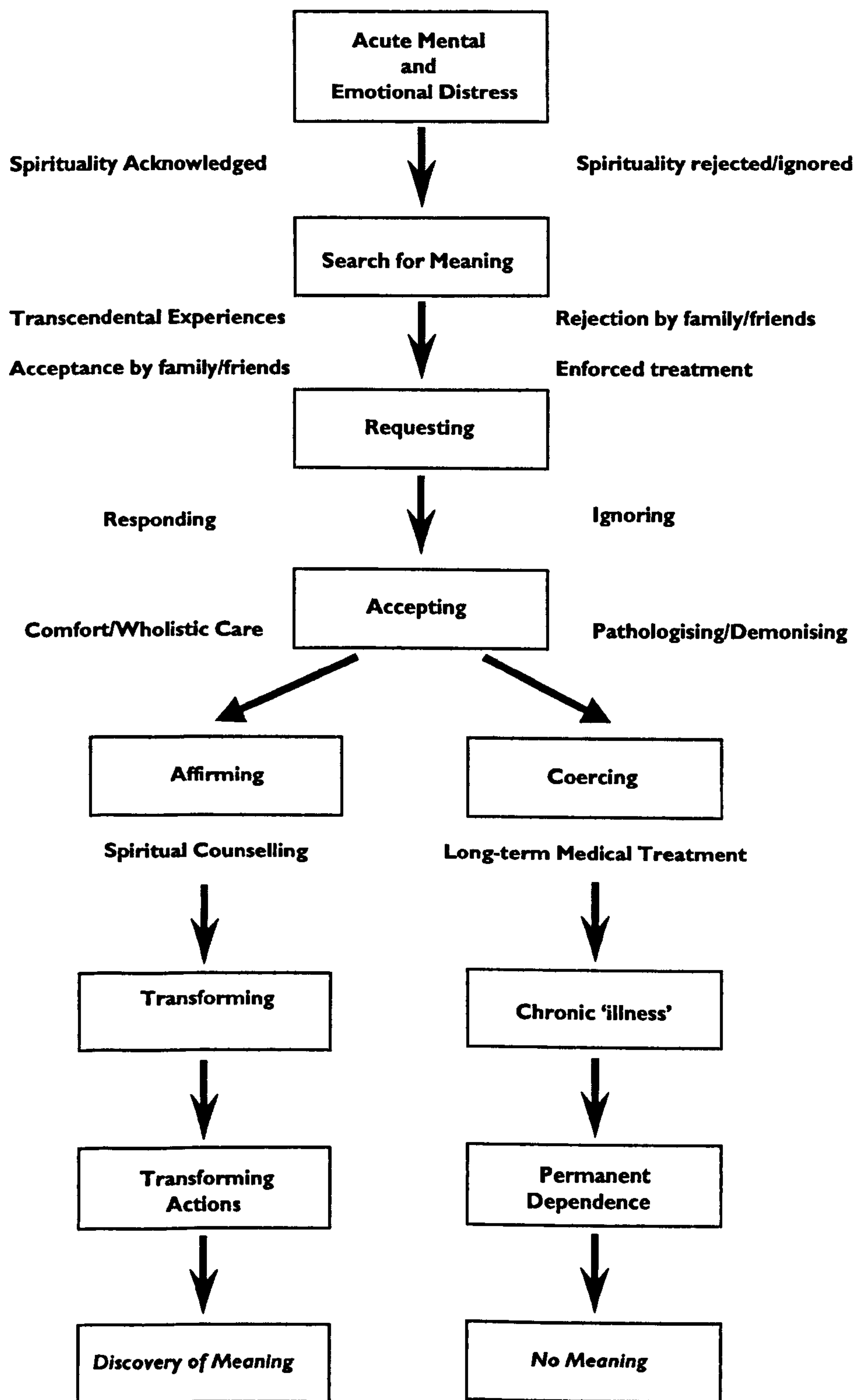


FIGURE 2. *The progress of the Search for Meaning.*

Philosophy, Psychiatry & Psychology

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SECTION THREE – EMPIRICAL PAPER

Mental health professionals' perspectives on spirituality and psychosis

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Recent publications:

Randall, F., Corcoran, R., Day, J.C. and Bentall, R.P. (2003) "Attention, theory of mind and causal attributions in people with persecutory delusions", *Cognitive Neuropsychiatry* 8(4), 287-294

Day, J.C., Bentall, R.P, Roberts, C., **Randall, F.**, Rogers, A., Cattell, D., Healy, D., Rae, P., Power, C. (2005). Attitudes toward Antipsychotic Medication: The Impact of Clinical Variables and Relationships with Health professionals, *Archives of General Psychiatry*, 62(7), 717-724

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Abstract

Based on previous research investigating mental health professionals' perspectives of spirituality and psychosis, the present study used both standardised and non-standardised self-report scales on a sample of psychiatrists, clinical psychologists and nurses. In line with the initial hypotheses, results indicated a difference between gender and response to the questionnaires: males were more likely to believe they could tell the difference between spiritual experience and psychotic symptoms. There was an association between participants' ratings of their own spirituality and rating the vignettes as a common spiritual experience. Participants rating negative content vignettes were more likely to rate them as mental health problems. Qualitative analysis expanded on the quantitative results,

Key words: mental health professionals' perspectives, own spirituality, mental health problems

Mental health professionals' perspectives on spirituality and psychosis**Introduction**

At the turn of the ^{Last} century William James (1902) made the connection between spiritual experience and psychotic experience, coining the term “diabolical mysticism” (James 1902: 426). There have been many attempts to understand this connection (Jung, 1933; Thalbourne, 1994) however there has been little systematic mainstream clinical psychology research.

Recent indications that this is changing are a book edited by Clarke (2001) called ‘Psychosis and Spirituality: Exploring a New Frontier’, a project currently underway by the National Institute for Mental Health in England and the Mental Health Foundation investigating ‘Spirituality and Mental Health’ and research carried out by Jackson and colleagues (1991, 1997) and Claridge (1997). Furthermore, evidence from several major organisations World Health Organisation (WHO) (Culliford, 2002), National Institute of Mental Health Executive (NIMHE) (Gilbert & Nichols, 2003) and Rethink (Martyn, 2005) regard spirituality and religion not only as an important area of functioning in clients’ lives, but as a contributory factor in self-management and recovery from severe mental health problems.

Clarke (2001) stated that it is “the subtle use of language, and other means, whereby the spiritual and the psychotic have hitherto been kept in essentially separate compartments”. She proposed that the “New Frontier” referred to in the title of the book represented a challenge in “linking the highest realms of human consciousness and the depths of madness”.

At some point in their lives between 1% and 3% of the population experience a diagnosed psychotic episode (APA 1994). The psychosis spectrum disorders (DSM-IV: APA 1994) include: schizophrenia (delusions, hallucinations, thought disorder, affective flattening and catatonic disorder over at least six months involving a significant deterioration in life functioning); schizophreniform disorder (which has the same presentation as schizophrenia, but shorter in duration); brief reactive psychosis (lasting for a maximum of one month); delusional disorder (a single fixed delusion); bipolar affective disorder (cycles of mania and depression); schizoaffective disorder (features of both schizophrenia and bipolar affective disorder); and schizotypal personality disorder (less overt psychotic experience). The continuity/dimensionality of psychotic characteristics, which are recognised as extreme expressions of traits that manifest within the general population, are now firmly established among psychologists (Claridge, 1997) and increasingly among psychiatrists (Van Os et al, 1999).

Jackson (1991) used factor analysis to empirically define spiritual experience in three categories: “psychic” experiences characterised by extra-sensory perception, apparitions, out of body experiences; “numinous” experiences involving a sense of the presence of an external agent, sometimes interpreted in explicitly religious terms; and “mystical” experiences characterised by feelings of unity with a larger whole. He also makes the distinction between the spiritual experiences referred to in much research of the “great mystics” (Wapnick, 1969) and the everyday spiritual experiences of “normal” people, who are less studied and commented on, rather than different in kind. These experiences may occur as a result of specific spiritual practices, life crises such as bereavement or under the influence of drugs and in some cases from out of nowhere.

Hay (1987) found between 30 and 60% of the population had experienced some kind of spiritual experience. Interestingly, the percentages of people reporting spiritual experience depended on how they were surveyed, self-report scales generated less than face to face interviews. A large majority of these experiences were viewed as life changing and enhancing.

Jackson (1991) proposed the term p-s experiences to describe reported similarities between people diagnosed as psychotic and those experiencing benign spiritual experiences. These experiences are viewed on a continuum and are very different from the unambiguous symptoms of psychosis such as delusions of persecution, thought broadcasting, catatonia, emotional blunting, poor pre-morbid adjustment, the factors associated with negative symptoms of schizophrenia and the most widely reported forms of spiritual experience like experiencing brief moments of unity with the whole. In this and later research (Jackson & Fulford, 1997) found accounts of p-s experiences could not be reliably distinguished using the Present State Examination (PSE), a standardised diagnostic tool (Wing, Cooper and Sartorius, 1974). This led to the tentative conclusion that it is not the form and content of the experience that determines the label it receives but more likely the context in which it is experienced and the amount of distress it causes. Additionally, the context, either positive or negative and the amount of distress is determined by the values and beliefs of the person experiencing it.

Jackson (2001) proposed a problem-solving model to account for the benign effect of intense spiritual experiences, as opposed to the deterioration found in psychosis. He suggested that both are experienced in emotional crises and are

accompanied by extreme emotional intensity. In the case of a spiritual experience, however, a “negative feedback” loop enables a constructive and adaptive insight into their experiences with reduction in arousal, leading to increased coping behaviour. In psychosis, ‘insights’ are viewed as more negative and threatening a “positive feedback” loop increases the state of arousal, which then precipitates increasingly florid experiences.

This account relates to a recent cognitive model of persecutory delusions (Freeman et al, 2002) that against a backdrop of possible trauma, anxiety (anxiety is thought to be a central emotion in the formation of persecutory delusions) and depression which feed into the individual’s persecutory threat beliefs causing arousal, these in turn are exacerbated through lack of sleep. This model clearly highlights the importance of difficulties in affect being the main precipitator in the formation of a persecutory delusion.

In line with the above, Clarke’s (2001) discontinuity model draws on Kelly’s Personal Construct Theory (Bannister & Fransella, 1971), and Teasdale’s Interacting Subsystems Model (Teasdale & Barnard 1993). Clarke proposed that a functioning individual operates within constructs or between two levels of representation that balance the logical and emotional aspects of the self. In psychosis and spirituality these balanced systems are “disjointed” and it is this discontinuity that creates the space for either a spiritual or psychotic experience.

Jackson (1991) proposed that one of the most important implications for his research on the relationship between psychotic and spiritual experience was the impact of the treatment of psychosis. Interestingly, Beck (1952) and Ellis’s (1955) initial case

studies were based on people with psychosis, and yet it has only been more recently that Cognitive Behavioural Therapy (CBT) (Kingdon & Turkington 1994) has been used in treatment. Kingdon, Siddle & Rathod (2001) proposed the development of “normalising rationales” as a way of working therapeutically with service users diagnosed with psychosis and “since mental health professionals are a group seemingly less religious than their patients, caution is needed in separating normal religious beliefs from religious delusion”. Research has supported the argument that psychotherapists are less religious than the general public (Worthington, Kurusu, McCullough & Sandage, 1996).

Sanderson, Vandenberg & Paese (1999) presented mental health professionals with a range of vignettes describing religious-type experiences and asked the participants to rate how authentic they believed these to be and whether they were pathological. The authors’ found that the experiences, that the participants believed to be more pathological, they also judged to be less authentic and unconventional. Sanderson proposed that mental health professionals’ evaluations were made with reference to their own cultural norms, questioning the legitimacy of this process within a multi-cultural society.

In line with the above research Eeles, Lowe & Wellman (2003) conducted a qualitative study exploring the criteria that nurses use to evaluate spiritual-type experiences reported by service users and their own experiences of spirituality. They found that the outcome of the experience (either positive or negative) was an important evaluative factor, together with the personal and cultural context in which the experience occurred. However, they found that although there was a relationship between participants’ rating common spiritual experiences as less pathological, they did

not find that these ratings of spiritual experiences were based on their conventionality as Sanderson had found. Eeles et al (2003) reported that a “reduction of personal bias is desirable to ensure beneficial treatment for patients, determining that sometimes dramatic and personally significant but essentially harmless spiritual-type experiences are not mistaken for the symptoms of mental illness”.

Previous research has shown that a person’s belief system (including their spirituality) has a large impact on their experience and therefore their mental health (Clarke, 2001; Jackson, 1991, 1997). This, coupled with the proposition that some forms of psychosis and spirituality have much in common (Jackson, 1991; Jackson & Fulford, 1997), indicates that to understand the perspectives of mental health professionals towards spirituality and psychosis, is crucial for the future care and rehabilitation of service users.

Expanding on the above research, the present study explored the relationship between mental health professionals (psychiatrists, psychologists and nurses) expressions of their own spiritual experience and their judgements of others’ experiences. Using questionnaires which included both Likert scales and open-ended sections to enable participants to expand on their answers, it was hypothesised there would be a difference between the participant variables (occupational group, gender, length of experience and age) and on stimulus variables (measure of their own spirituality and vignettes depicting p-s type experiences). More specifically that participants who rated high on the measures of their own spirituality would be more likely to rate vignettes depicting p-s type experiences as common spiritual experiences; and that participants’ rating the vignettes which describe distressing experiences would

be more likely to rate the individual as having a mental health problem. Qualitative data analysis explored and expanded on these hypotheses.

Method

Design

The study was a quasi-experimental, between-subjects design with three groups: psychiatrists, nurses and clinical psychologists as independent variables. The dependent variables were the scores on the revised Expressions of Spirituality Inventory (Macdonald, 2000) and scores on a questionnaire based on Eeles et al (2003) paper, which included rating six vignettes of p-s experiences (See Appendix 1.4)

Participants

748 mental health professionals were surveyed via post and email. Of these, 98 (13%) returned the questionnaire, 79 (81%) post and 19 (19%) email, there were no significant differences between the two methods of data collection. The sample was comprised of 58 females and 35 males, five participants did not stipulate their gender. The three occupational groups comprised the following:

89 psychiatrists were sent the questionnaires via email, of these 17 (19%) returned the questionnaires consenting to the study. The sample comprised 3 female and 14 male, age range between 20 and 51+, with 12 (70%) falling within the age range 31-50. Years experience ranged between 0-16+, with 7 (41%) falling between 6-10 years and 7 (41%) falling in the 16+ category, (see Table 1).

593 nurses were sent the questionnaires via post and email, of these 37 (6%) returned the questionnaire consenting to the study. The sample comprised 24 female

and 10 male (3 unknown gender), age range between 20 and 51+, with 27 (73%) falling within the age range 31-50. Years experience ranged between 1-16+, with 16 (43%) falling between 16+ years, with the rest of the sample spread equally between the ranges 0-5, 6-10, 11-15.

93 clinical psychologists were sent the questionnaires via post and email, of these, 44 (47%) returned the questionnaire consenting to the study. The sample comprised 31 female and 11 male (2 unknown gender), age range between 20 and 51+, with 29 (66%) falling within the age range 31-50. Years experience ranged between 0-16+, with 12 (27%) falling between 0-6 years and 14 (33%) falling in the 16+ category.

There was a significant gender difference $\chi^2(1, N = 93) = 5.69, p < .05$, the majority of psychiatrists were male and the majority of nurses and clinical psychologists were female. There was a significant age difference $\chi^2(3, N = 98) = 15.80, p < .001$, the majority of the sample were between the age of 31-50. There was a significant occupation difference $\chi^2(2, N = 98) = 12.02, p < .05$, the majority of the sample consisted of clinical psychologists and nurses. There was no significant length of experience differences between the groups $\chi^2(3, N = 98) = 7.55, p > .05$.

There was a significant religious affiliation difference between occupational group $\chi^2(12, N = 98) = 37.83, p < .001$, with just over half the nurses and clinical psychologist sample stating that they were not religious yet most psychiatrists 88% stated that they were religious. There was a significant current religious/spiritual belief difference $\chi^2(2, N = 97) = 14.55, p < .001$, with the majority of psychiatrists and clinical psychologists and only 32% nurses stating that they currently had

religious/spiritual beliefs. There was a significant attend religious services difference $\chi^2(2, N = 98) = 10.94, p < .05$, with the majority of nurses and clinical psychologists stating that they did not attend services, however, 65% psychiatrists did attend religious services. There was no significant religious upbringing differences between the groups $\chi^2(2, N = 98) = .257, p > .05$

Measures and administration

The questionnaires were split into three sections:

1. Demographics
2. Expressions of Spirituality Inventory, Macdonald, (2000) ESI, including information regarding spiritual/religious background
3. Information regarding service users' experiences and vignettes, (See Appendix 1.4).

- *Expressions of Spirituality Inventory (ESI), MacDonald (2000)*

A 30 item revised version of the original 98 item scale was used. The instrument was designed to operationalize a five-dimensional model of spirituality that was developed through factor analyses of 18 extant measures of the construct. These five dimensions are described as encompassing the core descriptive elements of spirituality. The measure is designed to access the expressions of spirituality as the authors propose spirituality cannot be directly measured. Using measures of behavioural, psychological, physiological and social correlates the five factors include: Cognitive Orientation Towards Spirituality (COS) (e.g. beliefs about the existence of spirituality and its

relevance to personal functioning); Experiential Phenomenological Dimension (EPD) (e.g. spiritual experience); Existential Well-Being (EWB) (e.g. positive sense of purpose and meaning in life, sense of self-directedness, self satisfaction and inner strength); Paranormal Beliefs (PAR) e.g. belief in para-psychological phenomena, spiritualism and witchcraft); and Religiousness (REL) (e.g. traditional religious beliefs and practices, mostly of a Judeo-Christian nature).

The measure had good internal reliability (.80-.89) for all of the five dimensions and good validity, correlating highly with a number of similar measures including the Spiritual Well Being Scale, Ellison (1983); and the Spiritual Self- Assessment Scale, Moberg (1984). The Cronbachs Alpha for the measures in this study was between 0.87-0.93 for all measures except EWB and PB, which were 0.20 and 0.49 respectively. For the purposes of this study, COS, EPD and REL where used in the analysis.

- *Section 3 - Experience of psychosis and vignettes*

This section asked for the number of hours worked with service users' with serious mental illness and gave participants the opportunity to (within the bounds of confidentiality) discuss service users' spiritual experiences. Six vignettes, from Eeles et al (2003) study were used, with some minor modifications. Three of the vignettes were more negative and distressing in outcome and content and three of the vignettes were more positive in outcome and content. (See Appendix 1.4).

Negative vignettes

- **Carl:** believed his wife was “demonic”, had been convicted in court for legal action taken out against him at work, believed he was chosen by God to bring message of unifying Christianity and that God was speaking to him though his TV. The experience was negative to his career and his quality of life.
- **Tony:** believed his ancestors were communicating with him about why there was misery and suffering in the world, the experiences were both comforting and distressing as they often made him angry.
- **Evelyn:** believed that she was experiencing ‘something alien inside her’, after practicing spiritual healing and a long period of prayer they went away. She subsequently changed her religion to Christianity as a result of this experience.

Positive vignettes

- **Beryl:** believed she had heard the voice of Jesus asking her to come and work for him, as a result decided to give up her career and become a spiritual advisor. She continued to hear the voice and was very successful in career.
- **Diane:** believed that she was chosen to be a sacrifice and that she was God, however, since taking up transcendental meditation and her faith in Bahai she believed her experience had taken to a higher level of spiritual awareness. Her experience was ultimately positive.
- **Anne:** believed that she had experienced a vision of an enormous female figure floating above the ground after an anti-nuclear demonstration. The experience

enabled her to understand the oneness of everything and study for a Masters of Theology.

The people in the vignettes displayed a variety of both psychopathology and spirituality and encompassed the three types of spiritual experience: psychic, eg. Evelyn's experience of alien heartbeat; numinous, eg. Beryl's calling from Jesus; and mystical, eg. Anne's vision. Only one of the vignettes, Diane, was known to the services and had a diagnosable disorder of manic depression.

Procedure

Prior to proceeding with the study, ethical approval was obtained from the School of Psychology and the relevant Local Health Authority Ethics Committee. All participants received an information sheet and initially a consent form, (however early on in the study, consent was implicated by the return of the questionnaire and this change was approved by the Local Health Authority Ethics Committee (See Appendix 1.3,)). The questionnaires were administered in the order listed above (See Appendix 1.4). Participants were asked to complete the questionnaire and return it by post for both email and postal surveys to maximise confidentiality.

Results

Statistical analyses

The SPSS 11.04 (SPSS Inc., Chicago, Illinois) was used for statistical analysis. Statistical significance was defined at the 5% and 1% level for two-tailed tests (unless bonferroni correction was applied).

Composite score for vignette data

Most of the vignette questionnaire data was descriptive and informed the qualitative analysis. However, four variables: answered on a 5 point Likert scale for each of the six vignettes “The experience described is a common spiritual experience” (SPIRIT); “The individual described here has a mental health problem” (MHP); and single statements: “Spiritual experience is pathological (comes from illness) (q8)”; and “I am able to tell the difference between spiritual experiences and psychotic symptoms” (q9) were used in the quantitative analysis.

Factor analysis was not conducted on these variables for two reasons. Firstly, the data was ordinal and any factor analysis on ordinal data is very difficult to interpret and secondly, because the data was derived from a non-validated measure, composite scores are more meaningful (Garson, 2006). Therefore the composite scores of either, belief that the person was having a common spiritual experience (SPIRIT) and the belief that the person had a mental health problem (MHP) for all of the vignettes, were used. The computed value of Cronbachs Alpha for SPIRIT was 0.72 indicating good internal consistency and for MHP 0.66 indicating acceptable internal consistency.

Normality testing

Investigation of the ESI’s three factors indicated that the distributions could be assumed to be normal: Cognitive Orientation to Spirituality (COS): KS Z = .950; $p = .327$; Experiential Phenomenological Dimension (EPD): KS Z = 1.16; $p = .134$; and Religiousness (REL): KS Z = .939; $p = .341$. Investigation of Spirit and MHP,

indicated that the distributions could be assumed to be normal for Spirit: KS $Z = .908$; $p = .382$ and MHP: KS $Z = 1.146$; $p = .144$. The distributions for q8 and q9 could not be assumed to be normal as the KS tests were significant for both questions. Question 8: KS $Z = 3.765$; $p = .001$ and question 9: KS $Z = 2.93$; $p = .001$.

Data preparation and analysis strategy

Although most of the data was parametric, because many of the variables were ordinal (SPIRIT, MHP, q8 and 9) the non-parametric equivalent of the one way analysis of variance, Kruskal Wallis test, the non-parametric equivalent of the t-test, the Mann Whitney test and Spearman's Rho correlations were employed in order to investigate the hypotheses that:

- 1) There would be a difference between gender, occupation, length of service, age, and response to the questionnaires;
- 2) Participants who scored highly on the measure of COS, EPD and REL would be more likely to rate the vignettes as a spiritual experience;
- 3) Participants rating the distressing/negative content vignettes would be more likely to rate them as a mental health problem.

Prior to any analysis the data was checked for outliers and missing data.

Outliers

There were 5 outliers for the variable Mental Health Problem. Mean replacement was conducted to ensure homogeneity.

Missing data

The only variables which had more than 5% missing data were ‘hospitalisation’ (answer to the question for each of the six vignettes “the individual described would benefit from being hospitalized”) 9 %, and ‘treatment’ (“the individual described would benefit from an intervention (medication/psychological therapy)”) 12 %. Nothing further was necessary as these were used descriptively and were not entered into any analysis.

(Insert Table 1 here)

Frequency tables

Table 2 shows the frequency and percentage of participants who either agreed or disagreed that the vignettes were either a common spiritual experience or a mental health problem. Neutral responses are not included in this table.

(Insert Table 2 here)

Spiritual experience

Of the total responses, 43% agreed with the statement that Beryl was having a common spiritual experience and 24% did not agree with the statement 89% did not agree with the statement that Carl was experiencing a common spiritual experience and only 3% agreed with the statement. 79% of the sample disagreed with the statement

that Tony was having a common spiritual experience and only 9% agreed with the statement.

Mental health problem

In line with the above frequencies, 58% of the total sample disagreed with the statement that Beryl has a mental health problem and only 8% agreed that she had. Only 1% disagreed that Carl had a mental health problem and 94% agreed that he had. Similar frequencies were calculated for Tony (6% and 77% respectively).

Hospitalisation and treatment

It is clear from those that answered the question regarding hospitalisation and treatment (See Table 1) that Carl and Tony were most likely to be hospitalised and Beryl and Anne the least likely to require hospitalisation. There were a few anomalies here, with one clinical psychologist stating that Anne would require hospitalisation. These anomalies and non-conformist views are addressed later. Similarly, Carl and Tony were the most likely to require treatment, with Anne and Beryl the least likely.

Interestingly, most of the responses in this sample were equally distributed between the occupational groups, however, 42% nurses believed Tony needed to be hospitalised, as opposed to only 13% of psychiatrists and 8% clinical psychologists. Additionally, 41% of nurses believed Evelyn needed treatment as opposed to 13% psychiatrists and 18% clinical psychologists (See Table 1). Therefore, taken together, the above rankings clearly demonstrate the influence of the stimulus variable (distress) on perception.

Correlations

The following (See Table 3) correlation matrix displays significant associations between the variables: gender, occupation, ratings on ESI (COS, EPD, REL), SPIRIT, MHP, q 8 and q9. In order to reduce the risk of making a type 1 error, Bonferroni correction was calculated at an alpha level of .005. As Bonferroni correction is a very conservative adjustment (Perneger, 1998) all significant results will be reported, however, those found to be significant at the adjusted level, are assumed to be more secure.

(Insert Table 3 here)

There was an inverse association between gender and being confident about telling the difference between pathology and spirituality (See Table 3, for correlation matrix). Males were identified in the analysis as 1 and females as 2, indicating a relationship between being male and confidence about telling the difference between pathology and spirituality. There was an inverse association between Cognitive Orientation to Spirituality (COS) and the statement that spiritual experience equals pathology, indicating that a higher rating of personal spirituality was associated with a less pathologising perspective on the vignettes.

There was an association between occupation and gender, Table 1, shows that most of the psychiatrists were men. There was an association between Cognitive Orientation to Spirituality (COS) with Experiential Phenomenological Dimension (EPD), Religion (REL) and SPIRIT. There was also an association between REL with

EPD and SPIRIT, indicating a relationship between participants' ratings of their own spirituality and rating the vignettes as a common spiritual experience.

The following correlations were non-significant at the adjusted alpha level. However, there was an association between MHP and q 8 (spiritual experience is pathological). This indicated a possible relationship between participants rating the vignettes as a mental health problem and agreeing with the statement that spiritual experience is pathological. There was also an inverse relationship between MHP with COS and SPIRIT, indicating participants who rated the vignettes that illustrated a person as experiencing mental health problems, did not rate themselves high on personal spirituality, nor did they rate the vignettes as indicative of a person having a spiritual experience.

Differences between variables

Hypothesis 1: There would be a difference between age, length of experience, gender, occupation, and ESI and ratings of the vignettes were tested with the following results:

Age and length of experience

There were no significant differences between age or length of experience and the questionnaire measures.

Gender

There was a difference between gender and the way the questionnaires were rated. Results indicated that there was a significant difference between gender x q9 (“tell the difference between spiritual experience and psychotic symptoms”) $\chi^2(1, 93) = 12.37, p < .001$. Results also indicated that gender x MHP was nearing significance $\chi^2(1, 89) = 3.60, p = .058$.

Mann Whitney tests indicated that males believe that they can “tell the difference between spiritual experience and psychotic symptoms” significantly more than females, $z = -3.52; p < .001$ and that males believed that the vignettes suggested a mental health problems more than females (See Table 1). However, as most of the psychiatrists were males the results were confounded.

Occupational groups

To investigate the above confounded results, a Kruskal Wallis test was employed to look at any differences between males x occupation x tell the difference ($\chi^2(2, 35) = 3.55, p > .05ns$). The result indicated that the difference found above was between gender and not between occupational groups. Due to the small number (only 3) of female psychiatrists the same analysis could not be run between female x occupation.

Mental health professionals’ religious and spiritual beliefs

In line with previous research (Worthington, et al., 1996) that mental health professionals would be less spiritual/religious than the general population. It is clear

(See Table 4) that on the measures from the ESI mental health professionals' have scored below the mean of student controls from Macdonald, (2000). This was apart from psychiatrists who scored above the mean for COS and EWB, indicating higher cognitive orientation to spirituality and existential wellbeing than student controls.

Relationship between spirituality and vignettes

Hypothesis 2: The hypothesis that participants who expressed openness to spirituality (as rated on the Expressions of Spirituality Inventory) will be more likely to rate the vignettes as common spiritual experiences has already been tested (see correlation matrix, Table 3). There was an association between participants' ratings of their own spirituality and rating the vignettes as a common spiritual experience.

Relationship between distress and mental health

Hypothesis 3: Participants rating the negative content vignettes will be more likely to rate them as a mental health problem. This was explored in the frequency tables (See Table 2), which clearly show, as expected, that the more negative outcome vignettes of Carl and Tony (and to some extent Evelyn) have been rated as having a mental health problem more than the positive outcome vignettes of Beryl, Anne and to some extent Diane. Additionally, the higher percentages of participants who believed that Carl and Tony would benefit from hospitalisation and treatment as opposed to Beryl and Anne (see page 18) are further indications of participants perceiving the negative vignettes as mental health problems.

Exploratory qualitative analysis

Barker, Pistrang & Elliott (2003) propose using a mixture of both quantitative and qualitative data analysis to enable richness and depth in any study.

Eeles et al. (2003) themes

The main themes, reported by Eeles et al (2003) the distinctions between: outcome; nature; context; and explanatory mode of experience were explored. All of these themes were present throughout the transcripts in varying degrees (See Appendix 3.2, for examples of these). Additional further tentative exploration was attempted; however a full quantitative analysis was well beyond the scope of this paper. The distinction between using and abusing drugs, which was mentioned in Eeles et al under the context of the experience, was identified in this study as a strong theme.

Further themes

Additionally, as an expansion of the Eeles et al study: mental health professionals own spirituality; collaboration; different perspectives and assessment were tentatively explored. The following quotes clearly illustrate the lack of consensus on the relevance of spirituality in mental health care: *“I think psychiatry remains quite split – but a significant proportion of psychiatrists either see no role for religion/spirituality, or actively oppose it. I have heard plenty of comments over time, labelling any spiritual experiences as part of an illness”*.

Furthermore, in one section mental health professionals were asked to discuss their own cases confidentially, interestingly many of these were similar in content to the

cases in the vignettes, indicating that these issues do arise in practice for many mental health professionals (See Appendix 3.2).

Finally, participants raised the issue of training. Although there no explicit question about whether mental health professionals would like training, responses included *“training not ‘covered’, briefly mentioned, at times, I felt as if covered as a ‘by the way’ not as much importance emphasised. Merely to meet ‘certain criteria’ of topics covered”*. These are all evidence of the uncertainty and diversity of professionals toward training (See appendix 3.2).

Further themes: pathologisers and spiritualisers

An interesting anomaly was that some participants did not conform to the ‘norm’. For example, as stated previously, one clinical psychologist believed Anne would benefit from hospitalization. Non-conformists were identified by assigning Tony, Carl, Beryl and Anne a rating of 1 for each vignette they rated opposite to the norm, and 0 for every vignette they rated the same. Each participant was then given a ranked overall score. Participants that rated Carl and Tony as high on spirituality (spiritualisers) were grouped and participants that rated Anne and Beryl as low on spirituality (pathologisers) were grouped. (See Appendix 3.3). There were 13 spiritualisers (of these over half of the sample (8) only rated one vignette (Carl or Tony) as either having a common spiritual experience or not having a mental health problem) and 50 pathologisers (of these, nearly half the sample (24) only rated one vignette (Anne or Beryl) as either not having a common spiritual experience or having a mental health problem). The top 10 from each group were explored.

After both authors' verified the transcripts, the following themes emerged from both groups (See Appendix 3.3), it is important to note that there was overlap between these groups and therefore, these categories must be treated with caution. However, the spiritualisers group tended to use a more normalising language "*Don't assume it's a problem for somebody or something that needs to be changed*". They also referred to the psychological aspect of person "*He had very low opinion of self*", the individual's understanding of their experience, "*I'd be looking at the sense they made of it, how they'd integrated it into their lives, what changes might have followed, whether they saw it as enriching or enhancing their lives or solely in a negative way and whether any life changes were perceived as meaningful and valued*", the cultural perspective "*socio cultural acceptance varies widely*".

The pathologisers group tended to take a more medical perspective "*Only in my experience of working with client who had psychotic symptoms with spiritual interpretations*", using more diagnostic terminology like psychosis "*history of psychosis*" and schizophrenia "*exhibits positive and negative symptoms of schizophrenia*" and words like malingering, "*likelihood that he's malingering to escape the consequences for whatever he's been convicted for*", there was also far more reference to the role drugs might have played in the experience "*drug use or a history of 'symptoms' which could be indicative of mental health problems.*" These all seemed to cluster around a more fact based, medical understanding of peoples' experiences.

Both groups made similar reference to a person's feelings "*anxiety related to being alone*", however, the pathologisers groups' answers related to the feeling/affect tended to originate from one participant, a clinical psychologist. The spiritualisers

group's responses tended to cluster around an individual experience, feeling based perspective. Interestingly all of these responses were relatively evenly distributed across occupational groups.

Discussion

Eeles et al (2003) examined the criteria that nurses used to evaluate spiritual-type experiences reported by patients and their own experiences of spirituality. They found the outcome of the experience (either positive or negative) was an important evaluative factor, together with the personal and cultural context in which the experience occurred. The present study expanded on their exploratory study using three groups of mental health professionals: psychiatrists; nurses; and clinical psychologists.

The results were predominantly in line with the original hypotheses that there would be a gender difference in response to the questionnaires; that participants who expressed openness to spirituality (as rated on the Expressions of Spirituality Inventory) would be more likely to rate the vignettes as common spiritual experiences; and that the vignettes with more distressing/negative content would be rated more often as involving a mental health problem.

Interestingly the finding that males are significantly more confident that they can tell the difference between a mental health problem and a spiritual experience was not what was expected when the hypotheses were initially stated. Although the whole study was exploratory, there was an underlying expectation that the differences would be found between occupational groups based on the models that each group generally adopt and therefore that psychiatrists, who would generally subscribe to the medical

model, would be less 'spiritually oriented' than nurses and clinical psychologists.

However, psychiatrists were found to be the most spiritual/religious of the sample (See Table 1 and 4), scoring higher (although not significantly) than nurses and clinical psychologists on measures of COS, EPD and REL. Furthermore, the finding that psychiatrists, who were predominantly male, were the most spiritual/religious of the sample suggests that religious affiliation rather than gender may account for the finding that males were significantly more confident that they could tell the difference between a mental health problem and a spiritual experience.

The finding that there was a relationship between participants' ratings on ESI and their rating the vignettes as a spiritual experience was not very strong, the correlation was relatively small (.30), indicating that within the data there was more than simply a relationship between these two variables. Eeles et al (2003) proposed the reason for the discrepancy between their findings and Sanderson (1999), might have been their use of a Likert scale. Additionally Sanderson's use of the construct "religion" with various references to the Christian bible, and their use of increasingly negative vignettes which Eeles et al (2003) believed were confounded with cultural beliefs may also have restricted the responses of the participants. Therefore the reason for the present study's discrepant results could be due to the limitations of using a restrictive, Likert scale as measurement and the use of a quantitative measure of spirituality, which was arguably biased toward measuring a monotheistic notion of spirituality/religion.

There was a clear finding of a relationship between mental health problems and rating the vignettes as distressing. As expected, Carl and Tony were rated as having

mental health problems. These results mirror those of Eeles et al (2003) that the personal biases of the participants, appeared to influence some of the responses they made to the vignettes. Therefore to investigate this personal bias more fully is crucial for future research.

The power calculation showed the need for between 150 and 200 participants. The sample size was 98 and this may have impacted on the results. Furthermore the present study included a potential unrepresentative sample, as only 13% of the mental health professionals surveyed returned the questionnaire (Shaw, 1975). These limitations need to be taken into consideration when interpreting the results.

Eeles et al (2003) used a qualitative approach with a selection of vignettes, which were deliberately difficult to categorise as benign or pathological. Using a more exploratory approach similar to Eeles et al, would have enabled deeper investigation of the relationship between psychosis and spirituality, in both service user and mental health professional.

The qualitative analysis that was conducted, added some depth and richness to the quantitative data, however, this was restricted due to limitations of the responses via questionnaire. In line with Eeles et al, mental health professionals were likely to consider the outcome of the experience; the nature; the context and the explanatory modes of the vignettes when making their evaluation.

There was also the difficulty translating Eeles et al semi structured interview into a quantitatively measurable self-report scale, as the final data was predominantly ordinal and therefore not suitable for factor analysis or parametric testing. This may have reduced the robustness of the findings. However, the qualitative element, which

would have been interesting to expand upon, enabled a certain degree of cross validation with the quantitative data.

In the present study, further exploration of the responses to the questionnaires allowed a distinction to be drawn between; “spiritualisers” and “pathologisers” who used different language when discussing the vignettes. There was a tendency for spiritualisers to use more affect based language, and pathologisers a more medical language. The lack of awareness training in spirituality/religion was highlighted by some participants. Meeting this need will be crucial for the future of a more person-centred, meaning based approach to mental health difficulties.

Future research would benefit from more in-depth qualitative analysis around: training issues; further understanding of the differences between gender; and the relationship between mental health professionals spirituality and that of service users.

Finally, it would be useful to conduct a randomised control trial to investigate whether awareness training leads to changes on measures of spirituality and mental health professionals’ perspectives (using the PSE perhaps) of service users. These recommendations would benefit from user involvement at all stages.

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Table 1. *Sample characteristics of participants*

	Psychiatrist		Nurse		Clinical Psych	
Male -1	82%		30%		26%	
Female -2	18%		70%		74%	
Age range						
20-30	6%		14%		16%	
31-40	41%		30%		29%	
41-50	29%		42%		37%	
51+	24%		14%		18%	
Years experience						
0-5	6%		19%		27%	
6-10	41%		17%		20%	
11-15	12%		22%		20%	
16+	41%		42%		33%	
Received training						
Yes	44%		36%		25%	
No	56%		64%		75%	
Christian	47%		9%		45%	
Non-Christian	29%		23%		10%	
No religion	24%		68%		45%	
Cognitive Orientation	Mean Rank					
To Spirituality	62.25		40.57		51.27	
Experiential	60.25		46.24		46.49	
Phenomenological						
Dimension						
Religiousness	59.19		44.76		48.86	
Tell the difference?	66.03		47.74		44.59	
Spiritual experience = pathology?	45.15		55.19		46.40	
MHP	40.06		49.85		48.32	
SPIRIT	48.53		50.29		45.94	
Hospitalized	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
Anne		100%		100%	2%	98%
Carl	50%	50%	57%	43%	18%	82%
Diane		100%	6%	94%		100%
Tony	13%	97%	42%	56%	8%	92%
Beryl		100%	6%	94%		100%
Evelyn		100%		100%		100%
Treatment	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
Anne	27%	73%	7%	93%	5%	95%
Carl	100%		100%		97%	3%
Diane	37%	63%	30%	70%	17%	83%
Tony	87%	13%	94%	6%	97%	3%
Beryl	13%	87%	6%	94%	2%	98%
Evelyn	13%	87%	41%	59%	18%	82%

Table 2

Frequency Tables

Spiritual experience

Definitely and probably disagree

Q	Frequency	Percent
15 Carl	88	91
17 Tony	77	79
16 Diane	59	48
19 Evelyn	46	47
14 Anne	40	41
18 Beryl	24	25

Definitely and probably agree

Q	Frequency	Percent
18 Beryl	42	43
14 Anne	28	29
16 Diane	30	25
19 Evelyn	15	15
17 Tony	8	8
15 Carl	3	2

Mental health problem

Definitely and probably disagree

Q	Frequency	Percent
8 Beryl	66	67
14 Anne	47	48.
16 Diane	40	41
19 Evelyn	39	40
17 Tony	5	5
15 Carl	1	1

Definitely and probably agree

Q	Frequency	Percent
15 Carl	91	94
17 Tony	76	77
16 Diane	21	22
19 Evelyn	15	15
14 Anne	15	15
18 Beryl	8	8

Table 3.*Correlations between major variables*

	1	2	3	4	5	6	7	8	9
1= Occupation	1.000								
	N	.98							
2= Gender	.34**	1.000							
		.00							
	N	.93	.93						
3= spiritual exp = pathology	-.06	-.13	1.000						
		.58	.21						
	N	.98	.93	.98					
4= tell difference between spirituality & psychosis?	-.25*	-.37**	-.031	1.000					
		.02	.00	.76					
	N	.98	.93	.98	.98				
5= Cognitive Orientation to Spirituality	-.02	-.01	-.37**	.11	1.000				
		.83	.87	.00	.28				
	N	.97	.92	.97	.97	.97			
6= Experiential Phenomenological Dimension	-.11	-.08	-.18	.09	.62**	1.000			
		.28	.46	.08	.38	.00			
	N	.97	.92	.97	.97	.97	.97		
7= Religiousness	-.06	-.09	-.21*	.14	.74**	.46**	1.000		
		.52	.37	.04	.18	.00	.00		
	N	.97	.92	.97	.97	.97	.97	.97	
8= SPIRIT	-.06	.02	-.05	-.16	.31**	.30**	.123	1.000	
		.57	.86	.64	.12	.00	.00	.24	
	N	.95	.90	.95	.95	.94	.94	.94	.94
9= MHP	.07	-.20	.28**	.08	-.23*	-.18	-.06	-.23*	1.000
		.50	.06	.01	.47	.03	.09	.56	.03
	N	.94	.89	.94	.94	.93	.93	.93	.93

* Correlation is significant at the .05 level (2 tailed). ** Correlation is significant at the .005 level (2-tailed)

Table 4*Descriptive Statistics for the ESI-Revised Dimensions for present study - Psychiatrists*

	COS	EPD	EWB	PAR	REL
No# of Items	6	6	6	6	6
Mean	15.50	8.75	15.28	7.87	11.69
S.D	7.68	5.37	2.38	3.90	8.26
Range	0-24	0-24	0-24	0-24	0-24

N = 16*Descriptive Statistics for the ESI-Revised Dimensions for present study - Nurses*

	COS	EPD	EWB	PAR	REL
No# of Items	6	6	6	6	6
Mean	10.76	6.38	14.21	8.73	7.37
S.D	6.00	6.21	1.76	4.15	5.23
Range	0-24	0-24	0-24	0-24	0-24

N = 37*Descriptive Statistics for the ESI-Revised Dimensions for present study – Clinical psychologists*

	COS	EPD	EWB	PAR	REL
No# of Items	6	6	6	6	6
Mean	13.20	6.69	13.99	7.95	8.61
S.D	5.90	4.95	1.69	3.15	6.45
Range	0-24	0-24	0-24	0-24	0-24

N = 44

Descriptive Statistics for the ESI-Revised Dimensions (Macdonald, 2000)

	COS	EPD	EWB	PAR	REL
No# of Items	6	6	6	6	6
Mean	14.39	9.89	14.94	12.47	13.61
S.D	4.96	4.75	4.52	5.14	5.81
Range	0-24	0-24	0-24	0-24	0-24

N = 938

APPENDIX 3.1: GUIDELINES FOR CONTRIBUTORS

Philosophy, Psychiatry & Psychology

Guidelines for Contributors

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Daubert v. Merrell Dow Pharmaceuticals, Inc. 1993. 509 U.S. 579.

Jackson, M., and K. W. M. Fulford. 1997. Spiritual experience and psychopathology. *Philosophy, Psychiatry, & Psychology* 4, no. 1:87-89.

Koenig, H. G. ed. 1998. *Handbook of religion and mental health*. San Diego, CA: Academic Press.

Piaget, J. 1937/1954. *The construction of reality in the child*, trans. M. Cook. New York: Basic Books.

Twycross, R. G. 1995. Where there is hope, there is life: A view from the hospice. In *Euthanasia examined*, ed. J. Keown, 141-68. Cambridge: Cambridge University Press.

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APPENDIX 3.2 – QUALITATIVE THEMES

Eeles et al 2003 themes

Outcome of experience

In the Eeles study, the main sub-themes of ‘outcome of experience’ which emerged were distress, functioning, risk, anxiety, emotional and fear. In this sample distress, risk and functioning appeared to be major concerns to the participants. For example, as a general answer to question 20, regarding evaluation, a nurse stated *“The outcome and the level of distress is also relevant and effects my evaluation.”* A clinical psychologist stated: *“I think a key thing is how well people are functioning in their daily life. I personally know many people from my childhood who would report hearing/talking to God on a regular basis, seeing signs etc – these people appeared very content and functioned extremely well on a daily basis”*. And another clinical psychologist stated: *“It seems from the above vignette that Anne is functioning well in her life (i.e. completed a Masters). However, I would want further information, to confirm that she is functioning well in all areas of her life”*. Risk assessment was referred to regularly throughout the questionnaire.

Nature of experience

These sub-themes from Eeles et al. included psychosis; positive; negative; control; conviction; frequency; duration. The main areas of similarity to Eeles et al, were psychosis, positive and negative experience, and degree of control and conviction. Psychosis was discussed in relation to other areas of functioning, culture and the effect

of time. For example: a clinical psychologist wrote that “*a good differentiation between psychosis and genuine relig/spirit experience is, that in the latter the patient shows coherence and ego strength in the other areas of life (family, job etc)*”. A nurse stated that it is “*Important to keep an open mind – treated for psychotic illness, but psychosis often has basis in person’s real experience/cultural aspect*”. And finally, a psychiatrist stated that “*Psychosis often becomes more malignant with time*”.

The impact of positive and negative experiences was discussed with regard to quality of life. A clinical psychologist stated that “*I would like to know the quality of their daily life, their ego strength, their coping mechanisms etc. If these are positive, the odds of a mental health problem diminish*” and outcome of experience, a nurse wrote that “*people with positive outcomes to unusual experiences do not need intervention*”.

In relation to amount of control, a clinical psychologist answered question 20a (how much would the amount of religious involvement affect your assessment?) with “*If socialised into religion from childhood belief structure may be different, amount of control (perceived) within the religious context.*” Conviction was mentioned, a response by a psychiatrist to the vignette of Diane: “*her degree of conviction that she is in fact God*”.

Context of experience

These sub-themes from Eeles et al. included: culture; religious/spiritual involvement; background history (family, psychiatric, developmental); behaviour (dramatic change; bizarre); Situation: (emotional, physical). The context of the

experience was predominantly focused on family history and change. A psychiatrist: “*The opinions of his family, friends and work colleagues*” and a clinical psychologist wrote: *I’d be looking at the sense they made of it, how they’d integrated it into their lives, what changes might have followed, whether they saw it as enriching or enhancing their lives or solely in a negative way and whether any life changes”.*

Explanatory modes

Again, these sub-themes from Eeles et al. included: physical; psychological; illness; medical; spiritual beliefs; bias understanding (spiritual experiences); feelings about person. Two areas feeling about the person and understanding the clients’ experiences came up repeatedly for example; a psychiatrist stated: *Yes, the level of ‘Alien’ experience would affect my judgement (e.g. a feeling of spirituality being far less problematic than God talking through the TV set.* A clinical psychologist: “*By understanding the clients’ life experiences I have never yet failed in being able to see a link between the client’s past and the current experiences which usually serve a ‘function’ for the client or delusions/hallucinations which seem to take on a symbolic quality of representing psychological ‘dilemmas’.*”

Further themes

Drug use

Drug use was mentioned briefly in the Eeles paper, however, in this study, drug use, particularly in relation to Carl, Tony, Diane and Anne was regularly mentioned.

However, interestingly, although medication use/misuse was mentioned, the effects of

side effects of medication were not and this could be a determining factor in some behaviours.

Mental health professionals own spirituality

Psychiatrist: *“I do pray myself for guidance in work and for patients”*

Psychiatrist: *“As I get older, and possibly wiser, I feel less inclined to judge whether a spiritual experience is ‘real’ or not. I continue to learn from patients and seek to discover a kind of truth between us rather than collude with a set of beliefs outside that context. As a psychiatrist working in this way I would like to think I am some kind of non-denominational spiritual healer”*

“You may have gathered that I ended up irritated by this. I really don’t think it’s an issue any more than political belief is. I don’t ignore peoples spiritual life, but I don’t share it and it has no place in mental health work. People who do bring their religion to work end up in trouble, in my experience (I say this as someone who has shared a catchment area with two consultant psychiatrists who were born again Christians, and with whom I had both a good professional relationship and a friendship)

Collaboration

A Psychoanalyst/Psychotherapist stated: *“Prior to my analytic training I trained as a doctor and worked in general psychiatry so we did cover delusional and hallucinatory experience in some detail and we had input from local clergy plus some of the psychiatrists training us were also Christians”.*

Unknown: *“Many ‘moons’ ago we had several discussions/debates with several religious leaders – where explored issues of religion, spirituality and mental and physical health with us – as well as care of the dying and terminally ill”.*

Different perspectives

Psychiatrist: *“I think psychiatry remains quite split – but a significant proportion of psychiatrists either see no role for religion/spirituality, or actively opposed to it. I have heard plenty of comments over time, labelling any spiritual experiences as part of an illness.*

Psychiatrist: *“But the area should be explored if we are to treat people holistically, and help understand them better. The case scenarios (which I suspect are deliberately a bit vague and lacking in background information) are indicative of the fact that a lot of people do have experiences they would describe as spiritual and these must not be labelled as mental illness”.*

Psychiatrist: *“I am aware that I am living in Christian country which is not my faith. I believe that only possible way to improve here is that state should not adopt single faith in modern societies and let people choose on their own. Most of European countries are still struggling because of their insistence on being Christian states although we know pretty well that they have lot of horrible things in last century in name of Christianity”.*

Nurse: *“People have to look at the whole picture of the individual. It also depends on what level of distress the experience is doing to the individual. Also if it affects there*

day to day living. I also think it depends on the person's culture. Example in certain countries it can be deemed gifted to hear voices".

Assessment

Risk assessment and mental health assessments were mentioned regularly, however, a few participants mentioned making a spiritual assessment:

Psychiatrist: *"Taking a 'spiritual history' helps – finding out that person's religious background, if any, what ideas and beliefs they have/had"*

Psychiatrist: *I am a humanist/atheist, but I don't let my own beliefs impinge on the assessment and treatment of patients. Also I respect that patients own spiritual beliefs and in complex cases I have involved the priest of their own religious order to be involved the assessment and treatment of patients.*

Nurse: *"Spirituality is an important component in holistic assessments"*

Psychiatrist: *"full detailed psychiatric and psychological assessment, exploring past, present history, views beliefs etc. excluding biochemical or pathological causation etc".*

P-S type experiences

Clinical psychologist: *"Elderly person speaking and hearing God's voice. Felt that God was communicating through them, Had a strongly religious upbringing with God being a significant feature"*

Nurse: *“An individual who has strong religious faith, presents as being not only ‘a loner’ but lonely, very lonely. Individual has experienced angels being present in the bedroom”*

Psychiatrist: *“Severely psychotic young man..... Believes he can talk to and hear his grandfather in heaven, also has a ‘girlfriend’ in heaven who has a name and is an angel. These two relationships give him great comfort”*

Training/awareness

Previous training

A psychiatrist stated *“training re trans cultural psychiatry. no specific training that I can recall about religious psychotic experiences”*. A psychiatrist stated: *we did cover delusional and hallucinatory experience in some detail and we had input from local clergy plus some of the psychiatrists training us were also Christians. A clinical psychologist stated that: “Although it wasn’t covered in my training, spirituality is an increasingly important area of my life and I have expanded my knowledge of different belief systems etc. which means I’d be less ‘panicky’ about clients discussing this kind of thing. Although I work mainly with a non-psychiatric client group, I often explore spiritual/religious beliefs and values with clients in therapy.”* Another clinical psychologist stated with regard to specific training: *“not in basic training but obviously in CPD since or I wouldn’t know about them now!”* A nurse stated: *“I was encouraged during my training to adhere to my approach that “spirituality” and “religion” were not just boxes to be ticked on a form. Classroom discussions provided an open-minded forum for all opinions to be aired. The inclusion of spiritual matters in essays was treated with respect by the tutors”*.

A nurse stated that *“I was encouraged during my training to adhere to my approach that "spirituality" and "religion" were not just boxes to be ticked on a form. Classroom discussions provided an open-minded forum for all opinions to be aired. The inclusion of spiritual matters in essays was treated with respect by the tutors”*.

Clinical psychologist: *“Can’t remember – but assume they were”*

Clinical psychologist: *“Probably all at some point”*

Psychiatrist: *“Undergraduate- briefly as a part of General Practice experience as part of multi-cultural awareness. Postgraduate – as part of psychotherapy training. Continuing Professional Development – as part of multi-cultural awareness”*.

Nurse: *“Very briefly (1 session) basically about having respect for various religious and spiritual beliefs”*.

Nurse: *“It was touched on”*

Nurse: *“Trained in area with large ethnic minority community of various religious beliefs and upheld cultural traditions all these had to be know before assessment”*

Training needs

A psychiatrist stated that *“I got very good training in India on that and see lack of this in UK”*.

A clinical psychologist stated that *“None of these incidents/experiences were covered in my training and in my current work I never see people with such experience – work in paediatrics”*.

Clinical psychologist *“I feel a bit out of my depth here and have already identified it as an area for CPD”*

Clinical psychologist: *“Not yet!”*

Clinical psychologist: *“Some by Mike Jackson, but could do with more”*

APPENDIX 3.3: FURTHER QUALITATIVE THEMES**Pathologisers**

Coding Manual

Code #	Code	Description of Code	Example
1	Symptom/ First rank/ hallucinations Delusions	Reference to symptoms	<p>“I never make a diagnosis on the basis of ONE symptom or experience alone!! She’d need other symptoms to be diagnosed as mentally ill “</p> <p>“more likely to be ill than Anne, has more symptoms already”</p> <p>“Exhibits positive and negative symptoms of schizophrenia”</p> <p>“drug use or a history of ‘symptoms’ which could be indicative of mental health problems”</p> <p>“Possibility of first rank symptoms”</p>
2	Psychosis Schizophrenia Schizotypy	Reference to disorders	<p>“young psychotic woman felt connected to everything/everyone</p> <p>“part of schizophrenia”</p> <p>“classical symptoms: passivity, hallucinations, delusions, language disorder”</p> <p>“No psychotic Symptoms”</p> <p>“Severely psychotic young man who I have seen for about 10 years”</p> <p>“Symptom of psychosis exacerbated by long term history of interpreting experiences in these terms”</p> <p>“Experiences were very typical of those associated with psychosis and consistent with other unusual experiences that the same individual interpreted in non-spiritual but nevertheless implausible terms e.g. alien abduction”</p> <p>“But then religious beliefs can</p>

			<p>support psychotic beliefs and delusions</p> <p>A If client has no religious involvement or conviction, might be more inclined to interpret as psychotic?"</p> <p>"Only in my experience of working with client who had psychotic symptoms with spiritual interpretations (on PSI for psychosis placement)"</p>
3	Medical/ Treatment/ Diagnosis/ Drug/s illness	Reference to medical language	<p>"any existing medical condition or problem"</p> <p>"Drug use, history of experience, age, family, history of psychosis"</p> <p>"Mental illness"</p> <p>"Needs proper assessment to clarify if she is ill, I suspect not"</p> <p>"Patient suffering from psychotic disorder and auditory hallucinations"</p> <p>"Symptoms responded to antipsychotic medication"</p> <p>"Temporal lobe dysfunction"</p> <p>"They are psychotic symptoms in the context of chronic schizophrenia but they do not trouble him. They are part of a coping mechanism for this man who has suffered greatly through his illness".</p>
4	malingering		"likelihood that he's malingering to escape the consequences for whatever he's been convicted for"
5	Bizarre content		"less likely to pathologies if content is less 'bizarre'"
6	Family/psychiatric history/ assessment	Reference to family history of psychosis	<p>"Age of onset, family history of psychosis?"</p> <p>"I would want to take a full psychiatric history – i.e. past medical and psychiatric history, family and personal history, social history. This would enable me to understand the context of these symptoms in her life and whether</p>

			<p>there were any symptoms of a psychiatric nature”.</p> <p>“Hx of schizophrena with family history”</p> <p>“Full personal medical family etc. history. Meds alcohol and substance abuse, other schizotypal experiences?”</p>
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NB: Colour denotes different participants

Spiritualisers

Coding Manual

Code #	Code	Description of Code	Example
1	Psychological/	Describing in psychological terms	<p>“possible psychological therapy to manage them and the psychological distress”</p> <p>“What evidence does he have that his new wife is ‘demonic’”</p> <p>“That these events were real to the client and may have been as s result of learning from early childhood (mother also believed similar)”</p>
2	Trauma/abuse	Trauma, Previous history of abuse	<p>“the history would make me suspect abuse”</p>
3	Individual/understanding	Taking individual’s perspective Trying to understand from individual’s point of view	<p>“impact on the individual”</p> <p>“don’t assume it’s a problem for somebody or something that needs to be changed”</p> <p>“her perceptions of her experiences”</p> <p>“her understanding of healing what is it that happens, other explanations she thought of”</p> <p>“if it is in a context where response feels fulfilling and solves past problems”</p> <p>“she seems to have made sense of her experience via her personal</p>

			<p>belief systems and there is nothing to indicate distress or problems in her functioning etc.”</p> <p>“It probably wouldn’t affect it very greatly but might help with gaining insight and understanding into the clients view of life, the world etc”</p> <p>“does she see it as a problem?”</p> <p>“made sense in the light of her previous experience of care”</p> <p>“Individual perception of own mental state past and present. Are any problems fo the individual arisign from these experiences? “</p> <p>“Own perception of mental state past/present”</p> <p>“Their own perception/interpretation”</p> <p>“Yes whether this experiences has had any negative impact on Anne’s life and whether she perceives this as a positive or negative life changing event”</p>
4	Cultural/ Family/ Community/ relationships Perspectives	Cultural perspectives Family/community/ relationship view	<p>“any negative impact on interpersonal relationship”</p> <p>“what support there is for him”</p> <p>“depend on validation and security of family/community</p> <p>“do others see it as a problem?”</p> <p>“Friends family concerned?”</p> <p>“Client also embraced gothic culture”</p> <p>“cultural norms, discussion with people of similar faith”</p> <p>“success or otherwise in masters might help to determine socio-cultural appropriateness of her ideas”</p> <p>“most especially is she happy with the way things are at the moment, and do others around her feel that way as well?”</p>
5	Feeling/ Emotion/ person	Feelings and emotions of person	<p>“Yet this experience is very common and seems to be part of human’s need to believe in some higher being. Psychotic experience are exaggeration of this”</p> <p>“the Jesus/demon explanantion made</p>

			<p>him feel special at a time when he was very low.”</p> <p>“the promise by faiths to make things or if you just believe and follow the path is tempting for people with emotional difficulties. Helps people feel important/loved”</p> <p>“I’d want to know more about the ‘other voices’ that can make him angry and upset and why they induce this reaction”</p> <p>“An individual who has strong religious faith, presents as being not only ‘a loner’ but lonely, <u>very</u> lonely”</p> <p>“Anxiety related to being alone seemed to exacerbate experience”</p> <p>“effect on his mood”</p>
6	Di/ stress	Level of distress/ Stress vulnerability	<p>“extremely distressing to clients involved”</p> <p>“impact on self and psychological distress or not”</p> <p>“certain phenomena under situations of extreme stress”</p> <p>“psychological distress”</p> <p>“He had a very low opinion of self, social problems fear of intrusion by others and the distress it was causing him.”</p> <p>“her experiences are not causing her distress”</p> <p>“it would probably strongly affect the evaluation e.g. whether the person resolved it/integrated into their view of themselves, their lives etc. or whether they were persistently distressed by it.”</p> <p>“is she worried or distressed”</p> <p>“I would like to know more about the explanation for misery and suffering. What distresses him about the voices”</p>
7	continuum	Reference to continuum,	<p>“As the experiences described were part of a larger process of transition</p>

		'normality' of experience	and change in her life and have led her to changes on her life she regards as meaningful and enriching I would not see the need to evaluate her mental health".
9	Spiritual/ Religious beliefs	Reference to spiritual beliefs, experience	"I would be interested to explore his spiritual beliefs in the past and present" "Previous religious experience, positive value of current experiences"
10	Value/ Meaning/ Quality of life	Reference to the meaning experience has in person's life	"I'd want to know more about his life generally, how he functioned in different life areas and whether he thought these experiences were preventing him from leading a meaningful life". "I can see no reason for her to be in a psychiatric mental health system. She has altered her life in response to what she believes a guidance from a higher power and appears to be working well as a spiritual teacher/advisor doing something she presumably values and gives her life meaning. I can see no reason to pathologies this by assessing m.h" "I'd be looking at the sense they made of it, how they'd integrated it into their lives, what changes might have followed, whether they saw it as enriching or enhancing their lives or solely in a negative way and whether any life changes were perceived as meaningful and valued." "if client's life not adversely affected by experience then would be less concerned"

NB: Colour denotes different participants

**SECTION FOUR – CONTRIBUTIONS TO THEORY,
CLINICAL PRACTICE AND LEARNING**

Contributions to Theory, Clinical Practice, and Learning*Implications for future research and theory development*

The present study attempted to investigate mental health professionals' perspectives, of their own and service users' spirituality. The results were in line with the original hypothesis that mental health professionals' own beliefs seem to impact on their judgements of service users' difficulties. This finding mirrors that of other studies Eeles, Lowe & Wellman (2003) and Sanderson, Vandenberg & Paese (1999). Based on the medical model's premise that mental health problems can be accurately measured and are ultimately diagnosable, the findings of this and other studies calls into question the validity and meaning of this approach to mental health difficulties.

The following areas would be fruitful to investigate further: in-depth qualitative interviews with mental health professionals exploring issues of spirituality from their own and service users' perspectives; the recent models from Jackson (2001) and Clarke (2001); the impact of training mental health professionals (possibly with spiritual leaders and service users) and any change in perspective towards service users as a result;

Expanding on Crossley & Salter (2005) themes of "spirituality as an elusive concept" and "finding harmony with spiritual beliefs" exploratory in-depth qualitative interviews could be conducted with clinical psychologists, other mental health professionals and service users. These could explore issues of spirituality from their own and service users' perspectives using the same vignettes in the present study and exploring the area of diagnosis and judgement, much like the themes in the Eeles (2003) study of outcome; nature; context; and explanatory mode of experience and clinical psychologists'

fears and difficulties around spirituality and religion. Additional areas to investigate would be training issues; and exploration of clinical psychology trainees' perspectives; clinical psychologists' use of their own spiritual practices with service users and as a way of helping them with their work; and the use of collaborative working with clergy/spiritual leaders. This last point leads on to an interesting area of investigation, how clergy/spiritual leaders would respond to the questionnaire in the present study (Domino, 1990).

There were striking similarities between the service user led search for meaning model of Macmin & Foskett (2004) and Jackson's (2001) problem solving model, implying that both are meaningful ways for service users to make sense of their experiences. However, these models are derived from different philosophical perspectives, the latter explaining the experiences as solutions to stress after trauma and the former, as a search for meaning, incorporating trauma, yet proposing that these experiences are more than just problem solving. Further exploration of both the 'problem solving model' (Jackson, 2001) and the 'discontinuity model' (Clarke, 2001), from a service user perspective would be helpful in unpicking the area and clarifying the usefulness of these models in the treatment of mental health difficulties and whether spirituality/psychosis as problem solving or a disjointed perception is relevant for them.

Further research would also be helpful in expanding the findings of Bilgrave and Deluty (2002) that psychologists with Christian beliefs tended to practice from a more cognitive-behavioural perspective, whereas those with more Eastern and mystical beliefs, tended to practice more humanistic and existential orientations. One of the most important findings of the present study was the lack of any systematic awareness training in the area of beliefs/spirituality. Further investigation could adopt a randomised control design and

assigning a matched (no training) control group and a training group. Baich's (1999) method of didactic and interactive teaching methods could be presented to the training group. Pre and post measurement of perspectives on spirituality using the present study's questionnaires, including in-depth interviews with a selection of both the control and training group, would enable investigation into effects of this type of training. All of these recommendations for further research would need to be mindful of service user involvement at all stages.

Due to the word count restrictions and the predominant focus on clinical psychology, the rich area of spirituality and religion in counselling theory (West 2000, 2004), psychodynamic theory (Jung, 1933) and existential theory (Van Deurzen, 2002) was not covered. Further research would benefit from drawing on these and exploring the reflective practitioner model with respect to mental health professionals' spirituality and religion.

Implications for clinical practice

Drawing on the above areas for future research the following are important for future clinical practice: training and awareness-raising and CPD for clinical psychologists; 'new wave' therapies; the recovery model.

Of note in the present study, was the obvious lack of any systematic training of clinical psychologists. Training and awareness raising within clinical psychology programmes would enable future clinical psychologists to understand the impact of spirituality on individuals' and its importance as a diversity issue. This would have a positive impact on the future of clinical psychology as a whole and bring it into line with

the developments already underway in nursing (McSherry, Cash & Ross 2004) and psychiatry (Royal College Psychiatrists Special Interest Group). Based on the ethical guidelines and diversity needs, it will be important for training to take place systematically across the UK's clinical psychology courses. It may not be necessary to have formalised training, but as clinical psychology develops the area of core competencies and reflective practice, the exploration could begin around one's own values and beliefs, thus enabling the service user to have access to theirs.

At a recent Psychosis and Spirituality conference (2006), the question of training arose, and the general consensus was this area needs to be a core part of the discussion between therapist and service user, not an explicit, tick box approach. In line with Pargament, Murray-Swank & Tarakeshwar (2005) and Miller (2000) this training would not need to be rigid, but an awareness raising exercise.

One of the clinical psychologists in the present study stated "*I feel a bit out of my depth here and have already identified it as an area for CPD*", there is a need for awareness-raising and training in CPD for all qualified clinical psychologists. Based on this present study and previous studies (Eeles, 2003; Jackson, 1991, 1997; Crossley & Salter, 2005) it is of concern that some service users are being treated in a certain way due to mental health professionals' prejudice. Jackson (2006) and Clarke (2006) are already implementing training days on the more specific area of spirituality and psychosis for mental health professionals to increase awareness of these issues. (See Appendix 4.1). Another area briefly touched upon was the implementation of a spiritual assessment. Callanan's (2005) recent development of the PIERS assessment is a step in the right direction.

'New wave' of therapies, which incorporate mindfulness as a core component, were also briefly mentioned. Mindfulness has been defined as "paying attention in a particular way: on purpose in the present moment, and non-judgementally" (Kabat-Zinn, 1994). After expanding present research, clinical practice would benefit from incorporating these newer therapies: Acceptance and Commitment Therapy, ACT (Hayes, Strosahl & Wilson, 1999); Dialectical Behaviour Therapy, DBT (Linehan, 1993a&b); Mindfulness Based Cognitive Therapy, MBCT (Segal, Williams & Teasdale, 2002; and Compassionate Mind Therapy (Gilbert, 2005) in a systematic way. What these therapies have in common is the importance of the therapist embodying the simple stance of present moment awareness, in a way that other therapies omit. Recent research by Chadwick, Newman Taylor & Abba (2005) has shown the effectiveness of a form of MBCT with people with a diagnosis of psychosis.

When practicing CBT, the therapist is not challenged to look at their own beliefs, dysfunctional assumptions and negative automatic thoughts (although many choose to). In mindfulness based therapies the therapist is required to become present with themselves, notice thoughts and feelings as they arise and practice accepting the moment as it is. Working in an adolescent in-patient unit where DBT is one of the main psychological therapies, it was heartening to see so many of the team engaging in the philosophical aspects of the approach. I observed that this strengthened the team and helped the young people see the benefits of present moment awareness and acceptance of what is, in action.

Only ten years ago it was almost unheard of to talk about recovery in serious mental illness, and as this study has focused specifically on psychosis and spirituality, the final recommendation for future clinical practice is integrating a more positive approach to

mental health difficulties in general and serious mental illness in particular. Moving towards a model of recovery and hope, and embracing a perspective which can incorporate this concept of change. That is not to speak lightly of the damage and distress mental health difficulties can create for an individual. However, more focus on creativity, music, dance, drama and poetry are all ways in which therapy can enable an exploration of what is 'right' for the individual. With so much focus on what is wrong, based on a particular world view, there is often little room for these creative ways of working with individuals. Bentall (1996) proposed his model of cognitive health, needs to be the starting point of any model of dysfunction. Therefore more focus from mental health professionals on what sustains the individual and what helps them cope would be helpful. This brings us back to the aim of this thesis, that so often, it appears that spirituality and religion are part of the solution, part of the positive aspect of an individual's experience (Martyn, 2005). Rufus May (2006) a clinical psychologist in Bradford has been running recovery groups, focusing on hope and compassion with people with a diagnosis of psychosis.

Using the terminology of Dialectical Behaviour therapy, that incorporates spiritual/mindfulness practices, services and service users need to come to a synthesis between two opposing view points – illness and wellness in all individuals – and accept the concept of a continuum, and be open to the possibility that acceptance of both is possible within any given moment.

Process/personal issues arising from the conduct of the research

Where do I start! The experience of writing a Large Scale Research Project was similar to my experience of the very challenging pregnancy and the birth of my son. I

knew at one level that all was going to be ok, that I would “get through it”, but the actual experience on a day to day basis was sometimes excruciating. The fear that it would not be what I wanted, that I would fail and that I would just not make it to the end was constant. Plus, there was a certain amount of evidence to back up my fears from a previous PhD which was near completion when personal circumstances stopped it from being completed.

The whole process was an exercise in paper, ideas and computer file management. I so often wanted to expand on areas and subsequently found myself lost down more than one alleyway, chasing an idea that was not the focus of the review or empirical paper. Because the area of spirituality in mental health care is wide and fragmented, with different philosophical perspectives, I was very mindful of keeping to the key areas of clinical psychology, theory, research and practice. Sometimes I was able to do this, at others I was less successful. However, drawing on perspectives from other disciplines enabled a clearer understanding of the area and also showed how clinical psychology has a long way to go in integrating a spiritual perspective in practice and training.

The topic I chose was very relevant to my clinical practice, choosing an area that was both intriguing to me psychosis, and relevant to me, spirituality. I was able to utilise my own spiritual practice of mindfulness as a way of managing the increase in stress (which is an understatement). At the same time as working on this, I was challenged with my husband having a serious accident, necessitating him being at home for over one year. This, coupled with the demands of my four year old, really enabled me to practice acceptance and being present with what I was facing. This was successful some of the time, however, I have to be honest and say that rather less helpful strategies like nicotine, alcohol and caffeine were also employed at times!

I have found the process frustrating, especially, when reading through the qualitative responses of mental health professionals and wanting to know more about their answers. For example, what did the clinical psychologist mean when he wrote “*difficult area to talk about ‘words are a source of misunderstanding’ (The Little Prince)*”, or the psychiatrist mean when he said, “*As a psychiatrist working in this way I would like to think I am some kind of non-denominational spiritual healer*”. I would have liked to ask about whether mental health professionals make decisions within a multi-disciplinary team, why nurses seemed to make the least use of the open ended questions and why the psychiatrists appeared to be the most spiritual/religious of the sample. The list goes on.....answers to these questions and the ability to have a face to face, real time, real life contact would have enabled a clearer picture of mental health professionals’ perspectives. Just reading paper, and collating numbers as a way of measuring a subtle (and unable to grasp) concept such as spirituality and of course psychosis leaves out the richness, the quality and the opportunity to explore this area more fully.

Interestingly however, although I am a strong advocate of the person’s point of view and the “idea” of qualitative analysis, when it actually came down to exploring the data that I did have in the open ended questions, I found the process very challenging and quite difficult not to keep trying to put everything into numbers. I found it difficult to let go of the sides and just go for it and use a less logical and more intuitive perspective. This realisation both surprised and challenged me.

I also found that the process of writing was very elongated, a process rather than a finality. I still consider the work incomplete, and could, if left to it, continue to make corrections until the end of my days. If I could do it over again I would laugh a little more,

and not take the whole experience so very seriously, not to say that the subject area isn't serious, just my approach could have been more exploratory and fun, rather than 'hold onto the sides and bite your lip' or else it will not happen. And however much I have found the experience quite challenging, I'm sure, in time I will be able to look back on it with fondness.

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APPENDIX 4.1:RECOMMENDATIONS FOR TRAINING

Recommendations for training (taken from Clarke, 2006)

Workshop for mental health professionals highlighted the following needs:

- Disapproval of staff expressing interest in spirituality from other staff
- Staff found peoples' religious concerns hard to handle.
- Patients are afraid to talk about it – talked about as a symptom.
- Inconsistent approaches
- Where staff canvass their beliefs with service users, other staff do not feel confident to tackle this abuse of vulnerable individuals.

It was felt that opening this discussion would result in the following benefits:

- Recovery acknowledges spirituality as an important element in supporting the service user to make sense of their situation in a positive manner.
- Increased confidence among staff to meet service user requests to talk about religious/spiritual matters.
- Greater acceptance of spirituality/experience as part of peoples' wholeness – staff and service users.
- Respect for peoples' positions – protection against evangelism; possible development of a Code of Practice.
- Enable staff to take a balanced approach to helping religious psychoses and bipolar disorder
- More openness about experience – whether illness or spiritual – or a bit of both.
Encourage a climate in which staff can be open about and acknowledge their breakdown experiences

- Encouraging holistic ways of helping people living through the breakdown/breakthrough journey – role of art and nature
- Helping people to work with bereavement in a sensitive manner.

The Aims of the Workshop were set out as follows:

- Allow people to share their views on spirituality and how they see it in relation to mental health.
- Explore the difficult areas around spirituality in the work setting.
- Come up with suggestions for guidelines and practice in this area
- Opportunity to try out ways of approaching religious/spiritual material therapeutically.

Recommendations for training trainee clinical psychologists (taken from Miller, 2001)

- encouraging open discussion
- help students to think more openly about spirituality and to differentiate it from participation in religious institutions
- model and teach professional respect for varying spiritual and religious perspectives; do not overlook prejudicial statements and attitudes among trainees, any more than one would ignore racist or sexist remarks
- the evaluation of spirituality as excellent material for teaching of assessment
- professional perspectives on spirituality and religion should be guided by a cumulative body of empirical knowledge, not by anecdote and prejudice;

- exploration of spiritual and religious issues during training and supervision and spiritual and religious issues should be addressed in professional supervision as part of the training of clinical psychologists.

SECTION FIVE – WORD COUNT

Word count

Thesis abstracts	403
Ethics proposal	5177
Literature Review	5560
Research Paper	6326
Contributions to Theory, Clinical Practice and Learning.....	2494
Sub total	19960

References and Appendix

Ethics Proposal – references and appendices	6150
Literature Review – references, figures and appendix	1567
Empirical Paper – references, tables and appendices	4231
Critical Review – references and appendix	842
Sub total	12790

Grand total 32750