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Citation: Fofie, N. N. Q. (2025). "Locked up, drugged up, encouraged to shut up" – How are spiritual experiences understood as mental health problems in mental health services in the UK?. (Unpublished Doctoral thesis, City St George's, University of London)

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Holding The Unseen: Spiritual Experience in Clinical Contexts

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Portfolio submitted in partial fulfilment of the requirements
for the Professional Doctorate in Counselling Psychology
(DPsych)

City St George's, University of London
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April 2025

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Acknowledgements

I would like to start by thanking my God and King for bringing me this far. Completing this doctoral programme has long been a dream of mine (since I was 17) and is something that I have spent most of my life since running towards. I started this programme a while ago and should have long finished. The process of being faced with completing this thesis forced me to reckon with myself, and with thoughts of self-doubt, about an inability to complete this task that I had nurtured. Thank you God, for teaching me that I can do all things through You who have given me strength (Phil 4 v 18).

I would like to thank my mother for believing in me and all the support – in love, food and finances, that she invested in me. I am who I am today because of your great example. I hope I have made you proud.

I would like to thank my amazing husband who cooked, cleaned, prayed, encouraged and sacrificed time to hold the fort as I did what I needed to do. Thank you bub!

I would like to thank my family – for all your celebration and support.

Thank you to my brother Jamie, the bestie I have been gifted for life. I hope this goes to show that we can do whatever we put our minds to, if we only believe.

I would like to thank my community, who feigned incomprehension when I suggested giving up, and made it clear that that was not an option. For all the pep talks, answering SOS phone calls, prayers and support – thank you.

I would like to thank all my supervisors in the duration of constructing this portfolio – to Dr Julianna Challenor who helped me choose my research question, Dr Jacqui Farrants who was incredibly patient with me, and Dr Ohemaa Nkansa-Dwamena – whose encouragement at various stages of the course and with the thesis gave me the belief and motivation I needed to make it to the end!

Thank you!!

Thank you to my participants. You entrusted me with your personal stories and deep musings, and I owe you a deep gratitude. I hope that I have done your stories justice.

Lastly to Nikita ... I am so proud of you. You do hard things, you do amazing things, and you do them well. Open your eyes and see that you have done far more than you ever thought capable.

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Preface

Holding the Unseen: Spiritual Experience in Clinical Contexts

Introduction

This portfolio is comprised of three pieces that provide insight into my journey undertaking the Professional Doctorate in Counselling Psychology at City St George's, University of London.

The first section of the portfolio is a doctoral thesis, exploring how spiritual experiences are understood as mental health problems in mental health services in the UK. The second piece is a publishable paper, summarising the research project in a condensed format. The final section of the portfolio is a combined case study and process report, sharing a snippet of my clinical work and formulation with my client Amara (pseudonym used), who spoke on a difficult experience, and explored her spiritual conceptualisations on the matter.

The three pieces are held together by the common thread of spiritual experience in clinical contexts, and very much reflect a range of dynamics for consideration in the matter of the prognosis and treatment of spiritual material in mental health services.

Section A: Doctoral Research

The doctoral thesis aimed to explore how spiritual experiences are understood as mental health problems in mental health services in the UK. The study made use of a qualitative design, recruiting eleven participants from a range of different religious and spiritual backgrounds, aged between 25 and 64. Participants were interviewed virtually, using semi-structured interviews.

Results were analysed using Reflexive Thematic Analysis (Braun & Clarke, 2006). The main findings were that spiritual experiences were understood as mental health problems through differing perspectives between the lived experience of participants, professionals and their loved ones; through bias; and through experiences of the system as violent.

The study highlighted a need for greater cultural humility as it pertains to spiritual experiences in mental health services. The participant base did not fit a neat criteria of specific religions or ethnicities, but had a range of differing backgrounds and mostly reported spiritual experiences that were not in keeping with their pre-existing spiritual frameworks. Further to this, the research highlighted a need for clinicians to be intentional in attending to spirituality, and aware of how their own intersectionality and positions of power influence the work.

Section B: Publishable Paper

The publishable paper presents findings taken from my larger doctoral thesis. It is written to the specifications of the *Journal of Spirituality in Mental Health*, which I deemed to be the most suitable journal due to its commitment to the study of spirituality with a focus on counselling and psychotherapeutic professions. The journal details that it seeks to 'provide insights into research and effective therapy in an interdisciplinary dialog that crosses the disciplines of psychology, spirituality, theology, sociology, cultural analysis, and other fields' (Journal of Spirituality in Mental Health, 2025), which are all topics represented in my research.

Section C: Combined Case Study & Process Report

The combined case study and process report provides insight into the gravity that spirituality can hold in the lives of our clients, and the cyclical relationship between the spiritual and the mental. My client Amara had a diagnosis of paranoid schizophrenia, which was viewed by her family as evidence of a spiritual problem. As such, she was taken by her family to a spiritual leader in her community, who sexually abused her under the guise of doing what he explained was 'necessary' to heal her. Amara wrestled with feelings of guilt and blame, as well as feelings of disappointment towards her family for permitting this to happen to her.

I provided an integrative assimilation of Cognitive Behavioural Therapy and Systemic therapy in my formulation and treatment with Amara. In the snippet of our clinical work, I tentatively explored her feelings towards the difficult things that had happened.

These three elements of my portfolio highlight a trend in my clinical work with regards to the disclosure of spiritual material in therapy, and tensions I have experienced with regards to limited published guidance on the matter that upholds respect for client's beliefs. I have explored these thoughts further in my post-reflexivity. It is my hope, however, that this research sheds light on key issues in the topic area, and that my work going forward in counselling psychology is able to honour the trust of clients in sharing these matters, whilst offering effective and culturally appropriate interventions.

Section A: Doctoral Research

“Locked up, drugged up, encouraged to shut up” – How are spiritual experiences understood as mental health problems in mental health services in the UK?

Nikita Fofie

Supervised by Dr Ohemaa Nkansa-Dwamena

Abstract

“Locked up, drugged up, encouraged to shut up” - How are Spiritual Experiences understood as mental health problems in mental health services in the UK?

There is much conflict in the interface between spirituality and mental health, particularly as it pertains to the experience of people who report having had spiritual or anomalous experiences. Previous research has shown that General Practitioners (often at the front door of mental health services) are conflicted in their understanding of the term “spiritual health”, often only pulling from their own spirituality or lack thereof and feeling ill-equipped to navigate these conversations. (Whitehead, Jagger & Hanratty, 2021).

Within mental health services, there has been a hesitation in mental health professionals engaging with spirituality when presented (Crossley & Salter, 2005), spiritual phenomena often being understood as psychotic symptoms (Cook, 2021), and service users with spiritual and religious experiences being afraid to tell, for fear of the repercussions (Macmin & Foskett 2004; ; Koslander, Ronnig, Magnusson & Gustin, 2021).

A qualitative study was conducted to understand how spiritual experiences are understood as mental health problems in mental health services in the UK. 11 participants were interviewed, aged 24-65 from a range of different religious and spiritual backgrounds, who reported their spiritual experiences were understood as mental health problems within mental health services in the UK in the last 10 years.

Interviews were analysed using reflexive thematic analysis (Braun & Clarke, 2006), from a social constructionist epistemological position. Findings indicated 3 key themes in answer to the research question- differing perspectives, bias and violence of the system. Differing perspectives of spiritual experiences between different parties – lived experience, professionals and others (friends and family) influenced the outcome of being understood in this way, with the different positions holding different levels of power in their interactions with one another. Participants experienced mental health services as carrying bias against spirituality, particularly confirmation bias towards diagnoses of psychiatric conditions, and experienced professionals as being resistant to listening to anything that differed from this. Participants also reported experiences of violence whilst under the care of mental health services, which resulted in a lack of trust towards services and ultimately avoidance of mental health services, although many reported they continue to experience spiritual phenomena and have felt compelled to navigate these away from services due to negative experiences.

The findings revealed a need for increased cultural competence in mental health professionals, as well as a greater sensitivity to the viewpoint of patients regarding their own prognosis, how they would like to be helped and their treatment.

Chapter 1: Introduction

Historically there have been many tensions between how spirituality and subsequently spiritual experiences are perceived in psychology, and in the field of mental health. There have been different schools of thought on the matter, with one of the founding fathers of the field of psychology- Sigmund Freud referring to religion as ‘the neurosis of mankind’ and maybe even a symptom of psychosis (Freud, 1937). Albert Ellis also shared this idea, postulating that belief in religion was a manifestation of mental illness (REBT, 2007) and a risk factor in future mental illness (Blass, 2007). On the other side of the camp, Carl Jung offered some criticism to this, and “he was for many years the main psychiatric exponent of the relevance of religion and ethical values to the human situation” (Dry, 1961). Nonetheless, there has been a tension throughout the last few centuries as to the relevance of spirituality in our perceptions of wellbeing, and therefore it’s relevance in mental health care.

McColloch (2006) proposed four different models through which we might perceive mental illness. These were

- Biological models, often also referred to as the medical model, looking at biological and chemical causes for mental illness and offering subsequent treatment
- Social or psychological models, considering life events, family dynamics and belief systems or thinking style
- Intuitive or spiritual explanations, considering the mind as a battleground for conflicting forces: the conscious versus the unconscious, good versus evil, etc.
- Existential belief, viewing what would be perceived as mental illness as another valid form of human existence

Similarly, and of frequent use in the field of healthcare is the biopsychosocial model of disease (Engel, 1979), which postulates that illness, including mental illness, is comprised of a combination of biological, psychological and social factors. This is further supported by the diathesis stress model (Meehl, 1962), originally designed to explain schizophrenia, which speaks of biological predisposition to mental illness, dormant until triggered by social or psychological factors.

Regardless, in spite of the tensions between spirituality and mental health and whilst there is room to formulate how one might understand or fit the relevance of spirituality in the life of an individual into any one of these models, they do not seem to provide much prescription as to how specifically spirituality should be handled as it pertains to our understanding of mental health, as well as its treatment.

Subsequently, this research sought to understand the impact of these tensions on patients of mental health services in the United Kingdom – and more specifically, of people reporting spiritual or anomalous experiences.

A search of literature was conducted to establish existing theory and research on the topic. This search was conducted using search engines such as CityLibrary Search, Google Scholar, Taylor & Francis Online, Wiley Library, PsychInfo and Psychub. Terms searched included but were not limited to ‘spirituality and mental health’, ‘spiritual experiences and mental health’, ‘anomalous experiences and mental health’, ‘psychosis and spirituality’, ‘religion and psychosis’ and ‘spiritual experiences understood as mental health problems’. The search of key terms on these data bases led to further exploration of the subject area in journals such as Psychology & Psychotherapy, Theory Research and Practice and Journal of Spirituality in Mental Health. Often the bibliography of one article would lead to many more notable articles and key writers in the subject area. The search was initially a wide search not limited to any particular time period, to establish the history of literature in this field. The search was then limited to research within the last 20 years, to establish recent findings in this area.

Glossary of Terms

For the purposes of this research, I would like to outline some key terms and their definitions, which are reference to throughout the study.

- Spiritual experiences – transcendental or anomalous experiences as defined and understood by the client, whether fitting religious frameworks or not, whether defined as such at the time or retrospectively
- Mental health problem – whether diagnosed or not, any kind of treatment that would indicate perception of mental health issue
- Mental health services – any services, whether NHS, third sector or private who provide community-based or inpatient services and treatment for individuals with any range of mental health difficulties or presentations
- Professionals – any staff members forming part of a mental health service or team that are responsible for the treatment or care of those in mental health services

Defining Spirituality

The ‘spirit’ is defined as the ‘animating or vital principle; the immaterial or sentient element of a person’ (Oxford English Dictionary, 2025). It further goes on to define the ‘spiritual’ as ‘of, relating to or deriving from the mind or intellect; associated with higher faculties such as reason, judgement, discernment etc.; intellectual as opposed to sensual, material or practical’.

The Royal College of Psychiatry define spirituality as ‘a sense of seeking the best relationship with ourselves, with others and with what may lie ‘beyond’ (Royal College of Psychiatrists, 2024). In literature, sometimes spirituality is used interchangeably with religion, however the two are not to be conflated. Religion refers to ‘the belief in and worship of a god or gods or any such system of belief and worship’ (Cambridge University Press & Assessment, 2025), whilst spirituality may encompass this but not necessarily be confined to the structure that religion provides. In a study looking at faith in the city of Birmingham, Gilbert & Parkes (2011) commented that ‘there is an increasing trend in the number of people who would not deem themselves to be “religious” but still have some sort of spiritual understanding underpinning life. These individuals do not fit neatly into classifications of religious faith, and there is a recognition that the term “spirituality” implies something more fluid, personalised and perhaps vague than religion.’ Gilbert’s work further explains that religious faith is not needed for a person to feel that they have a spirit or can engage with spirituality (Gilbert, 2010). Research has found a decrease in religion and religious leadership in the UK, whilst there has also been an increase in belief in God or a spiritual force, prayer and engaging with spiritual practices and report of religious and mystical experiences (Jones, 1994, Lukoff & Turner, 1992).

For the purposes of this study, I will be focusing specifically on spirituality and spiritual experiences as opposed to religion. My interest in focusing on spiritual experiences or spirituality more broadly as opposed to religion was inspired by my experiences of clients who reported themselves to be atheists, but were sharing spiritual experiences – which theoretically would not tally with their belief system. I had found from my own training that even with a focus on holistic methods of formulation, questions about cultural background and religion did not always encompass spiritual or anomalous experiences, and did not always account for the range of experiences reported.

Although ‘spiritual’ is a word that has been defined, there is not always clarity as to its practical meaning, and therefore its relevance in the field of mental health. Perhaps it is the immaterial or impractical nature of the very word that has made the spiritual so difficult to define.

In a study examining what General Practitioners (GPs) in the UK understand by “spiritual health”, it was found that was a general lack of clarity as to what the term means (Whitehead, Jagger & Hanratty, 2021). Definitions that emerged ranged from themes such as self-actualisation and meaning, transcendence and relationships beyond the self, expressions of spirituality to meaningless. Some practitioners reported that spiritual health was in their view synonymous to mental health. Overall, there was a common challenge in articulating what is meant or to be expected by the term spiritual health. Although GPs are expected to treat patients holistically and within their social and cultural contexts, GPs tended to pull from their own personal experiences, being more open to

explore or discuss this area of their patients' lives depending on their own personal approach to spirituality. As practitioners who are commissioned to be at the frontline of our healthcare system, signposting and referring patients to the most relevant services, perhaps this is an issue of concern.

The issue of similarities in the definition of 'spirituality' to 'mental health' is not a unique challenge. Literature makes mention of the definition of mental health as 'essentially about how we think and feel about ourselves and about others and how we interpret the world around us ... it also affects our capacity to cope with change and transitions such as life events,' (Rankin, 2005), which carries a striking resemblance to prior definitions of spirituality.

In a study examining the experience of clinical psychologists in addressing spiritual beliefs in therapy, it was found that the psychologists found the concepts of spirituality elusive – 'having several overlapping and contradictory meanings' and leaving them confused as to how to engage clients in a concept that they had not quite grasped themselves (Crossley & Salter, 2005). Rowe (2001) described spirituality as 'a Humpty Dumpty word that means whatever the speaker wants it to mean'.

This lack of definition of spirituality particularly within the field of mental health creates room for the misdiagnosis of spiritual problems. In 'Understanding Mental Health and Spirituality', Peter Gilbert (2014) highlighted the risk of pathologizing spirituality, when the need for human engagement with spirituality is not well defined and recognised in services. Gilbert warned of a range of different interpretations that could be given to any one issue from different perspectives, for example voice hearing being interpreted as evidence of psychotic illness, demonic possession or another dimension of human experience (Gilbert & Fulford, 2010).

In 1994 the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV introduced 'religious and spiritual problems', under the category of 'other conditions that may be a focus of clinical attention' (American Psychiatric Association (APA), 1994). This was due to their recognition of the fact that previous diagnostic manuals had failed to mention an area which formed such a big part of day-to-day life, with clinicians all over the world were encountering clients with difficulties pertaining to religious and spiritual problems frequently. The taskforce recognised a propensity that mental health professionals had in pathologizing or ignoring religious and spiritual issues (Lukoff, Lu & Turner, 1992). They believed in the importance of religion and spirituality in the culture of the population, and felt that a lack of identification under its own category in the DSM made religious and spiritual problems more likely to be subject to misdiagnosis (Turner, Lukoff, Lu, Barnehouse & Francis, 1995). Prior to this, a religious or spiritual problem would likely have been classified more generically under 'adjustment disorder' or 'phase of life problem' in the DSM III.

It is interesting to note that whilst the category was being formed, it underwent a few changes. It was initially to be named 'psychoreligious or psychospiritual problem', and was changed to just 'religious and spiritual problem', as the taskforce realised that the prefix 'psycho' does not precede every other problem, in the DSM, for example 'psychomarital or psychoacademic' (Turner, Lukoff, Lu, Barnehouse & Francis 1995). It could be presumed that even at this stage of wanting to progress in the recognition of spirituality and to legitimise associated problems within the world of mental health, there was still a real reluctance to let go of psychological conceptualisations and to accept them as themselves. Equally, in defining examples of the kind of problems that may be found in the category, the examples of 'mystical and near death experiences' were removed, being replaced with 'questioning or other spiritual values which may not necessarily be related to an organised church or religious institution (Turner, Lukoff, Lu, Barnehouse & Francis 1995). The authors report that they protested against this because they felt it was too vague and there was evidence of this in literature, but this was unsuccessful (Turner, Lukoff, Lu, Barnehouse & Francis 1995). Other examples of spiritual or religious problems that were named in the category included 'distressing experiences involving loss or questioning of faith, problems associated with conversion to a new faith, questioning or other spiritual values which may not necessarily be related to an organised church or religious institution' (APA, 1994).

This shift in the diagnostic criteria created an openness to new non-pathological ways of thinking and conceptualising client difficulties in the western world – where professionals were invited to consider a more holistic approach in understanding religious and spiritual problems (Prusak, 2016).

It was the hope of the authors that this diagnostic category would serve to encourage wider thinking about spiritual and religious problems amongst mental health problems. Unfortunately, even with this development, the application of this category in practice seemed to still prove a difficulty, especially as it pertained to spiritual experiences in the field of mental health. Spirituality was not just about 'thoughts, philosophies, communities or ways of living'; among those who were more likely to be pathologized and at risk of hospitalisation for mental illness were those cited what is often referred to as 'spiritual experiences' (Lukoff, 1994).

Operationalising Spiritual Experiences vs Mental Illness

The term spiritual experiences is often used interchangeably with 'anomalous', 'mystical', or 'self-transcendent experiences', and refers to the experience of phenomena or the extra-ordinary

(Yaden & Newberg, 2022), often outside of the realm of the sensory perception of others. In a book called 'The Varieties of Spiritual Experience: 21st Century Research and Perspectives', Yaden & Newberg divided the term into six main categories. These were 'numinous experiences (encountering divinity), revelatory experiences (voices, visions and epiphanies), synchronicity experiences (everything happens for a reason), mystical experiences (unity and ego dissolution), aesthetic experiences (awe and sublime) and paranormal experiences (angels, ghosts and other entities) (Yaden and Newberg, 2022).

Yaden and Newberg offered further insight into potential triggers for spiritual experiences, with a survey revealing prayer, transitional period, nature, grief and mediation as among some of the most commonly identified triggers (Yaden and Newberg, 2022), with their onset more likely to be spontaneous than sought after.

Some researchers have made differing attempts at operationalising the difference between spiritual or religious experiences and psychosis or experiences of psychopathology. This has emerged along with stories of people who have been unwell within religious organisations and remained undetected and undiagnosed (Sims 2007). It is identified that there is a need for training that stretches beyond the mental health profession and to spiritual leaders in their various settings, as the two are not so easily prised from one another (Noort, Braam, Gool & Beekman 2011). A study looking into the interaction of clergy with mental health in Wales found that they also can be seen as a frontline intervention, frequently identifying and referring cases of psychosis, suicidality and substance misuse on to medical professionals (Carp & Hoskins, 2020). The same study found a greater need for interaction between the two professions, recommending training on both sides to improve collaboration. In a study by Gubi and Smart (2016), chaplains described their role as being an integral part of multi-disciplinary teams in the National Health Service (NHS), contributing to holistic wellbeing in the same way psychologists and occupational therapists do.

In his recommendations, Professor Sims (former president of the Royal College of Psychiatrists Special Interest Group in Spirituality) named a number of variables by which he felt one could identify the difference between a person with religious persuasions and a person suffering with a delusional disorder. The variables constituted of the following: whether the person's beliefs were concrete or metaphorical; bizarre or meaningful; delusional or with clear boundaries of self; void of doubt or with the possibility of doubt – with the former being a person suffering with a delusional disorder and the latter being a religious person. Other variables pointing to psychopathology were evidence of psychiatric illness in other areas of life, concrete ideas literally acted on, loss of control and lack of insight, amongst other ideas (Sims 2007). Although these reflections and suggestions

provide some helpful points on which to contemplate, they provide binary categories, polarising the idea of faith against delusion as if to suggest that presentations fit neatly in those boxes or within those categories. Sims' own reflection of his thoughts is that they are primarily based on his insight to the Christian faith, and are therefore perhaps not as widely generalisable across other faiths or forms of spirituality. Sims commented that 'all religion, each faith, can only be truly known from inside' (Sims, 2007), perhaps highlighting the value of the subjective and lived experience of spirituality and religion, and perhaps how ill-equipped we might be to judge any construct we do not subscribe to from the outside.

Similarly, Lucas (2017) developed a Transcendent Assessment Tool with which to operationalise the difference between spiritual experiences and mental illness. The tool states that mental illness in comparison to spiritual experiences would be long lasting or chronic rather than brief, painful rather than pleasurable, common rather than rare, destructive rather than beneficial, precise or vivid rather than 'beyond words' and reinforcing of narrow beliefs rather than opening the mind to new beliefs. Lucas shared that he developed this tool having also had his own spiritual experiences. He also referenced Carl Jung and his open exploration of his spiritual experiences, as examples of how these experiences can be engaged with, without them being evidence of mental illness (Lucas, 2017). Lucas shared that his aim was to help reduce the way in which he felt spiritual experiences were frequently pathologized, labelled as 'religiously preoccupied' under Obsessive Compulsive Disorder, or 'Delusional' under psychotic disorders (APA, 2013). Although he took much of the criteria from suggestions in previous research, there did not seem to be much research further testing these variables and their credibility against spiritual experiences in the present day context.

There are some similarities between the two assessment criteria. Whilst the Transcendent Assessment Tool (Lucas 2017) seems to be more openly applicable to religious and spiritual experiences, Sims' criteria seems more focused on people from backgrounds of organised religion. Both tools seem to agree that religious or spiritual beliefs should have a limited effect on the rest of the individual's life, with Sims emphasising the importance of having boundaries of self and being able to doubt beliefs, whereas Lucas focused more on having short-lived spiritual experiences that do not overwhelm the person's entire life. It can be suggested however, that it seems that both measures do not take into consideration the level of impact and influence that spiritual or religious beliefs may have on an individual's life. Spiritual experiences may not always be fleeting, and the concept of faith in many religious and spiritual texts is not to have or entertain doubt, which in its very nature directly conflicts with some of the variables presented. The Mental Health Foundation reflected on this notion – 'To invalidate a person's spirituality no matter how distorted it is, is to invalidate the real core sense

of self and I think that once you do that you risk doing untold damage to somebody' (Mental Health Foundation, 2002).

Although both tools do not stipulate the same things, they raise an important point about nuance and navigating or wading through client content on spiritual or religious experiences, seeking to understand and critically evaluate, rather than resorting immediately to pathologizing or ignoring them. Research found that when spiritual experiences were shared in therapy, therapists had a tendency to remain silent when attempting to be neutral (Adams, 1995). In light of this, the potential usefulness of such tools in aiding clinicians to have a way of operationalising and understanding the potential difference between these experiences and mental illness is clear. Prusak (2016) alluded to this need in mentioning the criticism following the release of the 'Religious or Spiritual Problem' DSM category, commenting that many professionals felt these additions were made without empirical basis.

Whilst both assessment tools and the guidance provided with them serve as assistance that may help practitioners, they do not address the possibility of having spiritual experiences that do not necessarily align with one's religious persuasions or spiritual belief systems, or having more enduring or common spiritual experiences and yet being mentally well and functioning in other areas. This could be seen as reductionist, particularly as the western world has become more open to engagement in spiritual practices from other cultures, including for example, spiritual practices introduced in the field of psychology such as mindfulness meditation.

The Transcendent Assessment Tool (Lucas 2017) names positive experiences as spiritual and negative experiences as psychotic. Previous research does not agree with this stipulation, arguing that it is the power of the experience rather than the nature of the experience itself that differentiates a psychotic experience from a spiritual one (Cottam, Paul, Doughty, Carpenter, Mousawi, Karvounis & Done, 2011). It is also unclear in both cases how frequently symptoms must occur or if all variables must be present for an individual's presentation to be classed as spiritual or psychotic.

Existing frameworks for formulating spirituality

There is a notable importance of the understanding and incorporation of an individual's belief system in their care. A meta-analysis study found that in patients with strong religious or spiritual affiliation, religious or spiritually based therapy was more efficacious in comparison to standard treatment in mental health care (Keulen, Koelen, Eurelings-Bontekoe, Hoekstra-Oomen & Glas, 2023).

In alignment with the findings of this study, the authors recommended the greater use of 'integrative religious and spiritual treatment approaches that endorse an active search for the sacred, and how this reflects on a person's coping with mental illness, with emphasis on the mobilisation of hope, acceptance and forgiveness amongst other concepts' (Keulen, Koelen, Eurelings-Bontekoe, Hoekstra-Oomen & Glas, 2023). This fits with a personalised approach, where the focus does not lie primarily on symptoms, and where person-centred treatments in which religious and spiritual experiences, language and worldviews are recognised and explicitly addressed.

Whilst this is a helpful step in the direction of ethical practice for those whose spiritual experiences align with a framework of their understanding, it does not seem to acknowledge those who may not hold those beliefs but may have had those experiences, or individuals who develop their spiritual formulations of their experiences retrospectively.

This is better addressed by the Spiritual Emergency Network (Stanislav & Grof, 2017), whose work stipulates that there is 'evidence that many individuals experiencing episodes of non-ordinary states of consciousness accompanied by various emotional, perceptual and psychosomatic manifestations are undergoing an evolutionary crisis rather than suffering from a mental disease'. They refer to this as a 'spiritual emergency' – denoting crisis but also potential for hope.

The Spiritual Emergency Network considers experiences such as Kundalini awakening (powerful energy rising through the body); Shamanic crises (visions, journeys, encounters with archetypal figures); Near-death experiences; Unitive merging with God or universe/mystical states.

Their stance is that psychiatry uses 'controlling and suppressive approaches to terminate such experiences, and insensitive use of repressive measures which can lead to chronicity and long-term dependence on tranquilising medication, with serious side effects and impoverishment of personality'.

They emphasise on clinicians developing a good trusting therapeutic relationship, conveying respect for the client's process and its healing and transforming nature, and the avoidance of pathological labels and suppressive approaches for all non-ordinary states of consciousness. The network encourages full engagement with the material through meditation and introspection, and grounding activities. They coined a technique called 'holotropic breathing', a breathing technique designed with the aim to support in processing emerging material and past trauma as individuals navigate through these in their spiritual experiences (Stanislav & Grof, 2017).

The work of the Spiritual Emergency Network gives great language to a range of experiences that otherwise remain unidentified or undefined in literature, which is helpful and perhaps provides

language and support for individuals going through anomalous experiences that sit outside of their belief system.

However, whilst providing a framework for these experiences, it appears to formulate a belief system in and of itself, referring to ways of categorising experiences that seem quite specific in nature. For example, it states that the main forms of spiritual emergency are – awakening of the serpent power (kundalini), shamanic journey, psychological renewal through activation of the central archetype, psychic opening, emergence of a karmic pattern, possession state. These ways of framing experiences seem to pull from Eastern religious frameworks, and might not feel as helpful for individuals who do not feel their beliefs or experiences align with these. It also details a process through which a spiritual emergence might occur, which again is quite specific, and although it may cover some common areas of experience, may not necessarily be widely applicable.

The stance of the Spiritual Emergence network can also be viewed as discouraging of psychiatry, particularly of antipsychotic medication. Whilst the reasons for this are mainly around a belief that the medication limits the full expression of the spiritual experience and the individual's engagement with their emotions, it may also be considered controversial and potentially dangerous in cases where medication may be of benefit to the patient.

Another framework that can be used for exploring spiritual experience in mental health services is the APA Cultural Formulation Interview (American Psychological Association, 2013), developed to consider the role of cultural context, personal and community beliefs in cultural and spiritual client presentations.

The cultural formulation interview that asks what brings them to therapy and enquires as to what their explanatory model is. It seeks the client's cultural definition of the problem, asking questions such as 'what do you think is happening to you, what do you think are the causes of your problem, how would you describe to friends and family? What troubles you most about the problem?'. It then goes further to seek cultural perceptions of cause, context and support, with questions such as – 'why do you think this is happening to you? What the causes are? (including enquiring about if they think it is as a result of bad things, problem with others, physical illness, spiritual reasons). It also asks what others in family, friends or community think is causing the problem, with a focus on views of members of social network.

In the next stage, it seeks to determine stressors and supports – and whether there are any kinds of support making problem better, and any kinds of stresses making problem worse. It then seeks to enquire about the role of cultural identity – (acknowledgement of factors in some people's

background or identity that can make their problem better or worse) – maintaining curiosity about the most important aspects of the clients background or identity, and enquiring as to whether there are any aspects of either that make a difference to the problem or that cause other concerns or difficulties (examples include discrimination, race/ethnicity, sexual orientation, conflict across generations / gender roles).

The interview then seeks to examine cultural factors affecting self-coping and past help seeking, asking questions such as – ‘what have you done on your own to cope with your problem? What types of help or treatment were helpful or not helpful in the past? Has anything prevented / got in the way of you getting the help you need?’. It then enquires about any possible cultural factors affecting current help seeking by asking – ‘what kinds of help would be most useful now? Any other kinds of help family friends have suggested that would be helpful? Have you been concerned about this (therapy) and anything we can do to provide the care you need?’ (American Psychological Association, 2013).

The cultural formulation interview asks really useful questions explicitly, enquiring about the impact of the individuals background and encouraging explanation. Its inclusion of both individual views, as well as cultural context and the significance of the view of the community is very comprehensive and has the potential to be useful to people from different backgrounds without being narrow and prescriptive. It creates room for the explanation of the spiritual formulations of the client, and of their community, and an acknowledgement that there may at times be a discrepancy between the two, or stigma and related dynamics. Questions specifically acknowledging that there are cultural factors that can make things better or worse and enquiring about them within the individual’s specific context is a really good way of encouraging the clinician to maintain a curiosity on the client’s meaning-making. A criticism of this tool is that there is no guidance on the next steps of what to do with the abundance of information that can be collated from it.

A similar tool for examining and seeking to understand spirituality in client care is the FICA Spiritual History tool (Puchalski, 1996). Its goal is to identify spiritual distress, learn about spiritual resources and invite patients to share what gives them meaning and purpose. It uses guided questions working through the ‘FICA’ acronym:

- F – Faith, belief, meaning – determining whether the patient identifies with a particular belief system or spirituality at all
- I – Importance and influence – of spirituality in the patient’s life and influence on healthcare decisions

- C- community – are they part of a spiritual community? Do they rely on their community for support?
- A – address / action in care – how to address spiritual issues with regards to caring for patient

The FICA Spiritual History Tool is really helpful for understanding the beliefs and significance of spirituality in our patients, and how they might interact with their relationship with healthcare and their wishes. It forefronts the client or patient and acknowledges the role of spiritual beliefs as an influence in their interaction with healthcare.

It is not just significant to retrospective reflections on the client’s experience, but a tool that can be used on hand in healthcare. An evaluation into use of the FICA in palliative care found that it was able to assess different dimensions of spirituality and provide a framework to discuss meaningful and supportive elements of patient lives, such as communities and spiritual sources of strength (Puchalski & Romer, 2000). It identified the FICA as an important aspect of respectful care and treatment planning.

The role of cultural humility

Sims (2007) stated that in conjunction with use of the tools, it is important for the individual’s experiences to be compliant with their cultural and religious background (Sims 2007). A study found that African and Black Caribbean communities with an At Risk Mental State for psychosis had differing perceptions of wellness (in comparison to clinical perceptions of wellness), attributing more factors to spiritual causes or explanations such as witchcraft and ‘God’s testing’, and therefore were less likely to engage with mental health services (Codjoe, Byrne, Lister, McGuire & Valmaggia, 2013).

The United Kingdom is a multi-cultural society, with people from many different faiths (Department of Health, 2009). Gilbert & Parkes (2011) commented on the colonial past of the nation in contributing to the vast mix of different cultures represented in our country. They described culture as being comprised of many elements including family relationships, local neighbourhood and schools, belief systems in the local area as well as generationally- and how this is passed along through generations even with migration from other countries and cultures. In essence, the lived experience of culture cannot be simplified or attributed to any one thing for any individual, as it is made of a variety of moving parts.

This raises the need for services to be active in practising cultural humility, where belief systems are considered and incorporated in outreach and treatment plans for patients in the communities being served (Rathod, Kingdon, Phiri & Gobbi, 2010).

Research specifically into spiritual or non-ordinary experiences explains that what is deemed ordinary in some cultures is not seen as ordinary in other cultures, highlighting the problematic nature of painting all non-ordinary experiences with the same brush, from a lens that does not belong to the patient or participant (Taves & Barley, 2023). This research emphasised that clinicians must not assume that 'the ordinary-non-ordinary distinction is cross-culturally stable', explaining how appraisals are culturally constructed and therefore even the same phenomena may be formulated in one way in a certain culture, and differently in another (Taves & Barley, 2023).

Davis, DeBlaere,, Hook & Owen (2020) write about the globalisation of the world and the greater access we all have to each other's difference, creating a need to engage better with cultural differences. They described cultural humility as something that when practiced, impacts clinicians intrapersonally as well as interpersonally. They postulated that intrapersonally it causes a clearer view of personal strengths and limitations, whilst interpersonally it facilitates person-centred care 'through a lack of interpersonal superiority' (Davis, DeBlaere, Hook & Owen, 2020).

Myira Khan took this notion further. In her book on working within diversity (Khan, 2023), she explained that diversity is often taught and practised within counselling and psychotherapy as an add-on. She further explained that it can be seen as an additional thing, positioning the clinician as normative and the client as diverse, and ignoring the impact of the clinician's identity and the relational dynamic between the parties. Khan suggested an emphasis on working *within* diversity, as opposed to 'with', where diversity and intersectionality are seen as an integral part of the identities of clinician and client and inform the work on all levels including in training and supervision, as well as in the therapy room. Further to this, literature has also highlighted the need to deliberately practice increasing cultural comfort for spiritual diversity, as services work to earn more trust with spiritual communities (Davis, DeBlaere, Hook & Owen, 2020).

Put beautifully, 'If spirituality, encompassing religion and for many, culture, beliefs, attitudes, values, is addressed in mental health care, service users will receive a holistic and humane approach to care' (Gilbert & Parkes, 2011).

Assessing Risk

When risk is assessed in mental health services, and particularly when it comes to anomalous experiences, there is a fine line as it pertains to professional perception and clinical judgement on

what is actual and what is perceived, whilst also considering risk of harm to self, risk of harm to others, dignity and capacity. The Royal College of Psychiatry's recommendations on assessing risk encourage obtaining the client's consent to risk assess and their narrative of their own risk, and encourage co-production with the client, as well as the involvement of carers and other professionals as needed, in discussing assessments and management plans (Royal College of Psychiatry, 2025). It encourages clinicians to obtain a comprehensive history, on factors such as history of violence, criminal history, impulsivity, substance use, triggers to previous relapses and recent stressors, losses or threat of loss. It also encourages the consideration of environmental factors, such as protective factors, involvement in radicalisation, risk on release from restricted settings. It also requires clinicians to make a judgement on mental state, considering factors such as symptoms relating to threat or control, harm to self, restricted insight or capacity and the evolution of symptoms or unpredictability.

Ultimately, the assessment of risk as it pertains to individuals presenting with spiritual experiences is not solely due to the spiritual component of the presenting complaint, but their overall presentation and the clinician's judgement of their risk to self and others as well as their capacity in engaging appropriately with the outside world. It is however very much subject to the clinical judgement of the professionals involved in the assessment, and their perception and formulation of the risks involved, and this can at times differ from the individual's perception of their own risk.

A study looking into meaning making of delusional belief systems found that participants with psychosis felt they would be depressed, have a bleak life or go mad if they were to 'become sane' (Roberts, 1991). It reflected- 'We are familiar with the depression that can occur as a person recovers from psychosis but there may be a spiritual aspect to this too as the person adjusts to a loss of faith in their beliefs.' – highlighting loss of belief (even if in the delusional) as a loss of faith. The study provoked reflections on whether it could be seen as more humane to leave people in their beliefs, and the element of choice and possibly even insight in individuals ascribing to beliefs that may otherwise be viewed as delusional.

Research has also supported a continuum hypothesis as a way of viewing the distance between 'normality' and 'psychosis', pointing out that 'delusional beliefs' tend to be multidimensional in nature (Peters, 2001). There is therefore an emphasis on how the beliefs are embedded into the belief system of the person than what they believe, and how what they are saying or claiming is informing their interaction with the daily world.

The role of trauma in informing spiritual and psychological experience

Research has shown that there are strong associations between childhood trauma or adverse experiences and psychosis in adulthood (Varese, Smeets, Drukker, Lieverse, Lataster, Viechtbauer, Read, van Os & Bentall, 2012). A further study found that disturbances of self-organisation (emotion dysregulation, interpersonal difficulties and negative self concept) associated with CPTSD were predictors of the maintenance of psychotic symptoms, and would occur in the 90 minutes preceding paranoia, voices and visions in participants who were randomly assessed up to 10 times a day (Panayi, Peters, Bentall, Hardy, Berry, Sellwood, Dudley, Longden, Underwood, Steel, Jafari, Emsley, Mason, Elliot & Varese, 2024). These voices and visions can also be interpreted as spiritual, depending on the framework of the individual. The Spiritual Emergency Network hypothesise that spiritual emergencies occur to provide an opportunity for the processing of trauma (Stanislav & Grof, 2017).

Findings of a meta-analysis also provided support for an association between trauma-related beliefs and positive psychosis symptoms (Frost, Collier & Hardy, 2024). Findings were; a small to moderate association between trauma-related beliefs and hallucination severity, a moderate to large association with delusion severity and a large association with paranoia severity.

These studies, amongst many others, indicate a need to consider psychosis and related 'positive symptoms' that may be perceived through the lens of psychosis, through the lens of trauma. These findings are also suggestive of trauma therapies for psychosis that might target these beliefs and improve distressing symptoms that may otherwise be viewed as psychosis (Frost, Collier & Hardy, 2024).

One way of formulating this is the Power Threat Meaning Framework (Johnstone & Boyle, 2018). It takes a non-pathologising approach as an alternative method of formulation, prioritising the focus of the story of the client and 'what happened to them', and the role of power, threat and meaning-making in this, as opposed to 'what is wrong (with them)'. This method of formulating creates potential for perceiving the role of trauma and inviting conversation on it, as well as considering distress caused by engagement with anomalous spiritual material and understanding it's meaning, impact and significance, without the pathologisation that the label of 'psychosis' and more general illness model may bring.

A recent qualitative study looking into individuals with diagnoses of psychosis and a history of trauma found that a lack of opportunity to discuss traumatic experiences resulted in negative views towards self and deteriorating mental health (Campondonico, Varese, Berry, 2022). The study also identified direct links towards past traumas and the contents and characteristics of their psychotic

experiences. The study's recommendations highlighted 'the importance of implement trauma-informed approaches to understand clients' difficulties and provide support'. (Campondonico, Varese, Berry, 2022).

The notion of 'trauma-informed care' is the assumption that most people that we will encounter in healthcare settings may have been through traumatic experiences, and that due to the prevalence and impact of trauma, it makes more sense to treat our clients or patients mindfully, avoiding any causation of harm, as well as avoiding offering treatment in a way that may be re-traumatising (NHS England, 2025).

Whilst this is the aim of services, it seems that currently the implementation of trauma-informed thinking in mental health services in the UK is limited. A recent study into the implementation of trauma-informed care in mental health trusts in the UK found that out of 72 mental health trusts that were contacted, 70% of respondents did not have access to training on trauma-informed care, in spite of the prevalence. (McNally, Ragan, Varese & Lovell, 2023).

Literature on spiritual experiences in mental health services

Literature warns of many risks associated with pathologizing spiritual experiences in mental health services, both for the service users and for services.

Bracken & Thomas (2005) warned that viewing 'meaningful realities in terms of non-meaningful entities' through medicalising them result in importance of the experts, framing problems technologically, and a methodical approach that describes behaviour outside of its context – for example the concept of symptoms. Their description seemed to emphasise the risk of dehumanisation that the medical model can sometimes offer, as well as a shift in the weight of importance from the patient to the professionals.

The afore-mentioned paper on non-ordinary experiences in research offered critique on historical research in the field as being absorbed with 'either establishing or debunking their epistemological value', as opposed to keeping clients or patients at the centre of the matter (Taves & Barley, 2023). They proposed a call to subjectively recognise features of these spiritual or non-ordinary experiences, instead of grouping symptoms or phenomena into constructs which may not accurately represent the client's view on the matter – which also applied to pathologizing.

Professor Cook, former Chair of the Executive Committee of the Special Interest Group in Spirituality & Psychiatry at the Royal College of Psychiatrists, sought to normalise the experience of

auditory hallucinations, describing continuum hypothesis and encouraging that these be evaluated within the context of cultural norms (Cook, 2021). He went further to describe how it is normative of most faiths for their founders and key figures to have reported voice hearing, citing examples of Moses and Jesus. His encouragement was that it therefore follows that believers in those religious or spiritual constructs would also seek or want to hear voices, it being normative to their faith. Professor Cook was also keen to point out that people are able to report anomalous experiences whilst still leading healthy and normative lives (Cook 2020, Cook 2021).

A study into mental health indicators in spiritual individuals revealed that having unusual spiritual experiences was a predictor of engagement with modern spiritual practices (Faria, Underwood & Claridge, 2013). The study also found that modern spirituality held the same wellbeing benefits in the lives of participants as those with traditional religious beliefs – such as a reduction to existential threat, good mental health and general wellbeing.

A study examining the screening for schizophrenia spectrum disorders in the United States of America found that differences in belief on spiritual experiences between races, namely the endorsement of auditory and visual hallucinations, correlated with being screened as indicating mental illness (Peltier, Cosgrove, Ohayagha, Crapanzano & Jones, 2017). In essence, cultural beliefs around spiritual material made African Americans more likely to be screened as having schizophrenia spectrum disorders – the system not seeming to account for culturally normative beliefs in this area.

In a study looking into the spiritual and religious experience of mental health service users in Somerset, participants reported transcendental experiences, often interpreting them as the voice of ‘God’ or ‘the devil’ or a spiritual presence (Macmin & Foskett, 2004). The study found that participants had two main reasons for sharing their spiritual experiences; to gain comfort from their distress and to find meaning in what they had endured. Participants were naturally inclined to seek to make meaning out of what they had experienced, and the openness of loved ones and staff members in permitting this to happen made a significant difference in the outcome for service users. It was found that the response that the participants experienced determined their willingness to engage in treatment, their openness in allowing a level of control from friends and family, and their ability to feel equipped to fight the distress associated with their spiritual experiences. The study shared that participants experienced frustration at having their spirituality ignored or treated as a sign of mental illness, and also felt that religious groups were judgmental of their faith, accusing them of sinfulness or demonic possession. Participants expressed feeling dehumanised, and reported experiencing forced compliance with hospitalisation, medication and ECT treatments. In their view, being treated as unwell restricted the possibilities of meaning making and recovery. The study remarked – ‘Psychiatrists and

clergy, for instance, can and do exert power over service users whether or not they talk, and if they speak honestly and indiscriminately, they find little reassurance in the reactions they get' (Macmin & Foskett, 2004).

In a study looking into predictors of distress in people who reported spiritual experiences, it was found that changes in awareness and cognitive functioning, feeling experiences were caused by 'other people' and attempting to gain more control of experiences were higher predictors of distress. Lower distress was associated with spiritual appraisals, a feeling of having more support and understanding and a feeling of greater control and neutrality on the part of the participants towards what they were experiencing (Brett, Heriot-Maitland, McGuire & Peters, 2014).

In a study looking into inpatients' descriptions of spiritual experiences in mental health care in Norway, the spiritual experiences of participants were summarised under the notion 'Longing for wholeness' (Holm, Karlsson & Holmberg, 2024). This longing for wholeness through their experiences was comprised of 'feeling alienated and isolated, connecting to divine powers, the need to experience love in relationships and activities to enhance coping'. The study describes that participants felt ostracised and isolated in their hospitalisation. It described that participants felt reduced to a diagnosis and that 'their longing to emerge as a whole person in safe, loving relationships was reduced to fitting into a system' (Holm, Karlsson & Holmberg, 2024).

A similar study, also in Norway, looking into the lived experiences of spirituality from people subject to inpatient care found that participants perceived the presence of something beyond the mundane, were seeking to make sense of reality, and were struggling for acceptance (Koslander, Ronnig, Magnusson & Gustin, 2021). The study referred to these experiences as near-life experiences, explaining that professionals tended to label negative spiritual experiences as psychotic and positive ones as resources, however these were very much intertwined for the participants and ever-present. The study encouraged mental health staff to be more open and receptive, acknowledging complexity as it pertains to spiritual experiences without judgement (Koslander, Ronnig, Magnusson & Gustin, 2021).

In terms of the treatment of these experiences in services, a meta-analysis into religious and spiritual interventions in mental health care found that spiritual interventions in services had a significant effect on general symptoms of anxiety, reducing stress, alcoholism and depression (Goncalves, Luccheti, Menezes & Valida, 2015). Whilst the study was only able to examine 23 studies out of 4751 and perhaps had potential for much more widely generalisable results, it does signify some evidence towards the importance of spirituality not only in conceptualisation of patient problems in services, but also in treatment.

Along the same trajectory, a study in India into the views of psychiatric health professionals compared with traditional healers found that they both seemed to agree that stigma in mental health could be reduced by integrating spiritual care into mental health services (Ramakrishnan, Rane, Dias, Bhat, Shukla, Lakshmi, Ansari, Ramaswamy, Reddy, Tribulato, Agarwal, SatyaPrasad, Mushtaq, Rao, Murthy & Koenig, 2014).

Contrastingly, a study looking into mental health nurses and health literacy in Ghana described a dynamic where both the staff and the participants subscribed to similar viewpoints regarding mental health difficulties, for example the belief that mental illness is a curse or as a result of sin (Koduah, Leung, Liu, 2019). Staff explained that these views impacted their practice, and that they would sometimes recommend spiritual healing to patients (Koduah, Leung, Liu, 2019; Read, 2019).

Aims and rationale for research

Whilst these findings reveal the beginnings of a trend in the role of professionals and loved ones in the distress levels and outcomes for people who report spiritual experiences, the literature did not reveal much in the way of research into spiritual experiences in mental health services in the UK, how they are understood and treated and what the implications are. Most research seemed to focus on potential theories for operationalising spiritual or transcendental experiences, advocating for the role of spirituality including services like chaplaincy in mental health care or explaining links between spirituality and wellbeing for service users. The literature emphasised that service users ought not to be pathologized, and feel lonely and ostracised when they do. It explains that when practitioners pathologize over seeking to understand, they could be operating outside of the realm of cultural competence, and run the risk of dehumanising their clients whilst over-estimating their role and importance, and underestimating the role of spirituality in the lives of people.

There is a notable gap in the literature, which either speaks more generically on spirituality and its role in coping, or in a dichotomous way, pitting spirituality, religion and spiritual experiences against psychosis. Even with some propositions on how to tell if symptoms being experienced are evidence of spiritual experiences or of mental illness, there is little investigation into specifically how spiritual experiences are being understood as mental health problems in mental health services the UK, and what the experience or outcome is on behalf of the client or patient. The little research on people reporting spiritual experiences in mental health services seemed to be focused on people who

were already hospitalised, or who the research had identified as having psychosis, who then reported having spiritual experiences whilst in services.

My research, as documented in this thesis, sought to explore these gaps further, with a focus on the following elements:

- Literature with regards to spiritual experiences in the UK was very limited. I sought to find more about the landscape of interaction with mental health services in this area.
- The literature did not reveal much on spiritual experiences as self-identified, and frequently sought to define or theorise on what the spiritual experiences were, or explain them in the context of hospitalised participants already hospitalised for psychosis. This informed my epistemological position in this research as I sought to find participants who self-identified as having had spiritual experiences which were understood as mental health problems, with the research assuming a social constructionist epistemological position. This will be discussed further in the Methodology chapter.
- I was keen to investigate the mechanism through which spiritual experiences would come to be understood as mental health problem in our society in present day.

These factors influenced my desire to embark on this research, resulting in my research question: 'How are spiritual experiences understood as mental health problems in mental health services in the UK?'

Relevance to Counselling Psychology

Myira Khan's aforementioned work emphasised the gaps in counselling and psychotherapy training with regards to working within diversity. She emphasised the need to build anti-oppressive practice which 'explicitly acknowledges structural and systemic inequalities, systems of oppression and the entire power-oppression relational dynamic' (Khan, 2023). In her view, lack of acknowledgment of these things risks therapists becoming part of the problem, perpetuating dynamics that cause therapy to be of limited use and relevance to clients.

Vieten & Lukoff (2021) also emphasised that 'religion and spirituality are important aspects of human diversity that should be explicitly addressed in the field of psychology'. They further

explained that multicultural training is insufficient, and emphasised a need for specific training into religious and spiritual diversity, suggesting a competency framework that includes guidance on attitudes, knowledge and skills in psychology (Vieta & Lukoff, 2021).

As an integrated part of multi-disciplinary teams in mental health services in the UK, it is evident that psychologists, inclusive of counselling psychologists hold a significant role in patient care. Therefore as Counselling Psychologists it is important to be upskilled in all areas of relevance to the lives and difficulties of our clients. In order to understand the interaction of spiritual experiences with mental health services in our UK context, we must first ascertain the situation in services in the UK – what is happening, what is missing, what the implications are on these dynamics specifically with spiritual experiences. The following chapter (methodology) will detail how I sought to investigate this.

Chapter 2: Methodology

This chapter will seek to illustrate the rationale for the study, in addressing the research question: ‘How are spiritual experiences understood as mental health problems in mental health services in the UK?’.

The chapter will outline the ontological and epistemological assumptions that frame the research, details on the research design, participants, research procedures, ethical considerations, rationale and details of analytic method and reflexivity.

Theoretical aspects: Ontology & Epistemology

Ontology

Ontology is the study of being, and refers to ‘a formal, explicit specification of a shared conceptualization’ (Studer, Benjamins & Fensel, 1998). In research specifically, it refers to the positioning on the ‘form or nature of reality, and what is possible to know about that reality’ (Ponterotto, 2005). The ontological position of this piece of research is critical realism. Critical realism assumes that there is one reality, but that this is mediated by the social environment and the interaction between the participant and the researcher (Ponterotto, 2005). The nature of the research question lends itself well to critical realist positioning, as it is concerned with the phenomena of being understood differently than intended, where there is one reality – the spiritual experiences themselves – but different conceptualisations of them. This study is not concerned with ascertaining an absolute reality – as would lend itself to positivist ontology (Ponterotto, 2005), as this would not account for the dichotomy of different interpretations in the research question itself. It was also felt that a relativist ontological position, where reality is not absolute, but dependent on those interpreting it (Guba & Lincoln, 1998) would invite too much flexibility for the purposes of this study, detracting from the acceptance that something in fact did happen to the participants, regardless of the different standpoints through which it was perceived. It is however acknowledged that a relativist ontological position could have lent itself well in an exploration of the different schools of thought as it pertains as it pertains to spiritual experiences, if the object of the study were to debate what had occurred. However, for good ethical practice towards the participants, as well as in the best interest of the design of the study, the critical realist disposition suited best.

Embedded in the ontological positioning of the study is a value for classical science – the understanding that there are ‘regularities and systematic relationships between certain events and their outcomes’ (Walker, 2017). As such, the ontological assumptions in this study are that reality is one, but is mediated by socio-political, cultural, historical and economic differences.

Epistemology

Epistemology refers to the nature of knowledge, and what is possible to know (Willig, 2012). The epistemological position of this research is social constructionist. Social constructionist epistemology assumes that knowledge is created in conjunction with other people, as opposed to individually Berger & Luckmann (1966), and therefore that what is “known” is only such within specific sociological contexts. In other words, “reality exists within conversation between the knower and the known” (Holmes, 1986). The research question focused more specifically on clients who felt their construction of their ‘spiritual experience’ was different to that of those surrounding them – who defined it as a mental health issue and would subsequently connect them with mental health services. This research sought to unpick the various dynamics at play that occurred as a consequence arising from the different constructions (Willig, 2013).

There is much debate when it comes to the epistemology around what it means to have a mental health problem and how this is concluded upon (or perhaps more abruptly, the sanity-insanity conundrum and how each is decided upon). In a controversial essay titled “The Myth of Mental Illness” (1960), Thomas Szasz referred to attempts at defining mental health as “simply stating our preference for a certain type of culture, social or ethical order”. By this, he was perhaps hinting at the varying and sometimes opposing ways we choose to define mental health, and how ultimately our definition of what we class as ‘normal behaviour’ within any given culture may seem to favour certain groups or belief systems whilst simultaneously ostracising others. Here, Szasz inadvertently acknowledged the role of social constructs in seeking to define the meaning of wellness.

Theory on social constructionism stipulates that language is a foundational and integral part of how we construct reality. Berger & Luckmann (1966) stated that although language is subjective, it is through language that we attempt to achieve a sense of objectivity, and therefore shared understanding and experience. “Everyday life is ... life by means of language I share with fellowmen” (Berger & Luckmann 1966). It follows therefore that language, even in terms of how things are phrased or named, plays an instrumental part in how we conceptualise any given thing and the advised course of action following from that.

Social constructionist framework for the study was found to be the most suitable epistemological disposition, primarily due to the understanding through literature that discourse around spirituality and mental health has been a debate spanning centuries, filled with many different theories and points of view. There was also an ethical pull to regard the participant experiences with the same level of importance, as this seemed to be lacking in the literature. The study invited participants to partake in the study if they have had their spiritual experience understood differently from how it was intended. The aim of this choice of language was to capture those who did / do identify their experience as spiritual and were saying that they felt mental health services understood it as a mental health problem.

In compliance with the social constructionist framework, it was important that all language in the study did not indicate preference of one understanding or another – in order to allow the findings of the study to produce and construct their own meanings. For example, the research question needed to consist of the phrasing “understood as ...” as opposed to “misunderstood” so as not to attach any negative connotation to the question and thereby skew the range of experiences of respondents towards negative ones. Equally, all questions in the semi-structured interview had to be open and non-leading in nature, for similar reasons. In my position as a researcher, I tried to avoid assuming a position of correctness on any side of the spectrum, acknowledging that constructionism is focused on ‘discourse, meaning or experiences’ (Fryer & Navarrete, 2024). Literature reveals that the very nature of the definition of ‘spirituality’, and subsequently the understanding of ‘spiritual experiences’ is subjective, and socially constructed according to the lens of the person or group represented. Therefore, I took all information to be true, according to the social construct of the participant sharing it.

There seemed to be a gap in the body of literature for research that focused on a client’s experience of this difference in understanding within mental health services, and particularly from a social constructionist framework that valued the client’s perception of the experiences and reality of being understood differently from intended, as opposed to for example framing them as having a psychotic disorder. I was therefore keen to see how this positioning might impact on the research process and findings.

Rationale for Qualitative Approach

‘Qualitative research is concerned with meaning. It aims to shed light on how people make sense of experiences and what their behaviours mean to themselves and others’ (Willig, 2012). A qualitative study was selected as the chosen method of this study, in order to ascertain the depth of experience and capture the narratives of these clients in sufficient enough detail to analyse. The aim was not necessarily to show commonality of the occurrence of such experiences (as would be in a quantitative design or with a statistical science research paradigm), but rather to capture a snapshot and variation of the different factors emerging from these experiences. It was my desire that the findings of this research would further the conversation on the effects that these experiences can have on clients in accordance with the classical science research paradigm, seeking to ascertain any learning that can be taken from it into our work as mental health professionals.

Procedural aspects

Design

Data collection took the form of semi-structured interviews. Maxwell & Miller (2008) stated that some level of structure in qualitative research design helps to ensure comparability of data across the data set.

As such, semi-structured interviews were used to guide and prompt participants to speak around the topic of the research question, without necessarily enforcing themes.

Ethical Considerations

Whilst eager to conduct the study and to acquire the best possible richness of information and experience, it was important for me to hold the safety and best interest of participants in the utmost regard.

The topic of spiritual beliefs can be considered personal, and the topic of spiritual experiences even more so. It is often thought of as a taboo topic, where people can be reluctant to share such experiences for fear of being stigmatised. Intentionality about safe and ethical practice was therefore essential to the participant experience in this study.

The British Psychological Society (BPS) Code for Human Research Ethics (2014) emphasises the importance of maximising benefit and minimising harm in psychological studies. As such, the following protocol was adhered to:

- A screening phone call for each prospective participant – detailed in the ‘screening’ segment, a screening phone call was conducted following expression of interest in participating in the study. Here the prospective participant was assessed according to the eligibility criteria and assessed for risk of harm. This was to minimise the likelihood of participation in the study triggering any adverse consequences for the participant and their wellbeing. Participants also were given the opportunity to learn more about the study and what it would require of them, and to ask any questions they may have had at that stage.

- Dissemination of participant information sheet – this was issued via email to successful participants following the screening phone call. This was to ensure participants were as informed as possible on the study, the process, their input, the storage of their data and duration for this etc. Please see appendix B (page140-146) for the complete Participant Information Sheet.

- Informed consent – an Informed Consent Form was provided to participants prior to the interview, to be signed and returned before their interview commenced. The consent form explicitly asked for consent to record, transcribe and store the data, provided clarity on the handling of personally identifiable data in compliance with General Data Protection Regulation (2018). It also asked participants to opt in if they wished to receive a summary of results once the study was completed.

- Freedom to withdraw – this was reiterated to participants at every stage from the screening phone call to the day of the interview. Participants were informed that they were free to withdraw at any point up until 1st August 2020. If any participants were to withdraw prior to this date, all their data would have been securely destroyed. Beyond the given date, participant data was anonymised and transcribed, and therefore was no longer able to be removed from the study.

- Answering to best ability – participants were reassured that there was no correct or incorrect answer to each question and were encouraged to answer each question to the best of their ability. This ethical consideration was to encourage participants to feel free to give their authentic and honest answers to the interview questions.

- Freedom to terminate interview and have data deleted – Participants were informed that should they become uncomfortable at any point during the interview, they were free to withdraw without providing reason, and all their data would have been deleted.

- Debriefing – a full debrief was be provided following the interview. I asked each participant how they found the interview, how they were feeling, if they had any

questions and provided a debrief form for them to read and keep. Please see appendix B (page 146) for the Debrief Form.

- Signposting – this was able to occur at different stages of the process where necessary – following the screening phone call for those who were unsuccessful as participants or did not meet the criteria, and at the end of each interview for every participant.

There is more discussion to be had as it pertains to ethics within the chosen research subject area. The concept of something being understood as a mental health problem by a mental health professional is imaginably uneasy to navigate due to the power dynamics between the therapist (the ‘expert professional’ who may be viewed as the qualified to make certain judgements) and the participant, who may or may not have felt empowered in their own expertise of their experience. Due to my dual position as a practitioner (and therefore a representative from mental health professions) as well as a researcher, I anticipated that it was likely that there would be a reflection of this power dynamic in the relationship between researcher and participant – in spite of best efforts to remain neutral.

It was therefore of utmost importance that I as a researcher considered sensitivity in my approach as a high priority, due to risk that may lead to labelling (British Psychological Society, 2014). This was one of the main motivations for the social constructionist epistemological framework of this study – to create an equal playing field where I mirrored the curiosity and non-expert role of a researcher who values a client-centred approach and the contribution of cultural and social contexts in each person’s construction of reality.

Recruitment

Following ethical approval by the City (University of London) Research Ethics Committee, recruitment began through the dissemination of the promotional posters online (see appendix A, page 139 for copy of poster) via platforms such as Twitter, Instagram, Facebook & LinkedIn, and through my contacts in various mental health / psychotherapeutic settings.

In actuality, a number of participants were recruited via word of mouth, themselves having participated in the study and shared promotional information for the study.

Inclusion & Exclusion Criteria

Participants of this study were required to be:

- Over the age of 18 – Due to the sensitive nature of the study, I thought it best to only conduct the study on people who would be lawfully entitled to make their own decisions as it pertains to their mental health (providing capacity). This was also an ethical consideration. There is no upper age limit as I did not want to limit any prospective clients and did not have a justifiable reason on the grounds of age for doing so.
- Of any gender identity and sexual orientation.
- Of any spiritual / religious persuasions, or of none- Whilst many similar studies in the research area are focused specifically on one religion or spiritual belief system, this study sought to give a clear representation of what the common narrative of spirituality might be amongst those who had encountered mental health services as a result, as opposed to experiences amongst specific religious or spiritual groups. The study aimed to focus more on the commonality of experience (themes) in spite of spiritual or religious persuasion as opposed to on a diversity of experience within a specific group.
- Citing experiences within UK mental health services within the 10 years prior to the start of the study (2010). This was with the hopes of obtaining research findings that were as applicable to current practice as possible.

Screening

Following each participant's initial expression of interest, a stringent screening process took place to provide further information on the study and to ascertain their suitability for participation in the project; getting a sense of their mental wellbeing. It was important that no participant would be in a position where they will suffer harm as a result of participating in the study, as this would have been a breach of the study's ethical considerations.

Screening took the form of a phone call; a vetting phone call was arranged for each potential participant expressing interest in the study.

During the phone call, I enquired about the prospective participant's mental health background and asked questions to ensure that no participants were unwell at the time of study (for example, in an active psychotic episode). This was ascertained using clinical judgement, in the same manner that I would make such judgements clinically. Any queries pertaining to this were consulted upon with my research supervisor.

As part of the vetting phone call, prospective participants were be asked the suicidality question on the PHQ-9 (Kroenke, Spitzer & Williams, 2002). This was to ascertain risk and eliminate

possibility of harm. All prospective participants indicating having made plans to end their life in the last week would be eliminated from participating in the study and would have been signposted to relevant support organisations. Fortunately, this situation did not arise.

Only participants successfully vetted and found to be not actively suicidal and in a place of mental stability were encouraged to proceed in part-taking in the study.

Following the screening phone call, successful participants were given a week cooling-off period in which to consider and confirm their interest in participating in the study. Following this, they were contacted to book in their interview.

Participants

I was able to obtain a volunteer sample of 11 participants through this recruitment, who responded positively to the advert, reporting that they had had their spiritual experience understood as a mental health problem by mental health services in the United Kingdom in last 10 years at the time of interview.

Participants were recruited and interviewed as they expressed interest. This was to maintain the organic nature of the data collected, as opposed to creating any biases through choosing some participants and not others. Recruitment aimed at capturing between 6-15 eligible participants, in accordance with recommendations for Thematic Analysis in Professional Doctorate research projects (Willig, Rogers, Terry, Hayfield, Clarke & Braun, 2017). I was able to successfully obtain a final number of 11 participants.

Participants were between 25 and 64 years of age.

In terms of ethnicity, two participants were of Black British heritage, one was of Asian British heritage, and one identified as White European. The remaining seven participants were White British.

In terms of religious persuasion, three participants reported that they were Christian, one reported that they were Shamanic, one reported that they were mostly Buddhist and another reported that they identified with all religions. The remaining five participants identified as having no religion.

Please find below a summary of demographic information, along with a brief summary of the experiences of the participants.

Participant Summaries

Below are summaries of the stories of each of the participants, to provide context for further analysis of their experiences.

Table 1.1: Participant Summaries

<u>Pseudonym</u>	<u>Age Range</u>	<u>Religious / Spiritual Persuasion</u>	<u>Ethnicity</u>	<u>Summary</u>
Imogen	25-34	Christian	Black British	Imogen reported having numerous experiences of what was deemed psychosis and attributed to a diagnosis of Bipolar Disorder, which she saw as spiritual. Imogen cited having the ability to speak different languages and having a mission during her spiritual experiences
Nala	25-34	Christian	Black British	Nala shared on a number of spiritual experiences she had had. She was hospitalised on a number of occasions during her experiences. She found that her experiences did not always align with her Christian worldview and found a lack of opportunity to explore and understand them both in mental health services and in faith-based spaces. She has explored different religions and groups seeking meaning for her experiences. .
Millicent	35-44	No religion	British	Millicent spoke about spiritual experiences and encounters with the mental health system spanning decades. She was sectioned under the Mental Health Act on a few occasions, and offered a number of diagnoses over the years including Bipolar and Schizophrenia. She was not believed with regards to her need for cancer medication or properly informed of her rights to appeal her section or go to tribunal. Millicent later worked in Mental Health services in seeking to understand her experiences.
Claudia	35-44	Shamanic	White British	Claudia spoke of her spiritual experiences being understood as a mental health problem numerous times under the care of three different mental health teams. Claudia spoke of the clashes of her Shamanic belief system with the mental health system and the differences in ways of conceptualising these. Claudia took these comparisons from her lived experience as well as partial training in counselling.
Jimmy	35-44	No religion	White British	Jimmy described numerous experiences spanning decades which he later came to understand as spiritual. He felt that his experiences were initially spiritual, but have now become partially mental health issues due to the trauma and treatment given by mental health services. He felt that mental health services and pharmaceutical companies

				were financially motivated, to the detriment of those who encounter them.
Shanice	35-44	No religion	Asian British	Shanice described having Kundalini experiences and believed that they were partially spiritual and partially as a result of a manic episode. She described her experiences being triggered by alternative therapies and wellness practices. She described the system being violent towards her when she only had love to give. She shared that she felt she needed to be cared for in a safe place where she could recover, which she would have preferred to be at home, but due to the limited capacity of friends and family she had to be hospitalised.
Dillon	35-44	Christian	White British	Dillon described a number of visions he had had over the years which he understood to be messages from God providing direction in his life. The sharing and pursuit of these visions resulted in a criminal case, with Dillon spending time in a medium-secure psychiatric unit. He described the mental health system as having scared him to death and feels that he was greatly misunderstood.
Clive	55-64	No religion	White British	Clive described his experience as having opened up his chakras without appropriate understanding and guidance, which led to energetic experiences and diminished functioning leading to hospitalisation in mental health services. He has a background in sociology and evaluated the system from the lens of his personal experience (he described feeling pulled down and bullied) as well as from his professional experience working and teaching in caring professions.
George	55-64	No religion	White British	George described having a spiritual awakening (which he described as an energetic experience) and opting to go to hospital due to a turbulent home environment making recovery difficult. He described his experience in hospital as making things even more complicated with the introduction of medication making things more difficult to manage.
Cassandra	35-44	Identifies with all religions	White British / European	Cassandra described being brought up with a focus on Christianity and the scientific, and later having spiritual experiences that exposed her to things she did not think possible. She identifies as a witch and described not being well received in the mental health system and having some violent experiences whilst under mental health care for what she deemed as spiritual. She described her experiences being partially as a result of past and ongoing traumatic experiences.
Mary	25-34	Mostly Buddhism	White British	Mary described having an inclination to start fasting for health reasons. She felt that she grew spiritually and learned strength and resilience through this, but it was felt that she had an eating disorder and Mary was hospitalised

				on a number of occasions – including psychiatric hospitals and eating disorder units. She described the conflict between trying to progress in her spiritual views and values and feeling held back by the perceptions and wishes of the systems she found herself in.
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Data collection:

Data was collected through the conduction of virtual semi-structured interviews. These were due to be conducted in person initially at the research laboratories at City, University of London. Unfortunately, due to COVID-19 restrictions and university recommendations, these interviews were offered online via Zoom Communications video call. Each interview allowed for 90 minutes in duration and was recorded with the consent of each participant.

Participants were invited to answer demographic questions with regards to their age, ethnicity and religious persuasion, share what had inspired them to take part in the study, and to share more on their experience of their spiritual experience being understood as a mental health problem.

Questions included but were not limited to the following:

- When you first came across the advert for this study, what experience came to mind?
- How would you describe your spiritual beliefs?
- How do you know it was understood as a mental health problem?
- What did it mean to you to have your experience understood in this way?
(how did it affect you)
- How do you tell the difference between having a spiritual experience and a problem in your mental health?

Please see appendix C (page 146) for the full interview schedule.

As the interviews were semi-structured in nature, each interview followed a similar format, differing slightly to allow for clarifying and follow up questions, and the evolution of the questions as I

discovered what was more helpful either for the participant's understanding, or to ascertain the information intended by the question.

Rationale for Reflexive Thematic Analysis

Reflexive thematic analysis is a qualitative method used to identify, analyse and report patterns in the data (Braun & Clarke, 2006). Thematic Analysis can be described as a method, as opposed to a methodology, because of its ability to capacitate a range of different ontological and epistemological positions in its use (Willig, Rogers, Terry, Hayfield, Clarke & Braun, 2017). It allows for the identification of latent and interpretative themes, as well as semantic themes (Braun & Clarke, 2006).

It follows six main stages: familiarisation with the data, generating initial codes, searching for themes by collating codes, reviewing themes, defining and naming themes and then producing the report (Braun & Clarke, 2006). This process allows the researcher to really become immersed in the data set, in order to formulate themes from the understanding of what has been communicated.

As thematic analysis can be used effectively with a number of different ontological and epistemological positions, it suits this research well, as it allows analysis within a social constructionist framework. In this sense, reflexive thematic analysis within a social constructionist framework 'seeks to theorise the sociocultural contexts and structural conditions that enable the individual accounts provided', rather than focusing on individual ideologies or theories (Braun & Clarke, 2006), with the researcher also maintaining an awareness of their own influence and positioning on the research.

Reflexivity refers to 'the act of examining one's own assumption, belief, and judgement systems, and thinking carefully and critically about how these influence the research process' (Jamieson, Govaart & Pownall, 2023). Braun and Clarke (2019) offered some guidance on reflexive thematic analysis, encouraging researchers using reflexive thematic analysis to hold an awareness of the role they play in conceptualising themes, and the flexibility of the process. Braun and Clarke were keen to point out that the researcher is actively involved in interpreting the data, and that themes are not simply discovered lying in the data, but that they actively involve the researcher's decision making in constructing and pulling together the themes from the wealth of data and possibilities that the data provides (Braun & Clarke, 2006).

As such, this study sought to analyse the interview data through a process of reflexive thematic analysis, seeking to identify themes that speak to the different social constructions that may exist in answer to the research question.

Limitations of Reflexive Thematic Analysis

There are a few limitations of reflexive thematic analysis. Firstly, the approach can be seen as too broad. Whilst its broadness allows for its use within various ontological and epistemological frameworks, it can also lack a sense of structure, leaving the approach vulnerable to being used poorly and producing results that lack in rigour. It is important for the researcher to be clear on how to use the method within the appropriate research paradigm, and to follow guidance for appropriate use of the method (Braun & Clarke, 2019, British Psychological Society, 2018).

Further to this, this method does not provide existing theory to build on, in the way that other methodologies such as Interpretive Phenomenological Analysis (IPA) or Grounded Theory. As such, not building on existing theory within a particular area of research could produce outliers in the research. However, this also produces a conducive environment for new findings to be considered.

Another critique of the method is that inevitably it is the researcher's understanding of language and what is being communicated that will ultimately dictate what themes are constructed, and what importance is given to them. This does not allow for a concept of objectivity or easy replicability, however this perhaps would be more problematic within a realist ontological positioning. Braun & Clarke (2019) encourage reflexivity as a tool to regularly review the influence and impact of self on the research.

Elimination of other methodologies

A number of other analytical methods were not selected because they did not fit the either the aims or the ontological and epistemological positioning of the study. Whilst IPA may have been able to capture the experience of spiritual problems being understood as a mental health problem in mental health services, it would have focused solely on the phenomenon of the experience of the participant (McLeod, 2001), and perhaps not have accounted for the social constructionist angle of being able to examine the different constructions at play in *how* these experiences come to be understood in this way, albeit through the lens of the participants. The research paradigm sought to focus on a more balanced ontological view, where all the different realities expressed had equal standing.

Grounded theory was also eliminated as a method of analysis, because of its focus on constructing theory from the data (Tie, Birks & Francis, 2019). The research paradigm sought to examine the different constructions emerging through the research, as the literature in this area is limited. There was perhaps not enough rationale to create any one theory on how spiritual experiences are

understood as mental health problems in services. It is acknowledged that grounded theory could have been used if the focus of the study was to produce more of a theory on the beliefs of participants as to the nature of their spiritual experiences, which was described by a number of participants in data collection. However, the research question was more focused on looking into the interaction between participants and services, what the issues were and which constructions enabled this, and any recommendations resulting from this.

Analytic strategy

The Braun & Clarke (2006) six stage model of thematic analysis was employed in the analysis of the data collected. I transcribed each interview, familiarising myself with the data set as I did so. From this I generated initial codes with a view towards latent content from a social constructionist perspective. I then searched for the themes which emerged from the data, reviewed the themes, defined and named the themes and then produced a analysis report with this data (Braun & Clarke, 2006).

Phase 1 - Familiarisation with the data

According to Braun & Clarke (2006), the first stage of thematic analysis is familiarisation with the data. The process of transcribing all verbal data from the eleven interviews really aided with the familiarisation process, as it required going through each interview in detail to log every communication. I noted that there were things said in the interview that I did not have memory of, that were illuminated in the process of transcription, which caused a detailed focus on the content of each interview as verbatim account of each was required in compliance with the method (Braun & Clarke, 2006). Where relevant, I also attended to non-verbal cues in the interviews, such as shifts in emphasis, pauses and accent changes. Following transcribing the interviews I read through each interview a number of times, seeking to immerse myself in the data. I created an initial list of interesting points about the data, to revisit and perhaps develop through the analysis process. At this stage, my initial list consisted of considerations such as the role of power in the dynamics between participants and services.

Phase 2 - Generating initial codes

The coding process began by going through each interview to highlight and annotate codes from the text, seeking to deduce both semantic and latent content. Sometimes these were direct quotes in and of themselves, and other times this was surmised meaning from what was being communicated, driven by the data. Coding was conducted by hand, with Microsoft Word and Microsoft Excel, and

then with coding software. This was mainly a matter of trial and error, as I sought to establish the most efficient method for me.

Phase 3 – Searching for themes

This phase was characterised by identifying similar codes and messages that seem to have come through them, and collating them into initial ideas and themes. I created a series of mind maps to aid in doing this, also making reference to my initial list of interesting points, in beginning to formulate key themes and subthemes. At this stage, my initial themes were around ‘power of the system’, ‘self perceived as’, ‘perception of others’ and ‘bias’. Examples of these mind maps can be found in appendix F & G (pages 150-151).

Phase 4- Reviewing themes

The process of reviewing themes was an iterative process that involved going over the codes repetitively and reiterating the concepts mentally, to understand the commonality of the codes and their relationship to one another. Braun and Clarke (2006) advise that this stage is split into two levels – collating coded extracts for each them to understand if the content fits the themes, and then a consideration of the validity of the themes across the entire data set, as to whether they are an accurate reflection of the data as a whole. Within the first level, I collated a huge document with coded extracts relevant to each theme. This document was very useful to me even in phase 6, and was frequently revisited. A thematic map was also created, detailing four key themes and their subthemes. On the second level, I reviewed themes across the data set, paying attention to looking more broadly at the emergent themes relevant to the understanding of spiritual experiences as mental health problems, and aspects relevant to their social construction.

Phase 5- Defining and naming themes

This stage represented the final version of the thematic map before commencing the report. My final themes were:

- Differing perspectives
 - o Lived experience
 - o Of professionals
 - o Of others
- Bias
 - o Diagnostic ideas causing confirmation bias against spirituality
 - o Resistance to listening

- Violence of the system
 - o Traumatic interactions
 - o Violence and compliance dynamics
 - o Impact

These seemed to produce a good representation of the data in response to the research question and provided a good foundation to commence writing the analysis chapter.

Phase 6 - Producing the report

Here, the task was to explain the different themes and subthemes, how they linked to each other and how they answered the research question, with the social constructionist epistemology in mind which stated that analysis seeks to “theorise the socio-cultural contexts and structural conditions that enable the individual accounts provided” (Braun & Clarke, 2006). This process was also iterative, and the process of writing the report greatly aided in the further development of the themes. In this stage, ‘reality as socially constructed’ was removed as a subtheme and absorbed within the description and epistemological positioning of the ‘differing perceptions’ theme, as it was felt there was not sufficient evidence for it to constitute as a subtheme, but was more a significant code. Under bias, ‘motivation towards a particular outcome’ was changed to ‘diagnostic ideas causing confirmation bias against spirituality’ as this described the intention of the subtheme much more accurately. The theme ‘differing perceptions’, was renamed to ‘differing perspectives’, as carefully considering the difference between the two words, it was felt that ‘perspectives’ more closely aligned with the integrity of what was communicated in interviews. The full analysis, inclusive of the thematic map can be found in the analysis chapter.

Reflexive and evaluative aspects

Quality and validity

Within qualitative research, issues of generalisability, reliability and replicability are not always relevant (Yardley, 2000). Qualitative methods provide scope for depth of analysis; in that sense its research aims differ from quantitative methods which seek to provide information with statistical significance. Reliability and replicability is not as easily ascertained due to the subjectivity, and often the value in the subjectivity and interpretation, of various qualitative analytic methods (Yardley, 2000). Yardley further outlines that the characteristics necessary good qualitative research are sensitivity to context. Commitment and rigour, transparency and coherence and impact and importance.

The characteristic ‘sensitivity to the context’ makes reference to relevant theory or literature, empirical data, sociocultural setting, participant perspectives and ethical issues (Yardley, 2000). Due to the social constructionist epistemological position of this research, as well as the very nature of the research question and the ethical dilemma produced from the idea of being understood differently than intended, these factors were a constant consideration in this research.

Commitment and rigour makes reference to ‘in-depth engagement with the topic, methodological competence, thorough data collection and depth / breadth of analysis’ (Yardley, 2000). Whilst the method of reflexive thematic analysis was new to me, I frequently made use of guidance on use of the method in the form of articles (Braun & Clarke, 2006, 2019), as well as videos and other forms of material to familiarise myself with the process and standards expected. Data collection was thorough in this case, aided by a good set of interview questions which were tailored to provide answers towards the research question, as well as amazing participants who provided such rich data through their interviews. The analysis process took several months, and many drafts and revisions of the analysis chapter were produced to facilitate the depth and breadth of analysis.

Transparency and coherence makes reference to ‘clarity and power of description / argument, transparent methods and data presentation, fit between theory and method, reflexivity’ (Yardley, 2000). The clarity and power of the descriptions and arguments evolved as I continually immersed myself in the data and in the analytic process. The use of quotes in illustrating themes and the journey through them was to aid transparency in method and understanding of how the themes and subthemes were arrived at. I revisited the analysis to ensure adherence to the theoretical positions previously presented as I revised the analysis chapter. Reflexivity was a fundamental part of the process in engaging with reflexive thematic analysis. I made use of reflexivity boxes throughout the analysis chapter to illustrate this.

Impact and importance are divided into ‘theoretical, socio-cultural and practical’ (Yardley, 2000). In part these key points are addressed within the analysis, and further elaborated upon and evaluated in the discussion chapter.

Consideration of reflexivity

Epistemological reflexivity

Braun & Clarke (2018) emphasised the importance of viewing “researcher subjectivity as a resource rather than a problem to be managed”. As researcher, I was mindful of my expectations of the study and its ability to affect my identification of certain themes in data analysis. It was important to be mindful of my positioning as a researcher specifically within the context of epistemological

position of the study, where I was tasked with identifying social constructions contributing to the answer to the research question, with use of my own understanding of language and with full engagement with the analytic process, whilst remaining rigorous and avoiding taking the opportunity to offer my own constructions or theories. This was challenging at times.

Methodological reflexivity

In embarking on this piece of research, I came to the realisation that in my conceptualisation of the research project, I had not much thought of the possibility of receiving responses of positive experiences of this occurrence – for example encountering participants who were extremely grateful for mental health services identifying their spiritual experience as a mental health problem and who perhaps felt that they benefitted from it in some way. In that I realised my bias towards a certain outcome and took note to be mindful of this, particularly in selecting and constructing themes to be an accurate reflection of participant responses.

Personal reflexivity

My inspiration for conducting this study followed from my own experiences of clients reporting spiritual experiences in therapy. These reports were not uncommon, and I wondered if other therapists and mental health professionals more generally had experienced clients sharing their interpretation of these events so openly, and if they too experienced this sharing as frequently as I did.

I realised through my experience of these conflicts that it would perhaps be difficult for certain social and cultural groups to access support for similar reasons. I was therefore enthusiastic about the social constructionist framework of this study, for creating room for narratives like my own as well as narratives that differ. In a world where reality is mediated through socially constructed perceptions, no particular view of reality remains superior to another or can be imposed on another. This also felt important in protection (ethically) of the participant group.

As Braun & Clarke (2018) suggested, I have learned to view my subjectivity as a tool – where perhaps I was able to notice themes due to my exposure to the subject area and was able to bring a richness to the process due to my interest in the subject area. It was however of utmost importance that I maintained vigilance around remaining open, curious and reflexive – feeding reflexivity back into my work, in order to maintain validity. As such, I threaded reflexivity through my analysis, creating reflexivity boxes to acknowledge these thoughts whilst also not permitting them to colour my presentation of the data. I also kept a reflexivity diary, making note of my thoughts at various stages in the process, which I was able to make reference to in constructing the post-reflexivity segment of the

discussion chapter (see page 141). I also fed back any major tensions or concerns to my research supervisor, who was helpful in fleshing these out with me.

The following chapter I will detail the analysis report for the study.

Chapter 3: Analysis

Introduction to Key Themes

This chapter will detail the findings of this study, in the form of an analytic report produced using reflexive thematic analysis (Braun & Clarke, 2019). I will be exploring the themes and subthemes that were generated and understood from the interviews in answer to the research question ‘How are spiritual experiences understood as mental health problems in mental health services in the UK?’.

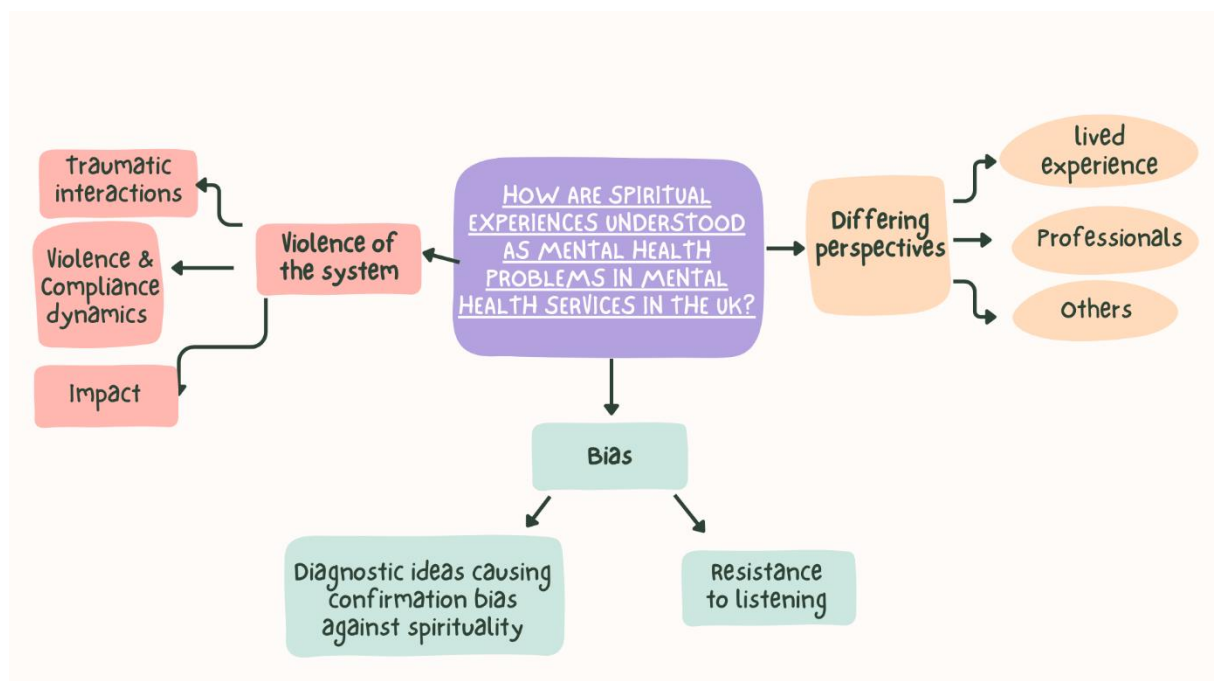


Figure 1 – Full Thematic Map

Three key themes that emerged from the data:

- Through ‘Differing perspectives’
- Through ‘Bias’

- Through the 'Violence of the system'

Please see Figure 1 for a full thematic map of these themes and their subthemes.

One of the ways in which spiritual experiences ended up being understood as mental health problems in mental health services in the UK is through differing perspectives – of what spiritual experiences even are, and of what mental health is, and therefore the appropriate treatment if required of both or either. This is centred around the idea of the view of reality as socially constructed; that from different lenses or points of view, the perception of is real (genuine, not in need of medical intervention, perhaps even sane) is based on differing social, cultural, educational and religious constructs of the matter. In the research, these differing views and the tug of war between the perceptions of various parties in the lives of the participants often resulted in choices being made out of concern for them that they perhaps would not have agreed with or preferred.

Further to these ideas of the impact of perspective on outcomes, the second theme that emerged in my analysis was 'Bias'. This theme was mainly centred around the participants experiences once in mental health services, and was divided into two subthemes – 'Diagnostic ideas causing confirmation bias against spirituality' and 'Resistance to listening'. Participants found that mental health professionals in mental health services were largely motivated towards the pathway of diagnosis and viewed all things including spiritual phenomena as evidence of their illness. It seemed that the mental health professionals held a view the that participants were mentally unwell and that they needed treatment, often including psychotropic medication, to make them better. Many were sectioned under the Mental Health Act (1983) as a result. Participants found that often when they would try to speak up to explain their view or to provide resistance, they often were not listened to. It was almost as though the bias that they were mentally unwell made services determine that they were not worthy of being listened to, about their spiritual experiences as well as about other practical matters. This will be explored further within the Bias theme.

Whilst a few participants experienced things only to the extent of bias, many participants recounted experiences that were violent in nature, hence the emergence of the subtheme 'Violence of the System'. Here I explored the nature of traumatic interactions that occurred between participants and the mental health system, violence and compliance dynamics that these experiences created and the impact on participants and their lives moving forward from these encounters.

Differing Perspectives: Reality through social construction



Figure 2 – *Differing Perspectives segment of thematic map.*

Through analysing the data, one of the key themes that became apparent was “differing perspectives” - how differing perspectives influenced the experience of someone with a spiritual experience being understood as having a mental health problem. It affected the lived experience perspective – of who the participants felt that they were, aspects of their view on their identity, their world views and perspectives of what was happening to them, perspectives of professionals or the perspectives of others (friends/family/wider society). The matter of how spiritual experiences are understood is a matter of perspective on spirituality and related content. The very definition of “spiritual” is subject to interpretation, and interlaced in everything said, as well as the idea of the spiritual being hinged upon belief. Further to this, through the interviews it became apparent that these different perspectives enabled some to hold more power than others.

The differing perspectives identified were of participant lived experience, professionals and of others. These factors influenced the way the situations were viewed, who participants went to for help, how they believed help was needed or if it was needed and what they viewed the process to be.

The idea of differing perspectives existing in answer to this research question is only possible on the basis of the ontological and epistemological underpinnings of this research. That is to say that from a critical realist positioning, reality is one, but is mediated by or understood through socio-political, cultural, historical and economic differences. This theme therefore sought to understand the differing perspectives the parties involved had of the same problem, and to extrapolate any semantic or latent suggestions from the interviews of factors contributing to the development of these social constructions.

Participants also had a positioning on this. As what is deemed a “spiritual experience” was self-identified and is perceived differently by different parties according to their own view, participants started to speak about the idea of what we deem as real as a matter of social construct, influenced by culture and other factors. Clive articulated these views aptly.

There's a school of sociology looking at the construction of reality and ... who we see we are. We weren't born ... I wasn't born as Clive, you weren't born as Nikita Quartey. You internalize that ... we internalize this idea ourselves through the interaction of our world ... when we were children and with family, then the wider world.(Clive, p3, 162).

Even from his positioning as a participant, Clive’s understanding of the very nature of the problem was a matter of differing constructions or understandings of reality.

Lived Experience

The first key perspectives explored within this theme was the 'Lived experience perspective'. This encompassed the perspective that participants held of what they were experiencing spiritually, how it affected them and what they felt they needed. These perspectives were described as formulated in part at the time of occurrence, and in part retrospectively.

It is interesting to contemplate what constitutes of a spiritual experience – especially as in recruitment for this study, it was self-defined, and participants were free to come forward if they felt they had had spiritual experiences. Whilst participant experiences were diverse in nature and were affected by different variables, there were some commonalities in their perspectives of the content and purpose of their spiritual experiences, some of which are outlined below.

One common factor shared amongst most participants was the understanding that they gained extra abilities in their spiritual experiences. Imogen speaks to how she felt her abilities changed ...

I could speak to lots of people, all languages, all ages, everything... So there was ... so one memory we was in the pizza shop right, with my mum and my sister, and this woman came into the shop and she was speaking in another language shouting at the man in the pizza shop, and I said to my mum and my sister, "I speak in tongues, I can understand every language," and I said to them "She's complaining because the man forgot to give her her garlic bread". I kid you not, the man was like "Sorry, sorry, sorry ma'am", and he got out garlic bread and gave it to her ... I just had the ability and the power to talk to other people. (Imogen, p4, 157).

Imogen's description of the ability to understand every language here transcended her natural limitations. In her tone and description, she seemed to hold an element of surprise and excitement at this encounter. Nala also described gaining additional abilities during her spiritual experiences.

I thought that, you know, I could ... er kind of like telepathic kind of abilities, which I guess now ... So there was a lot of prophetic stuff as well, I would say. (Nala, p5, 1126)

Aside from gaining additional abilities, a number of the participants described having bodily experiences – in terms of their bodily sensations and their emotions. For instance, George described new physical sensations ...

I experienced all these symptoms which were ... which I knew were absolutely spiritual awakening character. Because they were quite unlike anything else – energy rushing up from my body, visions of light sort of angelic figures, and a tremendous sensation of love ... of unity with ... whatever ... whatever existed and er ... I was sitting in one afternoon ... I was just sitting there trying to cope with this trauma, and as I say, the energy just exploded up my spine feeds off my head and just you know what quite ... very intense. And sort of visionary experiences. (George, p4, l135)

George described experiencing emotions and bodily sensations that were contrary to what he was navigating (trying to cope with trauma) through his spiritual experience. He also made mention of experiencing angelic beings. Similarly, Shanice described having other worldly experiences, transcending the confines of this planet and of the present time.

Just kind of went into this is completely different planet where, um, yeah, I felt like energy coming through my body. I was going into spontaneous like a cre- like mo- like yogic postures, feeling like volts of electricity coming through me to the point where I shaking. I was ... all kinds of things. Felt like I was going back into past lives. (Shanice, p3, l60)

Imogen also described the feeling of difference through her spiritual experiences, that she felt “superhuman”, and that it felt like a “dream-like state”. It was not uncommon for participants to report that what they experienced altered their emotional states positively. Millicent similarly described moving from a baseline of stress and depression to a state of relaxation and happiness from feeling connected with God, and receiving revelations. It was clear from many client recollections that the positive changes in affect were not unwelcome. More latent in these examples was the sense that these changes seemed to provide a sense of empowerment and significance to the participants, moving from their ordinary lives to something quite spectacular that far superseded their everyday limits, and felt important.

Similarly to George's previous mention of encountering angelic beings, many participants made mention of experiencing and interacting with spiritual beings. Claudia described one of such experiences...

Like when I was in training that I actually experienced erm ... what you'd technically call as a ... as a psychosis. But it was when I was actually working with a ... erm ... psychotherapist that I found myself connecting to all these different things that could be interpreted as spirituality erm ... so things like erm ... I connected with erm ... different spirit ... spiritual animals, if that makes sense and found my own spiritual ... spiritual animal that I connected to for years erm ... then I connected with other people that had were a bit more further on a spiritual path (Claudia, p3, l54).

Similarly, Nala described her experience of other beings within the context of having 'broken in' or gained illegal access into a spiritual network likened to Guardians of the Galaxy, where she had access to things she was not otherwise meant to see or be aware of.

Although not all participants were clear in their accounts of the meaning of these interactions with spiritual beings, Imogen described the beings that she encountered as having something that they wanted to convey to her or something that they wanted to achieve.

I'd get up, there'd be something standing there, someone standing there, in the midd- ... in the "middle of my dream" I'll wake up and I'll see things and they'll talk to me or try and communicate with me or they won't talk to me ... just things like that. And there's times when I'm sleeping at night I have things come and visit me, sounds very weird, this has happened since I was younger. (Imogen, p8, l210)

Hmm ... I'll give you one that freaks me out still to this day ... so I moved into a new flat right ... and erm ... so at night time, like a spirit would visit me (giggles). And whenever they would be around it would bring pain and it would bring suffering when they'd come and visit me, right? (Imogen, p7, l181)

Imogen went on to explain that she later discovered that a previous tenant had died of cancer in her flat and understood the spirit that she encountered to be the spirit of the person who had experienced the pain of cancer and died there, understanding that to be why they were communicating pain and suffering. It was not uncommon for participants to describe a sense of divine direction, intention and guidance, through experiences with other beings as described here, as well as through a general sense of presence or through synchronicity.

Reflexivity Box

Many participants were very descriptive on the content of their spiritual experiences, which I was intrigued about due to personal interests in theology and spiritual perceptions and explanations. During the analysis, it was tempting to focus on this, however it was important to highlight the experiences, but focus on their context in answering the research question.

Not all participants had a clear perception of their experience as spiritual at the time that they occurred, and did not always know they were having a spiritual experience. This was mostly defined / described as such in hindsight, which seemed to help to provide a greater sense of definition. Nala's earlier description of gaining extra abilities were partially aligned with normative Christian beliefs, in terms of her reference to 'prophetic stuff', and partially not, with reference to 'telepathic abilities', which perhaps reveal a mixed way of framing these experiences, perhaps with more emphasis on accurately reflecting the nature of the experiences than on aligning to the language of any one belief system.

Some participants described their experiences as being within / aligning with a religious construct, such as a Kundalini awakening aligning with Hinduism, or the experience of angels and demons aligning with Christian beliefs, however this was not always the experience. Often within one experience there were multiple factors which did not necessarily fit neatly into the boxes of specific religious constructs. Sometimes also the aligning of the experience(s) with a religious construct was retrospective through research and connection to like-minded communities, rather than in the moment. Often, it appeared that the stance they held at the time of these experiences was one of confusion, overwhelm but also a new sense of purpose, in the feeling of gaining an awareness something new. Jimmy described the process of making sense of his experiences within spiritual frameworks.

But the things that make sense to me now looking back, are the, the type of um... experiences that were Shaman ... going to other worlds and they, they have a sort of rite of passage, sometimes I think, where they start to hear voices and things like that and another way of describing it will be this the sort of, um, I don't know how much ... because I've read a bit about bits of it, but I've not got to the bottom of that and I've only scratched the surface of ... what people- But then the other thing that makes sense to me is some, I don't know what religion is, but it's like I think it comes- I think it's like an Indian time where they describe like Kundalini I'm like a like a, like an awakening, or breaking out. (Jimmy, p3, 156)

Claudia further illustrated the uncertainty whilst seeking to define her experiences ...

So, there was always an awareness around and even sort of some of the higher level of consciousness work that I felt my spirits were doing with me, I never shared it with anyone because there was an apprehension as to, I don't know what this means, but it feels like I need to go with it. (Claudia, p8, 1296).

Here, both Jimmy and Claudia described the process of going into their spiritual experiences, where it seemed Jimmy was able to make more sense of it as a spiritual Kundalini experience in hindsight, whereas Claudia seemed aware at the time of “the work that (she) felt (her) spirits were doing with her”, and subsequently felt the need to hide it but also to continue with it. In herself it seemed Claudia was apprehensive as to how this experience would be perceived by others, particularly without her own clarity at the time as to what it entailed or what significance it would have. One could suggest Claudia did not feel comfortable being vulnerable with the raw materials of her experience as it was happening. Jimmy, on the other hand, seemed to have embarked on research following these experiences, in search of understanding and providing context for his experiences. Some of the other participants reported needing to do this as well, with many reporting that the nature of their spiritual experiences did not align with their religious belief system prior to their occurrence.

Participants were keen to iterate how valuable these spiritual experiences were to them.

Claudia described that she learned more about herself, and that her spiritual experiences taught her more than her counselling training did.

But there was this kind of ... at that point of connection on to, like, erm ... feeling I was on a spiritual path. And just as you kind of learn more about yourself in relation to you when you do your training and stuff... I just found that life experiences taught me towards just different things that, that to me, kind of, I just, I don't know whether it was like a ... thoughts orientation thing. It just felt like I was on a spiritual path.(Claudia, p3, 167).

Millicent's interview also echoed the pivotal impact of her spiritual experiences. She explained that the times when she had these experiences were the only times she did not feel worried and felt a real sense of joy. She described the experience being transformative and producing a lot more empathy in her for things and for people

Reflexivity Box

Here I pondered on how inhumane participants may have found it to later have been told that experiences they found joyful were evidence of mental illness. I reflected on the fact that as practitioners we do not know it all, and the ethics of seeking to prevent something that brings our clients joy. I do however acknowledge that there is much more nuance to the conversation.

Nala shared that her experiences of voices during her first spiritual experience was positive and liberating, describing how her voices provided her companionship and would give her tips to help her in navigating day to day. This is significant because a number of participants, whilst describing that their experiences were positive, also felt that they experienced diminished functioning in their day to day lives and were not able to conduct daily life as normal. George began to share how he formulated his diminished functioning.

Um, well, I was, I was going through a lot of emotional ... Trauma, I would say. I, you know, hearing voices, seeing things, having visions in my head.

*And ... You know, I was just incapable of really dealing with the ... the physical world.
(George, p3, 160).*

Clive also described feeling so overwhelmed that his functioning was impeded.

And so about three days later I just couldn't function. I couldn't go to work erm ... and then the energy was just (points upwards with both hands) at one point, I was just rolled up in a ball in my living room because it's quite ... well it was quite painful. I thought my head was gonna explode. And because it's such an intense experience. I kept getting all these waves of energy and I just couldn't actually function. Erm ... you know it's hard to actually work out how to cook or do anything practical when it's really erm ... intense. (Clive, p5, l147)

It seemed that in some instances, it was described in a way that the importance and hyperfocus that the experiences brought made physical / practical things lose their importance, and in other experiences it made interacting with practical things difficult and almost as something the body had lost its ability to do or was unable to channel its focus into. Whilst for many participants, they spiritual experiences were empowering and joyous, they seemed to also be understood as having a difficult and stagnating characteristic to them. Claudia made reference to going through a Shamanic initiation, that she was recurrently told was evidence of psychotic illness which she felt was due to her difficulty navigating society at the time.

Participants often described feeling that they were straddling two worlds or experiencing something other worldly. This often came with an understanding that they had to learn to navigate or manage both worlds, balancing their lives with the new spiritual world that they had found they were also able to engage with.

We are spiritual beings having a human experience. Basically that you are spirit in a flesh body we, you know, navigate the world, but we also are part of the spiritual world that we also have to learn to navigate. Most people just don't learn to navigate that world ... Yeah, so then it kind of became how do I ... Navigate ... Both of these worlds, so to speak, (Nala, p14, l450)

Nala described being a “spiritual being having a human experience” – where spiritual is the default or original position, and humanity is the experience. It interestingly turns the very nature of the research question on its head, in its assumption of the spiritual as normative, however she did share that whilst she felt this was the case, the spiritual was still something that needed to be learned

and navigated. This might imply that Nala felt she was a novice in something that she had come to see as foundational to her ontological understanding of the world.

In terms of navigating between the human and spiritual experience, Shanice described having different levels of functioning during her experiences and described ascertaining how she tells whether she is having a spiritual experience or mental health issue based on her ability to function and navigate the world.

Erm ... So to me, that wasn't. I could think ... that it felt like there was energy coming through and stuff was clearing erm ... But it didn't result in me completely leaving the planet. Do you know what I mean?

So that's why ... Like for me ... in my experiences when I've completely lost connection with the earth and with what everything is actually around me. While in that state before, I was kind of dipping in and out of course or an altered state of consciousness, but was able to function in my, in my environment. So does that make sense? I don't know if that's quite what you meant, but that's my ... That's my personal way of differentiating it.

So, ... like the episode I had, I think two years ago where I wasn't in hospital. The Kundalini episode. So I could, like I said, I could feel the Kundalini stuff going on. And again sort of remembering past lives being a bit disconnected, but I managed to stay on the planet and function. (Shanice, p10, l335).

Shanice described a dichotomy between engaging with the spiritual but still 'managing' to stay on the planet and function – as if to suggest the view of the two as separate and opposing factors, and difficult to do together. According to the way Shanice seemed to understand things, it seemed like her health or mental health was at war with her spirituality, and she disclosed believing that both her mental health and spirituality were being challenged but that she did not believe she received the most appropriate treatment in mental health services (she was hospitalised on a few occasions). In her view, it was not that she was not having an issue in her mental health, it was that it was a spiritual issue too and perhaps needed to be understood and treated as such. This will be elaborated upon further in the subsequent subthemes.

Most participants shared that they had a background of trauma, and some had recent traumatic experiences. It was felt by many of the participants that these spiritual experiences were linked to the processing of previous traumatic experiences, and some even described it as an inevitable bubbling up or 'reckoning' with past traumas.

Clive shared a belief that the experiences he had were linked to unresolved past trauma as well as current stressors, and this experience was a shared one with many others.

It was quite hard to find a job and this triggered off quite intense anxiety. And ... But really it's anxiety erm ... related to unresolved trauma of my childhood. So is manifesting ... manifesting as the anxiety about work, but it was actually something far deeper.

And anyway, I managed to settle it down and I got more work, coz I ... did collar work supervising social work students and stuff. Erm ... and then that work got actually really busy and it was a new system of assessing the students, which is quite difficult using a new system and I found myself getting very anxious. Erm ... and ... erm ... and ... unusually anxious. And it was ... it was to do with this stuff that was coming up that I'd probably suppressed all my life really. These ... some anxiety around say childhood trauma, stuff that I had suppressed. (Clive, p4, 190).

This is something that other participants resonated with and reported both past traumatic experiences that they felt were significant in their spiritual encounters, as well as present stressors. Millicent shared this lens on links between the occurrence of these experiences and past trauma.

I really agree with the philosophy that ... You know what I experienced is because of trauma ... lots of traumatic things have happened. So naturally ... erm they've had an effect on my mind and body, so it struggles. I mean, I might qualify for PTSD diagnosis. I've no idea. (Millicent, p7, 1279).

Millicent described having had such significant trauma that it will have impacted her mind and body and brought about her spiritual experiences. Millicent's sense that she may qualify for a PTSD diagnosis may suggest an overlap in the features that occur in spiritual experiences, that we may understand as symptoms of PTSD, or perhaps even that a history of trauma creates a pathway for experiences of the spiritual.

Some participants even perceived this resurfacing of trauma through the spiritual experiences as being there to help them to heal from them – that going through the spiritual experiences that came their way would bring about just what they needed to heal from their past traumatic experiences, and any lessons they needed to learn about themselves or the world. Cassandra's recollections illustrated this ...

And, but the way I see it is the whole thing, you know. Basically the trauma actually comes from the fact that I've grown up in a lie, which is that I've been told ... I've got this happy family background, but the reality is that my dad's gay and my mum was just trying to have revenge on her family and it was just a marriage of convenience.

And it's not really a loving family at all. And my dad ... got a boyfriend at the same time that I had the second relapse, but they don't go to the parents like they're like the parents are untouchable. You know, they just blame the dysfunctional kid who knows something is not right.

Erm so, yeah, now my dad's ... My dad's happier and my mom I mean, I just ... It's, it's just, it's just really sad because if they actually looked into the whole family dynamic instead of just focusing on the person who can feel and is willing to be honest about like what's going on, you know, it's so much easier. (Cassandra, p8, l249).

Just as earlier, Millicent made mention of being at a trauma survivor's retreat when her spiritual experience happened and of her symptoms being that of PTSD, Cassandra provided background on her understanding that the difficult circumstances occurring in her family were what she was processing in having her spiritual experience, as she shared that these events coincided with one of her 'relapses' (in her own words). Her reference to herself as "the person who can feel" suggested that her 'relapse' or spiritual experiences was a natural response to the circumstances she found herself in. In essence, the spiritual experiences in her view not only occurred because she could feel, but signalled an invitation to honesty and healing beyond just herself.

Shanice and Jimmy also described having difficult circumstances amongst family in the lead up to their spiritual experiences. Jimmy believed this created a fragility that brought them on, and lead to him being in mental health services. Nala also seemed to hold a similar perception, feeling that unstable present circumstances alongside a background of trauma were what brought on her spiritual experiences.

Participants described feeling a greater purpose in their spiritual experiences coming about – in clearing ‘stuff’ out, in changing them, in resolving trauma and in helping them to have an impact.

Some participants shared that they themselves reached out for support with mental health teams, for not knowing where else to go, but knowing that they needed help. Of the 11 participants interviewed, 10 participants reported being hospitalised, with a mixture of voluntary and involuntary admissions, and with a range of differing views as to whether they feel they should have been there and were unwell in some sense, or whether they felt it was a total misunderstanding of their spiritual concerns as evidence of a mental health problem. Some described feeling like they were different to everyone in hospital, and did not feel able to relate to those that were mentally unwell, that they deemed different from themselves. George illustrated these sentiments ...

And everybody else there was, you know ... They were, they were not well people, they had some of them did have ... well you know there were those who are simply depressed and there were others who were had some other kind of problem, illness as you would say it. And there were one or two I was able to communicate with on level. So, you know, we like the same kind of music or something like that. But a meeting of minds wasn't really going to happen. (George, p6, 1247)

Here, George’s description illustrates his feeling that he was fundamentally different from those he was hospitalised with, and even a view that he was mentally in a different place to those he was grouped with, or perhaps viewed the same as, when his spiritual experience was viewed as a mental health issue. It would have been interesting to know more about the differences George felt there would have been between himself and someone who was mentally unwell, however George was reluctant to share his rationale. Perhaps George’s reluctance could have been attributed to a

concern that he would be reformulated in the same way within this research, or of concern of my researcher-practitioner role.

Reflexivity Box

I would have been interested to hear much more from George with regards to the detail of his experiences, but his seeming reluctance to share more, along with the decision to conduct the interview via audio only, caused me to feel curious about the possibility that the response of other professionals to his story may have caused a level of harm that he did not wish to be repeated. I felt tentative to ensure that I continued to demonstrate an openness and respect towards his viewpoint for the remainder of the interview, even with limited access to his story.

Some were having such a vivid experience that they did not realise they were in hospital, and found that their awareness of their physical environment was diminished in the duration of their spiritual experience. Nala for example described believing that she was being taken to a safe place because she had 'broken the spiritual network' and had access to information now about the spiritual world that would not have ordinarily been permitted. She described believing she was being taken somewhere for protection, and only later coming to realise that she had been hospitalised for perceived difficulty in her mental health.

Participants explained that different cultures also had different provisions for these spiritual experiences, where they were not necessarily pathologized. Some spoke about the need for a safe space to go, where they could be cared for and be in touch with nature until the experiences pass. This idea of there being different ways of framing these experiences according to different cultural constructs further illustrates participant awareness of the mediation of different social constructs in the understanding and treatment of these experiences. Millicent illustrated these sentiments ...

Erm ... well from that you know that book that I said about the psychosis and spirituality, there's some really good stories in that ... it was years ago that I read it. I should re-read it, I've still got it but, like there was one woman who had like a "psychotic episode", I think she was in India, and she was just looked after in a spare bedroom by a family, given food and water for a while, made sure she was comfortable and looked after and she just came out of it naturally... er ... eventually. So I do think you need to be put in a safe space, because I think you are quite vulnerable, and I was vulnerable, you know I was speaking to a lot of people, making friends,

people I'd never normally talk to. I was very open. So I think you can be quite vulnerable but erm ... I definitely don't think the way to do it is send police, lock people up, drug them coz ... if you're vulnerable and traumatized already that just adds layers and layers of trauma. So, I think being put in a safe place, being looked ... like cared for and loved, I think would be really good way to treat a person. (Millicent, p8, 1348).

Here, from her research of other experiences, Millicent described that there was precedent in other cultures, namely Indian cultures, for a different non-invasive method of treatment. In essence, the book she had read and the insight she had gained into this practice provided another option based on the idea of spontaneous recovery, which she felt was better suited in understanding and treating. Interestingly this book was on psychosis and spirituality, perhaps indicating the fine line participants had to walk in venturing towards literature in the area of diagnoses and it's overlap with spirituality, to find meaning and solutions, even if they did not subscribe to such diagnoses, as Millicent did not seem to here.

In conclusion, the lived experience perspective of participants was that something lifechanging had happened – which they saw as spiritual, saw as a pathway to healing from past trauma, did not feel they brought upon themselves (was not normative to their previous experiences or even belief systems) but could not ignore. It brought them a range of different feelings, including a sense of vulnerability but also experiences of joy and many positive aspects were cited. It forever changed their view of the world. Many viewed it as a gift to learn to navigate, and many felt that although they were vulnerable when they first started to have these experiences, they feel that are different from those you would find in a psychiatric hospital – or not mentally unwell. In essence, most participants did not perceive themselves to have needed psychiatric intervention, or to have been the same as those who were mentally unwell.

Professionals

The interviews illustrated that most professionals who participants encountered seemed to believe that they were mentally unwell. The impression that their responses gave to participants was

that they perceived their encounters with spiritual material as evidence that they were mentally unwell. There were only a few participants who recounted helpful experiences with professionals whilst in mental health services. Overall, the participants experienced professionals as using a medical or illness model and therefore perceiving the 'symptoms' of their spiritual experiences as requiring medical intervention. It is important to reiterate that the perspectives of professionals as illustrated in this subtheme were not taken directly from professionals, but through the recollections of participants and their impression on how they were perceived by professionals based on things that were said and done.

Participants felt often penalised for expressing their spiritual experiences, as being viewed as mentally unwell ultimately would lead to professionals having the power to section them under the Mental Health Act (1983), thereby stripping them of their liberties. As aforementioned, of the 11 participants interviewed, 10 cited experiences of being hospitalised in psychiatric hospitals, and cited difficult experiences of things they were told by professionals whilst in hospital. Participants explained that professionals would perceive their experiences through different labels – diagnosing them with a range of different difficulties including schizophrenia, bipolar disorder, schizoaffective disorder, and sometimes with changing diagnoses, which gave the participants less confidence in the viability of the professional's perspective. Dillon described one of such experiences

Yeah. Initially it was persistent delusion disorder. But as it's on the ... schizoaffective scale ... or whatever they want to call it. They just called it schizophrenia in the end. (Dillon, p9, l262)

. To Dillon, he was in no way mentally unwell, but was having visions and trying to pursue what he felt God was calling him to through those visions. To the mental health system, he was mentally unwell. In his case, the implications were not limited to mental health services. He felt his spiritual experiences were understood as symptomatic of mental illness by three different systems – the police, the criminal justice system and then mental health services.

Erm ... yeah courts, police. They ended up not knowing what to do with me. So I think they just were like "Well we might as well send him to a psychiatric hospital. He's obviously deluded because she has not been receptive to what he's trying to

communicate". And then I went into services ... In 2012. So that involved a psychiatric hospital. A medium secure, I think that's what they call it. And then I went into another psychiatric hospital medium secure.

And then ... two residential facilities. All the while ... I didn't feel like I was being received, what I was trying to communicate. Blank faces. Like I was scientific subject. (Dillion, p6, 1152).

Dillon had described having prior visions, warning him that he would be misunderstood and 'trapped' by the mental health system. He felt that the services misunderstood his motives, as he felt that they were inspired and directed by God, and that this was not given adequate consideration. Dillion's experience speaks to the interconnection between our different systems in the public sector, and the impact of the understanding of professionals across the board on the experiences of individuals encountering their services. Dillon's experience could perhaps be seen as evidence of the lack of consideration of spirituality / cultural humility not just in mental health systems, but in other public sector services that lead him there. His description of being passed along to different services, and met with 'blank faces', illustrates a cold and uncaring disposition that he felt was the perspective of the services he encountered.

Many of the participants shared a desire to have their experiences accepted for how they perceived and explained it, not wanting to be met by the panic of professionals, and really wanting the sharing of their experiences to be normalised. Cassandra described these feelings ...

*It's, it's so difficult. It's so difficult, but just any opportunity to have conversations, talk like, you know, to feel comfortable enough as a patient with a member of staff, that if you like- that, whatever you share., they're not going to panic. Whatever you share, they're going to go, "Oh yeah, I've heard that before". "Oh yeah, that's okay". Because you're so vulnerable, if the member of staff starts panicking, that's like, you know, it just adds a whole ton of "oh s*** am I crazy?", and then it can really spiral. But if you've got a member of staff, who's going, "Yeah, I've heard that. Yeah, I've heard that people like see visions of Gods and Goddesses, and they think that they are them and that's really normal, yeah that's... that's just part of your spiritual development", like if ... if you had that attitude and from staff, I think that would make a huge difference. (Cassandra, p11, 1396)*

Cassandra described how she would have liked to have been spoken to, and how experiencing the panic of professionals would have inspired more panic in herself whilst going through those experiences. Her reference to the 'attitude' and 'panic' of staff infers that she discerned personal and perhaps unprofessional dispositions in the perspective of staff towards her.

Reflexivity Box

With my practitioner hat on, I experienced feelings of guilt that 'we' as mental health professionals needed to have this explained to us by people who had suffered due to our lack of calmness and approachability.

Millicent also explained a need for a whole different set of vocabulary, feeling that avoiding terms like 'psychotic' or 'schizophrenic' would have been more helpful to describe these experiences. Participants had differing views on psychiatric terminology, with some expressing similar views and others finding it pathologizing and unhelpful, some feeling in part that they were unwell and therefore partially agreeing with the language, and some expressing that they did not agree with the language, but did not have an alternative way to describe their experiences that would be commonly understood.

A number of participants reported that their experiences could be understood appropriately given the right religious or spiritual framework. It was their impression that the perception of professionals towards their experiences was tainted by a lack of spiritual competence. Clive illustrated these sentiments....

Erm, but at this time ... another part of this experience, It's quite funny but if you look at the, if you look at the literature about kundalini awakening, that goes back thousands of years, they describe the process. And one of the things was, I was hearing this amazing flute music. Ethereal flute music. And that is ... is a classic. Apparently that's the heart chakra opening apparently, erm ... but I had the whereabouts by then to realize I can't tell them that. Because if I say to say to them, "I'm hearing something", they'll put that down as schizophrenia. (Clive, p6, l166)

Clive's feeling was that he had to hide his experiences from mental health professionals, for fear of it being pathologized. His tone perhaps infers thoughts that professionals were wilfully ignorant, and frustration on the lack of education that in his view was widely researched and commonly available. Claudia described a similar experience.

My experience as an outpatient has been pretty ... pretty shocking. I kind of then went on to see someone in an early intervention team. And I literally to try and get me on board with the medication-based approach. I've had so much thrown at me to suggest. So I was called I was called grandiose, I was called "lacking insight", I was called "fixed and rigid belief system" because I wouldn't go with an illness-based model, but it goes completely against my core, which is a shamanistic approach is not illness, it's the complete other end of the spectrum erm ... but but also erm ... You're not gonna, you're not going to agree between a shamanistic approach and the psychiatric approach because they're two different ... Like approaches, but to try and get you on board with the way a psychiatrist thinks, they throw anything at you to try and kind of break you down to that way of thinking and and I- For me, my experience in in that is ... It didn't work. I didn't take their medication. And then what they tried to do is then up the diagnosis to make it more significant. It's still not worked erm ... and then I just left. So my experience ... I think a big part of my shamanistic path which has been eight ... I think it's been eight years since my initiation and I think a big part of it has been navigating a psychiatric system that is a very fixed rigid illness based disempowering non-emotions medication orientated. (Claudia, p5, l165)

Here, Claudia described her experience through outpatient mental health services. Fundamentally she felt her Shamanistic lens was at odds with the psychiatric lens, however she described being subject to the perceptions of the professionals that she was mentally unwell, and feeling like she had to resist. Interestingly, much of the language Claudia cites that professionals used towards her sounds disempowering – “lacking insight / fixed and rigid belief system” and assumes the

Reflectivity box:

This caused me to reflect on what consideration was taken for Claudia's religious beliefs in this situation, and more widely what consideration there is for the belief system's of our clients. Claudia described feeling as though it was the priority of professionals to indoctrinate her with the medical approach, and it does not sound like Claudia felt there was any consideration for her own description of the problem or way of perceiving it.

correctness of the professional and therefore the incorrectness or blindness of the patient in being able to produce a valid or helpful understanding of their own experiences. Her view was that professionals used diagnosis as a tool of power, increasing the severity of diagnoses to gain more control.

Shanice also had a similar viewpoint, with regards to the lack of cultural competency influencing the understanding of spiritual experiences in our mental health services.

But there was no- obviously it isn't, it isn't in the paradigm of Western mental health system, there was no understanding and it was quite funny because when I was like ... one time when I was due to be released, they ask you all these questions. I can't remember exactly what they were. But they're like, "oh do you think that other people can ... do you think you can hear other people's thoughts" or ... And actually, normally I don't really think I can hear other people's thoughts but I'm quite sensitive to people's energy.

You know, and they're like, they asked me sort of kind of questions like "do you believe in angels?" or things that really, people in the alternative scene kind of believe anyway, you know, but they were like the measures of whether you're mad. (Shanice, p6, l186).

Shanice alluded to the feeling that there were different goal posts within mental health services – that what in some areas would ordinarily be seen as normal within certain circles, was seen as evidence of illness and needed to be denied in order for a person to be seen as well. Shanice may have felt that she was being asked to fundamentally deny her beliefs, and experiences that had been important to her and significant to her own sense of healing, in order to gain her freedom.

Nala also described her feeling that the lack of cultural competence amongst mental health professionals as it pertains to spiritual experiences has real consequences.

... because I used to work in ... like a referral centre. And so we see you'd have the first look at... you have to first look at experiences. Right. And they'll be this these things of ... You know, boys, going into the GP and being like, Oh, I've been, you know, looking at

the Bible and I've been looking at this, these are the insights and now you are just like, "oh yeah, he's unwell ... early intervention!" and it's just like, Okay. Yeah, but like there's stuff to engage with them and you see what I mean.

And the whole thing of ... "Oh yeah, this boy, you know, is trying to ... trying to become a prophet. Oh yeah unwell." And it's just like ... bruv ... this, you know, you know, I was saying... something has tried to come up and you are just closing the lid. (Nala, p21, 1736).

Nala went further to explain that she felt this lack of cultural competency within mental health systems negatively affected men particularly from Black Christian communities, causing restriction and being a cyclical relationship with services. Previously, Nala had mentioned that it is her view that "we are spiritual beings having a human experience" and further described the perception of a fully functioning human being as not holistic within the mental health system, making inference to a lack of consideration to the spirituality of a person within services. Nala alluded to a tension between people trying to grow and develop in themselves in the spiritual sense as well, and it being perceived as illness.

Many participants were keen to speak about their experience of psychiatrists. They believed that psychiatrists had too much power, and were sometimes suspicious of the psychiatrists' motives. Clive illustrated these sentiments.

I think I've stopped ... stopped doing this before COVID started, but I was doing a support group for people that are going through spiritual crisis, not just Kundalini but others experiences and people can have. And I tried to publicize that to people going through the hospital and there was this ... "no, the psychiatrist won't allow that".

So the social work- I mean ... the social workers working in the hospital said "I think what you're doing is great, but I can't get to put that past the psychiatrist". Which is outrageous! (Clive, p11, 1376).

Clive's example of not being permitted to run a support group for others going through 'spiritual crisis', whilst it does not directly disclose the psychiatrist viewpoints and could have been for a number of reasons, is suggestive of a lack of interest in allowing open conversation on spirituality within those hospital environments. It is also interesting to note the difference in opinion and approach between the social workers and psychiatrist. The difference in approach between different

professions within mental health services was felt by some participants, with the consensus being that harsh approaches were often taken by psychiatrists, and that sometimes other professionals were kinder, and other times they were swept up under the influence of the medical model, perpetuated by psychiatrists.

Clive spoke further about the impact of the viewpoints of professionals in his life, reflecting on the power that the perception of professionals had, in creating formulations / diagnoses with real life restrictions as a consequence. In his case, he shared he lost use of his driving licence for a number of months, following a diagnosis of psychotic depression.

Participants often reported feeling as though professionals were judging them. Here, Cassandra described feeling that the staff were not equipped to help them and were therefore just policing their actions.

I didn't realize that the mental health staff are just police. They're just police to get people to behave a certain way. They're not actually erm ... they don't have the amount of training and resources that's needed to ... or the experience, like, I think if a lot of them have actually had this experience, then ... you know, they're able to be with you without a part of them sort of judging. (Cassandra, p4, 198).

This points at Cassandra's feeling that there was a lack of understanding in the minds of professionals, therefore their default view or perception was one of policing and judgement. It seemed that she felt the disposition of professionals was more towards behaviour management than it was to help, and therefore it can be inferred that Cassandra found professionals to be controlling, and perhaps condescending.

There were a few instances where participants recalled being offered gloomy perspectives of their future prospects by professionals. Millicent described this further.

Erm well when I was admitted there apparently ... within about a day they said that it was psychosis. They thought it might be schizophrenia. And then they said it was bipolar type ... type one. But then when I got out ... coz I was under a section, because I didn't ... they didn't tell me I could go to tribunal you know ... they didn't tell me anything about the mental health act, nothing. I had no information. So I didn't know I could challenge to know it, didn't know anything about that.

So I was under a section for about four years, so I think it was section 17 after that. And then ... erm ... Yeah, like I'd have known I'd have gone to tribunal and got it removed. Erm ... But yeah, it was just erm ... pretty ... pretty horrible. So when I got out, I was going to a psychiatrist, and he was saying "you'll be on lithium now for the rest of your life. You know, you've got to lower your expectations of your life and everything. Anyway, after about a year, I just stopped taking it didn't take any for maybe 10 years and I was absolutely fine, didn't have any problems. (Millicent, p5, l179).

Millicent's recollections echo the feeling of many of the participants in their recollection of their experience under 'the system'. It was almost as if the psychiatrist in this instance had taken it upon themselves to manage Millicent's expectations of the future, and it did not indicate that they had much hope for her life.

Millicent also references being ill informed and not being given information – perhaps alluding to a wider issue of assuming that individuals would not need tribunal / to challenge / know their legal rights in such situations. Again this highlights a power dynamic between professionals and the service users, with the cost to Millicent being four years of her time under a section with diagnoses which she did not agree with, and experiences which she attributed to her spirituality.

Reflexivity box

This caused me to reflect on the ethics around how people in the mental health system are treated and spoken to, and more specifically, what the purpose of telling someone who has capacity to reduce their expectations would be – and who would gain from that, if at all.

It is unclear what was truly felt or perceived in the minds of professionals. One could deduce from the reports of changing diagnoses and caution in these examples that perhaps there was an element of confusion with knowing how to perceive or navigate the spiritual phenomena that the professionals found themselves presented with.

Claudia also spoke to being told by a psychiatrist to pull back her life and avoid open water swimming for fear of relapse. Similarly to Millicent, Claudia describes the prognosis giving a bleak outlook, and the need to be resistant to the bleak and restrictive outlook professionals had of her future. Interestingly, whilst her perspective was that this was a spiritual experience that needed to happen to progress and possibly to process trauma, and might happen repeatedly and needed to not be restricted, the view of professionals seemed to be that these experiences were evidence of psychotic illness, towards which one needed to be careful and restrictive in their life activities in general to avoid it repeating. Claudia described what she felt was happening.

... Kind of almost like because they diagnosed you with a psychosis and they believe it's something that re-occurs, that actually, you should never achieve anything, because you have to pull your life back so much and never get stressed and never do this or never go out your comfort zone, because it might come back. To me, I've approached it in the completely opposite way and just gone "you know something if shit happens, I'll deal with it" and actually I've just gone on. (Claudia, p12, l465).

It seemed that Claudia perceived that professionals were experiencing fear, and recommending avoidance as a result.

The implications therefore for participants were either that they would need to submit or forgo their own views and succumb to treatment that even those participants who did not seem to agree with, or to avoid mental health services and learn to manage without their support. Negotiation or a meeting of minds was not referenced at all in the duration of this study. Cassandra illustrated this further.

Erm ... because then you'd feel understood and heard. But I do remember this one and consultation with a psychiatrist and I was ... talking to her about what was going on in my mind, you know, because I ... so far as I was concerned, it was her job to help me make sense of it. And I

think I just ... to be fair, she probably couldn't control this, but I could see this moment where a shadow kind of crossed her face and I could see the judgement on her face of like "This person doesn't make any sense, we can just kind of throw them in the bin" kind of thing. And that was how it felt.

*And but again I don't ... I don't blame her. Because, I mean, I was ranting and raving at the time, but I do feel that the ranting and raving kind of it gets created from the attitude of the staff. Because the attitude of the staff is "contain a problem and demonize the person" rather than erm, you know, look for ... look for understanding and go, "yeah, that must be really s***what you're going through." Or "that must be really meaningful what you're seeing". You know, they're so scared of it. (Cassandra, p5, l130)*

Cassandra echoed the understanding that professionals were experiencing fear, and described feeling judged and written off or discarded, in her understanding because the psychiatrist viewed her spiritual material as an indication of illness. Interestingly, Cassandra alluded to the attitude of professionals setting off a cycle – in that it would cause patients to feel frustrated, and to rant as a means of reasserting themselves, which would then reinforce the idea that they were unwell and cause further judgement. Cassandra also alluded to a lack of empathy and understanding, based on fear of the spiritual. This cyclical experience for Cassandra and others who experienced similar would have meant an inability to challenge the views of professionals, or make themselves heard.

Reflexivity box:

As a professional myself, I observed curiosity in participants regarding my perception. Some, through scepticism, wanted to know what I believed and if I was on their side, and sometimes participants were less direct, but I observed hope regarding my perspective and therefore potential to cause change in the profession. I felt that in asking, they wanted to know my professional stance towards spiritual experiences and how I would navigate this in practice. Some participants also assumed that my choice of research topic and therefore attention on this matter in general meant that I was trustworthy and perhaps different from the professionals they had interacted with, and many expressed hope for my research and change they hoped it would bring amongst mental health professionals.

But at the end of the day, I just have to, and I've got, I've come to peace with it now because I'm like, Okay, well actually, if you are having a spiritual awakening, then that is an act of God, and you kind of can't really expect erm ... medical professionals who the whole medical thing is about the non-existence of God, basically. And I think ... like for me to expect people to have that kind of training, I guess, and and you know everyone's human. You know I'm human, they're human, you know, they could turn around to me and go, well, and they have done, you know, said "oh well you could have said that in that way. And then we would have understood you" kind of thing. But I think it is just all about like ... having more honest dialogue. And it's really hard to have that when the way- they're not interacting with you as a human being, they're interacting with you as an authority figure and when there's that authority differential ... erm ... I think it's very difficult for empathy to happen. (Cassandra, p11, l365).

Cassandra reflected further on the role of authority in allowing for honest dialogue between professionals and those who find themselves in services as patients. It seemed that staff attitudes, from body language to facial expressions and perceptions of authority played a substantial role in causing my participants to feel that professionals understood their spiritual experiences as mental health problems and ostracised them for it.

Cassandra commented further on this, making further reflections on a need for training and the idea that professionals do not necessarily need to agree with participants or identify the source as real to connect with them. Clive offered similar reflections, explaining that he found that ward staff were mostly arrogant, however professionals who were nice to him made all the difference. Mary also echoed this.

Erm ... a lady would even come to me for sort of advice who worked there, about things and she would ask me about meditation and ... in that regard, when one admission while I was an eating disorder unit, erm one of the occupational therapists decided to set up a relaxation group for the patients and also for some of the staff and knowing that I was kind of er ... enjoyed it and it was very much into meditation practice, erm they asked if I would sort of lead the lead the group, which was such a lovely thing to be asked to do and it really gave me some sense of kind of direction and purpose, while I was in there, to be able to do that. Erm ... so that was some of the more kind of lovely, lovely moments. (Mary, p4, l108).

Mary's description here makes a stark difference to other narratives. She described her interests in meditation practice (which from her interview she perceived as a spiritual practice) being thought of, welcomed and her being trusted with the opportunity to lead others in this. Her memories of this are very different to the encounters with mental health services that the other participants reported – in that they seem to hold a very positive and meaningful value. This illustrates the positive impact that an openness in perspective and attitude from professionals has the potential to have. Mary went further to describe other positive encounters with professionals.

The involvement of a couple of chaplains, a Hindu chaplain and a Christian chaplain in the Eating Disorder unit was quite helpful as well because they were able to come at things from a kind of more ... understanding the, the role of spirit I guess - of spirit of mind, emotions. That seems to be ... that seems to be quite important because I felt that the ... the erm ... the treatment and the diagnosis that came from the psychiatrist, it was based on particular kind of views of reality that seem to be quite ... quite prescriptive in the sense of ... "this is normal, and if you deviate from this normal than something wrong with you". Erm ... whereas the kind of approach that takes into account erm ... the role of kind of our spirit and our mind and emotions and experimenting with life. This seems to be a bit more bit more open somehow. Yeah.
(Mary, p7, l228)

Here, Mary described the involvement of religious chaplains as providing a sense of relief from the view perpetuated by other professionals, in that the chaplains provided a more holistic view of individuals and were more open to understanding and perhaps perceiving things from a spiritual perspective. The presence of chaplains not only helped to provide a cultural context for Mary's experiences, but helped to normalise what she was going through, perhaps fostering a better sense of safety and belonging in a system that felt otherwise contrary to her beliefs. Unfortunately, in interviews with participants, these experiences were few and far between.

it was the understanding of most participants that their spiritual experiences were seen as evidence of mental illness by mental health professionals. Participants felt that this perspective started with psychiatrists and a medical model view, filtering down through mental health services. It was their view that these services often lacked the cultural competence to consider other religious or

spiritual contexts through which these experiences could be understood, and subsequently other treatment options.

In addition to this, participants experienced the attitude and body language of professionals to be unpleasant, affected by a power imbalance and not open to listening or challenging. Occasionally, participants reported having positive encounters with professionals, which demonstrated kindness and openness to their spirituality and made a big difference to them. In these encounters, participants did not report professionals necessarily agreeing with their stance, but just being open and kind.

Others

This subtheme reflects the role that the perspective of friends, family and loved ones also played in the spiritual experiences of participants being understood as mental health problems. Participants described the people in their lives noticing changes in their behaviour and being concerned. This would then progress to feeling the need to report the changes or seek help – and this would often be to mental health services, thereby connecting them with the mental health professionals mentioned in the previous subtheme. In other words, the perception or understanding of the presentation of my participants as a mental health issue often started with the ‘others’ in their lives, who in almost all the cases acted as a bridge to access to mental health services. It is important to note that the perspectives of others as portrayed in this subtheme were captured through the lens of participants, as opposed to directly from their loved ones.

One participant reported having a bad relationship with a family member who then weaponized reporting their spiritual experience to police, in a bid to have them sectioned. Participants were very much susceptible to the view of the people in their lives – their family members and loved ones, who it seems had the power to determine their will being taken from them (through sectioning and hospitalisation) based on their perception of the changes in behaviour or report of a spiritual experience, and based on their own world views and what they were accustomed to. One could argue that this also points to a societal or cultural propensity within the UK to view spiritual phenomena as evidence of a mental health issue.

A number of participants reported that their spiritual experiences were concerning to others. Mare described this sentiment.

I think, again, just kind of feeling like- I didn't feel as low as I did that first time when I fasted, but I did feel that I kind of lost my focus a little bit so I was meditating more again. And my husband and parents were quite concerned about me. And my behaviour changed a little bit in the sense that, erm I was less talkative, because I kind of found that I wanted to just naturally kind of preserve my energy for this inward focus and erm ... so yeah being concerned about me and because of I now had a mental health kind of history as it were with the unit, it felt like it was ... was here for mental

health services to just kind of swoop in basically that's what they did so ... (Mary, p5, l146).

Here, Mary illustrated how the concern of her husband and parents and their perception of her mental health history was instrumental in linking her with mental health services, in her engagement in a fast which she felt was a spiritual matter and spiritually motivated (as opposed to evidence of mental ill health). Her language and tone in the quote implies that she was being watched closely, and that there was tension as her choices were being perceived as illness. She further explained that as a result of their concern, her parents took her to hospital. In this case the medicalisation of what Mary viewed as spiritual, began in the perception of her family members.

Cassandra echoed a similar experience, of the sharing of spiritual material causing concern about her mental state amongst loved ones.

So I worked out that there were certain things that caused alarm to my friends and family. And that was talking about spiritual topics. Erm ... behaving in unexpected ways. Erm, and when I say- like it was because that hospitalization, what caused it was because I was posting stuff about philosophy on Facebook. And one of my friends got in touch with my mum, and my mum turned up and started telling me I was ill and rounding me up and I'm like "this is not nice".

So, erm ...Yeah, basically I just made a decision from that moment on, that if I was experiencing anything that was out of the ordinary, I just wouldn't communicate it, and if I had to isolate myself so that I wouldn't alarm anyone I'd do that. And so that's what I've been doing ever since.

Because I'd rather be on my own, not locked up, having a bit of inner turmoil, but like still freedom to go for a walk or go to the gym or get in the bath and choose what I want to eat. I'd rather have all of that than sort of being a prison. (Cassandra, p11, l365).

Here, Cassandra compared being hospitalised due to mental health to being imprisoned, and raised interesting points of reflection on the power of the perception of her loved ones quite literally on her freedom. Her description of her resolve to keep spiritual matters to herself could indicate feeling monitored, scrutinised and shamed by others for sharing her views.

Shanice also echoed similar sentiments, more specifically speaking about the height of her spiritual experience causing concern for others, whilst having a more depressed presentation caused others to feel more at ease.

For me everyone else around me was terrified in the state. I don't want to downplay it because obviously it was quite traumatic for my kids actually my daughter who's older erm and who kind of had an understanding of what was going on a bit. But for me, there was nothing wrong when that was going on. I was having a quite a good time.

You know, I was in this sort of manic joyful state and felt like loads of stuff was being processed. It was those around me that considered it and mental health crisis. You see what I mean.

Erm ... And actually when I was depressed and really wanted to die afterwards, when I had this huge low, everyone else's was kind of, kind of fine about it because I was staying still and I was "normal". You know, for me, that was when I was like "My God I need help, because I may not ... may not want to be here. You know I may ..." I was only just clinging on to not committing suicide really.

So I guess whether it's a mental health crisis depends on whose view- whose ... window you're looking through (laughs). You know. (Shanice, p10, I350).

In Shanice's view, her depressed state was of greater concern and her risk was higher, however to the others in her life, it seemed as though her 'manic joyful state' produced more concern. It seemed that the people in her life were more comfortable with presentations that they were familiar with and could understand, such as depression, and experienced fear with what seemed foreign and with what they perhaps perceived was outside of their control. This causes an interesting point of reflection as to the way bias in loved ones could affect their ability to adequately ascertain risk in such situations.

Shanice's reflection here also raises the conundrum that what was joyful for her and felt like it needed more of her time, attention and momentum, was awful and even traumatic for others in her life. This may have raised an internal conflict of guilt or feeling compelled to sacrifice her joy in

pursuing the spiritual for the sake of her friends and family. This is similar to Cassandra's statement of preferring to take inner turmoil to avoid arousing concern in others.

Nala also expressed realising that her behaviour during her spiritual encounter was concerning to others and feeling the need to hide it.

Then it was like oh people think that probably I'm schizophrenic right because I've been, you know, trying to walk through walls and (giggles) You know, talking to these voices or ... You know, just doing like weird stuff, which I didn't think was weird, but I knew that other people thought it was weird, like even like even just the same with the contact lenses. Right, it's like ... In my head that makes perfect sense. But I know that other people think it's weird. ... So it oh was people don't understand, like, okay, but I still thought that the voices were valid and I definitely continued to live with them without telling anybody that that's what was happening. (Nala, p16, I543).

Nala went on to describe going on holiday with her mother and sister, and spending the majority of the time having an internal dialogue with the voices, without them knowing. In this snippet of the interview, Nala recounted perceiving the voices she was experiencing as friends, but making the decision to keep this experience internal, for fear of the response and consequence of sharing this with her loved ones. Her thought process even whilst attending to the experience was the view of others and how she might need to amend her behaviours so as not to arouse concern. She also shared a preference for not having medical intervention in her life generally, and therefore was avoiding arousing suspicion that would lead people towards this. This was a shared experience amongst participants.

Once mental health services were involved in the care of participants, there often seemed to be an alliance and trusting relationship between 'others' and 'professionals'. George described it like this:

Well, in that I was ill and my ... neither of them (his parents) knew really what the future held, because the doctors were saying, oh, you know, some kind of ... breakdown and er ... it's to do drugs with schizophrenia or something like that, which of course terrified

them. You know, they had no understanding of these things. What, what ... they trust medical authorities, you know, what are they going to do? You know, so ...Yeah, it was, it was pretty tense. (George, p6, l208).

The trust that his parents had in the professionals and perhaps their ability to accurately ascertain or diagnose the problem resulted in a feeling of stuckness for George and perhaps a feeling that his voice and perception of the issue as spiritual could not be understood.

Reflexivity Box

Here, I reflected on notions of client confidentiality, the encouragement in services to work with friends, family and carers within a limited capacity, whilst centering the client's own goals in their own care. It seemed that when it pertained to spiritual experiences, the perspectives of loved ones (and whether or not they perceived the spiritual experiences as concerning or evidence of illness) carried much more weight than that of the client themselves. In essence, their community's viewpoint had the power to sway the outcome of coming to mental health services, regardless of their own formulation of the issue.

Whilst many of the other participants were concerned that the 'others' in their life would act in concern or protection of them, there were a few instances spoken of where others viewed the spiritual experiences and subsequently the individual as threatening towards them. For example, here, Dillon described how a series of dreams and visions he had which he believed were from God, and his expressing them to the person they concerned, was experienced as harassment.

Erm the dreams that had of particular situations ... She, she arose in some of them. So a dream, 2003, that she'd be walking up the stairs to the computer labs, like that came true 2006 / 2007. So it all confirmed that it ... it was the same person. I made an attempt to get to know this person. At the time she was busy with a study and she, she wasn't really interested in going for coffee. I just wanted to find out what these visions meant and everything like that. And er ... She then started dating some guy. He started belittling me and this made me feel really, really uncomfortable. I felt things ... like things were going wrong. So I wrote a letter to her, describing my dreams and visions to her. And I think basically it freaked her out. Erm ... Yeah. That ... I think that freaked her

out. Certainly with input from this fella. Which is ... which ... which is kind of significant at the same time. Freaked her out, and things started to go wrong from there. Like I could feel the en- the positive energy that was there, was disappearing and I really wanted for her not to worry or panic or anything like that. So I would send more communication to her, try and explain you know there's nothing to worry about. I feel that God's telling me something. She was in the Christian union so thought she'd be open minded and receptive to what I was trying to communicate. Erm ... She ended up going into student services and complaining of harassment. I panicked even more which made me want to send more communication. (Dillon, p5, l122).

Dillon later ended up in forensic mental health services, and the trajectory of his life was very much affected by the perception of the person he shared his spiritual experiences with, although possibly affected by additional factors. From Dillon's perspective, he wanted to understand and share the dreams and visions he had been having, which he earlier described had been happening for a while before he met the person that was in them – who he tried to share them with. Although it is outside of the scope of this study to comment on whether his advances should have resulted in forensic intervention, Dillon did make clear that from his perspective, his motivation and understanding of the whole matter was spiritual, however the others involved in the situation perhaps did not view things in the same way. We can infer from his description that the other person in the situation perceived him as threatening, as a result of relentlessly sharing his spiritual ideologies pertaining to her with her.

Whilst many resolved to keep spiritual matters to themselves and away from loved ones to avoid medical intervention, Shanice was able to reach an understanding with her loved ones where they were able to understand her wish to avoid medical intervention. Shanice shared that after horrific experiences in hospital, she came to an agreement with her loved ones to help her in the home, however they were ill-equipped to manage her navigating through the spiritual experience themselves.

... towards the end of these four episodes I kind of knew that was going to happen. I had tried getting my friends to help me within the home and it was too much for them. I wasn't sleeping. I was really out of control.

And so I kind of resigned myself that actually hospital would be the place I'd have to go that happens again. You know. And it's not that I didn't need maybe a safe space to be in and kind of somewhat some way to help with that mania, but the fear... Even now I have it, the fear that if that happens to me again, the only the only place I've got to go, is somewhere where I will be seen as completely crazy and locked up and ... You know, yeah. (Shanice, p7, l239).

In this example, although able to have her preferences acknowledged by loved ones, there was a realisation of a lack of resource that her loved ones had in being able to manage the symptoms of Shanice's spiritual experiences, thereby resulting in a reliance on mental health services either way.

Not only were participants at the mercy of friends and family in their perception – whether they thought they were mentally unwell and services they would contact to help, but they were also at the mercy of others in terms of their capacity to support, for example in Shanice's experience, having nowhere else to go apart from hospital, despite not agreeing that they were unwell and not agreeing with the medical lens or their treatment.

This theme explored how having differing perspectives of spiritual experiences resulted in the self-reported spiritual experiences of participants being understood as mental health problems. Perspectives of the lived experience of participants, of professionals and of others were explored (the latter two narrated through the view of participants).

Almost all the participants referenced other cultures in their bid to explain what they felt had happened to them. They explained that different cultures say different things about religion and spirituality, and furthermore, different cultures have different interpretations of what had happened – from being natural to being a kundalini experience to being a result of trauma.

In the experience of participants, the lens adopted by friends and family towards their spiritual experiences was at odds with the idea that their experiences could be genuine, and therefore pathologizing in nature – handing them into the care of mental health services. The mental health

systems they often found themselves in and the professionals they encountered as a result often held narrow lenses towards spirituality, drawn from a western scientific and possibly atheist perspective, where the possibility of a spiritual experience invading someone's life and every day experience whilst maintaining their sanity was not something they seemed to consider or agree with. They were more often than not viewed as unwell.

Participants often then found themselves stuck – where their loved ones trusted and believed professionals, and professional perceptions had the final say over their care – all the while disagreeing with the perception of what was happening to them and therefore how they should be treated – and all the while wishing to progress with the joy and necessary processing that they felt their spiritual encounters had brought them.

Through this theme we explored how participants themselves were cognisant of the links between perspective and social – however in the absence of the realisation of this amongst all parties and awareness of its impact, all parties may have been susceptible to operating with a rigid understanding of their own correctness, which could have been unhelpful to other parties involved.

In the next chapter, we will be exploring this further, seeking to understand how the bias of mental health professionals impacted the understanding of spiritual experiences as mental health problems in mental health services.

Bias

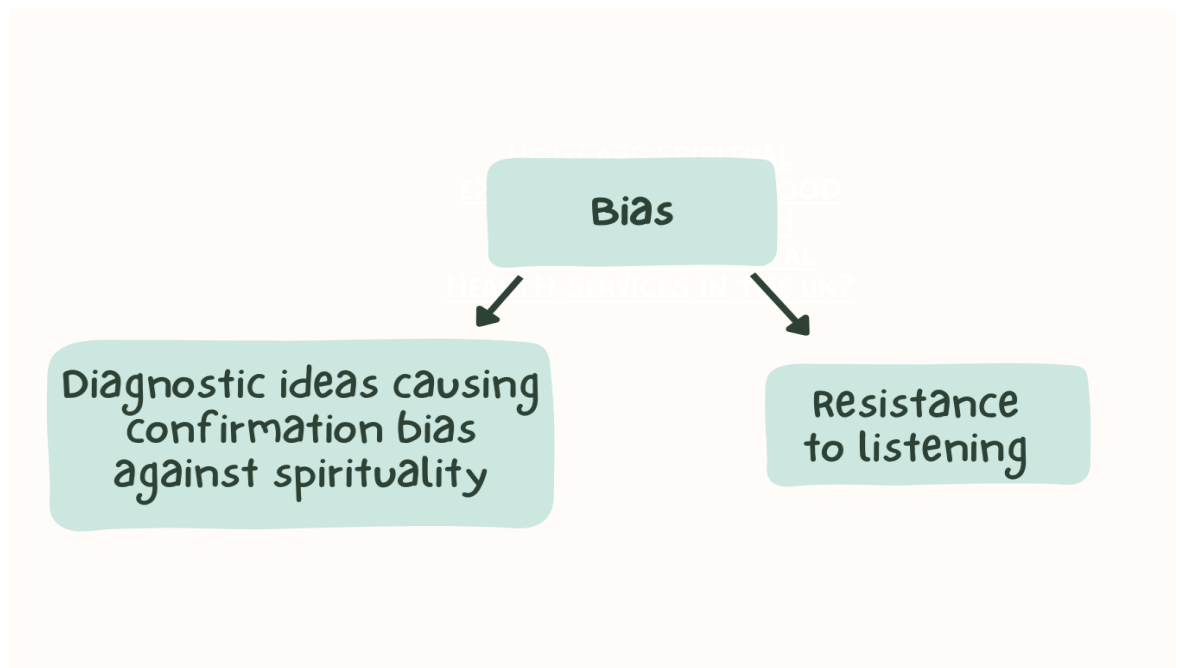


Figure 3 – Bias segment of Thematic Map

How are spiritual experiences understood as mental health problems in mental health services in the UK? – through bias. Participants described that they frequently felt that the nature of what they were experiencing was bias – against spirituality and perhaps *towards* everything that services treat fitting into the neat boxes of psychiatric conditions.

The theme of Bias is in two parts – diagnostic ideas causing confirmation bias against spirituality, and the resistance of professionals in the mental health system to listening to what the participants were keen to get across.

In essence, what emerged from the data was the feeling from participants that professionals they encountered in mental health services were motivated towards a particular outcome – that they were unwell and therefore needed to be made well through medical intervention. This resulted in selective bias, where material spiritual and otherwise all seemed to be formulated into the understanding that the participants were mentally unwell, supporting a further need for treatment.

This was upholstered by the experience of professionals as being 'resistant to listening'. Participants cited many examples of trying to advocate for themselves and point out bias or guide professionals in the right direction as it pertains to what they believed was happening to them, but to no avail. We will explore these notions further in this theme.

Diagnostic ideas causing confirmation bias against spirituality

A common feeling amongst participants was the idea that the bias of professionals was poised against spirituality. Participants experienced professionals as using the medical model or way of viewing things to inform their interpretation of what was happening, and formulating everything under this umbrella even when challenged by participants. It was not the experience of any of the participants that encountered services for the professionals to be aware of what they reported to be spiritual experiences, and to agree with their definition. It is almost to say that they did not believe in any possibility of these spiritual experiences happening, and furthermore believed that for it to be reported meant it must mean that they were mentally unwell.

Shanice described a juxtaposition of going through quite difficult emotions during the experience, for what she perceived to be a greater purpose, with the Kundalini experience happening with the purpose of clearing out negative things in her. Alongside her belief that the spiritual experience had come about for a good or healing purpose, Shanice believed that coming under mental health services and being given psychotropic medication was detrimental to the spiritual process that was trying to occur.

So I would be locked up, willfully given drugs that I knew would suppress something that I believe to be cathartic. There was always a sense of whatever was happening was cathartic and was my body's way of erm ... of healing itself, like a vomiting up of all the unprocessed stuff in me. (Shanice, p7, l212).

Here, I had asked Shanice what it meant to have her spiritual experiences understood as a mental health problem. Shanice was speaking about her understanding that taking medication was

suppressing the naturally cathartic / healing effect that the spiritual experience would have had on her, having earlier described having past trauma that she felt the experience was healing her from. Having her experience understood in this way had practical implications, including on what the prescribed treatment plan would be and on the level of choice she did or did not have in the matter. Shanice was of the belief that psychotropic medication stunted her ability to process and release the unprocessed / traumatic content from her past that the spiritual encounters gave her the opportunity to process.

Similarly, Claudia also had an unpleasant view of the mental health system, viewing her interaction with it more as a journey of 'pain to purpose' in her spiritual experience.

So there's an element of using the pain and even though my spirit guide took me into that situation, I think she took me into that situation erm ... for that purpose. To actually utilize it. And actually, to, to, to make sure that self-care wise I stay well because Shamanically, you can ... people on shamanic paths can be affected more mental health-wise erm ... but I think there was a reason for that on my own spiritual path because there's a stubbornness there. (Claudia, p11, l407).

Here she was referencing ending up in mental health services as part of her spiritual experience that was orchestrated for her good – that she would learn how to be independent of it through suffering and learning to avoid it, as opposed to through agreeing with, healing through and benefiting from it. It was Claudia's view that mental health services were unhelpful, but in essence that her spirit guides had made the most out of a bad situation caused by mental health services.

In speaking about his experiences within mental health services and his concerns at the time of becoming institutionalised, George said,

... erm ... so it's like ... Certainly diagnosis, if that's what you want to call it, should-should be a very painstaking process, not something that medical authorities rush into. (George, p9, l384).

His feeling was that mental health professionals were overly eager in offering diagnoses, not fully considering the tension on individuals who perhaps did not see things in the same way, or the gravity of such on the outcomes for the individuals concerned.

Reflexivity Box

This caused me to reflect on the temptation towards a position of arrogance that professionals can hold in our own diagnoses and formulations, and that of other professionals. I reflected upon the risk of talking amongst ourselves as professionals, and not engaging in joint formulations and developing shared understanding with our clients, whose lives these diagnoses, formulations and the recommended treatment ultimately impact.

Shanice shared this difficult experience, illustrating the tension in the different views between herself and the psychiatrist and the psychiatrists' adamantness towards a particular outcome.

This is really, this was such a painful memory ... well I mean, it actually- Luckily, when I was hospitalized, when I was sectioned, I was in such a manic state of like ... I was a little- I was like, kind of dancing the whole time and I actually got hoola-hoop and was like hoola- hooping and the- God I was in such a ... amazing like bliss state that the whole hospital experience wasn't that traumatic – most of it. And yet there was one time where I was hospitalized and I was actually in a really erm ... like refined kind of space, but it felt at the time that I had ... I don't know what it was. I was doing kind of like India- A lot of it was like about Indian past life. And I felt like I was doing Indian dance moves or Indian kind of movements were coming through me.

And I was actually in front of the psychiatrist for like a review, I think, and I couldn't control what was happening. And all I wanted to do was to prostrate in front of him. Erm ... and it felt like I had God coming through me and I was seeing him this like sacred ... And I kept saying, you know, and he was- I think he like sounded the alarm, and called all these people to come and restrain me, and I kept trying to say, "I'm just feeling like I've got God coming through me. There's no violence in me". There was no ... You know, it was unusual what I was doing. I was doing weird kind of movements and I was begging them not to inject me and I ... and I was pinned down and injected, you know. (Shanice, p6, 1164).

Shanice's account of this experience sounds like there was limited tolerance for what she was going through, despite her description of not displaying distress or violence. It sounds as if Shanice was trying to display kindness towards the psychiatrist, and it seems as though she found the alarm being sounded, being restrained and medicated, frightening and unwarranted. Although by her own admission her actions at the time were unusual, it seemed as though the context geared everything towards a response that perhaps was not appropriate for what Shanice mentioned she was experiencing, and with the joy that she said she was displaying.

Shanice described the euphoria from her spiritual experiences as protective and buffering from the actual extent of the trauma she experienced in hospital. She described these being painful memories, and I imagine that the realisation of her intentions in hindsight and the treatment she was offered by professionals would have been difficult in recollection.

And the fact that they told me- you know, they've said things like, "If you don't continue to take medication, there'll be community mental health order and you'll be forced to" and they told me things like, "Your brain is unwell. The more this happens to the more unwell, you'll get", which is not true.(Shanice, p7, l219).

Shanice's example is a clear example of how bias not only caused her spiritual experience to be operationalised as evidence of a mental health issue, – attributing it to the brain and being unwell, but also of threat to engage with mental health services, making it seem sinister in nature and abusive.

Dillon also spoke of prior diagnosis colouring the perspective of a psychiatrist he encountered.

Yeah ... when I first went in ... I was sat in the psy- I can remember sitting in the psychiatrist's office. And he was like his eyes were boring into me and I looked out the window because I could see some birds flying out the window. Erm ... So I was just like, concentrating on them. And then after, he wrote up that I was won- ... My eyes were wondering like our seeing visions and things. And this is consistent, you know, they

*write things like this to confirm a diagnosis to confirm a problem when it's nothing.
(Dillon, p9, 294).*

Dillon seemed to be offended by this formulation of his reaction to feeling intimidated by the psychiatrist as 'seeing visions'. In his view and according to Shanice's recollection, it seemed as though the psychiatrists in these scenarios had diagnosis-tinted lenses, and were perhaps exhibiting confirmation bias in seeking out evidence in their behaviour that would further confirm the diagnoses they had in mind. Their bias was confirming what they believed. It seemed that they were not able to perceive their behaviour- in Shanice's case as non-threatening, and in Dillon's case as non-psychotic.

Dillon had more to say on the matter. He described feeling that services were against human beings and described services as *"a monster that comes to get you, comes to eat your soul"*. He shared that after requesting and reading his clinical notes his feeling was that *"every little thing even every little non-thing they twist around and for everything to work against you"*.

Dillon had some powerful feelings towards the mental health system, as oppressive, a monster, and motivated towards it's own interest. Dillon hypothesised sinister intentions of the mental health services he encountered, as though it needed to have users of it's services and needed to attribute all material as evidence of illness for it's own gain. There is a clear feeling that the bias he experienced in mental health services was detrimental to him, with personification of the system as abusive and something he was 'lucky to escape' from. Shanice had similar sentiments.

Imogen shared her understanding that different contexts influence the perception people have of what it means to be well or unwell.

We have people who are mediums and who "claim" (motions inverted commas) they can speak to the dead and claim erm ... even in like religion – special people who hear God and like see God or get information. Why is it in a religious community these people aren't seen with mental health issues? Why is it that when we have people in churches or ... I dunno spiritual groups, their not seen as crazy or mental illness. But when it comes to "the mental illness" (motions inverted commas) like industry, people are like "oh yeah no their crazy" or "there's something wrong with them, we need to put them on drugs". Someone needs to connect the two and think "well hang on a

minute ... what ... what is this?“, because ... yeah. That’s it. That’s all I’ve got to say. ... if tomorrow I spoke about another spiritual experience that I had today, the first thing would be “okay, have you taken your medication? I think we need to start you back on your medication Imogen. ... this is just part of your diagnosis, this will happen time and time again. (Imogen, p14, l492).

Imogen’s reflection was that in a different context, the same phenomena or experiences would not be seen as mental illness. She seemed to be expressing being relegated to the confines of her diagnosis as the only possible explanation for her having spiritual encounters, whilst in other groups or settings it would otherwise be seen as normative. Nala made very similar reflections about her conversation with a mental health nurse who had expressed that patients talking about spiritual stuff was silly, who seemed to hold a double standard in terms of her own spirituality.

she was like, into this like kemet practice like ... So it sounds like ancient Egyptian ... they're usually very ... like they're usually very Black spaces. So I was first of all shocked by this, this is some ... you're telling me you're part of some kemet community? and that you know you have to wear white when you pray you have all of these rituals. And you had these you know this altar in your home and you know these things in your house, that you invite the spirits into and I was like “Hold on! You?” I was like ... hold on (Nala, p22, l773).

Nala picked up on a duplicity, and perhaps in her view a hypocrisy of the nurse she encountered. It was as though it was okay for the nurse to engage in spiritual practices and beliefs of a very similar nature to Nala in her private context, but felt unfair that in expressing a similar way of thinking and experiences in that vein, Nala had been hospitalised and deemed mentally unwell. In essence Nala may have inferred from this experience that it was given to some to be chastised for the same beliefs that it was permitted for others to have and practice freely – the differences between them as highlighted by Nala being in this case race (as Nala had mentioned the nurse was White British), as well as profession.

Reflexivity box

This caused me to reflect and ponder on, given more information, what the criteria would be between determining who would be deemed mentally unwell in this context.

Would the nurse feel comfortable in sharing her spiritual beliefs and practices with her colleagues? Was the nurse's spirituality welcome here and Nala's not? Was it that all spirituality was not welcomed or did not have space in this context? Would the nurse have been deemed mentally unwell too?

It caused me to reflect further on my personal beliefs and on how much of ourselves we bring in to our professional roles and even in formulating and understanding a person's mental health difficulties.

Claudia shared some further factors that she felt may contribute to the confirmation bias she experienced.

Erm ... but there's an element of me wanting to say, within that within the psychiatry profession in built into is too much ignorance and arrogance, but at the same time, it's almost like the people there truly believe that the approach that's being used is of benefit to someone if that makes sense. So it's working out, when you have meet those people, as to I generally think they think they are helping people with the approach without ... It's working out kind of how you can break down ... like when someone has a spiritual experience, it's I almost want to kind of say, who is the best person to actually educate a psychiatrist around the fact that an illness based approach isn't appropriate for everyone. Because as a patient you ... there's a power divide. There's a power divide if that makes sense. And you can't do it as a patient because I tried. And it comes across that they are ignorant and arrogant, because of just ... just an inability to see in any other way. (Claudia, p13, l512).

Claudia was able to acknowledge the possibility that mental health professionals did not have ill intent against spirituality, but did not have the appropriate education. She pointed out the difficulty in challenging professionals due to a power differential between professionals and patients, and the inability to express that she felt things were being medicalised that perhaps did not need to be. She spoke of feeling psychiatrists and psychologists were “*brainwashed by their own training*”, and shared thoughts the spiritual direction was leading more towards meaning making and feeling the emotions that she felt psychiatrists were seeking to treat. Claudia expressed that the consequence of this professional bias and the difficulty in submitting to it would be that those having spiritual

experiences would be prevented from the emotionally healing or cathartic process that she believes it is designed to be, by the prescription of the professionals – the effects of antipsychotic medication. Her description made it seem as though psychiatry and spirituality were in direct conflict with one another, and the treatment recommendations at odds.

Clive's view was that one would have to protect themselves from these diagnoses in order to have a positive outcome.

But, my guess is that ... If someone does have some more understanding this is spiritual experience and does not internalize the ... does not internalize the mental health diagnostic label so much that they will have a more positive outcome. (Clive, p11. L491).

Clive's statement recommending participants themselves needing mental protection from the idea and effect of diagnostic labels in his view illustrates the tussle between mental health services and individuals on the perception of spiritual matters. There seemed to be a stubbornness on both parts – with professionals exhibiting confirmation bias in line with diagnoses, and participants feeling the need to build a strong resistance in the opposite direction.

Bias was not only experienced in the direction of confirmation bias towards diagnoses, but also in the form of resistance to listening to any opposition against this. This will be further explored in the next subtheme.

Resistance to listening

Participants reported experiencing professionals that they came into contact with actually not wanting to hear anything of a spiritual nature. It was often not that professionals were unaware of how participants were perceiving their experiences, but that they did not want to hear it. Participants described feeling dismissed and sometimes feeling as though mental health professionals had already drawn their conclusions and were not actually considering what they were reporting. A few participants despaired as to how they were going to get through to those they were speaking to. Dillon described these sentiments.

That they sent the crisis team in initially. Erm ... And yeah, they- I could tell because they weren't listening to me. They'd already made up their minds. And then erm ... obviously, one time when I was in the police station ... and they sent these couple of psychiatrists in. Erm ... I'm not stupid guy. I think that I'm quite articulate in the way I communicate things. But they weren't listening and when they basically concluded that are suffering from mental health problem and sent me to the psychiatric unit, that's when I knew things were starting to get ... tricky. (Dillon, p14, l491)

Dillon seemed frustrated here and powerless in his ability to present a differing view. His feeling was that no matter how much he articulated himself, he could not get through to the various mental health professionals and teams he was encountering. His descriptive choices around examining his intelligence imply frantic efforts to be understood, that it seems were futile. Mary shared a similar experience.

Erm ... then the following day the psychiatrist came to see me and he said, "We're thinking about putting you on some antipsychotic medication. How do you feel about that?" and erm ... I was quite shocked. And I remember sort of explaining to him that I really didn't feel it would be necessary, and I tried to explain this and sort of explaining now ... why I had undertaken the fast and how actually despite my physical appearance, I sort of felt much better in myself and that ... I thought that the idea of medication was to kind of maybe relieve anxiety in some way or something like that. But I felt that I wasn't really suffering from that at that time and erm ... that I was okay basically. And er ... he didn't say anything. He just left the room, and so I asked him, as he was leaving, what, what was his decision. He said, "No we're going to put you on this ... this medication". (Mary, p3, l73).

Mary's description of her experience here exemplifies how despite her wishes and her numerous attempts to explain her disposition, she was not listened to. From Mary's recollection, there was no response to what she said or attempt by the psychiatrist to explain his disposition or decision making. This implied an apathy or absence of feeling towards the desperation of Mary's attempts to communicate her viewpoints. Cassandra described the emotional impact of similar experiences on her.

I guess I felt quite let down because it's almost like ...It's like if you're a child who's being abused and you know what's happened. And it's a fact. And you go to an adult me say "This is what's happening to me" and they go, "Oh, no. You're lying". It's that kind of, you know, kind of invalidation of what is happening, what is real for the person. (Cassandra, p4, l103).

Cassandra likened the experience of not being listened to, to a child being abused and not being believed or helped by their responsible adults. Through this example, Cassandra might have been expressing the disappointment in turning to the system which she may have expected to help her and perhaps to have more knowledge, and finding that her perception of the spiritual experience was not taken on, or feeling that she was not believed.

There was a shared feeling that professionals had been 'brainwashed' by their own training. We can therefore infer that participants felt that the training professionals had had, had not entailed any training on how to navigate patients with spiritual content, and had caused them to believe that experiences with spiritual content were symptomatic of mental health issues. Dillon illustrated these thoughts.

Sounds pessimistic but I don't think there's any ... I don't think they're open to thinking about things differently. The psychiatrists, they're not open to it. Diagnose it, medicate it. If he doesn't comply, or the medication doesn't, make him fit in with what we think he should be doing. And that's it. (Dillon, p9, l269).

Here, Dillon's suggestions echo Claudia's earlier sentiments, in that he suggested that psychiatrists were actually more interested in success stories and making people fit within the

psychiatric / medical model than considering any other hypothesis as to what may have been happening. Claudia shared some further thoughts.

I just think that on my own path and maybe I was unlucky, I met a number of psychiatrists that had very black and white thinking erm ... and wanted control wanted power, those kind of things. Whereas, I'm sure there are psychiatry is out there that actually are a little bit better but on my own path, I didn't meet those. And in the end I left a psychiatric service with three psychiatrists basically saying you're unwell, I put a complaint in and then that person who answered the complaint, saying, "Apparently, you don't believe you're unwell". (Claudia, p7, l253).

Claudia touched on how mental health professionals or psychiatrists in this instance were frequently in a position of power, in that they were in the position where they were able to determine 'well and unwell', based on their clinical judgement which seemed to often have been swayed negatively by reports of spiritual experiences. Here, the statement 'apparently you don't believe you're unwell' is so confident in its own correctness, and lacking in confidence of the patient's beliefs, even as it pertains to the quality of her own care. The implications of this for this participant was a feeling of distrust in services, in the ability to listen to and support her without labelling her as unwell and being unwilling to consider her perspective. Even after submitting a complaint, there was an adamance in their stance that seemed to come through Claudia's recollection of their response. Claudia recounts the complaint response as lacking cultural humility and referring to her views in a condescending tone with use of the word 'apparently' in reference to them. Clive echoed thoughts on the power held and exhibited by a system that refused to listen.

And the psychiatrists, the medical profession have so much more influence and ... you know ... and people are not are not listened to.

So there's a lot wrong with the system. For general mental illness there's a lot wrong with the system. But for someone going through a spiritual awakening type experience, erm ... it's made even- ... Well well ... I'll give you an example. When ... when I was discharged because after six months after I got discharged thank God and erm ... And when the guy, the psychiatrist, did a discharge summary – he sent it to my GP. No, he said, no, I had a severe depression, blah, blah, blah. He sees it as anxiety, but it was

severe depression. No it bloody wasn't! Now, I knew I was not listened to at all. My experience was ... I was incredibly anxious because I was having this Kundalini experience. I was blown off my feet. I knew ... I had a very ... I thought Kundalini was really dangerous if you didn't know what you're doing. And that's where the anxiety was and ... and yet, till the very end, he didn't take- he didn't take account of what I... what I experienced. He, you know, he was the psychiatrist, he's ticked so many boxes in you know ... in the in the manual. So, so this is what it has got to be. He thinks he has a reason. It's a bullocks way of going about things. (Clive, p11, 1397)

Earlier, Clive shared that he had even prepared with research, in a bid to get professionals to understand what he felt he was experiencing. This still did not result in things being perceived spiritually, nor prevent hospitalisation or dictate a different treatment pathway. Here Clive expressed frustration in not being listened to, and actually that the diagnoses he ended up being discharged with – namely the anxiety – were more likely symptoms of the spiritual experiences and not feeling equipped to handle them, than the cause or diagnoses in and of themselves. Clive's perception of the main presentation being having a spiritual encounter did not seem to be reflected at all in his recollection of his discharge summary. Clive felt like the drive to diagnose him was more of a tick box exercise than an accurate reflection of what he was experiencing and trying to express.

Reflexivity Box

Here, I reflected on how the lack of openness in listening to and acknowledging what our clients are trying to express to us can result in extreme frustration and upset for the clients we are trying to help, and an understanding of healthcare professionals as having sinister intentions.

I thought about the notion that whilst we are 'the experts' on psychological theory, mental health, or psychiatric diagnosis and medication (depending on the discipline), clients remain the expert on their own lives and experiences.

Some participants had more direct experiences of resistance to listening at the hands of professionals, including being encouraged to be quiet about those experiences. Millicent described one of such experiences.

So erm ... like both times lots of strange things happened and it's this thing called synchronicity. You know ... like massive changes in my thought patterns and my perception ... erm all sorts of things like time and ... Just the universe and that sort of thing and it felt quite ... I guess quite like a divine experience erm both times really but. And as I say both times I've sort of ... Locked up and drugged, basically. And if I tried to talk about anything spiritual they they it called a delusion and ... sort of encouraged me to shut up about it really, so ... (nods) ... Yeah. (Millicent, p2, l45)

Millicent describes a very helpless experience of having her liberty taken away from her in many ways, from her physical freedom, to having the influence of medication which she refers to as being 'drugged', and then not even having her freedom of speech, in being encouraged to shut up. Unfortunately this was not an isolated experience. Some participants expressed similar and worse treatment at the hands of mental health services who perceived their spiritual experiences as mental health problems. For example, the following experience that Claudia recalled ...

And they kind of sit there and sort of, I think the first second second psychologists that I saw when I said I was in spirituality is ... She just rolled her eyes and said "not again". So she that that kind of so it's it's a negative and it's taken negatively, which I get I think, because I think there's an association to if you're on if you connect spiritually your mental health is worse. That's kind of the take. But the way I see it is if you connect to a spiritual path, if you are interested in spirituality, to me, I think that that can indicate someone who is maybe an older soul i.e. someone who has been more lifetimes, if that makes sense. So sometimes they do take on more challenging things. So they might have an increased risk of say mental health type problems compared to someone who is a younger soul who may be as come on a lifetime to experience, maybe one or two challenging things. (Claudia, p8, l269).

As Claudia exemplified here, participants often had their own theories as to what was really happening, why there seemed to be an interaction with their mental health, and what the correct explanation or way of perceiving things in their view was, and they were keen to get this across, but very rarely felt able to or well received. Claudia's recollection of the reception of her views by the psychologist implied that her views were unwelcome and would not be treated with kindness. George's experience further exemplifies this.

There was th- there was a guy there who ... I don't know quite what his qualification was. I mean, I assume he was a ... psychologist or something, who was, I think he was from Sri Lanka and er ... I did approach one point I sort of said well ... "What's this thing that someone keeps saying to me about an eightfold path or whatever", and you know I got no sort of particular response from him about it or so I just decided, You know, I realized that this ... we weren't on the same wavelength and er ... There was no point in driving home the point at all. (George, p6, l231).

There was not much mention of psychologists throughout the study in the reports of participants, however these two examples show that psychologists in the experience of participants were also very much absorbed in the bias against spirituality, and the resistance to perceiving or understanding the perspectives of the participants.

Participants reported various experiences of bias against their spiritual beliefs in the mental health system, and feeling that professionals were motivated towards diagnosis and medical treatment, and resistant to listening or paying attention to anything that was said that would contradict this way of conceptualising their difficulties.

Participant experiences were unfortunately not only limited to a biased view of their spiritual experiences, but were sometimes even violent in nature. We will be exploring this further in the next theme.

The bias of professionals towards diagnostic labels or the medical way of viewing things, and against formulation with culturally or spiritually informed frameworks had implications on the level of openness between both parties, and it seemed that both professionals and participants were hardened towards each other. Ultimately this would not have had good implications on their care and treatment.

Shanice's sentiments sum up the implications very well.

So yeah, so it's quite frightening. It's quite frightening to know that that part of your experience won't be heard ... (Shanice, p7, l229).

... I don't think there's a separation. It's kind of like I ... It's not that I was misdiagnosed as a ment- I was in a mental health crisis, and I probably needed some kind of care, but

there was no acknowledgement that any of it was a spiritual experience, to the point where that certain things happened and it felt like a violation and not being heard at all, from my experience. (Shanice, p3, 137).

Shanice shared that not feeling heard inspired her motivation to participate in this study.

Um, Yeah, so then um ... I wanted to anything that might improve the understanding of ... mental health issues, I guess. And because I didn't feel heard and at no point in my experience did I feel heard, really. So I would if there's anything that would benefit people that experienced something similar, you know, or or just increased yeah understanding, (Shanice p2, 123).

Almost all the other participants shared this sentiment. They were keen to participate in this study as a way to have their experiences and views heard by professionals. In some way, the desire to be heard by professionals in this area never really ended, even after their times in mental health services did.

The next theme will explore participants experiences of the mental health system as violent, the dynamics this created and the subsequent impact.

Violence of the system

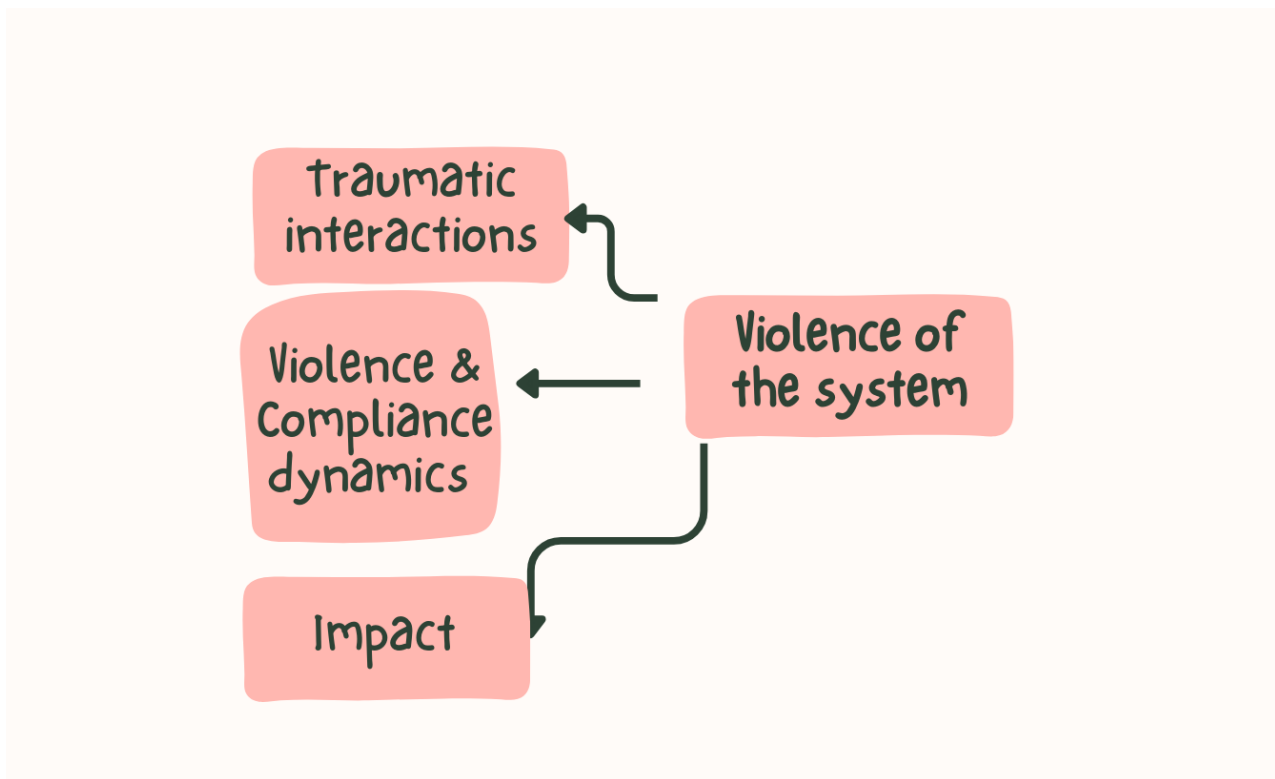


Figure 4 - Violence of the system segment of Thematic map

How are spiritual experiences understood as mental health problems in mental health services? Through the violence of the system. Not only did participants report there being differing perspectives – which enabled some to have more power over the situation of the participants than others, and not only was bias reported, where there was partiality against spirituality and spiritual content, but some actually experienced the mental health system as an aggressor. There were many different kinds of violent interactions that participants reported, at the hands of those who were – whether fitting or not – supposed to be looking after them and their needs in a time of vulnerability.

The violence displayed by the system is comprised of three parts – traumatic interactions, the dynamics they created – in terms of violence and compliance, and the lasting impact.

Traumatic interactions

A trend that emerged time and time again from the data was the report of traumatic interactions. Participants recounted experiences of professionals being rude and disrespectful to them. Traumatic interactions reported by participants included loss of their freedom (usually through being sectioned), being forcibly medicated, feeling bullied, being spoken to harshly, being insulted and being threatened.

In the first instance, many participants found the process of being sectioned quite traumatic. Clive made reference to this in his interview.

Well, I mean, I was locked. I had my liberty taken away from me. I couldn't ... I was literally locked up you know. That's not very nice. (Clive, p9, l306)

... Because actually, with these kind of experiences ... they're very energetic experiences. So you have all this energy and ... if you talk to anyone in the know, the first bit of advice would be grounding. Look at ways to ground yourself and being in nature, it's very grounding. Actually literally lying on the ground, or walking in the countryside. Perhaps walking barefoot in the grass or whatever. But look at grounding the energy because the- what causes the problem is experiences that ... it's having too much of this energy that takes you (stretches arms upwards) ... erm ... makes it hard to function in the physical environment.

But obviously, there's no understanding of this within mental health services, so their solution is to lock you up then wack you full of ... sort of antipsychotics. (Clive, p9, l292).

... And ... and erm ... And to be in surroundings, where they can- see we were locked up. I couldn't even ... the first week I wasn't even allowed out of this room. And when you go through this kind of experience, that's the worst thing. (Clive, p8, l287).

Clive spoke to not only the unpleasantness of being locked up, but the belief that this was in direct conflict with what he needed for his care and healing in navigating through his spiritual experience. In his description, he juxtaposes the idea of being locked up with imagery of the countryside and freedom to be able to ground himself in nature. This may be both literal and act as a metaphor for being able to the contrast between being fully express what he needed to and what came naturally to him in his energetic experience, in comparison to the directly contradiction in his language with being locked up by mental health services and medicated with antipsychotics – as if to suggest that this would have not been grounding or healing for him, and been counterintuitive to what he felt was needed. Cassandra shared similar views.

And I wouldn't even behave in- like I'd know what was expected in terms of my behaviour and just don't go outside normal because it was too traumatizing to be locked up and ... and have everyone think that you're nuts and, you know, it's just horrible. (Cassandra, p4, l118).

Cassandra spoke to regulating her presentation so as to be allowed to go outside whilst in hospital, implying a performance requirement in order to avoid the unpleasantness of being 'locked up'.

It was the viewpoint of many of the participants during their hospitalisations that they did not want to be medicated, or did not want to be given strong anti-psychotic medications. For some, they explained that they were averse to medication more generally, however in most cases they recalled being forcibly given medication, and at times even blackmailed to take the medication or else not be allowed to leave. Shanice shared a recollection of one of such memories.

*So it's like ... these really terrifying experiences happened to me in hospital - being pinned down, having my autonomy taken away, having ... being injected with drugs. I mean, that is such a violation, literally, having your trousers pulled down being injected in your bum, being pinned down onto the bed. You know, like, this is f***ing huge violations of your, of your body and your and your, your yeah ... everything.*

And being forced to take medication that you just don't agree with, you know, of not having that autonomy over your body. And yet there is no platform, when you get out

to talk to people about that to have that erm ... discussion, you know, and my attempt to do and I wrote to the hospital to say about my treatment there. And this guy, the psychiatrist, who didn't listen to me ...and and actually caused me to be injected, you know, it's just ignored because honestly, most people when they get out of hospital are not in any place to launch some kind of complaint, because they're unwell.

You know, so that's a huge thing to me, is I think there's a word for it. You know, like not rhetoric not restoration and ... What's the word. You know, there's, you know, It's ... can't think of it now.

Not making a making amends ... but you know that ... yeah not retribution. It's something like that. (Shanice, p2, l551).

Shanice's recollection of being medicated in hospital was not a recollection of the administering of care, but of being violated. She was vivid in her descriptions, with her language inferring intense feelings of restriction, perhaps shame, and dehumanisation. Shanice also made reference to the differences in power even when making a complaint regarding her care, as Claudia did earlier. It seemed that even when dissatisfaction with the violent nature of her treatment was reported, it was not adequately listened and responded to.

Millicent also shared her experience.

And they just drugged me basically ... didn't tell me what any of the drugs were. They were about, I think at one stage there were twelve different drugs a day. (Millicent, p4, l127).

When speaking about medication, a lot of the words chosen to describe the experience was "being drugged" or being "pinned down". This describes a violent overthrowing of a person's will to administer medication and is violent because in the view of the participants, it was an invasion of their internal world and biochemistry, based on the interpretation of their spiritual experiences as evidence of mental deterioration in need of medicating, and at all costs. Millicent's recollection here is that she was not involved in knowing or being told what was being given to her, and not really being involved in her own care. Clive share similar sentiments with regards to medication.

Until after a week or so of all the heavy crap load they were giving me, just ... just meant I could hardly do anything physically, and ... It was a horrible experience and I started have panic attacks and stuff and ... erm it's really, really horrible. (Clive, p6, 1180).

Clive spoke to the impact of the medication he was being given on feelings of loss of control. The impact of the way medication was administered in all these examples is that it was experienced as detrimental, seemingly both at the time and in their memory.

Mary also recounted invasive treatment being administered against her will, and the difficult memories this left her with.

Erm but erm a different psychiatrist came to see me from an eating disorder unit and he ... erm ... yeah, he came into the room and then he just quickly decided I should be admitted into an eating disorder unit. So that's what happened. And then I was put on a feeding tube and it was all quite ... yeah, quite shocking in some ways, it was such a ... kind of a roller coaster experience. I remember erm ... because the feeding tube was in me, I wasn't allowed to lie down. So I ... and I was admitted in the evening I think, so I just spent the night sitting in meditation with two nurses on either side of me holding my hands down so that I wouldn't try and pull the tube out which I never tried to do. (Mary, p3, 163).

Whilst we are unable to know or comment on any risk there may have been to herself or protocol on that, Mary's memories of the experience are harrowing and sound like they would have been difficult both to experience and to remember. Mary describes being shocked, and it seemed throughout her interview that her feeling was that the choices of professionals were excessive in reaction to what she was expressing. She shared that she was trying to engage in fasting as a spiritual practice, and was forcibly prevented from doing so with a feeding tube without discussion. She implied feeling that the nurses holding her hands down overnight was an excessive response to a threat that she had not made (no remove her feeding tube). In doing so, the team were taking away any ability she would have had to remove the tube, and perhaps exhibiting fear that she might do so. It seemed to be a resource heavy response – to have one nurse on either side holding each hand down for the duration of the night.

Whilst many participants were given antipsychotic medication, Millicent spoke to being denied medication for her physical health during her time in psychiatric hospital.

Well yeah, I mean, I felt like everything was interconnected and you know it's quite amazing. And like I say, all these strange things happened and I was getting all these erm ... it felt like messages I suppose from the universe. Erm ... and yeah, that was pretty amazing, but unfortunately I ... I had erm a van with all my all my belongings in pretty much and when they sectioned me- and I've had breast cancer twice as well, but when they sectioned me they didn't believe me, so they didn't give me my breast cancer treatment they thought was a delusion. (Millicent, p4, l112).

Millicent described the dichotomy between having amazing experiences of a spiritual nature whilst being in hospital but being denied medication for her breast cancer and not being believed. This was a big failure on behalf of the system which could have had huge detriment to her physical health and exemplifies the problem with not listening or believing patients on all fronts, on account of spirituality. The impact of this could have been fatal.

Shanice also spoke to being left traumatised following her time in hospital.

Perhaps, yeah, a lot of people ... if their spiritual experience... I guess it depends how extreme, but say like me, if you end up having to go into Helston or mental hospital, you possibly go in because you've got some kind of initial trauma childhood trauma or something unprocessed. And what happened is in hospital... so I experienced a lot of trauma, so as well as having quite a good time because I was so manic, I also got assaulted – so I got hit in the face. I know I was ... I was actually really off the planet. So I don't remember it that well, but it was really distressing for my family.

And then the last time I was hospitalized, again, it was so badly staffed. There was one girl who was so violent she needed to have 24 hour watch which she never got that watch, and at one point she like had me pinned down by my throat, had like urinated on

*me. It was ... like it was just horrific, this experience in being in hospital. To the point where then when I got out, I really had like remnants of like some PTSD. Where I saw like homeless people or people on drugs, I was f***ing terrified of them because they remind me of that effect complet- ... when someone's so out of it that you just don't know how they're going to respond, and that took a good few months to go away.*

So what I'm trying to say is that ... Is you're not. You're like, it's a whole new layer of trauma. So if your mental crisis is such that you are sectioned or go to hospital, it's such a huge extra layer of trauma and not only is there that extra layer of trauma, but it's really taboo. So I don't tell many people that I've been, you know, I've been a mental hospital. Obviously all my good friends, but I wouldn't, I would never share that with someone, I just met, and even like new friends. I don't necessarily share that information, unless I think they're quite broad minded. (Shanice, p14, l526).

Shanice described harrowing experiences not only of her treatment by professionals which she previously mentioned, but of being assaulted by others in hospital on a number of occasions. Unfortunately she was not protected, in an environment that was purposed to provide safety and healing, despite herself being vulnerable and therefore perhaps not being in the best position to defend herself. These experiences resulted in an additional layer of trauma occurring from being in hospital. She describes the hospital environment as being unpredictable, and the experiences she had in hospital leaving her with PTSD as well as shame in sharing, not just because of the stigma but also because of what happened to her.

Nala expressed feeling tortured by being kept, prodded, examined, and also felt that there was a lack of transparency about her care.

Erm ... it's a lot of waiting rooms. And I think like when I first got there I was relatively calm. But I don't know I guess after a couple of hours like by the end of it, I was like screaming in the hospital room. I was just going off.

Because I'm like bro. I've been in this space for so long you man. I come into push and prod and to do your test, this this that. And then it's just like I'm in a room with all of you man. And you're just looking at me.

And it's just like there's that, but there's also what's going on internally.

And, it's just like, yeah. So then by the end of it, I was like, I don't know if I was restrained ... I remember that I wanted to leave. And then my dad was like basically like no and then I was in hospital bed. (Nala, p6, l151).

In these experiences, it did not seem that there was much thought given to the experience of care that would be received on the side of the participants – with a lack of transparency in care causing distress, as well as having difficult experiences within mental health care, whilst also trying to navigate the spiritual experiences which were ongoing for participants whilst all this was happening. Clive summarised this sentiment well.

So it's incredibly negative experience.

So, you know, going through the kundalini experience was traumatic in itself, but the mental health system was like a double trauma really. (Clive, p10, l341).

In sharing his own recollections, Clive also described experiences of being threatened by staff.

And it's outrageous. I think it's actually illegal that they ... that they ... Firstly, when I didn't want to go to this place, secondly I was gonna get nothing from it ... that they threatened to section me if I didn't go. I don't think that's legal, but they were saying I have to take all these tablets otherwise they'll section me again. I don't think that is actually legal.

*Erm ...And it was really oppressive and they wanted me when ... after I was discharged to go to this day centre the hospital. Now I'm ... you know I'm trained in social work, I've worked in mental health services. I know ... I've done group work training and all that kind of stuff. I didn't need any of this s***. I mean I wasn't going to learn anything. Because of the state I was in, I just needed time to recover. I didn't want to be doing these, you know, like star- outcome stars and have all these plans are doing stuff, because I wasn't in a position to be able to plan to do anything. I just needed to recover.*

And then they were actually threatening to section me again if I didn't go into ... into this day centre and I hated ... I hate- I'm not- I love playing music, I love being creative

but I hate like making things and I've always been a crap drawer. I j- you know, and I was made to go to this session and with other people do all these drawings and makes some stupid stuff. (Clive, p9, l321).

Clive experienced the system as oppressive and forcing him to do things contrary to what he felt was best for his recovery from his spiritual experience. It seemed that the offer of medication and use of a day centre was posed as perhaps a favour or a lighter treatment option, with the consequence of being sectioned if he did not comply. Clive's choice in the matter was very limited. He described feeling bullied by the system.

Then my experience was ... I've never been so I never had so little control. I wasn't listened to. I was bullied and so and that's so ... I felt bullied!

I felt put down and bullied. (Clive, p9, l317).

Unfortunately participants experienced traumatic interactions and various points in their journey with mental health services. In experiencing and reporting spiritual experiences, according to their descriptions they experienced being locked up, drugged, physically hurt by others in the environment and not protected from that, their physical health being put at risk through negligence, being threatened with loss of their freedom and being bullied.

This illustrated a very unsafe and uncaring environment or system for participants. Shanice summarised this well.

There's just n- well obviously there's a feeling of having absolutely no support and ... I mean mine's a really extreme example so ... Basically that the feeling that I needed this thing to happen to me and that the only thing I would receive was kind of violence. (Shanice, p7, l210).

Reflexivity Box

It was very difficult to hear these experiences and again I experienced guilt in my professional identity being part of a system that had caused this harm. This also however highlighted to me the importance in pursuing this research and in not defending treatment which was wrong and inhumane. I was sure to maintain a stance of empathy and open listening in my researcher role in the interviews.

Violence and compliance dynamics

It seemed that through displays of bias against spirituality, and acts of violence towards them, participants came to perceive that they could not continue to share their experiences within mental health services and get what they wanted from the situation – which first started as wanting help and later became about wanting their freedom. Many felt the need to act, according to what they perceived those overseeing their care wanted, in order to be seen as ‘getting better’ and therefore to be released from hospital, or in some cases discharged from community mental health services. Participants were able to share what they said or did, and one even recounted being told to stop saying certain things as the psychiatrist would find them unwell. It seemed as though what started out as important and significant spiritual experiences became hijacked by a system pathologizing them and restricting them, and therefore the focus became freedom, before returning to trying to understand what happened and processing it in a different environment.

George’s sentiments illustrate the dynamics that were at play.

Erm ... what they were seeing I think it was someone who was quite anxious. I think anxiety was probably I was more towards the anxiety than the depressive sort of.

And actually ... And I can't remember the names of the pills that they gave me. Erm ... obviously, they were intended to calm you down and sedate you in some sense. So that I was ... I was compliant and to that extent, they succeeded.

Interviewer: Hmm.

George: And because I wasn't exhibiting any florid symptoms. There was no need to section me or anything like that. Therefore, I sort of got through it.

... Pretend that whatever it was they wanted, I'd comply with. And so I did. And within a few months they let me go, thinking that I was a success story. (George, p3, 189).

George describes a level of resignation that resulted in compliance, in order to attain his freedom. He described that his compliance was likely viewed as a success story by the system, which George may have felt was the price he had to pay to attain his freedom. George was not alone in this experience, a number of my participants felt they needed to deceive the staff into believing that they were “recovering” from the content of their spiritual experiences, in order to be deemed from the psychiatric perspective as no longer experiencing psychotic stimuli and making a recovery. Cassandra described a similar process.

Yeah, I think ... There's two times I've been in the hospital and the second time I went I made a decision that anything I went through, I just wouldn't confide in anyone ever again. (Cassandra, p4, l116)

Cassandra described realising that her silence was necessary – perhaps for her safety or her smooth transition through the service.

Reflexivity box:

As a mental health professional myself, I found Cassandra’s conclusions here such a shame. I feel that as mental health professionals, and particularly in talking therapies, we pride ourselves on being the place where people can come and confide in us, where anything can be explored without judgement and with unconditional positive regard, with the only caveats being risk to self or others. It is heartbreaking that Cassandra’s conclusion for her own safety was isolation, and not feeling able to share her thoughts or beliefs with anyone else.

Many shared that they continue to have spiritual experiences to this day, but would not dare to bring this to the awareness of a mental health professional. In this, it strikes me that the intended outcome of professionals when they go into helping professions with the aim of helping people in this area has not been met. The view of pathology being treated through psychiatric and psychological intervention is not met – firstly because the problem cannot be agreed upon and is not jointly defined as pathology, and subsequently because participants felt they needed to mask and act in order to seem recovered. For the participants as well, we can infer that they also did not receive the support that they expected from their interaction with services. It becomes a lose-lose situation, where the violence executed by the system is so painful that it causes the people to seek to escape it and the professionals not to achieve what they intended.

Shanice described not really feeling seen, and therefore making decisions based on this.

I mean in my meetings, there's the psychiatry is when we were there. It was completely perfunctory so it felt like ... I could have been anyone. They were sort of just going through a tick list. "Are you hearing voices? Are you doing this? Da da da. Have you slept? Have you eaten?". There was no sense of that was that that could be anything beyond my ... Presentation.

You know ... there was no interest in in me really. It was kind of like a ticklist and ... that's how I felt at the time. And I just knew ... it was a bit like doing an exam at school. I knew I had to ask the right questions to be able to be let out. (Shanice, p13, l470).

It seemed that not being evaluated and understood holistically caused Shanice to produce answers out of compliance, rather than because she actually meant them. It seemed to be an infantilising position with a power differential between the powerful psychiatrist and the nameless and helpless patient, in her view; she related it to doing exams at school.

And then I went on to have another episode where was hospitalized, but I actually didn't take the drugs in hospital because you can actually hide them in your mouth. So I didn't take the drugs. (Shanice, p4, l102)

... Erm ... So, I mean the way you deal with it at the hospital is ... I just answered the questions as I knew appropriately to seem not crazy. But I think it w- they, I think they were ... I was my- I was able to be incredibly lucid. So all this weird stuff was going on, but very quickly within like a week I was almost like "normal" and could act appropriately. (Shanice, p6, l195)

Shanice's compliance did not begin and end with that first incident with the psychiatrist, but through her experiences it seems that a distrust had been formed between mental health services and herself, where she no longer felt able to exhibit her true feelings or trust the treatment being offered to her. She also did seem to feel empowered to decline, but was now in a state of continuous compliance with the system, to perhaps result in a milder experience whilst in services, and ultimately to win back her freedom.

Claudia seemed to arrive at similar conclusions.

Erm ... but from day one I felt things like psychic stuff. I felt all these weird connections, but it just happened that I met the right people as an inpatient.

Who said "I have been stuck in here for six months, because as soon as I say I've got psychic skills they say I'm ill". So I've met people in there that ed- ... almost that I listened to, they educated me so it almost felt like as an inpatient I didn't actually say much to the psychiatrists, because I instinctively knew from a mixture between gut feeling and speaking to other people. (Claudia, p8, l112).

Claudia described being coached by fellow patients she encountered in hospital as to what she should and should not say, in order to not be seen as unwell. This could suggest that the experience of feeling excessively pathologized and therefore withholding aspects of their presentation was not limited to my participants, and perhaps not necessarily limited to those who presented with spiritual experiences.

George described his compliance being rewarded.

I would say. But, you know, as I say, because of what they were giving, the stuff they were giving me, it became very hard just to know that the great deal physical pain ... in my mind ... not just sort of mental anguish, but actual physical pain erm ... Which you know might seem unusual- which might seem strange to some people ... anyway. That was it.

And after I think about three months, they decided I was well enough to send me to some kind of halfway house done in Sevenoaks. And within I think about a month, my parents managed to get me out, or I manage that I managed to get released and they gave me, you know, they said, Oh, well you know that I'd done very well or something. (George, p4, l103).

George described the experience of being hospitalised and medicated as very painful, and yet tolerating the mental pain was being seen as a job well done. It seemed that at some stage in the midst of these occurrences, his own desires were lost in the priority to appease the expectations of his treatment by those around him.

Claudia shared a similar feeling of pain.

And that got to me because I was just like, I've just got to end of a shamanic initiation and you've just basically turned around and try to label it with something which clearly shows me you don't understand this. And it gives me no confidence in you whatsoever. And the only reason you're doing it is to try and coerce me again into taking your medication. And ultimately that emotionally hit me. But then at the same time after I ... after about 10 minutes of processing the emotions, I literally went 'well I don't have to listen to them, it's only their opinion'. You know, I can just leave. And ultimately, I just like, Okay, my decision is made I'm not going back to her. And I'm not going back to that service and I just requested discharge. (Claudia, p10, l379).

By contrast, whilst having similar spiritual experiences and feeling equally hurt by being pathologized, Claudia seemed more empowered to make decisions around her care. This was perhaps partly as she was not under section but voluntary admission at the time. She described reminding herself that the stance she was encountering was an opinion and seemed to feel empowered in having and expressing opinions of her own and making her own decisions.

It was not uncommon for participants to explain that they continued to have spiritual experiences to date. Millicent explained that to date, she continues to have spiritual experiences.

I get days where I can feel that Presence and feel joy erm ... so it still happens but on a smaller scale. And in fact, I think if I told the psychiatrist, they'd probably say oh it's like, rapid cycling, because when ... when you read into it, that's what they'd say. But for me it's just that some days I feel really connected with God or the universe. And then other days I just don't so much. (Millicent, p7, l260)

Millicent shared a sense of unmatched joy that the experiences brought, and comfort that continuing to engage in the spiritual still brings. Like many of the participants, Millicent shared that she has repeated / ongoing interactions, and not just one spiritual experience. For many, the initial spiritual experiences that occurred were just the beginning of something they came to view as a gift to learn to navigate. For many this seemed to have happened in spite of disagreement with their experiences in mental health services, or negative treatment that they recounted receiving, however

at this point in their journeys many felt they could no longer entrust services with these experiences. The next subtheme will explore this further, looking into the longer term impact of the interactions participants had with services.

Impact

Something that became apparent throughout the research was the lasting impact that having their spiritual experiences understood as mental health problems had on the participants. Many described a lifelong impact – both of traumatic memories, as well as of a distrust of mental health services, and a reluctance to ask for help from them.

Many described a feeling that they must just manage and find a way to manage moving forward. It was clear to many that they could not return to mental health services for help, however to a few there was a feeling that they had no choice but to surrender themselves to the mercy of the service, for lack of alternative support. One participant stated that the system had scared him to death. Jimmy articulated his views on the impact of his interactions with services.

But they, they're really ... they really have to bully people into taking these meds, very often, that they become hooked on for life. And and the drugs are so strong. Um, It's a, it's and they, they don't they don't they they wreck the quality of life because you sort of like I'm ...

I'm, I'm very fragile at the moment. And I don't know how I get to a place where ... I'm more recovered and more sort of ... able to look after myself better and and and have a better quality of life. Um, and I put that down to psychiatry.

And it's not it's not ... it's not the psychosis is is not ... it's not only that, it's just not listened to and just thought- it's just that, like they that their authority can't be questioned. They're like, um ... er ... That he was gutted when I fought off that psychosis. Actually, I know it. I fought off that section, uh, he ... they were they were, they were like desperately trying. But ... I don't know. It's petty ... petty stuff, but it's had like a really profound impact on me. (Jimmy, p6, 1181)

Jimmy spoke to the disempowering impact of having to fight for his own freedom and not being listened to. The stress associated with this conflict seemed to have a lasting effect, not just in the moment, but long after.

Reflexivity box:

This particular interview with Jimmy- that left me with a harrowing feeling. His description of feeling like his life had been ruined by medication and his functionality diminished, and that he had no choice in the situation felt like the antithesis of what we aim to provide for people that come into mental health services. It was clear that hope was depleted, and I felt both motivated to provide encouragement, and ashamed of the system I also represent.

One of the lasting legacies of the violence that participants encountered was a loss of trust.

George articulated similar sentiments.

Erm ... Because I knew that the kind-... if I were to talk about the kind of experiences I was having, they would assume that I you know that I was mentally ill. So, you know, why would I trust them? (George, p6, l225)

George articulated clearly that knowing he previously was understood to be mentally unwell very much limited chances that he would allow for that assumption to happen again. The tone of George's interview was generally quite guarded, and he opted to conduct the interview with his camera off. An interesting consideration in this regard is just how much mistrust was sown in George from his experiences, potentially infiltrating all the way through to his interaction with this research.

Millicent also spoke to the impact of the system's apparent closed-minded approach to spirituality:

Erm ... Well, I was just so happy I didn't really listen to them. Erm ... and d'you know ... like if they'd ... if I'd have understood it as what it was I think I would have sought some help, it's just the trouble is the only help is quite brutal isn't it? (Millicent, p5, l162).

From Millicent's statement here, it was not that she was no longer in need of help, and perhaps there might have been ways that the mental health system could have helped, however her feeling that the help the system offers was "quite brutal" would have caused reluctance in any

willingness to seek it's help, for fear of adverse consequences, perhaps such as those described earlier in this theme.

Imogen shared similar thoughts.

Erm ... to this day ... and he- and I also met him afterwards coz my mum was furious, obviously ... but to this day I don't understand how a psychiatrist of how many years of experience can sit in front of me and think that there's nothing wrong. ... I felt like they couldn't look after me and I felt like I didn't really want to tell them anything really. ... I feel like after this time ... because I've been involved with mental health professionals since I was about 15 ... I feel like after this experience my trust for them definitely decreased. And I ... didn't really trust them anymore. (Imogen, p9, l270).

Imogen also described wanting help from mental health services, and feeling a sense of disappointment in what had been offered. It seemed that she had given the services several chances – through her description of having been under services since she was 15. At this point it seemed she felt services did not help her appropriately and no longer had trust to offer.

Jimmy shared that he believed he had now developed a problem in his mental health, because of how he was treated by mental health services.

Right, you ... Well, I basically what I'm trying to say is, now I'm ... uh I have a problem in my mental health.

Um, but probably that's ... there's an element of brain damage there.

And and I don't think if people were being honest, I don't think anyone would really dispute that and and ... and if ... that's what I sort of resent ... Um ... So I do have a problem with my mental health, but I think initially it was a spiritual ... It was a spiritual breaking out and and and just like a chance for renewal, but it's just gone really wrong because of the system. (Jimmy, p9, l318).

Jimmy believed that his spiritual experiences being understood as mental health problems by mental health services, and the subsequent treatment he was offered, was ultimately detrimental to healing and caused a mental health problem that he believed was not there to begin with. His

feeling was that he now had to remain reliant on the system for help he perhaps did not initially need, and now had to live with a problem he felt that they caused, bringing up some difficult feelings of conflict within him.

Claudia seemed to agree with this way of thinking.

It almost felt to me as an inpatient, that there were people just stuck. And there are people just stuck in a system that did not understand them because I felt there was a number of people in there that were on spiritual paths and actually were being treated more with an illness-based model. And it wasn't doing them any good. And they were like, it was almost like it was reinforcing the same pattern, which is ... If you're an inpatient, you must have a severe illness. You need medication ... oh medication isn't working. Oh, you must be really seriously unwell then. (Claudia, p5, 1134).

... But for me, it was just like, and I actually found that my own experiences as an inpatient, because I knew ... there was a mix. I knew that I don't respond well to medication ... There was this from one side, which was the psychiatry side because they believe it's an illness. It needs controlling ... That you put someone on the highest dose of medication to basically kill something in your brain that was what it was put as to me ... That I think was the psychiatry stance from day one. My stance was I knew that I don't respond to medication very well in that I have strong side effects. I knew from day one that I stood my ground and literally for me ... My experience was me actually setting boundaries with a psychiatrist to say I'm not taking your medication. Erm ... I take the lowest dose and literally and I left there in two weeks. (Claudia, p4, 192).

Not only did Claudia share in the belief that the illness-based model was unhelpful to those with spiritual experiences and limited their progress, but she spoke of her technique in being boundaried and deciding the dosage of medication she would consent to taking. She felt she was acting perhaps to prevent long-term impact in her life, perhaps akin to what Jimmy seemed to be describing in his.

Clive also believed that mental health services did not improve things for him.

Erm ... Four and a half years now, I had what the term is a kundalini awakening experience. And it was very difficult at the time and I ended up being in contact the mental health services, who were- and their intervention just made things a lot worse. And there was no understanding of this kind of um ... experience. (Clive, p2, l18).

I seemed that for almost all the participants, following their encounters with the mental health system, use of mental health services no longer felt like an option for them. Claudia articulated this clearly.

And actually there's almost something in me, very similar to something when I was impatient and they were trying to control me, saying this is an illness and trying to disempower, there's something that's very much in me that knows that ... the one thing that will stop me from going back there, is that there's just something that based on that diagnosis, I will never be re-entering a mental health service. Because I'm not having medication forced on me. And there's something in me, I determine ... like a determined bit of me ... a stubborn bit of me that goes "I will be looking after myself from now onwards. There's absolutely no way no way I'm going back there".

And it almost ... there's almost me using that pain of that situation to actually say, no matter what, no matter what circumstances, no matter what life experiences come my way from now onwards, I am not going anywhere near a psychiatrist, if that makes sense.

Erm ... so I actually think it keeps me safe in a really weird way, because in going back into work my self-care has been so much better if that makes sense because I'm like, "I ain't going ... this is not failing." (Claudia, p11, l394).

By understanding their spiritual experiences as mental health problems and treating them as such, it seemed that participants were left with a sense of having to manage on their own and navigate their own way forward. For many, the experiences they were reporting had not stopped, but it seemed in their view that mental health services only compounded the issue by pathologizing and restricting them, so much so that they felt they had to move forward on their own, and many felt afraid to allow any possibility of needing and encountering mental health services again.

Participants experienced violence in lots of forms, perpetrated to them by various services, professionals and fellow patients within the mental health system. My participants reported being

locked up, being medicated against their will, feeling bullied, not being seen as anything more than their presentation and being intimidated.

Participants described that not only was their time in hospitals and community mental health teams difficult, but they found their aftercare inadequate, and felt disempowered and not listened to even when they submitted complaints. They felt they needed to avoid mental health services and their intervention; both during their time under their care through compliance with their requests and minimising their symptoms, and after their time under services by avoiding exhibiting behaviours that would cause concern or intervention.

The lasting impact of this was a sense of distrust for mental health services, and feelings of shame and fear on the side of the participants. It was not uncommon for them to feel that they were traumatised by mental health services, and had no choice in their own best interest than to cope on their own.

Conclusion

This analysis chapter has explored how spiritual experiences were understood as mental health problems in mental health services, through the lives of the participants. Differing perspectives towards the spiritual experiences were explored, which seemed to be at odds with one another. Bias was explored as another theme, with bias towards diagnosis and resistance to listening impacting the ability of the participants to feel that their views were represented and considered in services. The violence of the system was the final theme explored, where it was established that some participants suffered incredibly difficult experiences at the hands of mental health services, felt they needed to be compliant to pacifying services in order to gain their freedom, and left services with an ultimate distrust and feelings of pain.

The discussion chapter will further consider these findings in relation to the literature as well as its implications for Counselling Psychology, policy and practice.

Chapter 4: Discussion

Consolidation of findings

The participants of this study, who reported that they had spiritual experiences, were understood as having mental health problems. Participants described that this occurred because the different parties were communicating different messages and professionals did not seem keen to listen. Participants experienced mental health services to be biased towards diagnosis and resistant to considering holistic formulation which would acknowledge their sense of spirituality and their views of what was happening to them. Further to this, participants described that they were treated violently, with unpleasant staff attitudes, traumatic interactions, and were ultimately left with a sense of distrust towards mental health services.

Overall participants reported that mental health services were an unpleasant place to be for them, in view of the way they felt their spiritual experiences were perceived. They also believed that their experiences in these services were not just restricted to them, and they theorised that services are a difficult place to be for people who report having spiritual experiences.

Dillion summarised it in this way:

You know, I was very, very fortunate that I got out of system, but there are people that can't stand up for themselves and ... my Goodness me that ... that's, that's a horror. That's nothing short of a horror. I'm ser- and I'm serious about that. It's nothing short of a horror.

Findings vs Literature

The theme 'Differing Perspectives' highlighted a tussle between individuals, professionals and their loved ones when it came to defining their spiritual experiences, and therefore the appropriate treatment. It spoke to the chronic miscommunication between parties – where participants said they were having spiritual experiences and professionals and loved ones believed they were mentally unwell, and took action based on this on their behalf.

Literature seemed to echo this tussle; studies in the literature search did not seem to give much light to the experiences or voices of those who had spiritual experiences outside of an assumption that they were mentally unwell (Macmin & Foskett, 2004; Holm, Karlsson & Holmberg, 2024). Previous studies in the literature search seemed more weighted with theories and research seeking to define spirituality or boxing spiritual experiences as psychosis. As such, this study was unique in it's upholding of the social constructionist epistemological position – in allowing participants

to self-define their spiritual experiences (as per recommendations from Taves & Barley, 2023), encouraging them to share their views on the spiritual phenomena, as well as on their encounters in services, and amplifying their voices at the table of discussions on mental health services.

This study raised important reflections about the right of service-users to self-define and choose treatment path or at the very least to have a voice that is listened to and considered as it pertains to their own treatment in mental health care. As such, the study was clear in not labelling or categorising participants according to diagnoses as a way to make sense of their experiences, but taking their views and experiences fundamentally as matter of fact.

Koslander, Ronnig, Magnusson & Gustin's study (2021) was the only other study from the literature search that gave voice to the lived experience of participants who found themselves in mental health services as a result of their spiritual experiences, however the study focused on mental health services in Norway. Therefore this study provided a unique insight into the lived experience perspectives of people in the UK encountering spiritual phenomena and being understood as mentally unwell, within the last 10 years.

Findings from this study indicated that the experience of the participants under mental health services resulted in them feeling that their spiritual experiences were not listened to, not believed and that these narratives or perhaps aspects of themselves were unwelcome. It highlighted an active bias in mental health professionals as described by participants, both towards diagnosis – with displays of confirmation bias, and away from the idea of listening to the experiences of participants, despite concerted efforts to offer explanation of their experiences.

Earlier literature suggests that clinicians responses to spiritual experiences hold incredible weight in determining 'whether the experience is integrated and used as a stimulus for personal growth, or whether it is repressed as a bizarre event that may be a sign of mental instability (Greyson & Harris, 1987). Literature further warned that 'negative reactions by professionals towards spiritual experiences can intensify the individuals sense of isolation and block their efforts to seek assistance in understanding and assimilating those experiences' (Turner, Lukoff, Lu and Barnehouse, 1994; Khan, 2023; Vieten & Lukoff, 2021). As it pertains to assessing risk, we are not able to comment objectively on how the individuals presented to the professionals and how they were risk assessed, but we would hope that there is not a bias purely for spiritual or religious content especially in pre-diagnosed patients, and more that there is an assessment of its interaction with their daily life, and of potential harm to themselves or others, necessitating intervention. Participants admitted to needing a place to rest and recalibrate, but believe that their experiences were completely shut down and discouraged

and they were not allowed the opportunity to grapple or critically engage with the contents of their experiences within our services. Tools such as the Cultural Formulation Tool (American Psychological Association, 2013) could have been utilised to understand the depth and significance of the participants' views, and the FICA (Puchalski, 1996) in understanding how this would interact with their preferences for treatment.

The consequence of bias was therefore in the long term not only unpleasant for participants, but directly linked to their long-term outcomes. This is something that participants from this study also agreed with, with one participant, Jimmy, still seeming to battle in himself regarding his understanding of his spiritual experiences and lamenting on the life he felt the mental health system had taken away from him.

This research hints at many different prospective socio-political, cultural, historic and even economic differences that participants felt were mediating the different positions on what had happened to them and the subsequent results. Further to previous studies which simply referenced participants seeking to make meaning of their experiences (Koslander, Ronnig, Magnusson & Gustin, 2021), participants also sought to make meaning of why they were being understood as mentally unwell, and treated with prejudice.

For example Nala made inference to the similarities and differences between herself and a mental health nurse, upon discovering a similarity in spiritual beliefs. In discovering that the mental health nurse engaged in spiritual rituals outside of work, she hinted at contemplating what was different between herself and the nurse, pointing out racial and professional differences. Nala could have been beginning to formulate an idea that it was racial bias that meant that as a Black Woman, her engagement with these things meant she was seen as unwell in comparison to her White counterparts. Whilst it is unclear if this is the case in this specific example, it would not be a far-fetched notion, as literature has illustrated a tendency for Black people to be more likely to be screened as having schizophrenic spectrum disorders (Peltier, Cosgrove, Ohayagha, Crapanzano & Jones, 2017).

The difference also existed in Nala's example between the nurse being a mental health and Nala being a patient of the service. It could be speculated that the difference in power between professional or non-professional enabled the nurse to feel confident in sharing her spiritual beliefs, whilst Nala felt she had to hide hers for fear of the consequences. Further to this, Nala described the nurse being able to discuss her spiritual beliefs and practices, whilst she referred to patients sharing their spiritual experiences as 'silly'. This very much speaks to Khan's encouragement (2023) towards

practitioners in being aware of their positions of power, and how a lack of attentiveness to this can result in oppression for the client, which seemed to be Nala's felt sense.

Participants sought for meaning through their experiences, and sought to be understood. This aligns with findings of previous studies, indicating the significance of seeking meaning to participants, and the distress caused by loss of control to others and lack of spiritual appraisal (Macmin & Foskett, 2004; Brett, Heriot-Maitland, McGuire & Peters, 2014). In their own self report in this study, participants felt that they were being pathologized, and that there was a lack of understanding of spiritual paths, and a lack of literacy on spiritual experiences. Participants perceived mental health services to be incompetent. Amongst a host of diagnoses that participants mentioned they were given, none of them mentioned being diagnosed with a 'religious or spiritual problem' (APA, 1994). This raises questions as to whether this category was considered by the professionals handling their care; of if this diagnostic category is being utilised as intended. An evaluation of this diagnostic category reflected that 'clinicians are failing to utilize the code due to a lack of understanding and knowledge' (Harris, Rock & Clark, 2019).

In the design of this study, there was no direct questioning or interviewing of mental health professionals. As a result, it was not possible to get a self-reported picture of their stance when it came to spirituality. Their views could only be inferred from the report of their words, behaviour and actions as recalled by the participants. It is plausible that professionals experienced the same uncertainty as it pertains to addressing spiritual content as reflected in the literature. Research interviewing GP's (Whitehead, Jagger & Hanratty, 2021) and another study interviewing Clinical Psychologists (Crossley & Salter, 2005) revealed the tendency to resort to their own spirituality, or lack of belief or comfortability with such, as a determinant in addressing the topic or their client's needs for spiritual health. The findings from this research could therefore be seen as presenting some of the risks of when it is left to personal factors to determine engagement with spirituality (rather than training). Put frankly, the risks are that enough subjectivity is left to create room for people to be abused and traumatised by the systems intended to care for them.

A surprising finding in this study was that most participants reported spiritual experiences that fell outside of their spiritual or religious belief system at the time, with only one participant describing their spiritual experiences in context of a belief system they already had prior to the experiences, and continuing to retain it after. Equally, the majority of the participants did not hail from ethnic minority backgrounds – with only three of eleven participants reporting ethnic minority backgrounds, differently to perhaps initially expected when embarking on the study. This perhaps illustrates a need that goes beyond cultural competence, perhaps more towards cultural humility and

an openness to listen. As described in the literature review, culture is comprised of many elements including family relationships, local neighbourhood and schools, belief systems in the local area as well as generationally- and how this is passed along through generations (Gilbert & Parkes, 2001).

Cultural competence is described as ‘the ability to engage knowledgeably with people across cultures... It suggests that there is categorical knowledge a person could attain about a group of people, which leads to stereotyping and bias, and it denotes that there is an endpoint to becoming fully culturally competent.’ (Khan 2021). Much of the literature recommends cultural competency, which is unfortunately not always relevant, particularly when clients or patients do not present or fit in the neat boxes of culture or religion that we expect them to exhibit.

By contrast, cultural humility is ‘a dynamic and lifelong process focusing on self-reflection and personal critique, acknowledging one’s own biases. It recognizes the shifting nature of intersecting identities and encourages ongoing curiosity rather than an endpoint. Cultural humility involves understanding the complexity of identities — that even in sameness there is difference’ (Khan, 2023).

This is what research revealed was needed in mental health systems – a continuous commitment to learning and understanding, and an ability not to focus on who is right or in which category, but on the lived experience of patients. Hussein (2024) offered the reflection that ‘conceptualisations of mental health can be more difficult when one may not hold the dominating cultural values of the society one lives in’.

It is interesting to consider that participants reported many of the spiritual experiences they had in this study as being better explained by eastern religious and spiritual frameworks, for example Kundalini or Shamanistic experiences. Perhaps the issue of cultural humility also has to do with an awareness of various cultural influences on our culture within society in the United Kingdom as time evolves. A book on cultural humility and mindfulness practice spoke on the ‘cultural diffusion of mindfulness’, commenting on how removing the practices from the philosophies and community concept that they originated in resulted in risks that this society was unaware of (Davis, DeBlaere, Hook & Owen, 2020). Some participants did mention in their interviews that they were at a meditation retreat or engaging in Eastern spiritual practices without much knowledge of risks when the onset of their spiritual experiences occurred.

Participants of the Somerset study reported that they felt dehumanised from forced medication and hospitalisation (Macmin & Foskett, 2004). This was very much echoed in the findings of this research. Participants were keen to describe traumatic memories of being pinned down to the ground to have medication administered, some even reporting a natural aversion to medication which

they did not have the chance to express. Participants shared reports of harrowing experiences whilst hospitalised, one not realising where they were at first (Nala), one participant (Shanice) being beaten and urinated upon in the hospital environment, and one participant (Millicent) recounting divine assistance to escape the environment!

Participants also reported a lack of appropriate aftercare. Their experience of life following being stepped down from hospitalisation was of being cajoled or blackmailed to stay in services and of the same pathologisation they experienced whilst being hospitalised.

From inception – the point of referral, to the process of being in community or inpatient mental health services, and the stepping down of care – the participants described a process of not always going wilfully, however being often willing to receive the help of the services whilst there, for hope that things would improve for them. Some participants even detailed explaining their viewpoints or presenting research to staff to get their point across. By the end of their time with services, most participants had revoked this willingness to engage openly with services, having felt that services had broken their trust and acted in ways that were damaging to them. In essence, for these participants, spiritual experiences were understood by the system as either something that did not exist and therefore did not warrant speaking about or giving any kind of recognition, or as something that needed to be suppressed through bullying and the other direct and indirect ‘tactics’ aforementioned. It did not seem in the view of participants that mental health services had mistakenly harmed them, but rather that the system’s actions were to an intended end.

The findings of this study were filled with thoughts and sometimes direct accusations that participants had towards psychiatrists as being socio-politically and economically motivated, in executing power against them and medicating them for ulterior financial gain. Whilst it is not within this study’s scope to seek to verify this, perhaps these strong feelings that participants displayed were as a result of a desperate bid to understand the evils that they felt were done to them at the hands of psychiatrists. Perhaps the difference in positioning between mental health professionals and the subsequent distance that can ensue (whether educational or financial) holds potential to make professionals and services detached or desensitised from the harm that these perspectives and actions can have on clients.

Participants reported feeling the need to detach themselves from mental health services in order to forge paths of their own, centred around seeking to gain further understanding for the spiritual experiences and gaining appropriate support. Those who did not feel able to detach from services did not seem best pleased about this and exhibited a level of blame towards services for disempowering them from being able to do so.

Limitations of the study

One of the limitations of this study was the participant size. The choice of qualitative methodology, focusing on depth and quality of responses, caused restrictions in the breadth of response that may have been more possible to gain from use of a quantitative methodology. For example, use of quantitative methodology such as surveys may have been better able to ascertain how common these experiences are, or how much the incidence of spiritual experiences being understood as a mental health problem in mental health services occurs. Results with a larger participant size may have been more widely generalisable to the experiences of people encountering mental health services across the country, whereas the choice of qualitative method provides a snapshot of a few experiences, which provide food for thought and points of consideration, but may not necessarily provide an accurate reflection of the handling of spiritual experiences in mental health care.

My initial research question was 'How are spiritual experiences understood in therapy'. Upon publishing the promotional poster, I began receiving many responses from people reporting having had spiritual experiences understood as mental health problems in mental health services – but not necessarily therapy. As such, I consulted with my supervisor and we thought it wise to tailor the question, co-constructing it according to the demand of the respondents. This widened the scope of the research to encompass client experiences with any clinicians in mental health services, including nurses, psychiatrists, social workers, support workers etc.

On the one hand, this change in research title following response to my recruitment poster indicated that I was arriving upon a topic that respondents had much to share on, and that the topic could be identified with by respondents, and was useful to respondents when reframed. It provided points of reflection and recommendation for clinicians regardless of their professional background. However, it was limited in its insight into how spiritual experiences were responded to within the specific context of therapy, which the initial research question may have provided more insight into, with more specific recommendations for therapists. Much of the interaction of participants was with nurses, psychiatrists and other mental health professionals, without much focus on psychology, however this remains relevant as these varying professions tend to work together in multidisciplinary teams in mental health services.

The question 'How are spiritual experiences understood as mental health problems in mental health services in the UK', whilst general and intended not to be leading, through use of the

word ‘understood’ as opposed to ‘misunderstood’, perhaps was still directional in nature. It selected participants who specifically had their experiences understood as mental health problems, perhaps limiting the wider question of how spiritual experiences are perceived in mental health services – whether as mental health problems or otherwise. Perhaps framing the question in a more neutral manner may have allowed for a greater breadth of experience of the topic within services.

Participants for the study were recruited through a volunteer sample of participants who opted in to the study following seeing the advert for the study. A number of the participants came through seeing the study advertised through a blog which was a support platform focused on ‘reframing mental distress as a potential catalyst for positive change’ (Emerging Proud, 2025). This could indicate that those participants were in some ways more invested in the topic and partial towards a particular positive formulation of their experiences than may be representative of a more random sample, having sought this group out, been proactive about reframing their mental distress and having actively sought to participate in this study. Many participants shared that their motivation for taking part in the study was to contribute to change in the mental health field.

Another limitation of the study is that the actual view of professionals, mental health services, and the friends and family of participants were not gathered by self-report. One of the initial ideas in the inception of the study was to explore service user experiences, in comparison with staff views or accounts, which would have allowed for perhaps a more accurate representation of the actual views of services by their own report. However, it was felt that this study design would place more emphasis on the debate between patient and professional view. This study instead chose to value the self report of participants without debate – not seeking to find out what ‘actually happened’, but what the lived experience of service users were, as this would be the ultimate determinant of their actions and the outcomes for them moving forward.

One of the things that was quite notable through the findings was the lack of information on the experience of participants with psychologists. Whilst this factor was outside of the study’s control, it did not provide much insight into the role of psychologists in the dynamics described. Much of the emphasis from participants was on psychiatrists, based on their experiences.

Implications for policy

One of the major criticisms participants had to make about their care in mental health services was of their hospitalisation and treatment under the Mental Health Act (1998), where they reported they were ‘locked up, drugged up and encouraged to shut up’. Participants observed the poor treatment not only of themselves, but of others they met while hospitalised, themselves being

hospitalised under the Mental Health Act (Department of Health, 1983). In a study examining the guidance and application of the Mental Capacity Act (Department of Health, 2005) as it pertains to best-interest, it was found that the process is fraught with bias and is often conflated with the clinician's evaluation of 'best medical interest' (Taylor, 2016). In the findings of my study, it reached the extent that other patients were providing guidance to participants on how to evade the system, coaching them on what to say and what not to say to avoid being perceived as mentally unwell and subsequently lengthening their stay.

... but it just happened that I met the right people as an inpatient. Who said "I have been stuck in here for six months, because as soon as I say I've got psychic skills they say I'm ill". So I've met people in there that ed- ... almost that I listened to, they educated me so it almost felt like as an inpatient I didn't actually say much to the psychiatrists, because I instinctively knew from a mixture between gut feeling and speaking to other people

The Mental Health Act (1983) is not without flaws, or findings that reveal a tendency to be interpreted in a way that facilitates the segregation of different groups. This includes for example, 'the disproportionate number of people from Black and Minority Ethnicities detained under the Mental Health Act' (Independent Review Board, 2018). Recommendations from an independent investigation of the Mental Health Act (1983) include the recommendation that 'safeguards should be created so that patients are able to continue religious or spiritual practices while detained in hospital. These should prevent the use of restrictive practices that limit a person's access to religious observance.'

This is a notable recommendation acknowledging behaviours from staff who have restricted religious practices under the Act, and a call for change. However, very little was said on this area in recommendations, and the concept of 'spirituality', falling outside the realm of religion was not mentioned. These recommendations also were provided in the context of recommendations on culturally competent care for individuals of Black and Ethnic Minority backgrounds in mental health services. Whilst this is a very useful finding particularly considering the overrepresentation of this population being detained under the Mental Health Act (Independent Review Board, 2018), it perhaps speaks to the binary assumptions of 'cultural competence', that do not account for presentations or recommendations that may fall outside of these norms or stereotypes – such as the mix of spiritual experiences described by this study's participant group who were predominantly atheists or agnostics of White British heritage.

The Independent Review Board made further pertinent recommendations:

In this regard, the vulnerability, racism, and fear experienced by service users in hospitals which are intended to be places of safety for those detained under the MHA warrants urgent attention. Participants highlighted lack of compliance with the Human Rights Act 1998 and the Equality Act 2010 (specifically, the Public Sector Equality Duty) and application of the principle of least restrictive practice.

The evaluation went further to explain that ‘wards should not use coercive behavioural systems and restrictions to achieve behavioural compliance from patients, but should develop, implement and monitor alternatives’.

Perhaps the findings of this study, the literature and these recommendations make a good case for a review into policy around how spiritual experiences are handled in mental health care, not leaving it to the views and personal persuasions of individual mental health professionals, but providing guidance in how these cases can be safely and humanely treated, and what the best practice is of care in these cases.

Implications for practice, training & supervision

Both prior research and the voice of participants in this study highlight a need for further training of mental health professionals in the area of spirituality and spiritual experiences. Some participants used the study as an opportunity to educate me, perhaps viewing me as a representative of the mental health system. In some interviews, this presented as spending chunks of time offering in depth teaching on their theoretical conceptualisations of spirituality.

An earlier study pointed out scope for both clergy and mental health professionals to train each other, as it was found that both were lacking in the information they needed to bridge services and provide a good level of care to those in community (Cook, 2021). Perhaps this goes further than just clergy in the Christian sense, that there may be scope for more joint working with community groups and continuous professional development with services working with community to reach a more bridged understanding and ways of working for the benefit of service users.

There is also scope for better supervision of staff in mental health services, promoting holistic and non-discriminatory practice and encouraging person-centred care and cultural humility of staff in services, even to concepts that they may not understand or be able to formulate.

Participants had a fair amount to say on the changes they wanted to see in mental health services. These included but were not limited to openness to the perception and impact of diagnosis

on different groups of people, taking learning from how other cultures handle spiritual experiences and curating safe places to rest with minimal to no psychopharmacological intervention. This may indicate a need for co-construction with service users with regards to spirituality in mental health services – to better ascertain how their needs can be more appropriately met in services.

Both Khan (2023) and Vieten & Lukoff (2021) spoke of a need for further training on diversity and religion/spirituality in counselling, psychotherapy and psychology training programmes. Vieten & Lukoff further described proposed competencies including attitudes, knowledge and skills, screening for importance of religion and spirituality, how it affects coping, if they feel they have any religious or spiritual problems. Although the impact of implementing these competencies is yet to be tested, it raises a good suggestion regarding holding professionals to a high standard of care with regards to spirituality and religion, requiring professionals to be held to a standard because of its significance in the lives and the problems of our clients.

More broadly, this research calls for further attention to trauma-informed practice in services. Many participants reported prior experiences of trauma that they felt the spiritual experiences occurred to help them to process, as well as traumatic experiences in the midst of their spiritual experiences. This buttresses previous findings of the need for more widespread implementation of trauma-informed care training in mental health services (McNally, Ragan, Varese & Lovell, 2023) and more focus on trauma-informed approaches, both in the treatment of clients more generally, and in our understanding and formulation of their difficulties as clinicians. Further attention to trauma informed ways of working could help to prevent the reoccurrence of the kinds of difficult experiences the participants reported at the hands of services.

Implications for Counselling Psychology

An apparent finding from the conduction of this research was the lack of information and feedback on encounters with psychologists: This caused me to reflect on my perspective of psychology professions as seeking to understand and sometimes even advocate for our clients. I wondered about how the presence of psychologists and talking therapies very much seemed missing from the experiences of those I interviewed.

When it came to participants who did engage in talking therapies during their time in mental health services, they reported feeling that the therapy they were offered also followed a medicalised approach, and were critical of the use of Cognitive Behavioural Therapy (CBT) as an inappropriate form of talking therapy for the presentations they had. One participant reported feeling talking therapies were ill-equipped to aid. Another participant described 'only (seeing) a psychologist once' in her time under numerous community mental health teams.

In its recommendations, the Independent Review Board of the Mental Health Act (1983) commented:

Over-reliance on medication, lack of access to psychological therapy, culturally insensitive care and overtly discriminatory practice were perceived as extensions of the individual, societal, and institutional racisms experienced by Black service users and their families in everyday life. (Independent Review Board, 2018).

Although this comment specifically referenced Black service users, the sentiments are very much applicable to feelings of being ostracised or discriminated against based on their spiritual experiences by the participants in this study. Participants shared a pervasive feeling that mental health services had become part of a system that did not listen to them, or that was not interested to be part of the conversation around supporting those with spiritual experiences.

Participants fed back that they would have greatly appreciated more access to psychological therapy and offered this as a recommendation moving forward.

The implications of this study in the field of Counselling Psychology stretch beyond recommendations in the area of direct clinical work. The British Psychological Society Division of Counselling Psychology (DCoP) state that their values include 'promoting the wellbeing of our diverse society', working creatively, compassionately and collaboratively' and 'working ethically and effectively' (British Psychological Society, 2025).

If these are the values that Counselling Psychologists are encouraged to uphold and encourage, then it is of note to emphasise the importance of Counselling Psychology voices represented in multi-disciplinary teams in mental health services.

It was clear from the recollections of participants that they were each vulnerable at their time of encountering mental health services; the findings raise important reflections on whether they were respected and treated as such, regardless of differences in belief or opinion between themselves and other concerned parties. Participants described major failings of services in appreciating their

diversity, working compassionately or collaboratively and in ethical practice. Given our ethos in Counselling Psychology, perhaps this research provides a charge to advocate amongst colleagues more on behalf of those more vulnerable, towards better experiences for our spiritual clients.

This research raised important reflections on the imbalance of power between staff and service users with spiritual experiences. Perhaps this provides an opportunity to bridge the gap, using our humanistic ethos to meet such clients where they are, advocating for good patient care. Khan (2023) spoke to a need for anti-oppressive practice, in clinicians holding an open understanding that all humans – both ourselves and clients – are layered with intersectionality, affecting our individual lives as well as the dynamics that ensue between us. The findings of this research support this notion, of working within diversity and viewing diversity as an integral part to all our lives, as part of ethical conduct, as opposed to as an add-on, which facilitates distance between clinician and client. Whilst some studies have spoken to the integration of spiritual practices in mental health services, perhaps with further research could shed light on specific evidence-based interventions that could be helpful for clients specifically in the area of spiritual experiences.

Suggestions for further research

Embarking on this area of research, which is highly debated in literature, highlighted gaps in knowledge with regards to the incidence of spiritual experiences being understood as mental health problems in mental health services. An area of research that might be of benefit is a quantitative evaluation on the occurrence of these spiritual experiences, establishing how common these experiences are.

Some further areas of quantitative research that may be of benefit to the body of literature could be research seeking to ascertain what the views of mental health professionals are with regards to the formulation and treatment of spiritual experiences, and if there are any barriers to appropriate engagement with either. It would be of further benefit to establish if there are there any examples of good practice in this area, that can be used to inform policy and practice in the field more widely.

Post-Reflexivity

I made the decision to embark on this research following numerous experiences across my journey to becoming a Counselling Psychologist, where clients shared spiritual material with me, within the context of therapy. As a practising Christian, of Black British Ghanaian heritage, I come from

a culture that does not question the reality of spiritual experiences. On one occasion whilst visiting family in Ghana, I came across a front-page newspaper article detailing how a man had been turned into a snake following spiritual ritual practices. I came to realise that in my heritage, spiritual occurrences, problems and ways of thinking were commonplace, so much that this was perfectly normal subject to be found in a newspaper.

As a clinician, I frequently found myself feeling torn, contrasting this open acceptance of spirituality that I take from my cultural heritage, with the awareness of the Western paradigm that I experienced more from British culture, of associating the spiritual with questions of sanity. I had come to perceive that within British Black and Ethnic Minority circles, there was a general mistrust of authorities, and within this area specifically, a fear of sharing spiritual material to avoid not being believed.

I came to wonder about my role as a clinician when presented with this phenomena, feeling that my training had only equipped me to perceive these presentations as evidence of mental illness, and witnessing my colleagues doing the same, but wondering what the risk was of believing my clients or taking them at their word.

Specifically, I contemplated whether believing the report of clients would change what I was treating, change how I treat, change how they trust me and how it would affect our therapeutic alliance. I explored these thoughts in clinical supervision, and contemplated why I seemed to be attracting clients who were often referred to psychology for different things, but ended up opening up about these experiences specifically to me. I wondered if it was something about my race and perhaps assumptions about the community I come from and our understanding of spirituality that led participants to feel open in speaking with me about this. In some ways, I took this trend in my practice as an invitation or 'calling' (pun intended) to pursue this area of research.

In the process of conducting the study, there was a large amount of rich material to analyse. I found in my analysis that I frequently underlined "How Are". There were many different interesting threads that I noticed when immersing myself in the data, and there was a temptation (as someone who is keen on theology) to follow excitement about the different theories the clients presented on what they felt was happening to them spiritually. I had to exercise discipline in realising I needed to focus on the codes and themes that contributed towards answering the question of *how* spiritual experiences came to be understood as mental health problems in mental health services in the UK, for the participants that were interviewed.

It was an honour to have had the opportunity to interview the participants of this study and to hear their stories. In some ways this also came with a weight of heaviness, in the difficult experiences they described which I sometimes experienced shame about as a practitioner, and in the responsibility to accurately reflect participant views. I experienced tension in the scientist-practitioner balance, as I sought to uphold respect for participants and not to fall into the trap of representing their experiences incorrectly as they were complaining about, given that they had respected me enough to share their experiences with me. This experience echoed the conundrum I face with clients who have presented similar experiences, in advocating for them amongst colleagues in multi-disciplinary teams that I have worked in.

Conclusion

This research, alongside prior literature outlines that there are people who experience having spiritual phenomena, who are being understood as being mentally unwell and enduring unfair treatment at the hands of mental health services. Research is clear in its findings that clients want to discuss and explore these experiences and gain support for their distress, in a way that does not cause them to feel pathologized or restricted.

It is imperative that as scientists, practitioners and policy makers, we improve in recognising these experiences, and that we become more competent in discussing these experiences, valuing the views and perceptions of our clients as much as our own. We cannot provide good patient care without engaging with the reflexive cultural humility that helps us to realise that there is always more to learn when it comes to human experiences and behaviour, and that our own way may not be the only correct way to view things.

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APPENDIX

Appendix A: Promotional Poster for the study

DEPARTMENT OF COUNSELLING PSYCHOLOGY,
CITY UNIVERSITY OF LONDON



HAVE YOU HAD YOUR
**SPIRITUAL EXPERIENCES
UNDERSTOOD AS A MENTAL
HEALTH PROBLEM**
BY YOUR THERAPIST?

We'd love to talk!

SHARE YOUR EXPERIENCE AND CONTRIBUTE TO A GROWING
BODY OF RESEARCH INFORMING THERAPEUTIC PRACTICE IN
THE UK

FOR MORE INFORMATION ABOUT THIS STUDY, PLEASE
CONTACT NIKITA.QUARTEY@CITY.AC.UK

This study has been approved by City, University of London Research Ethics Committee.

Appendix B: Research Ethics Application

Principal investigator/researcher – Nikita Quartey

REC reference number- ETH1920-0520.

Spiritual experiences understood as mental health problems in therapy in the UK

Please tick
or
initial box

1.	I confirm that I have read and understood the participant information dated 05/12/2019 Version 1, for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data at any time before 1 st August 2020.	
4.	I agree to the interview being audio recorded.	
5.	I understand that my data will be anonymised, and that direct quotes from my interview will be used in the write up and publication of this research	
6.	I understand that my anonymous data will be made open access, to underpin journal publication.	
7.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
8.	I agree to take part in the above study.	

Name of Participant

Signature

Date

Name of Researcher

Signature

Date

I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.

Spiritual experiences understood as mental health problems in therapy in the UK

Nikita Quartey

I would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. You will be given a copy of this information sheet to keep.

What is the purpose of the study?

I (I) was interested in the relationship between client's expression of strong spiritual beliefs and how their therapists understand them, particularly when therapists understand them as a mental health problem. I would love to hear your experiences of this.

I am conducting this study as part of my Professional Doctorate in Counselling Psychology at City University, From January 2020 to November 2021.

Why have I been invited to take part?

You have been invited to take part in this study following your response to our advertisement, as you have shared that you have once had a spiritual experience that has been understood as a mental health problem by your therapist. We would love to hear more about your experience.

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in the project. You can withdraw from the project at any stage before **1st August 2020** without being penalised or disadvantaged in any way. After this point, I will be unable to remove your contribution moving forward, but it will all be anonymized by that point. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw prior to the above mentioned date and without giving a reason.

What will happen if I take part?

Phase	Explanation & estimated dates
Screening Phone Call	You will have already had a screening phone call to find out more about your interest in participating in the study and for you to find out more about the study (February – July 2020)
Interview	If you decide to go ahead, you will be invited for a 1:1 interview about 2 weeks after the screening phone call, lasting approximately 90

	minutes. It will be semi-structured, asking a few questions to invite you to share more about your experience of having your spiritual experience understood as a mental health problem. This is the main thing you will be asked to participate in. Interviews will be held at City University in London. (February – July 2020)
Analysis	Data from your interviews will be analysed using thematic analysis, looking for any shared experiences or themes across all the interviews conducted. (January – May 2021)
Sharing of information	The project will be written up into a thesis and a publishable article. We hope to share a concise version of our findings with you by September 2021.

What are the possible disadvantages and risks of taking part?

The main possible disadvantage of taking part in this study is the sensitive nature of the topic being discussed. Each person's experience is unique to them, however we are aware that in some cases recalling and sharing the experience of being understood in a manner other than intended can be distressing and can bring up difficult emotions. We would encourage you to only share as much as you would feel comfortable with and be mindful of your wellbeing at each stage.

Although the study will require you to commit to attending a 90 minute interview in Central London, you will be given an allowance towards travel expenses and in appreciation of your time (see expenses).

What are the possible benefits of taking part?

Whilst participating in this study can bring up difficult memories / negative emotions, it may also be a refreshing experience, where you will have the opportunity to narrate your side of the story, with the ultimate aim of better understanding experiences like theirs to contribute to the wider knowledge and protocol around therapeutic practice.

Expenses

You will be afforded a £25 transport allowance towards travel expenses on the day of interview. This will be issued in cash on the day of the interview.

How is the project being funded?

Any expenses incurred by the project will be self-funded by I.

What should I do if I want to take part?

If following reading this information sheet you are still interested in taking part in this study, please send an email confirming your interest to I at [REDACTED].

Once received, we will be in contact to book a date for the interview within two weeks. I may follow up with a phone call to see if you are still interested if I have not heard back from you within a week of the screening phone call.

What will happen to the results?

A summary of results from the study will be sent to you if you have consented to receiving these on the consent form. The results from this study will then be written into a thesis and submitted as part of my portfolio for the Professional Doctorate in Counselling Psychology. In addition, a publishable article with a shorter version of the study will be written and submitted to a psychological journal. Finally, a summary will be written and shared in collaboration with the Centre of Mental Health, so that our research findings can be disseminated more widely. The Centre of Mental Health will not have access to any personally identifiable data at any point.

Will my taking part in the study be kept confidential?

- Only I – Nikita Quartey – will have access to your personal data before anonymizing.
- All personally identifiable data within the recording (eg. names) will be replaced with pseudonyms. Direct quotes may be used, but no personally identifiable information will be shared.
- An audio recording of the interview will be taken. This will be stored securely on an encrypted laptop and backed up on OneDrive, both only accessible to I – Nikita Quartey.
- Our only restriction to confidentiality in the study is if you should disclose any information relating to risk of harm to yourself or others. On this occasion we may need to breach confidentiality for safeguarding purposes. In that instance we will endeavor to inform you first, although this is not always possible.

What will happen when the research study stops?

Following the study, data (excluding personally identifiable data, which will be deleted at the point of transcription) will be held by I and City University for 10 years, after which it will be destroyed. Your contact details will be destroyed following the dissemination of the results of the study.

Who has reviewed the study?

This study has been approved by City, University of London Research Ethics Committee.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is **Spiritual Experiences Understood as Mental Health Problems**.

You can also write to the Secretary at:



Anna Ramberg
Research Integrity Manager
City, University of London, Northampton Square
London, EC1V 0HB
Email: [REDACTED]

Data privacy statement

City, University of London is the sponsor and the data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see <https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/>).

City will use your name and contact details to contact you about the research study as necessary. If you wish to receive the results of the study, your contact details will also be kept for this purpose. The only person at City who will have access to your identifiable information will be I – Nikita Quartey. City will keep anonymized data from the study for 10 years after the study has finished.

You can find out more about how City handles data by visiting <https://www.city.ac.uk/about/governance/legal>. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) <https://ico.org.uk/>.

Insurance

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Further information and contact details

For any enquiries about the research, please contact:

Nikita Quartey (researcher)
Trainee Counselling Psychologist
[REDACTED]

Dr Jacqui Farrants (research supervisor)
Consultant Psychologist
[REDACTED]

Thank you for taking the time to read this information sheet.

Debrief – ETH1920-0520, 05/12/2019,

Spiritual experiences understood as mental health problems in therapy in the UK

Thank you very much for taking part in my study- Spiritual experiences understood as mental health problems in therapy in the UK.

I am very grateful for your time and for all that you have shared. I hope that taking part in this study was an enjoyable experience for you too.

I decided to conduct this study because of my interest in how therapists understand spirituality and more specifically, how they interpret reported spiritual experiences. I am interested in looking at how a therapist comes to understand a spiritual experience as a mental health problem, and what factors might inform this, but also what effect this has on client and their therapeutic relationship as well as the work that is able to be done.

The aim of the study was to hear about your experience of having your spiritual experience(s) understood as a mental health problem in therapy, and how that affected you. We will be analysing the results from a social constructionist perspective – the idea that the differentiation between what we consider to be a mental health problem and what we consider a spiritual experience, is socially constructed. This therefore leaves those who don't fit within the social majority feeling excluded – whether that be because of their spiritual / religious beliefs, because of their ethnic background etc.

A lot of research in this field focuses on spirituality as a coping mechanism, therefore I believe this research will bring a different angle of understanding to the field.

If you would like to seek any further support after participating in this study, here are just a few places you can contact

- Your GP
- Samaritans (Call 116 123 for free, or email jo@samaritans.org)

Thank you once again for your time and commitment.

Spiritual experiences understood as mental health problems in therapy in the UK

Appendix C: Interview Schedule

Semi-Structured Interview (90 Minutes)

- What motivated you to take part in this study?
- When you first came across the advert for this study, what experience came to mind?
 - (Can you tell me more about this experience)
 - (What actually happened / tell me about when you had your spiritual experience understood as a mental health problem?)
 - (Clarifying questions, expounding on the facts)
- How would you describe your spiritual beliefs?
- How do you know it was understood as a mental health problem?
 - (What makes you say that?)
 - (How do you make sense of that?)
- What did it mean to you to have your experience understood in this way? (how did it affect you)
- Was this the first time you experienced something like this?
- How do you tell the difference between having a spiritual experience and a problem in your mental health?
- What do you think could have been done differently?
 - (By your therapist)
 - (Would you have done anything differently?)
- Is there anything else you would like to add? Or perhaps anything you would have asked if you were I?

Appendix D: Evidence of Ethical Approval

City, University of London

Dear Nikita

Reference: ETH1920-0520

Project title: Spiritual experiences understood as mental health problems in therapy in the UK: a social constructionist perspective

Start date: 23 Jul 2020

End date: 30 Nov 2021

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology low risk review. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

The approval was given with the following conditions:

- ...
- ...
- ...

Please ensure that you are familiar with [City's Framework for Good Practice in Research](#) and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;

- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

- a) Adverse events
- b) Breaches of confidentiality
- c) Safeguarding issues relating to children or vulnerable adults
- d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology low risk review, I do hope that the project meets with success.

Kind regards

Trudi Edginton

Psychology low risk review

City, University of London

Ethics ETH1920-0520: Nikita Quartey (Low risk)

Appendix E: Example of Worked Transcript

special connection w/ his spiritual special gifts

was in touch with their spiritual side (counts 2 on her fingers), I could understand all languages apparently ... I could speak to... speak in all languages- there's lots of parts of it which I feel like hrm... is this psychosis? Or is it more ... is it both? Erm ... yeh ... Do you want me to explain what happened? she feels reductionist / was confused

NQ8: Yeah, go ahead. Go for it

IM8: So erm ... so how can we ... how can we- ... so, one part of it is, that I was feeling like I had to s-... tell a message to everyone - like something was gonna happen or something important I had to tell people... and erm ... I didn't know what it was. But I knew that when it was time to say the message, something would take over me and that message would be relayed and it would come through me. permission + submission

Another one was that I felt ... erm ... yeh like I could speak to lots of people (participant counts on her fingers), all languages, all ages, everything. I just had the ability and the power to talk to other people. And really ... in that moment, or in the experience, I kinda felt ... erm ... not attached to this world. That sounds very very (giggles)... very odd. Not attached to this world, not here - that I was kind of seeing and experiencing this world ... not how a normal human would - and ... it was a very like dreamlike state, a very odd state to be in and ... when I was in it ofcourse, I didn't feel anything of it. I obviously didn't think it was "delusions" or anything like that ... erm I thought it was normal. And because my erm ... delusions were quite intelligent or believable to a stranger, people kinda played into it and played along. So, I was in this like state of psychosis for quite a long time, and even spoke to my psychiatrist ... needed the freedom to be able to do what would be required as the right time is to carry out instructions

erm and even my erm ... I had a nurse who looked after me as well. They didn't know I was ill (laughs) ... which is a bit kinda disturbing. Erm and ... so for a long time I didn't think anything was wrong, everyone was playing into it and everyone didn't think there was anything wrong. And then erm ... coming out of it is when I really started to reflect and think about actually what happened, and that's when you kind of ... you don't ... when you're speaking with erm ... so I had like a social worker so ... who helped me - like a mental health social worker. I had lots of people in my team to help me talk through the experience, it was very very traumatic. When I came out of it, I was like ... 'what happened?'. There was elements ... erm ... of the experience that I've forgotten, erm I ended up in like strangers' houses, (giggle) like all sorts, and when sitting do- ... it was about when I sat down and reflected on what happened ... experience did not feel abnormal -> felt normal + intimate

is when it gets a bit rocky, because I can sit down with a psychiatrist whoever it was and talk about it and they'd be like ... "okay this is what it was. It was a manic episode, it was psychosis, it was this, it was that", but I was like "but how can you simply just explain it like that?", how can it be that simple? How can you ... you - you didn't have my experience. It was literally surreal and it was out of this world. There is no way ... I just don't believe even up to this day that that experience was just ... "mental health" - it can't be ... it just ... to me it can't be. And I've had like other spiritual situations ... traumatic part of the experience / traumatic ending when comparing to humiliating

erm, when, I'm not "in an episode" or I'm not unwell, that ... can't be explained by mental health. I haven't probably gone to a professional and spoke through it with them necessarily but ... yeh ... I don't know if that was like very vague. I don't know what else to say authorizing figure on the matter over-simplifying experience

NQ9 (06:28) Okay, so it sounds like you're really kind of wrestling with ... erm ... what you've ... what you've experienced and how the professionals have classified it, and it doesn't feel like it's ... elaborate enough kinda thing

IM9 Yah I just felt like it was easy enough for them to just go "oh yep, it was this ... erm ... next. Next conversation please" ...kinda thing who is the authorizing? the one who lived it or the one who writes in it? "proof" that spirit is a via other exper

ing beyond ... or constraints

this what really think? feel conditioned say? (ACCESS)

se of being asked rather he had + action identified

atence + mis.

in sense of guardianship + responsibility

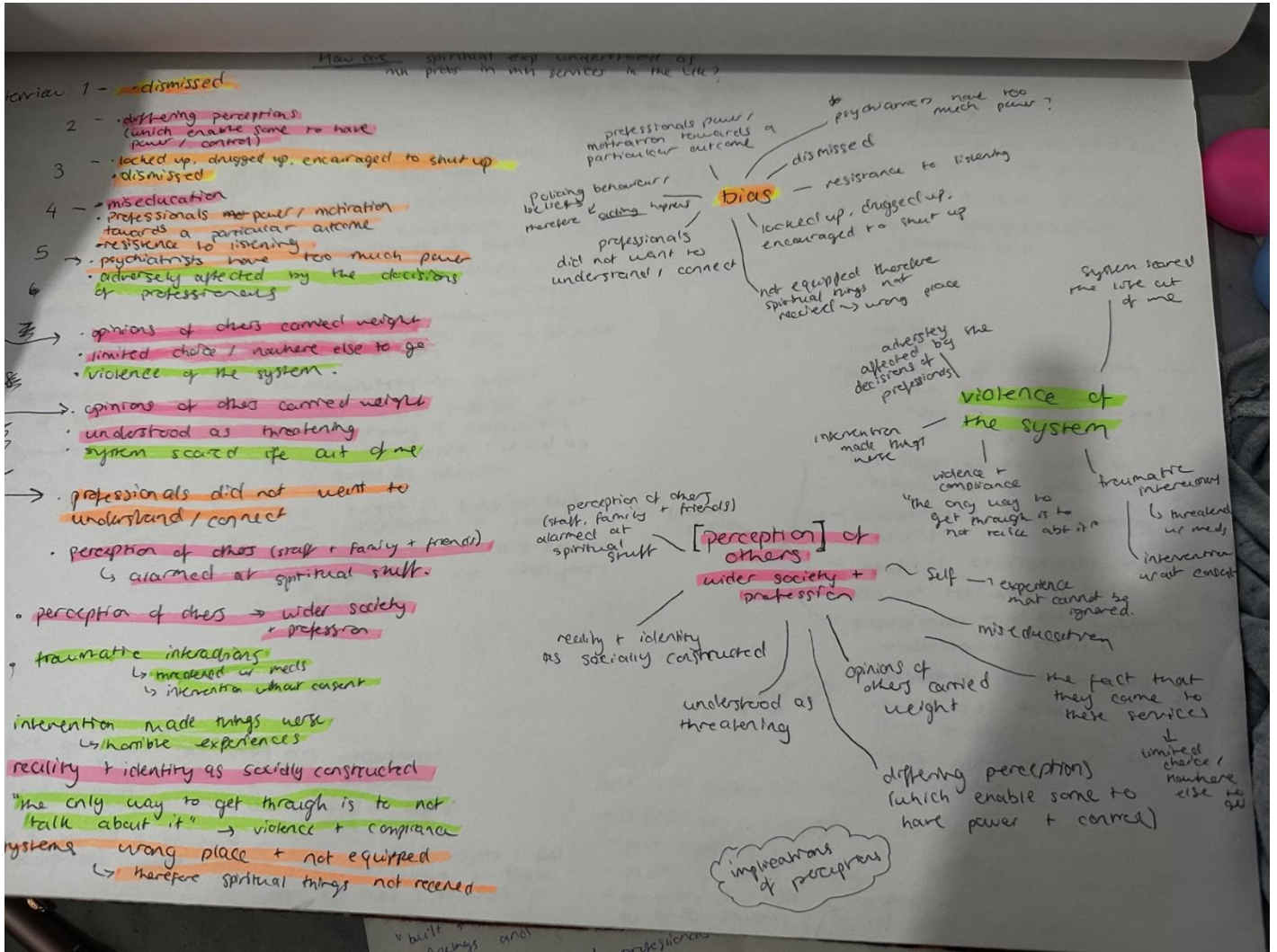
arture, risk, per in the experience

not health" sufficient in plaining

perception of bias professional attitude towards (sacred) experience

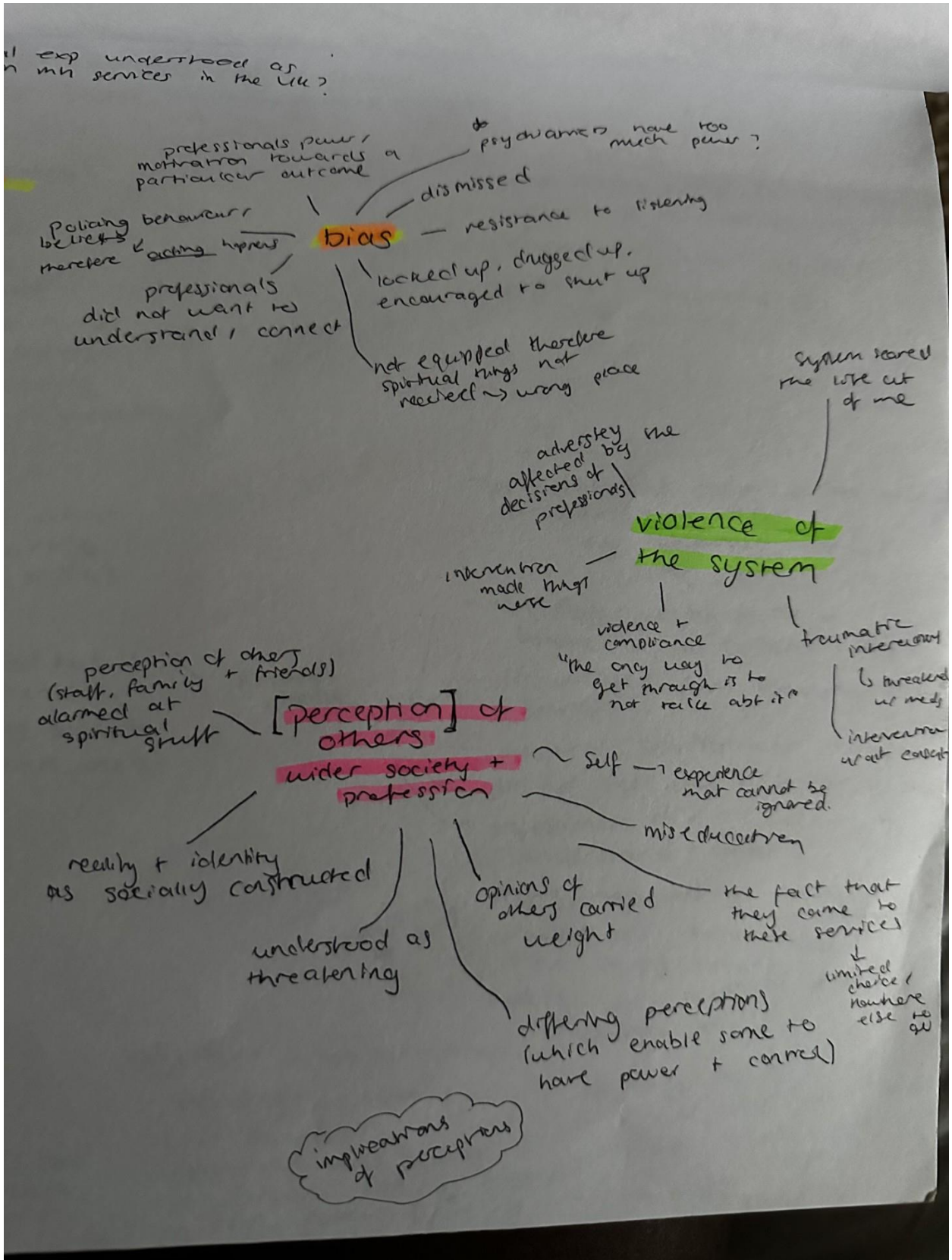
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Appendix F: Example of 'Searching for themes by collating codes' – Thematic Analysis Phase 3



Appendix G: Example of 'Reviewing and Naming Themes' – Thematic Analysis

Phase 4

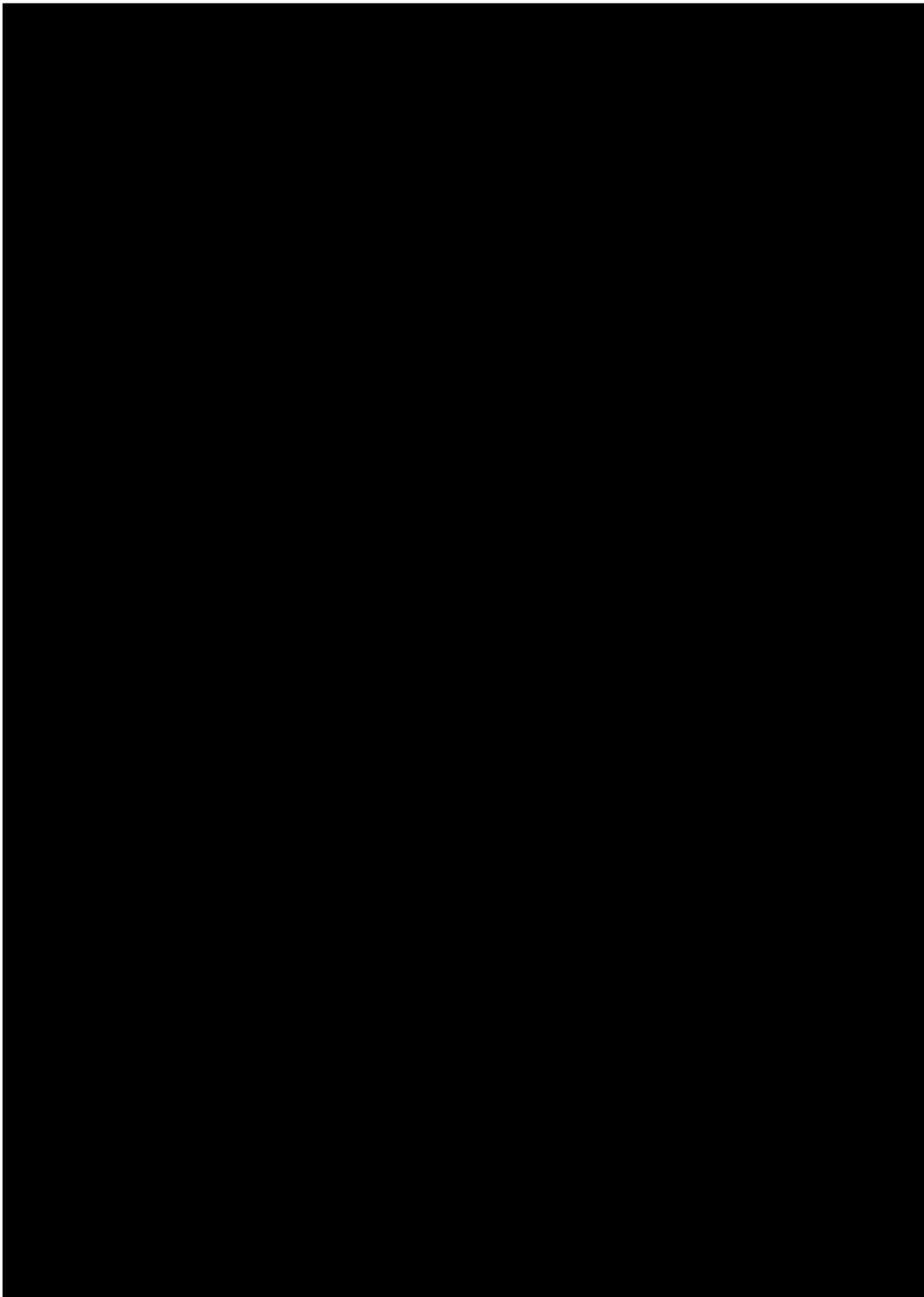


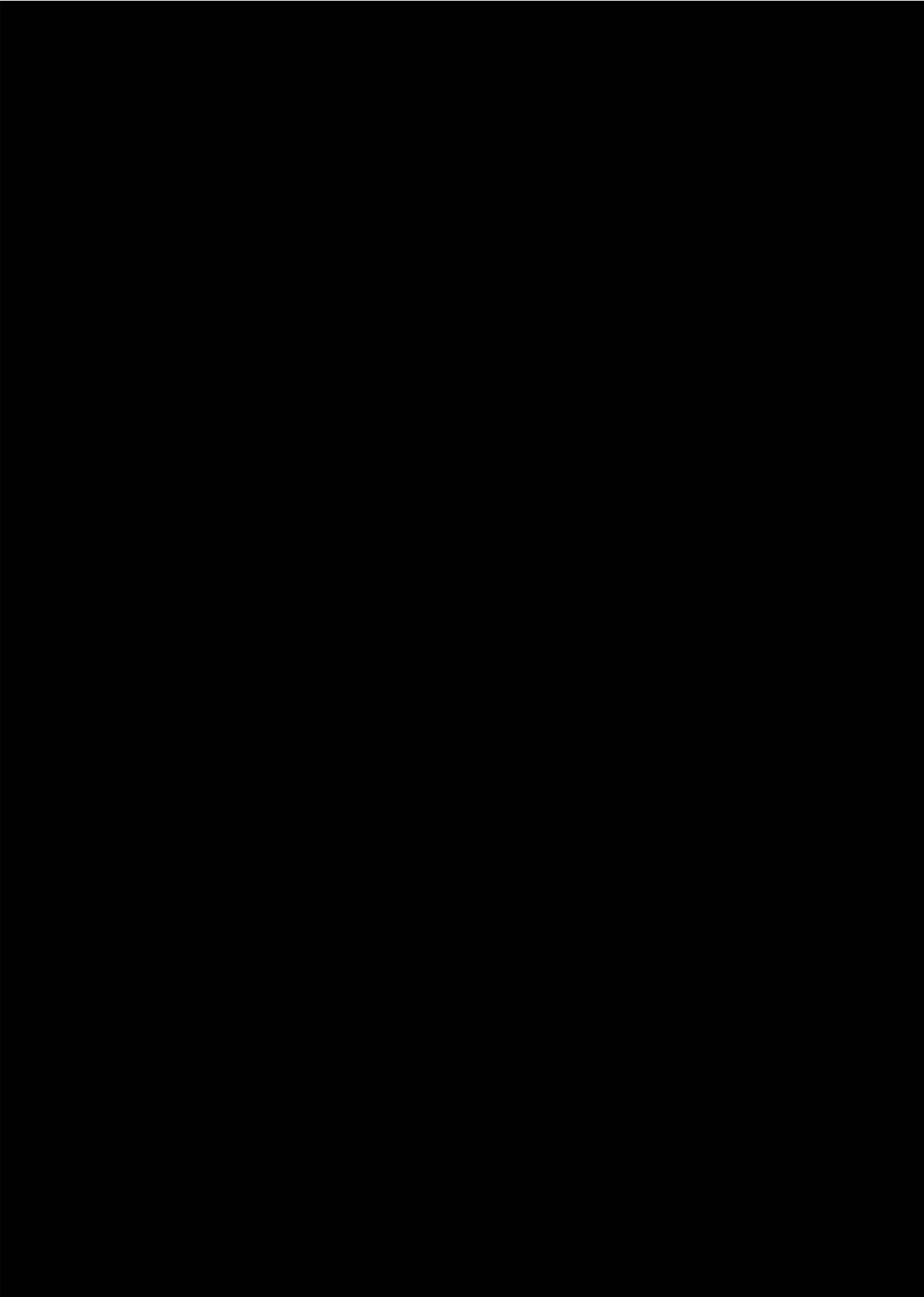
Section B: Publishable Paper

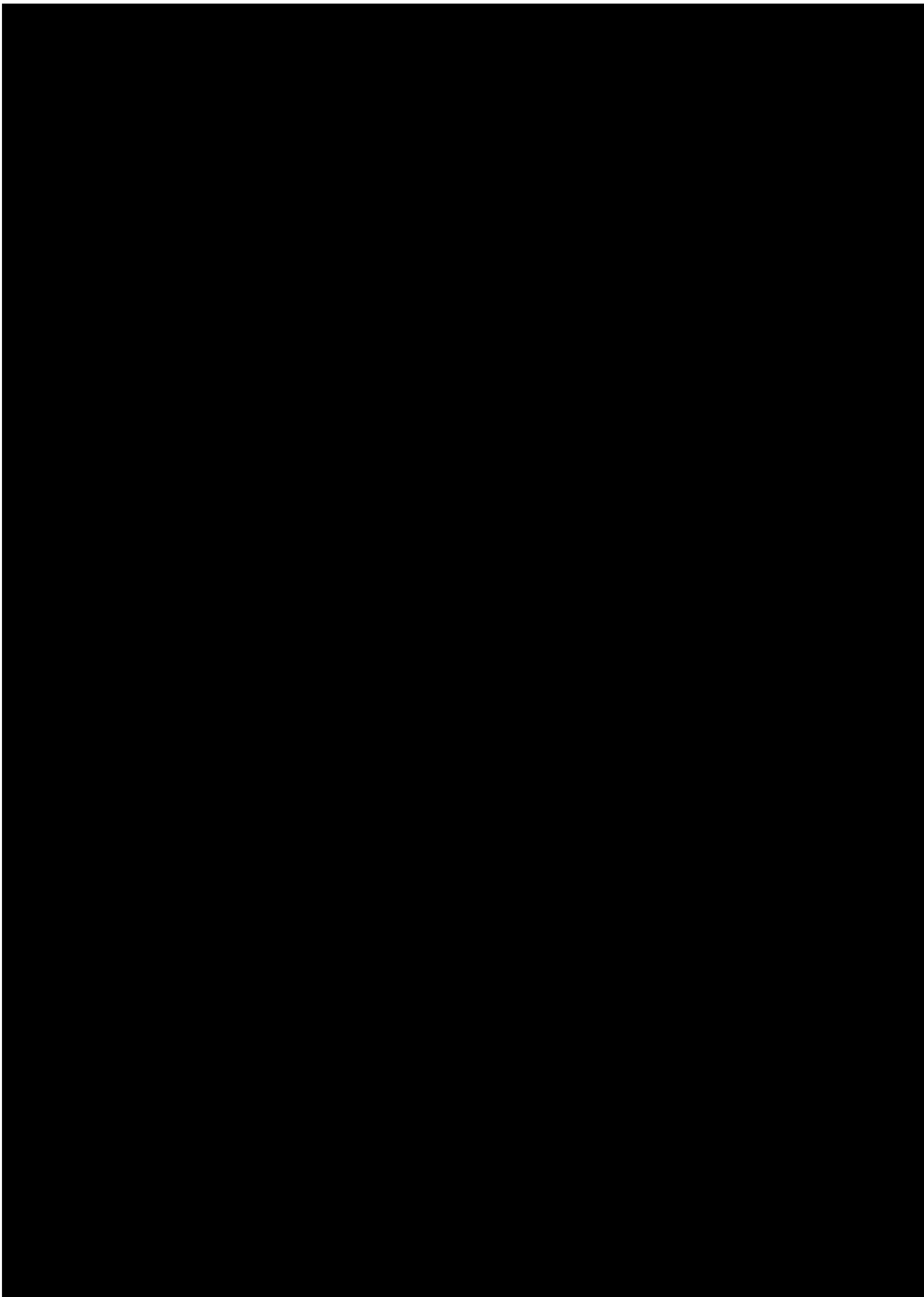
“Locked up, drugged up, encouraged to shut up” - How are Spiritual Experiences understood as mental health problems in mental health services in the UK?

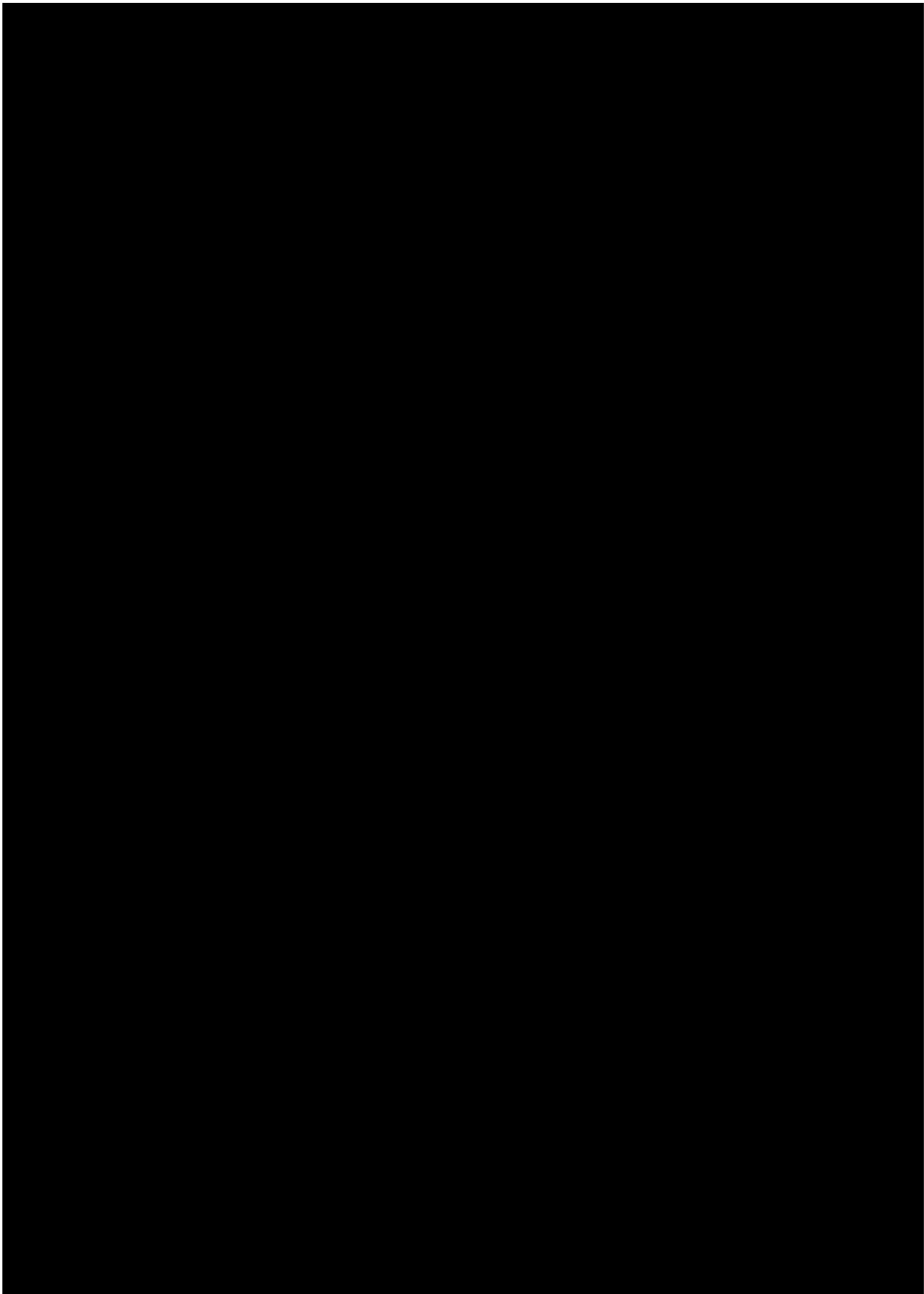
Submitted to the specifications of Journal of Spirituality in Mental Health

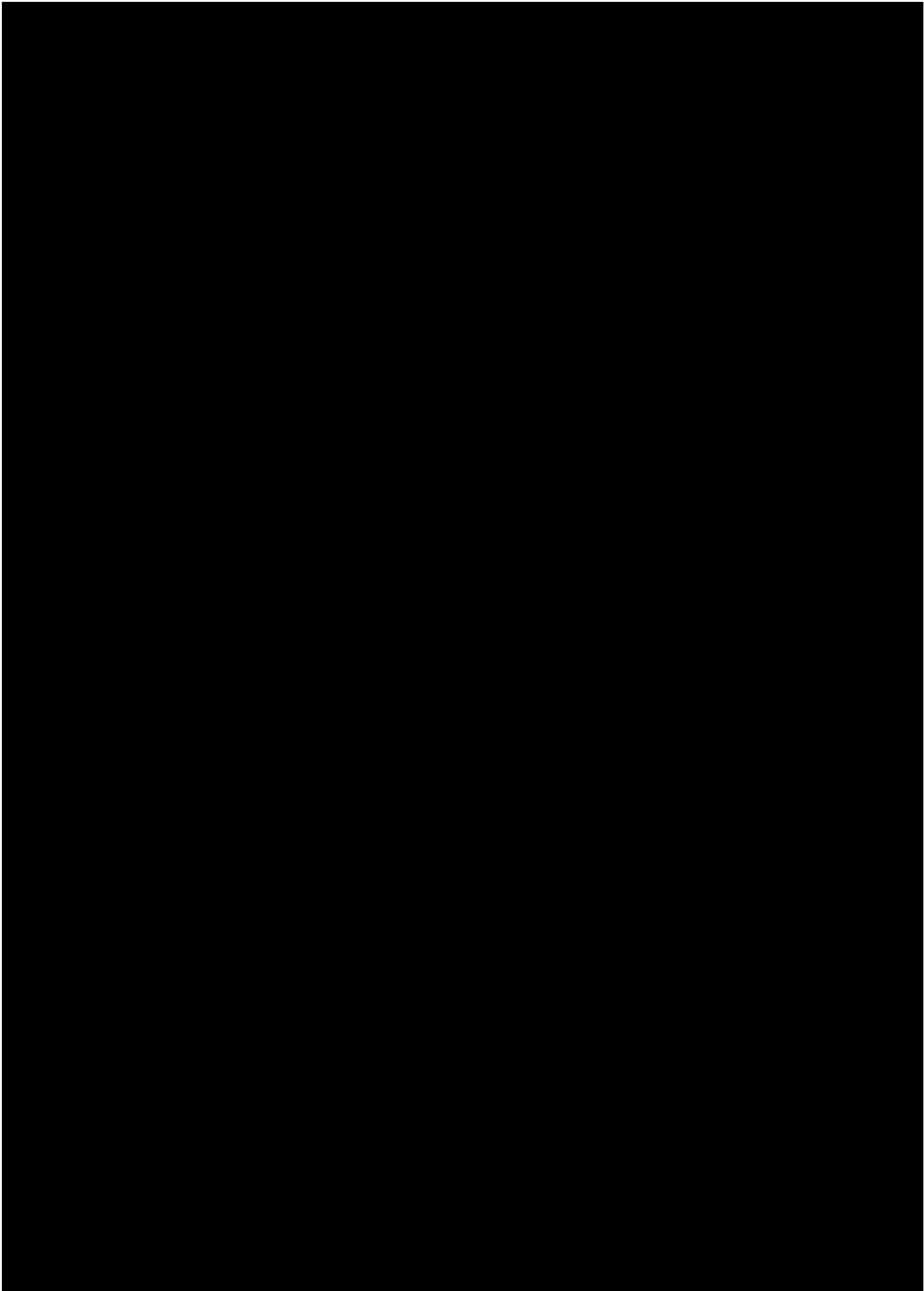
Nikita Fofie

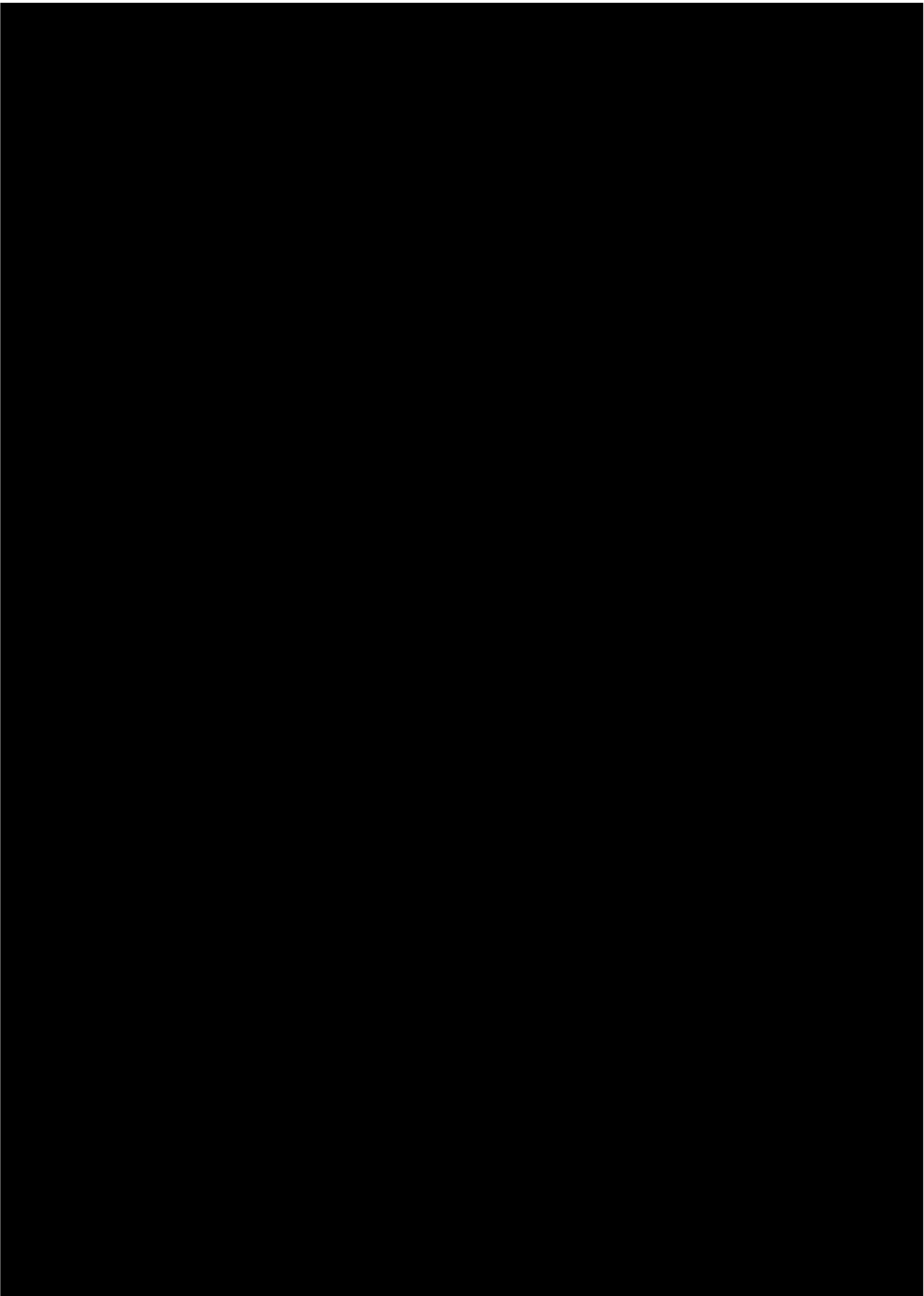


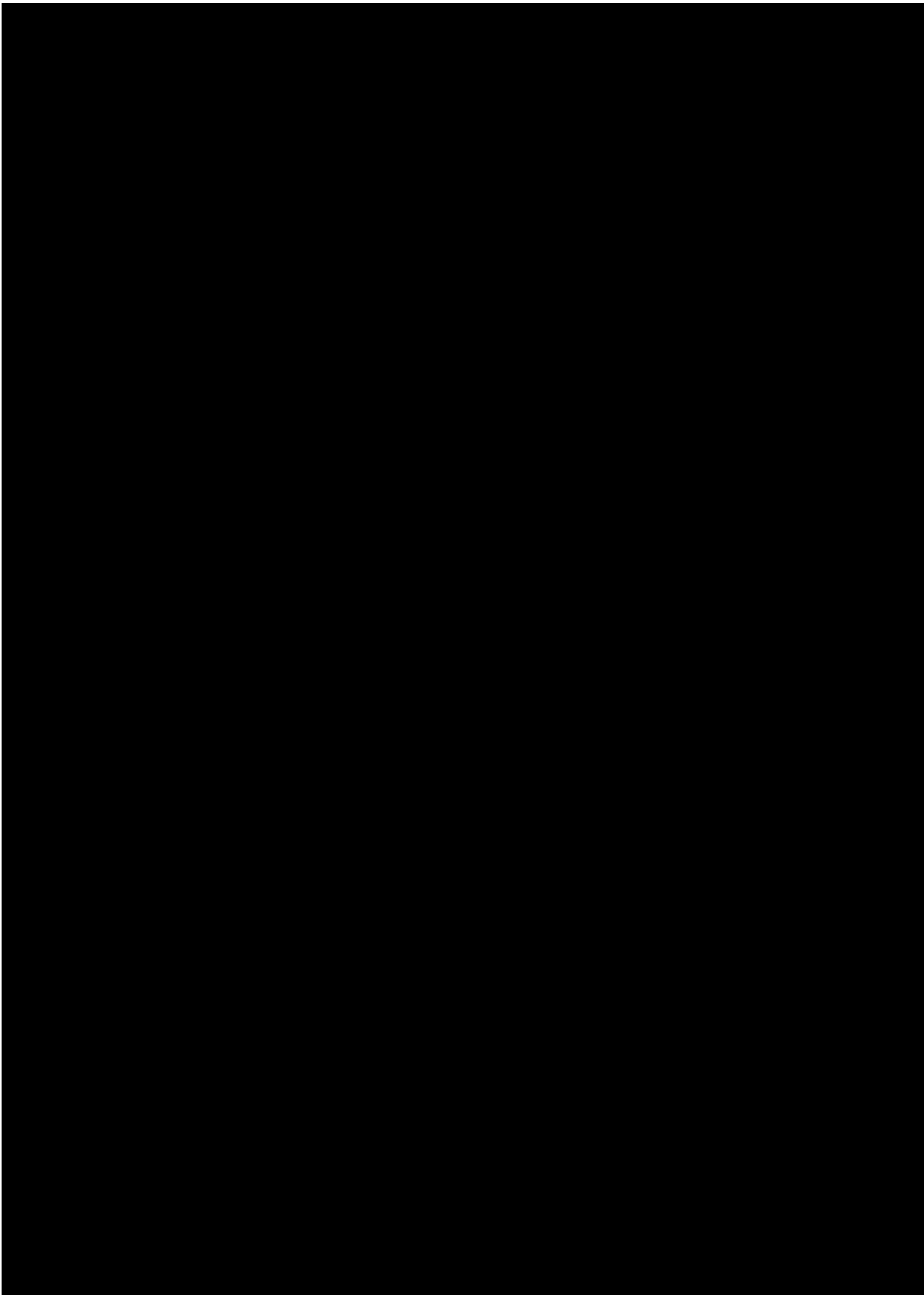


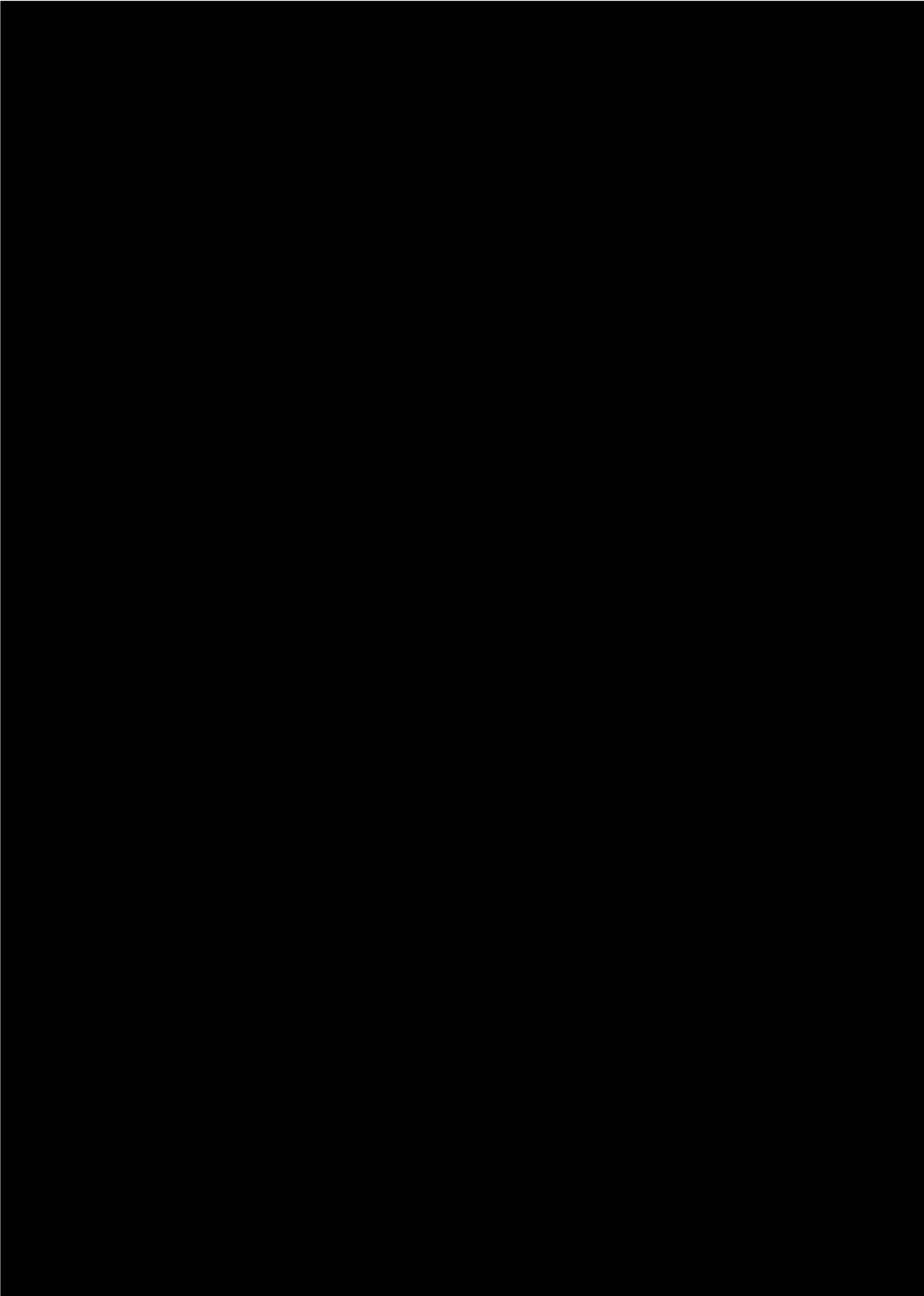


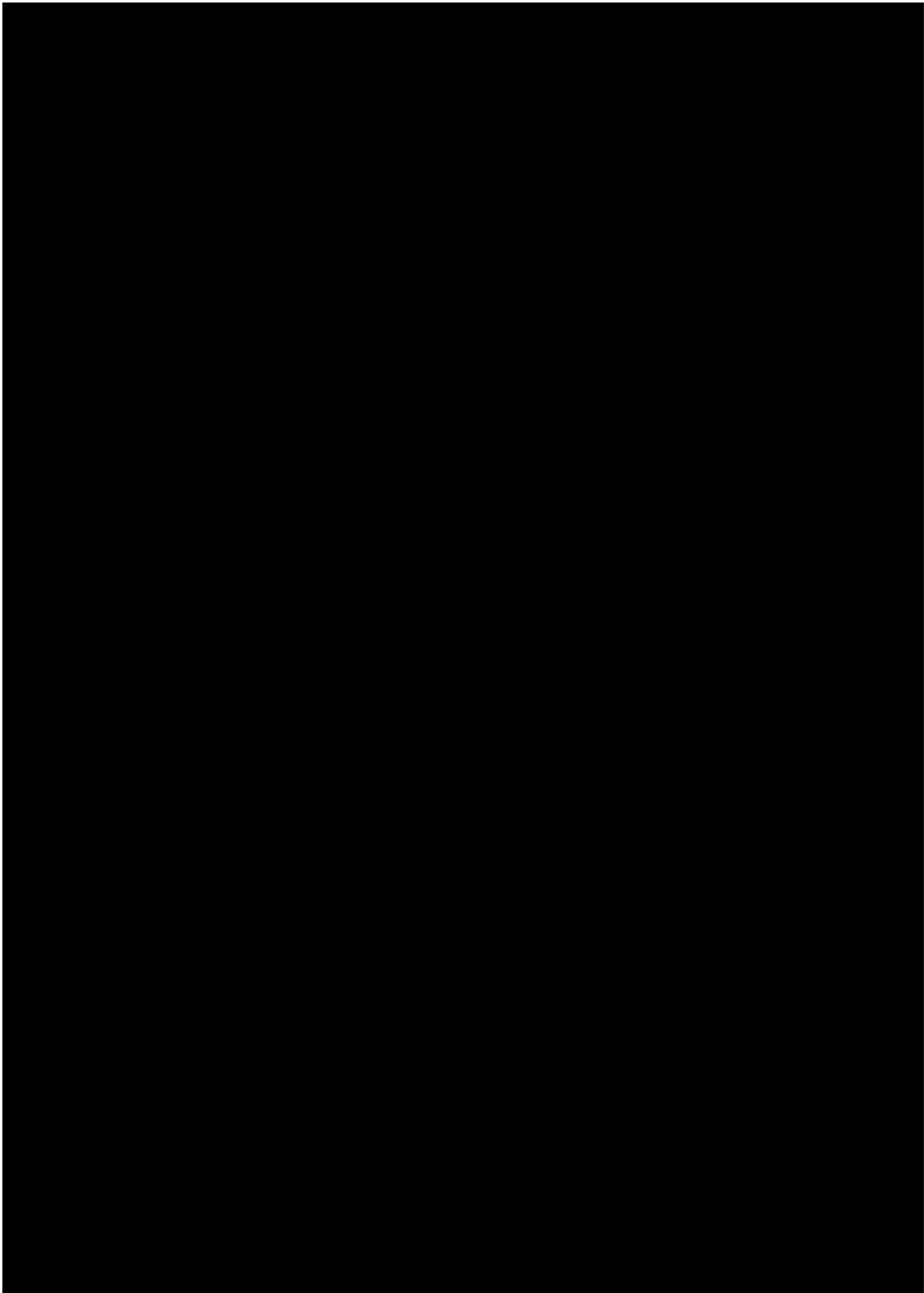


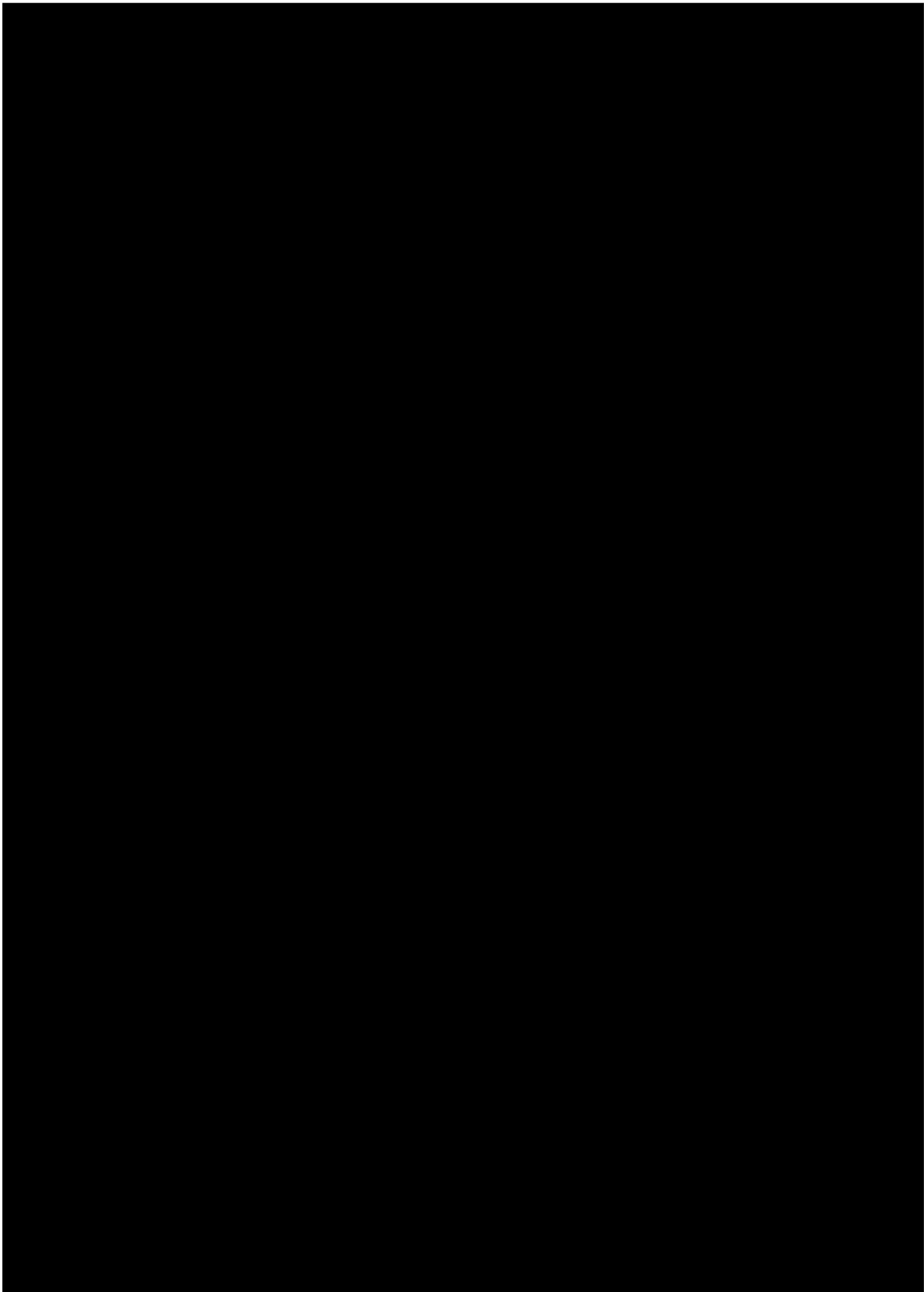


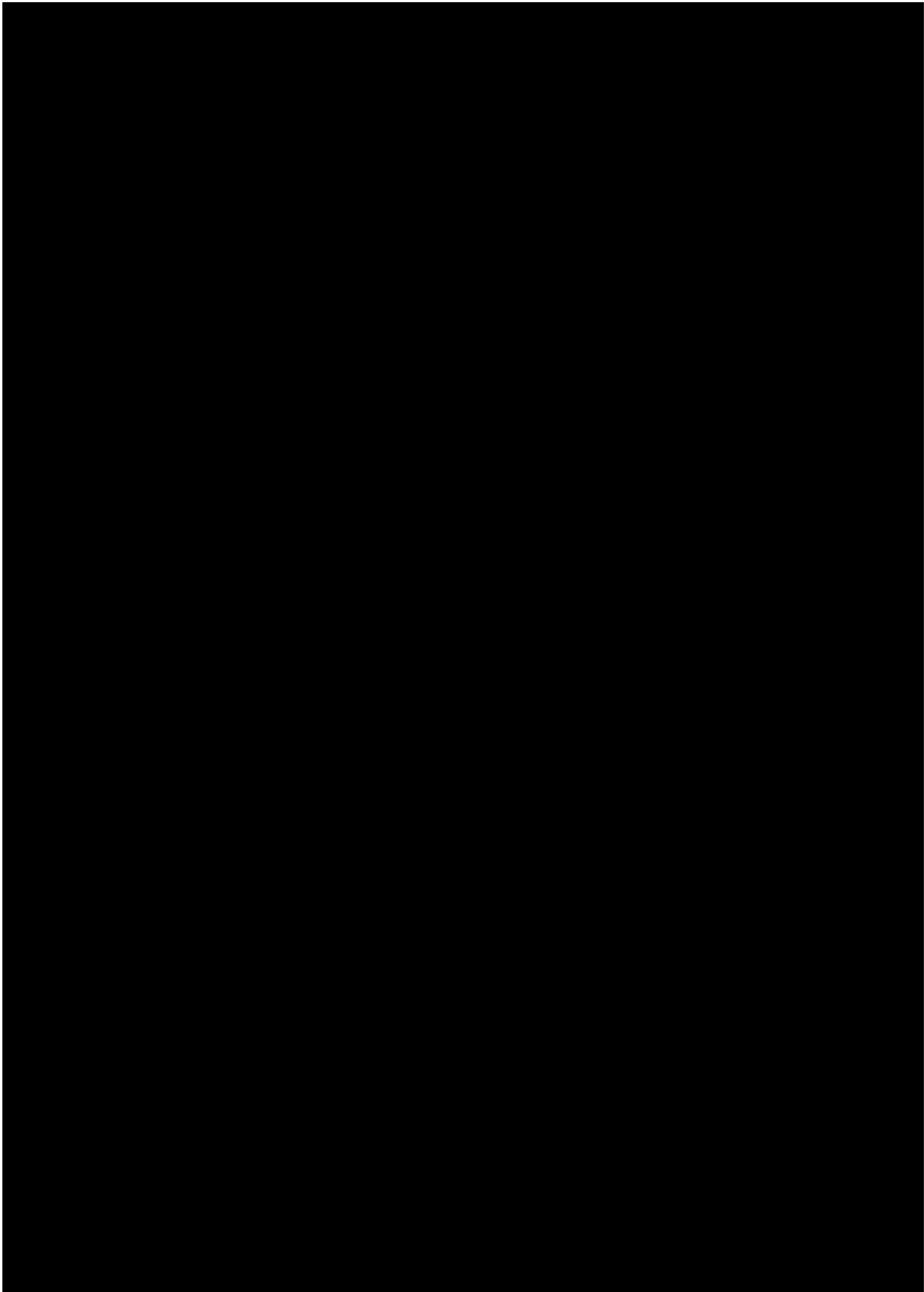


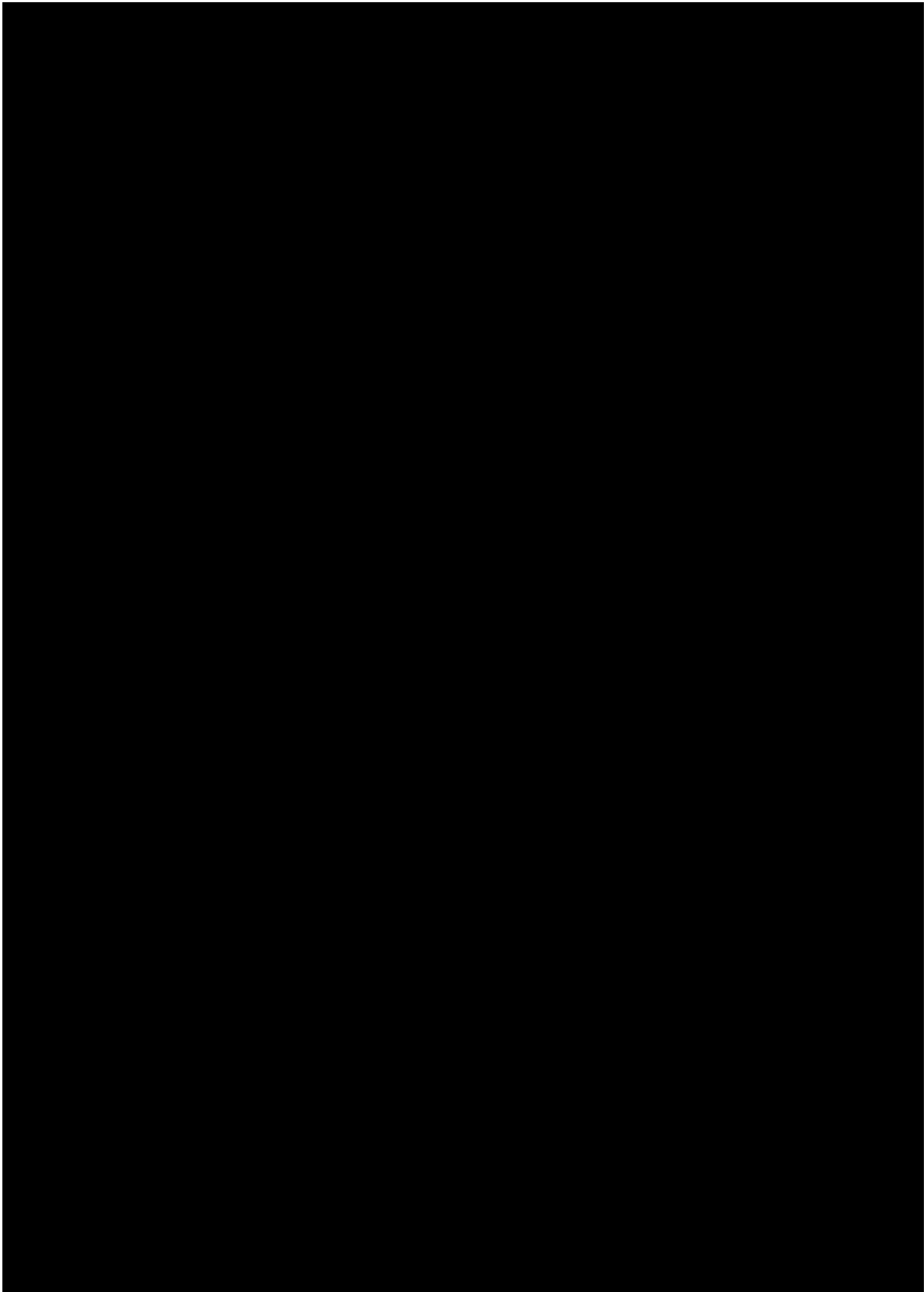


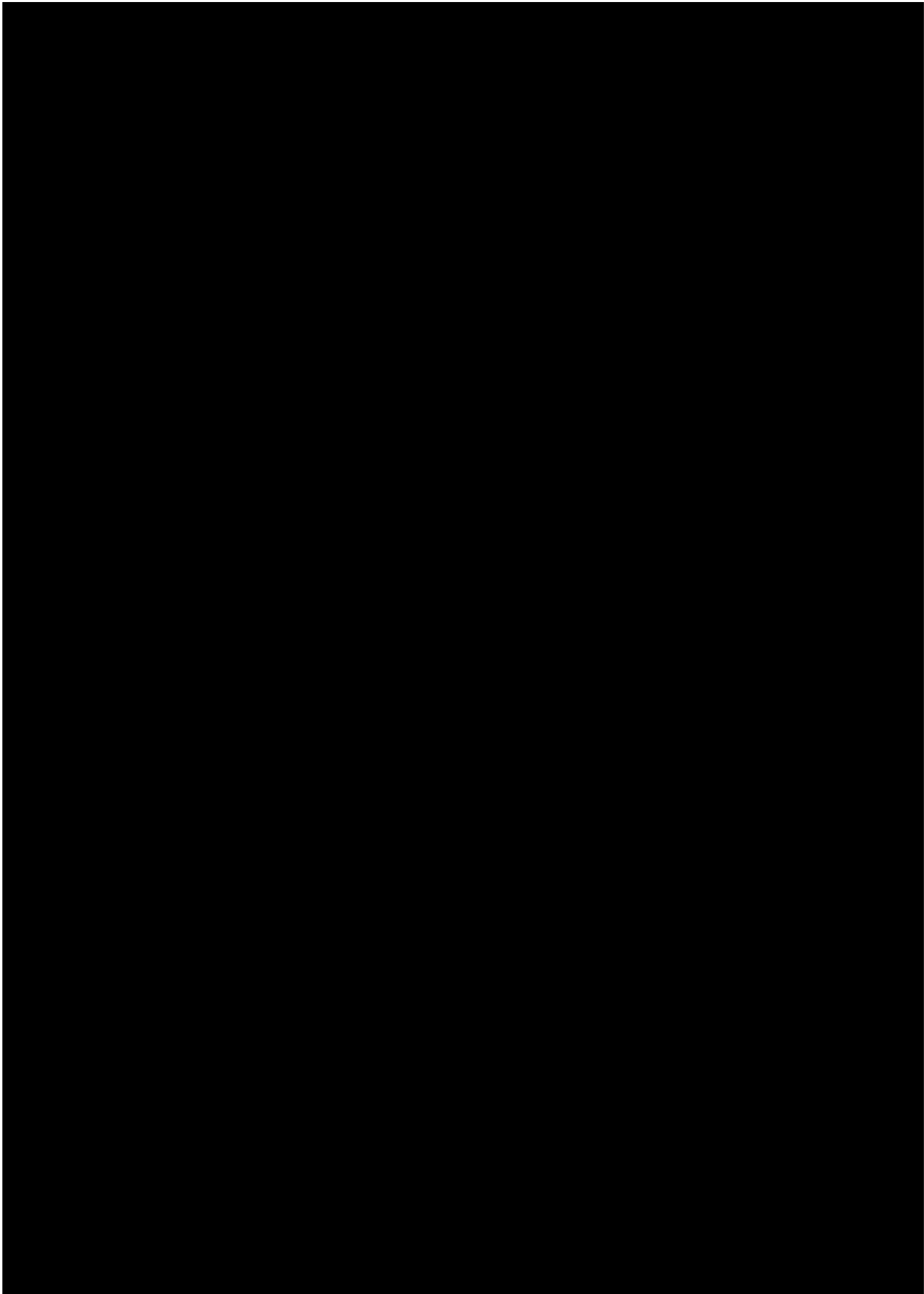


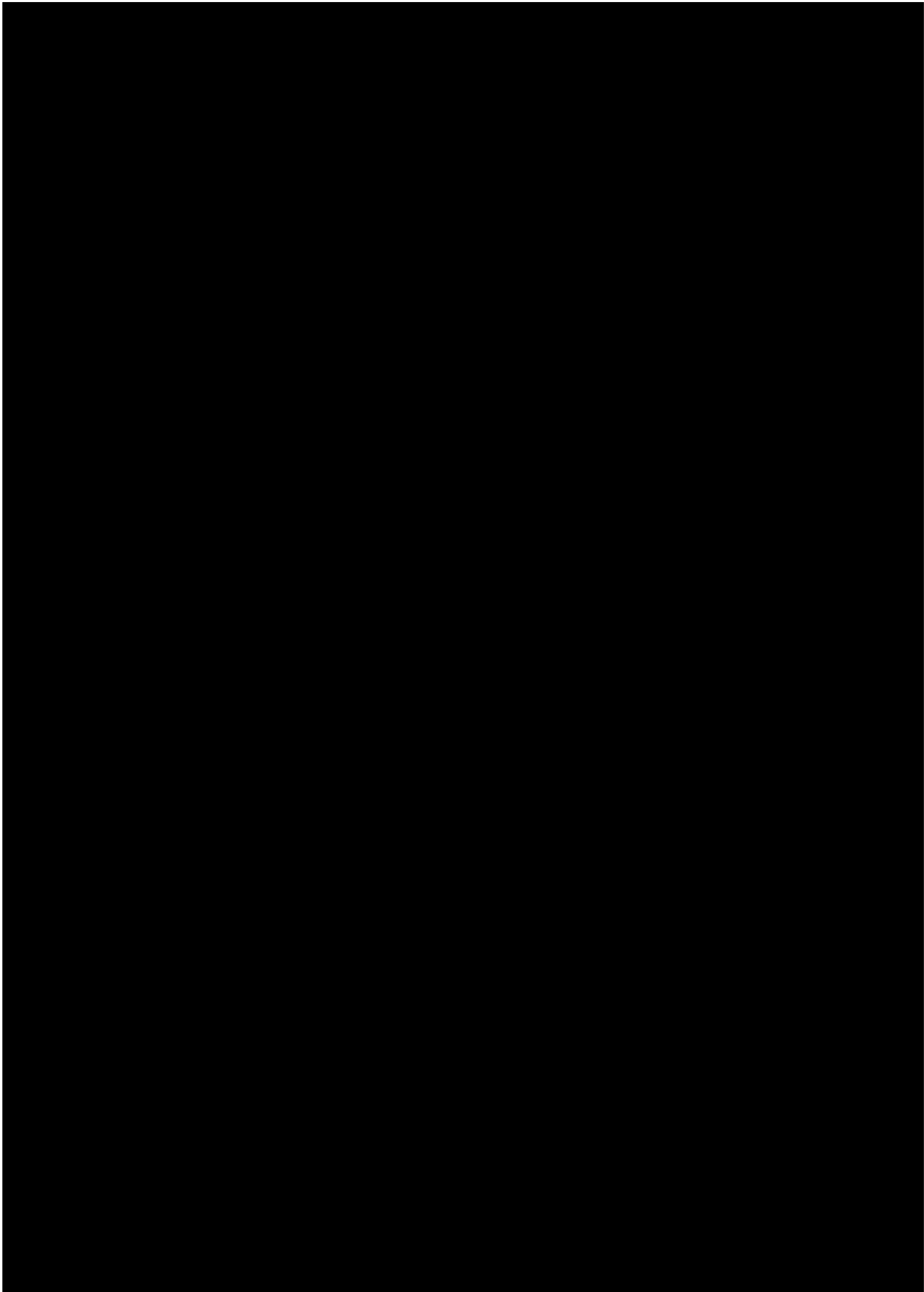


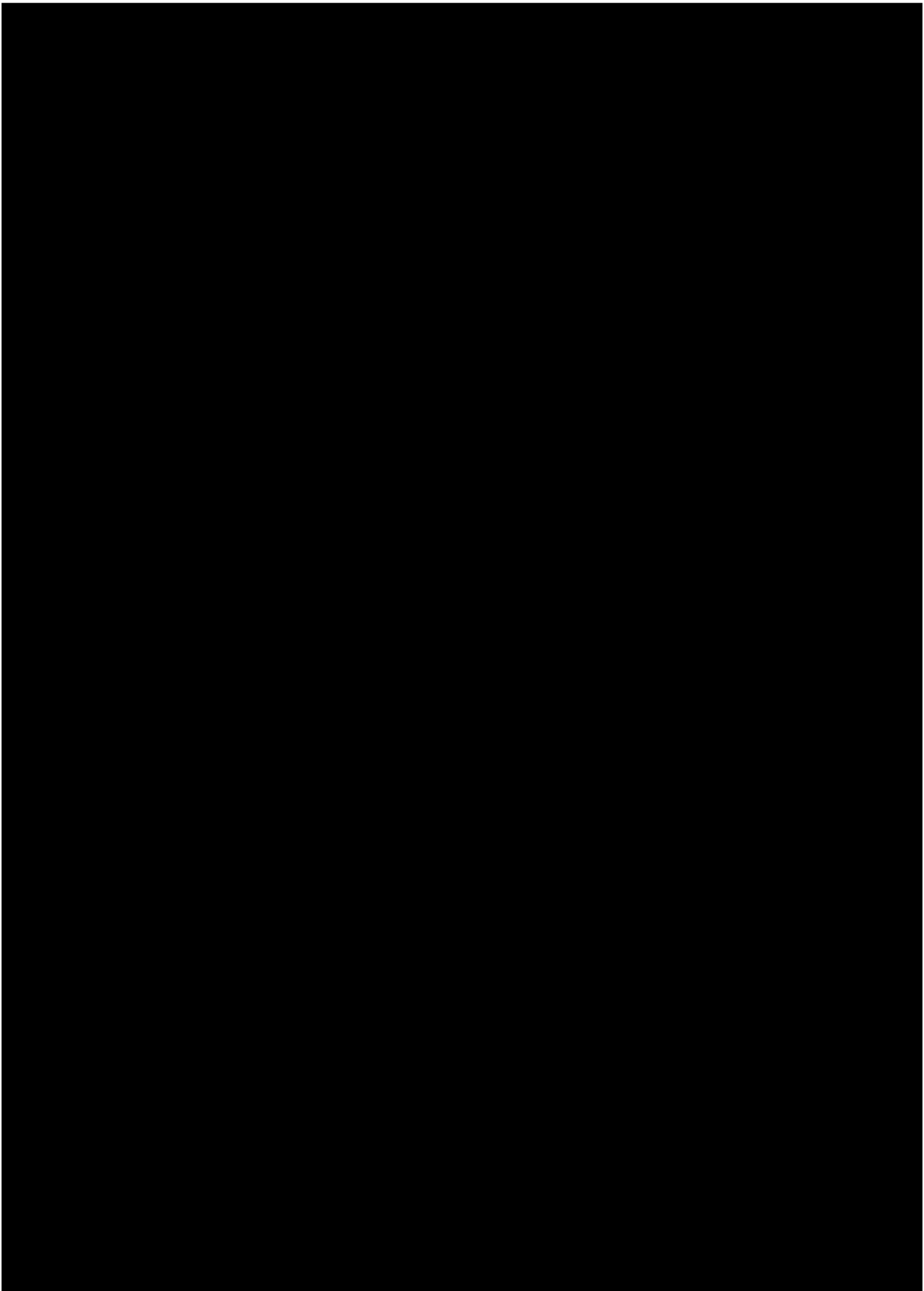


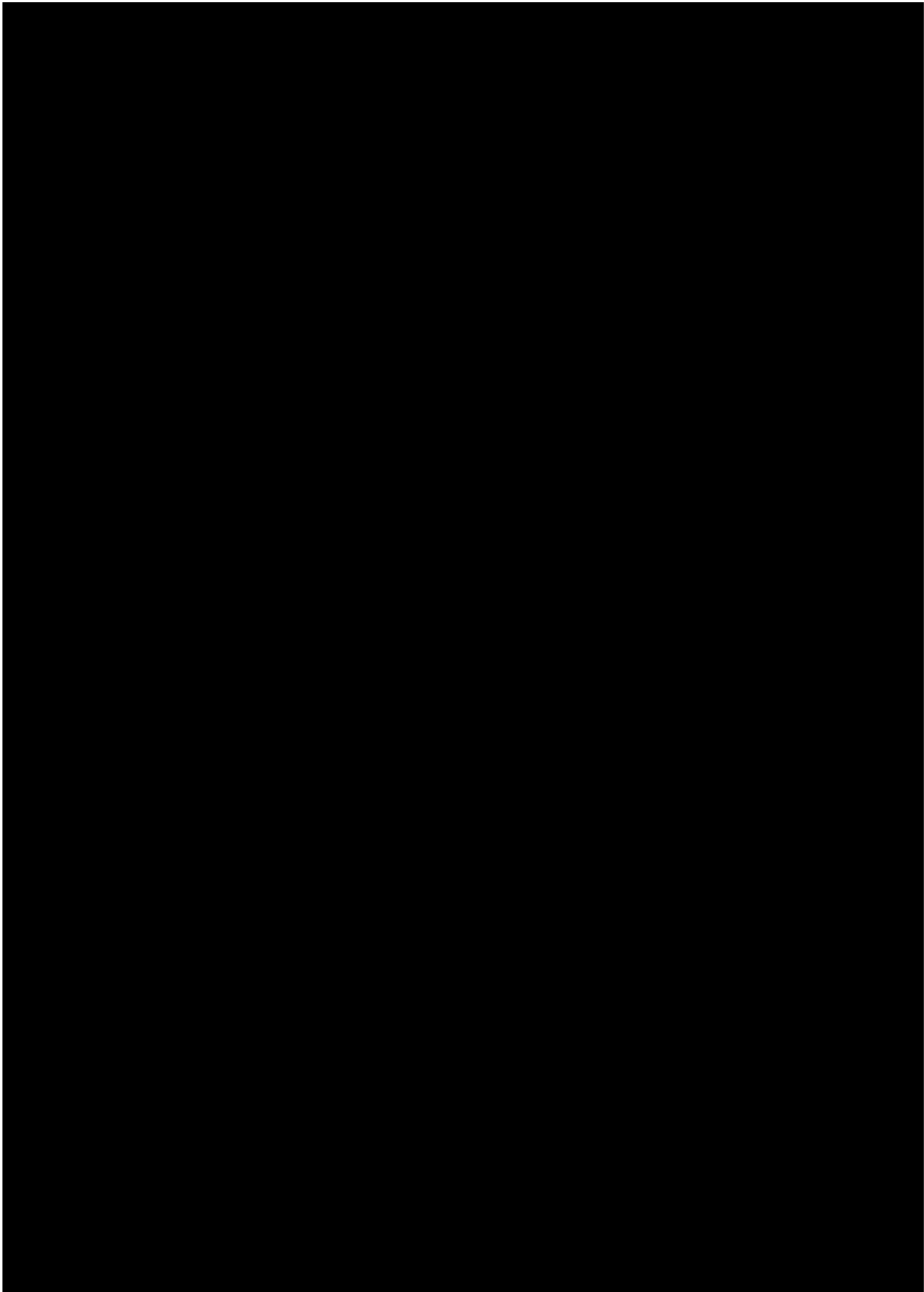


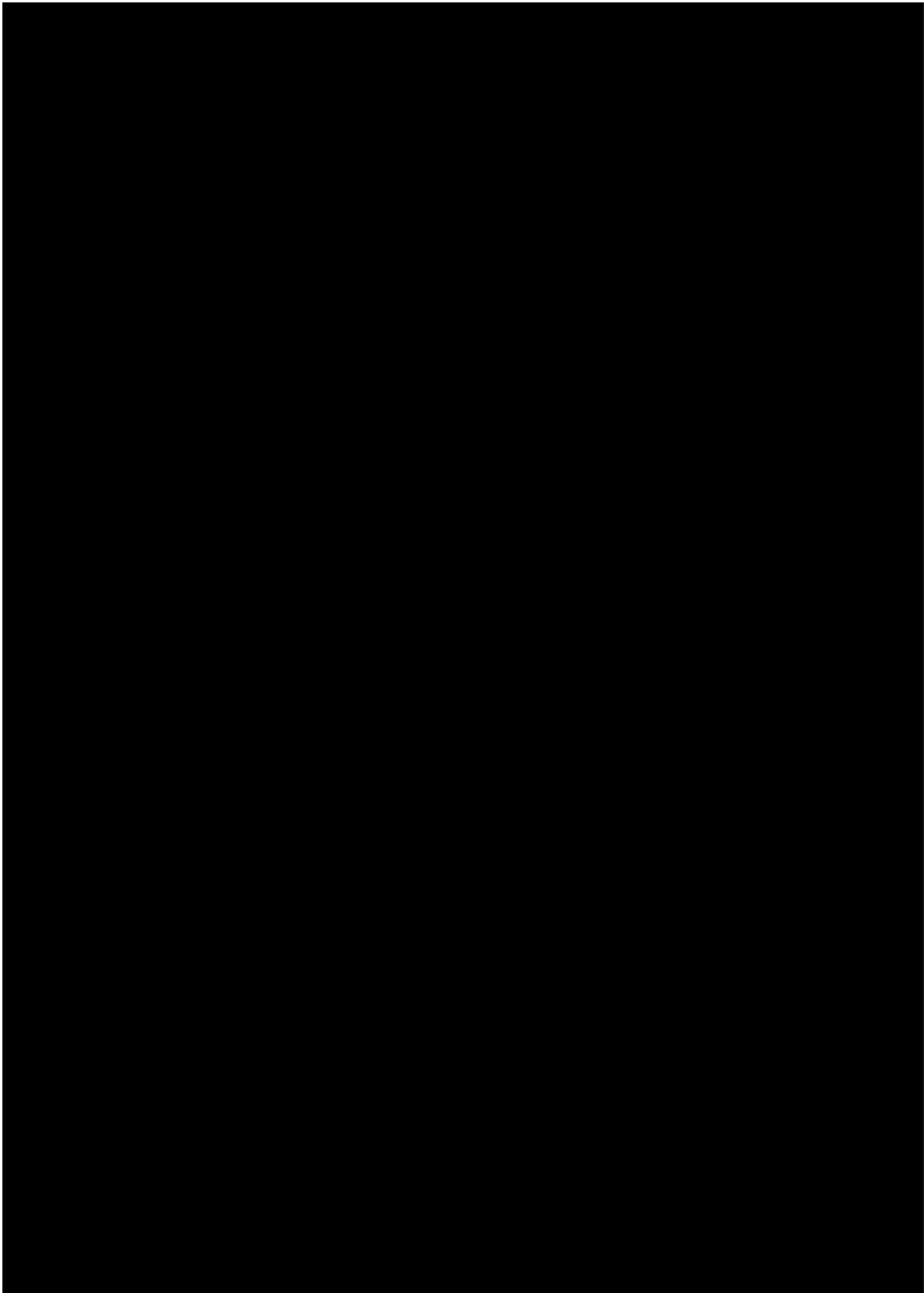


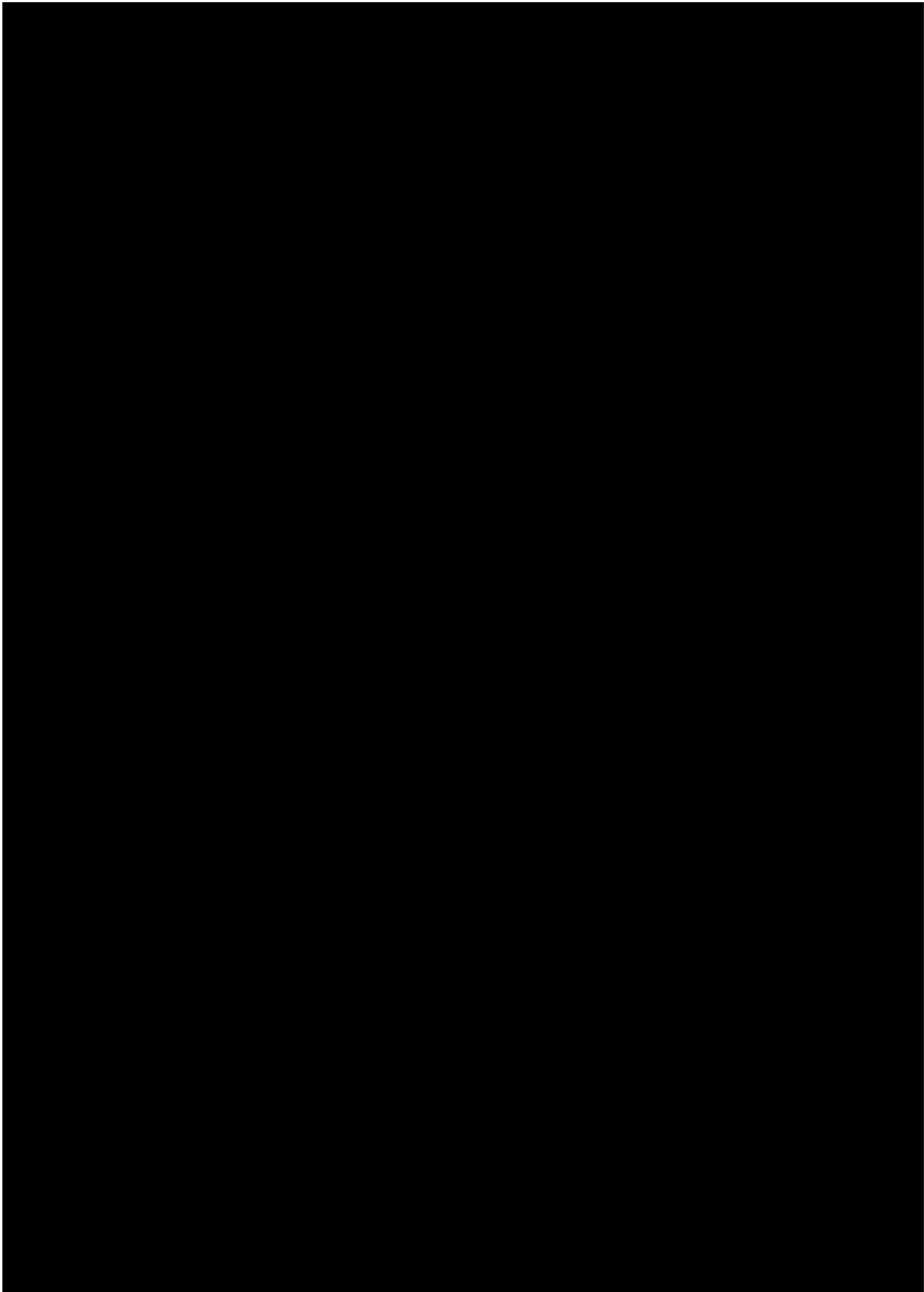


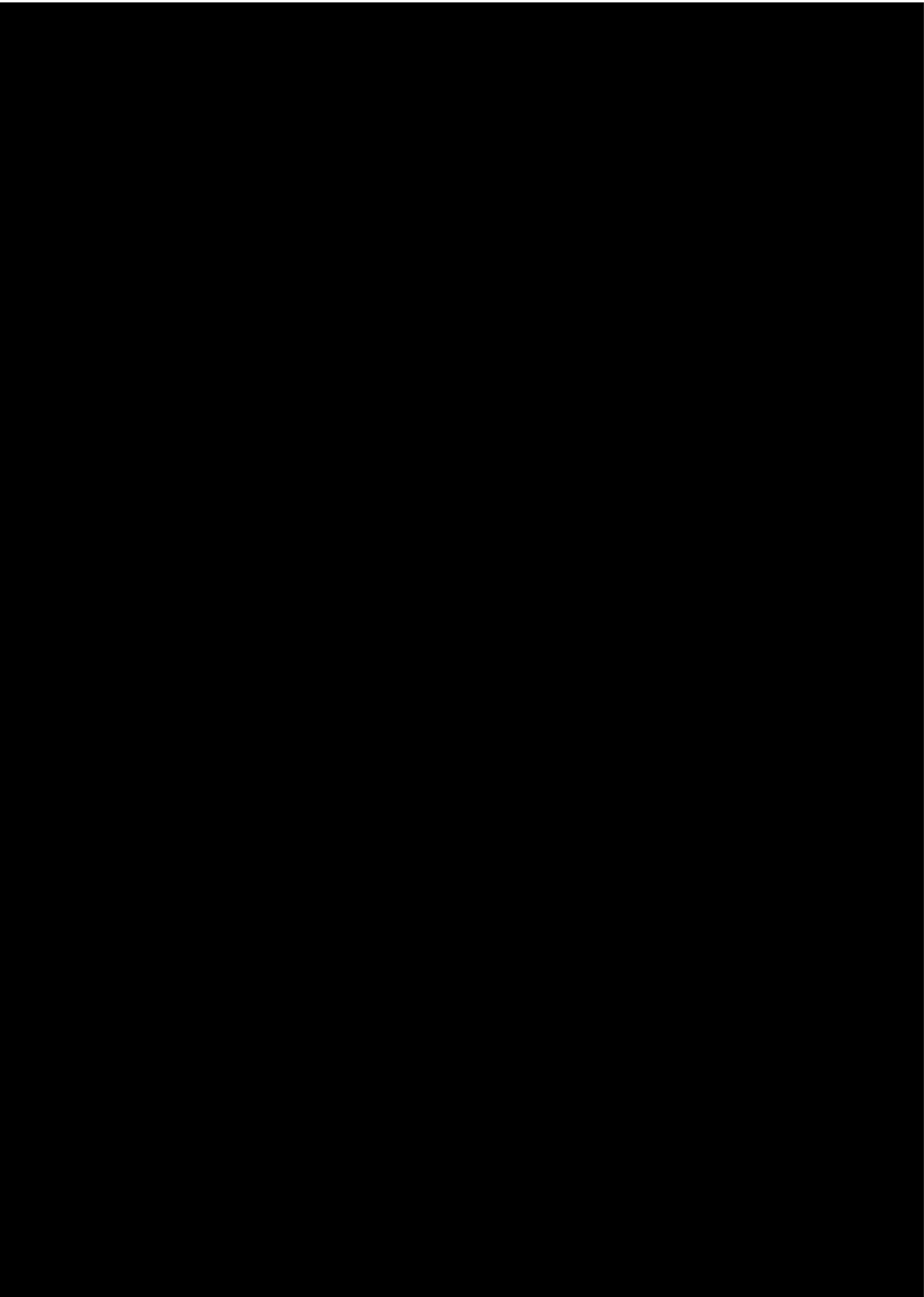


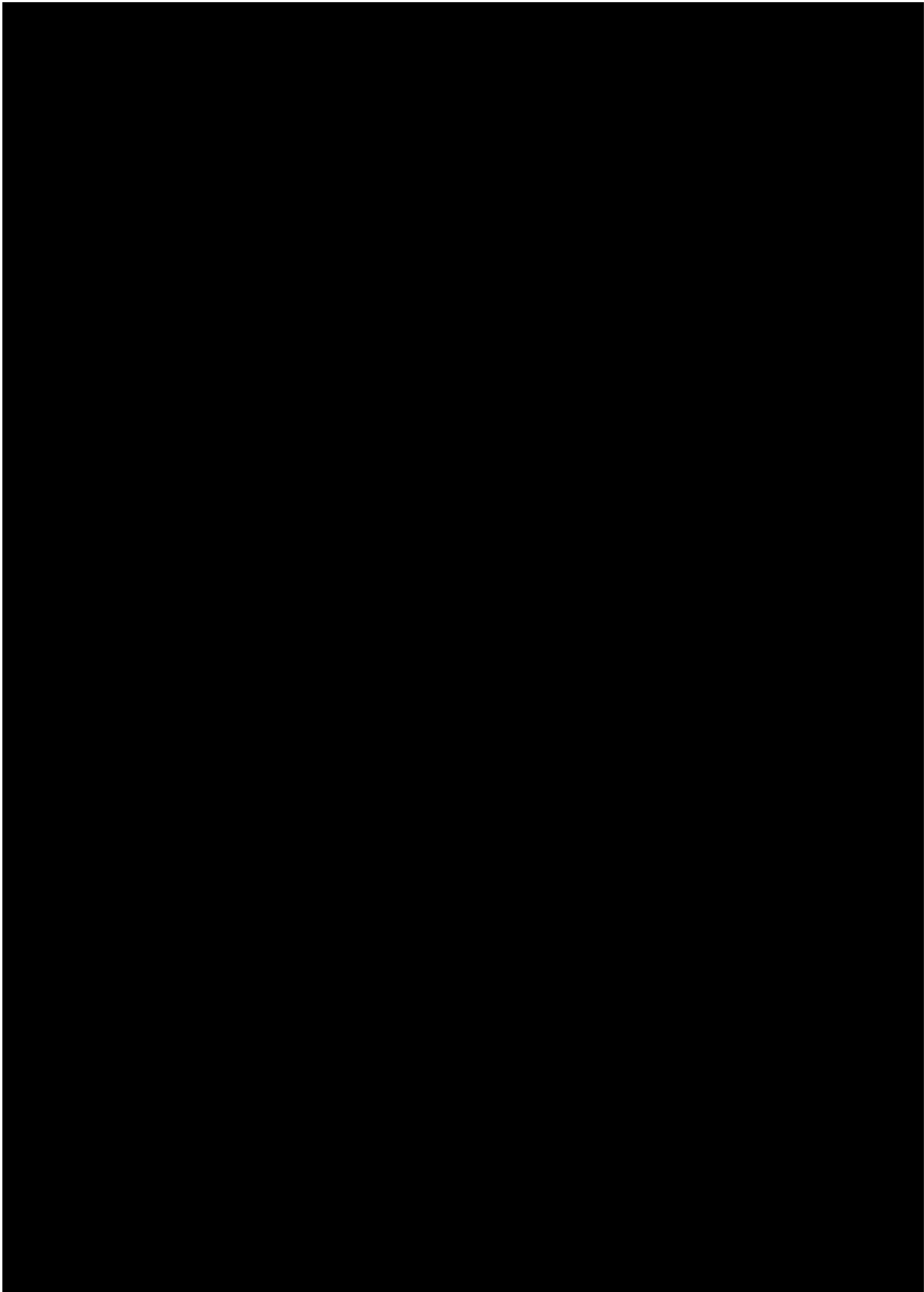


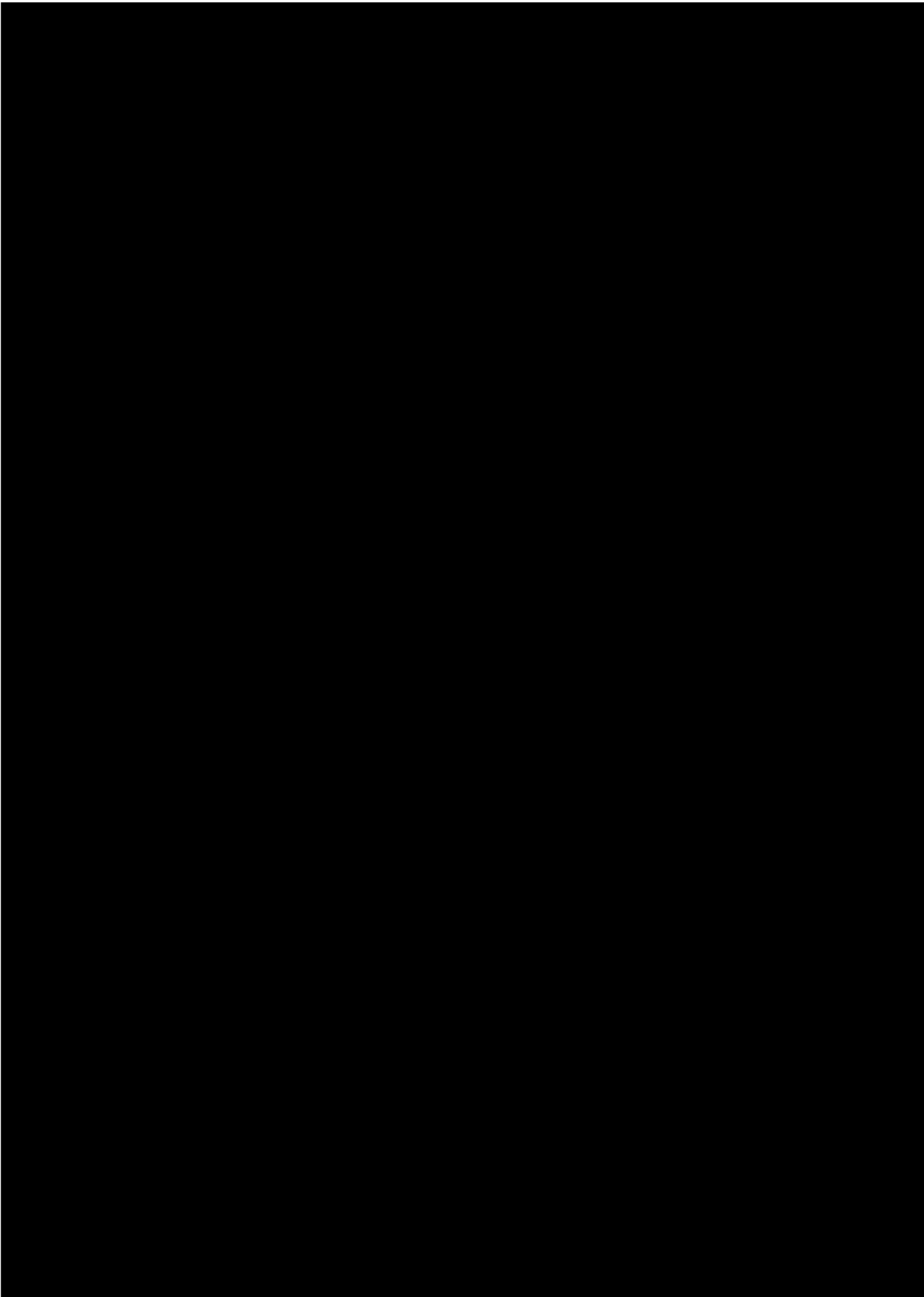


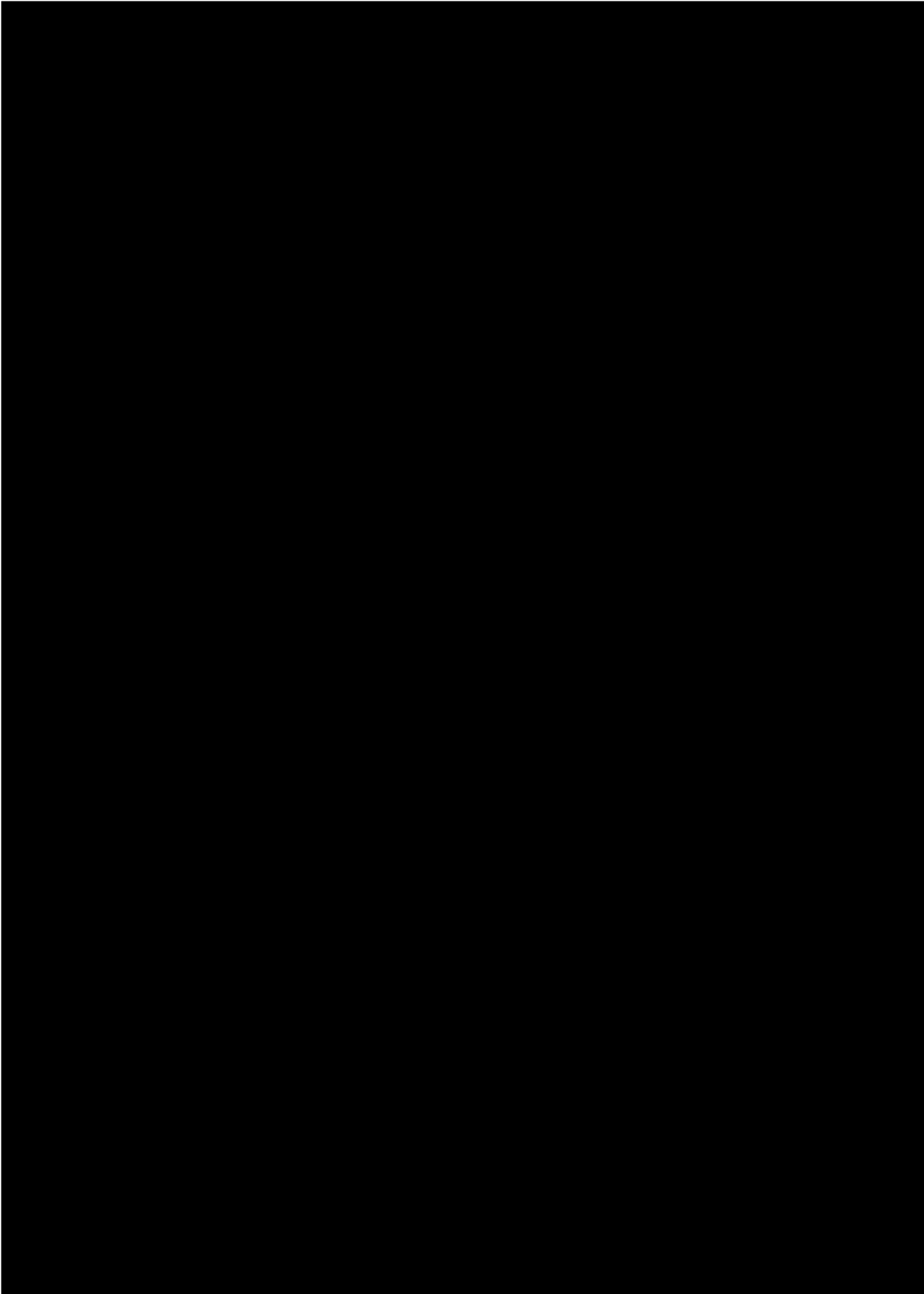


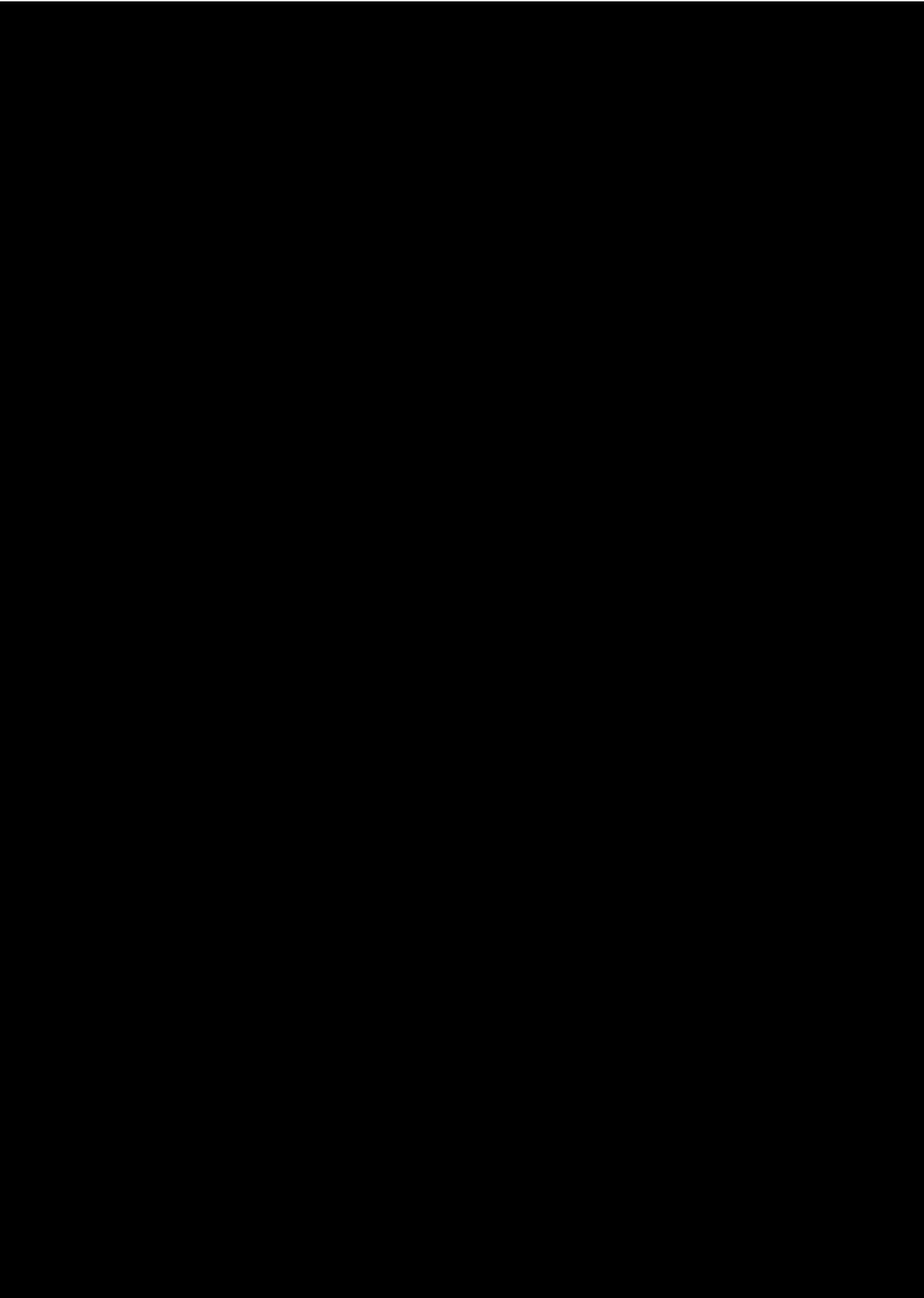


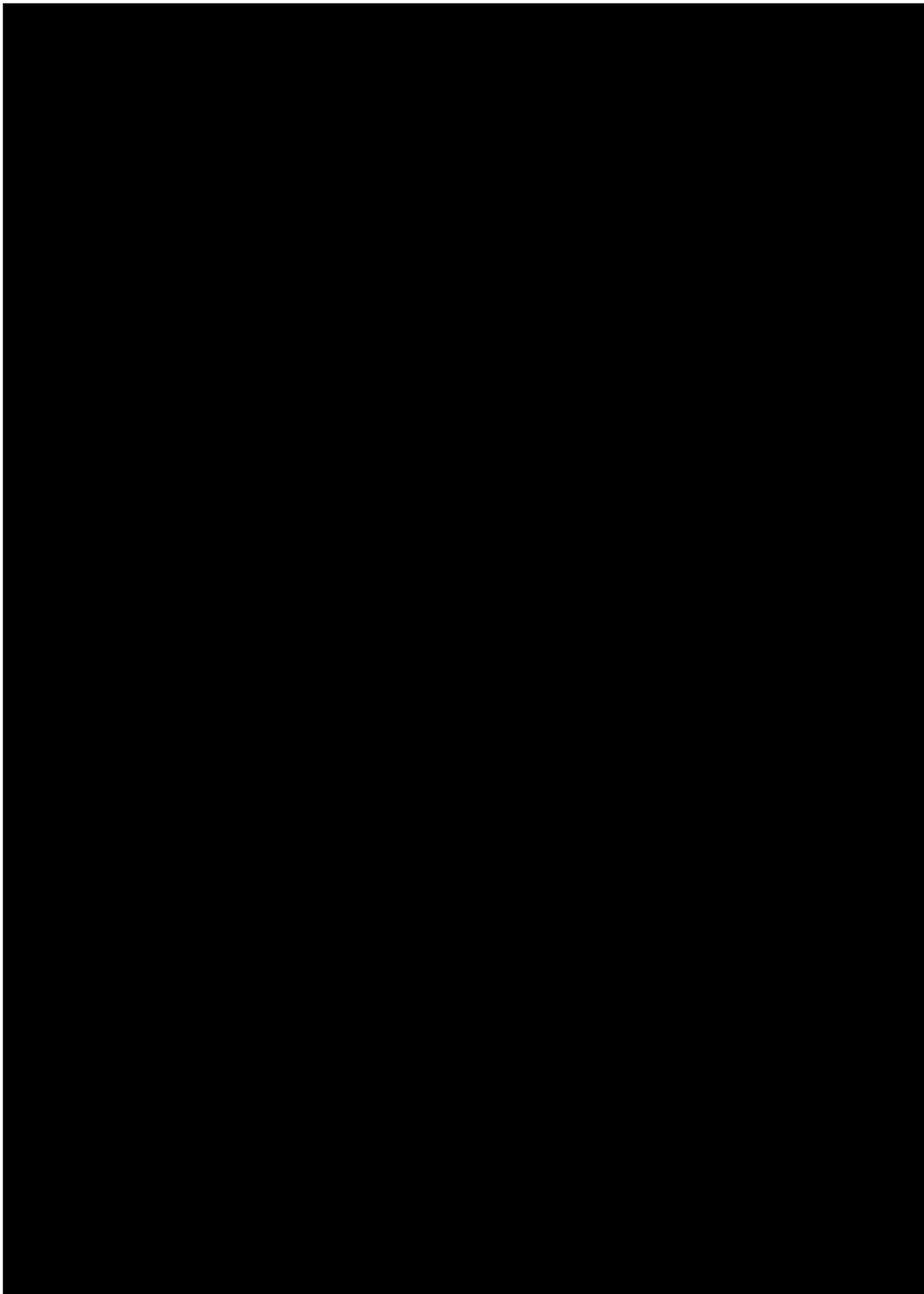


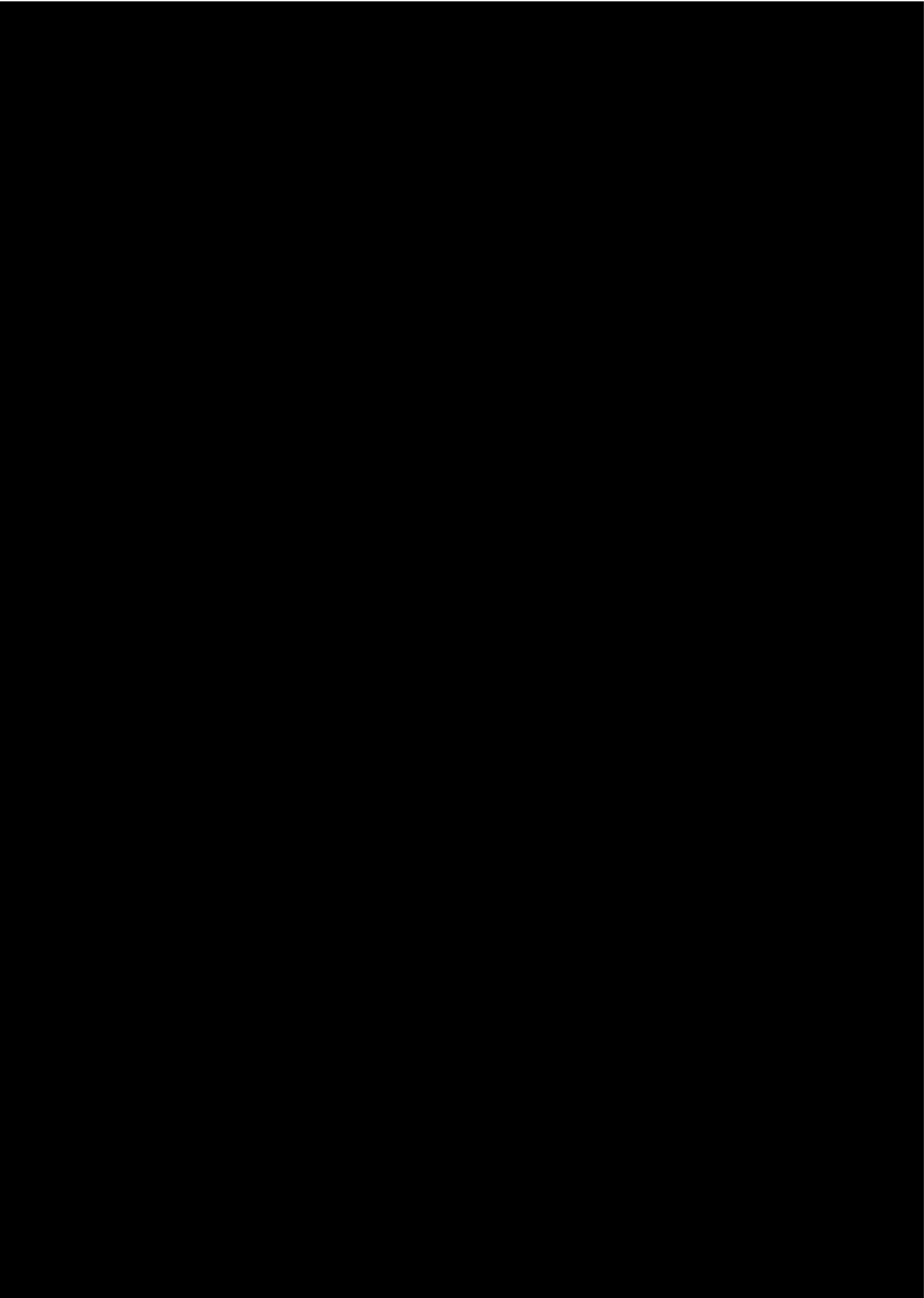


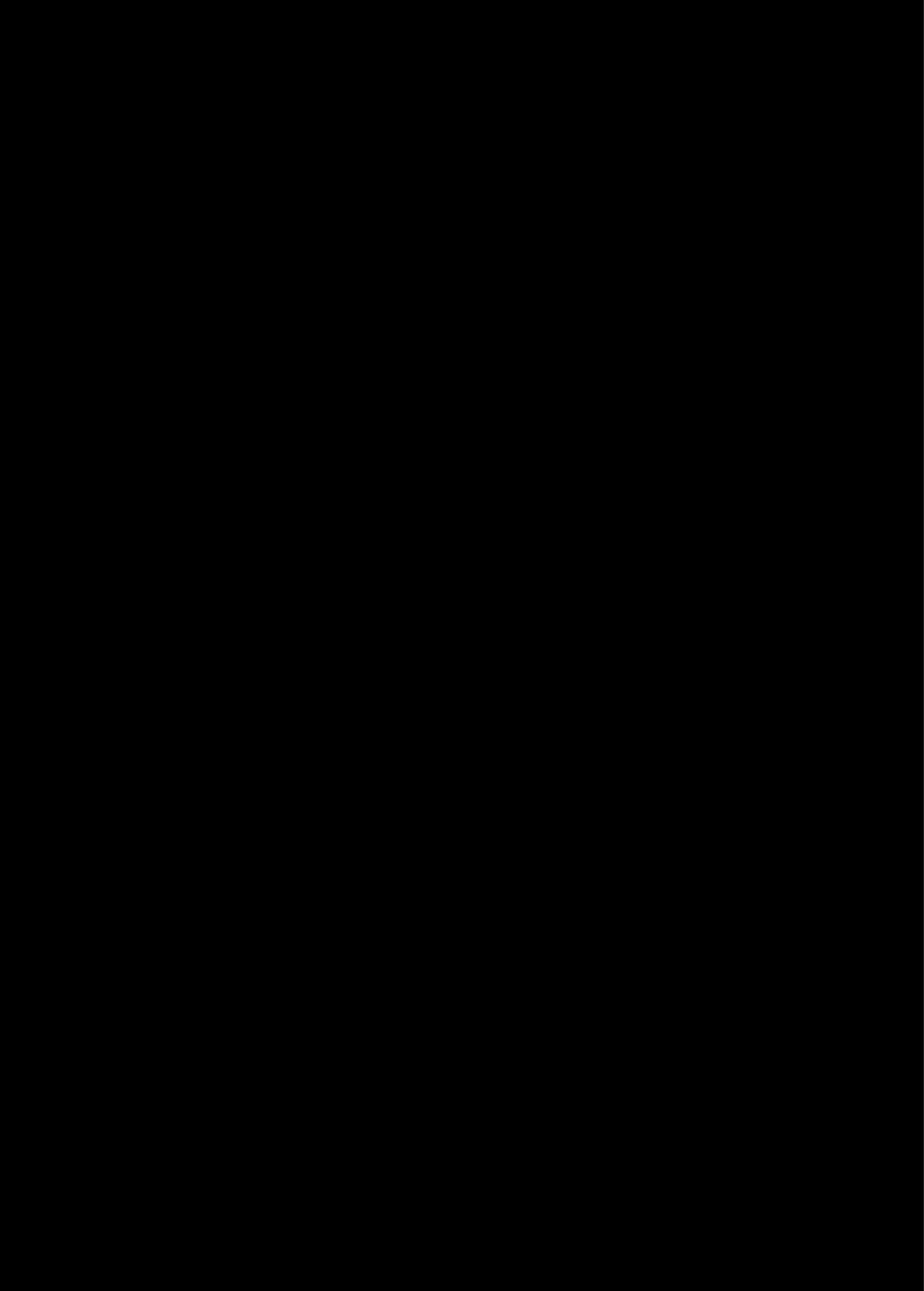


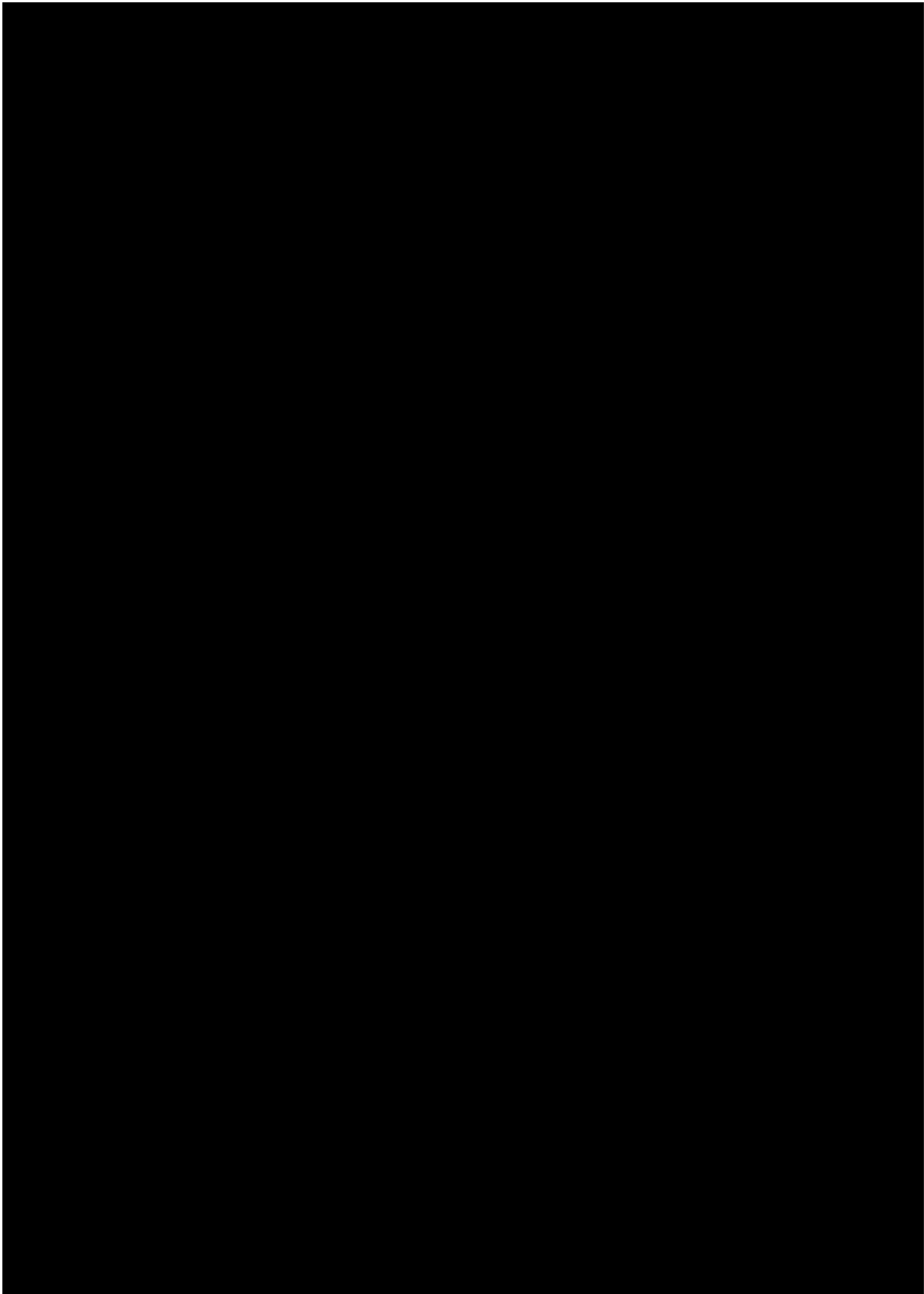


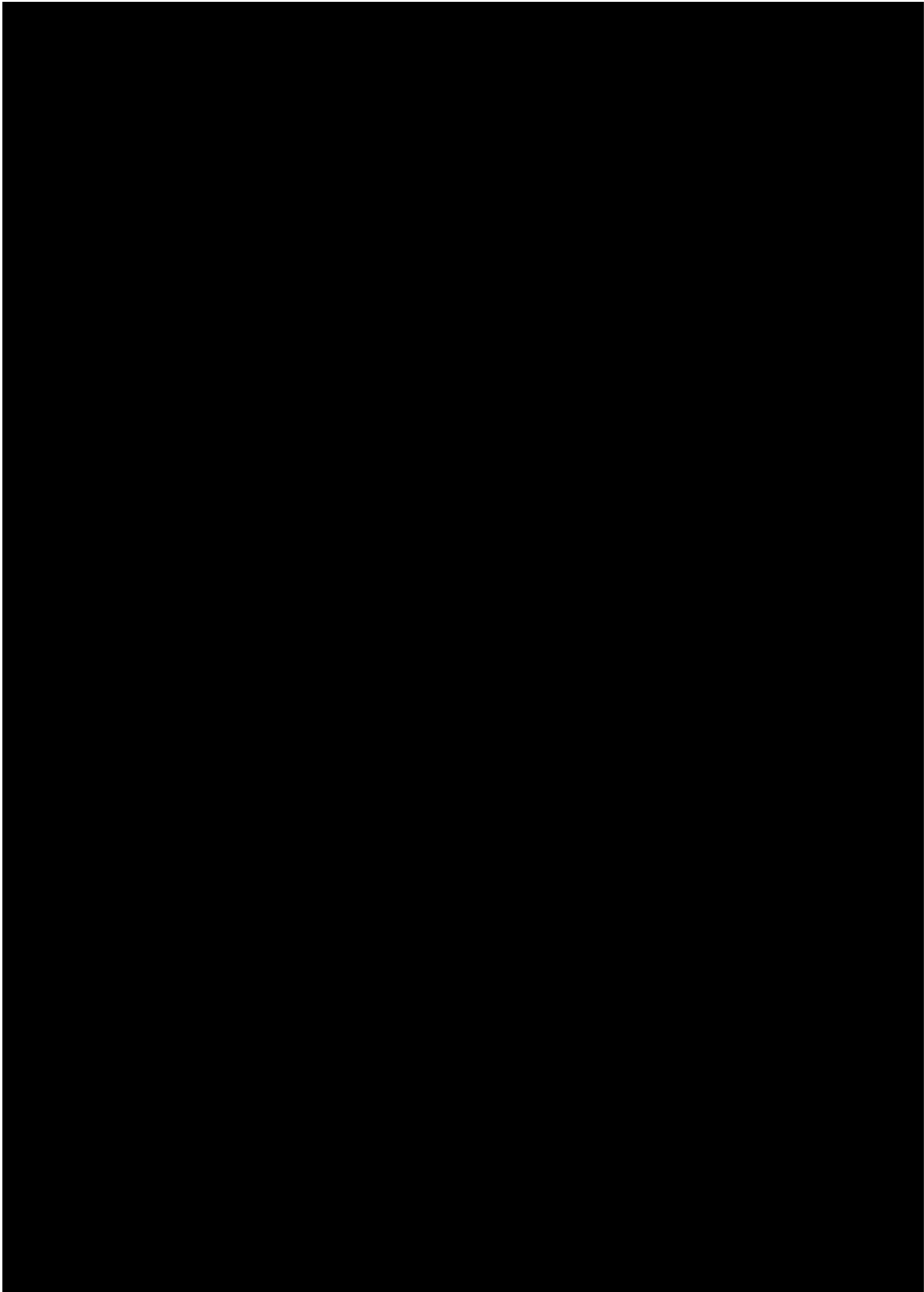


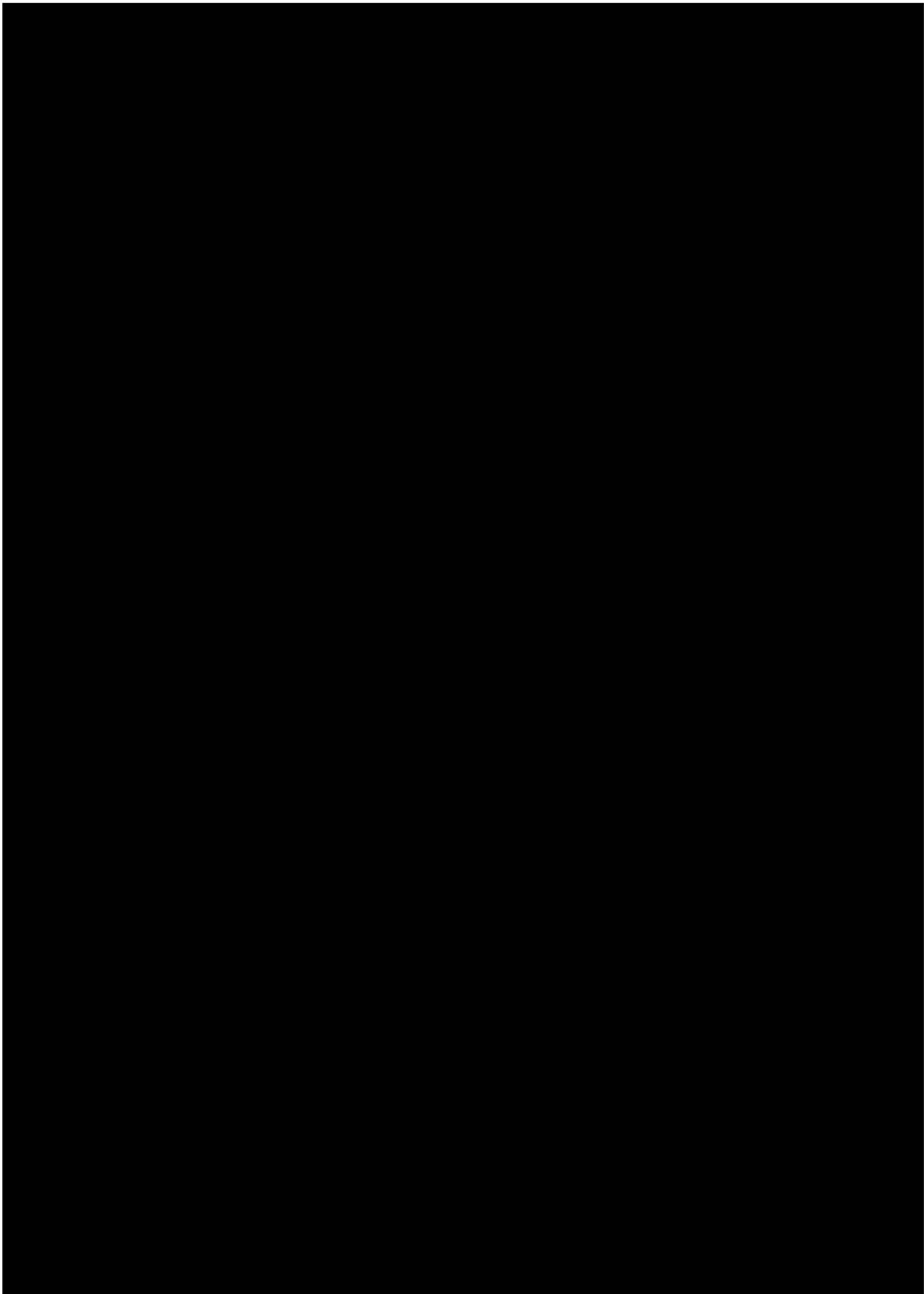


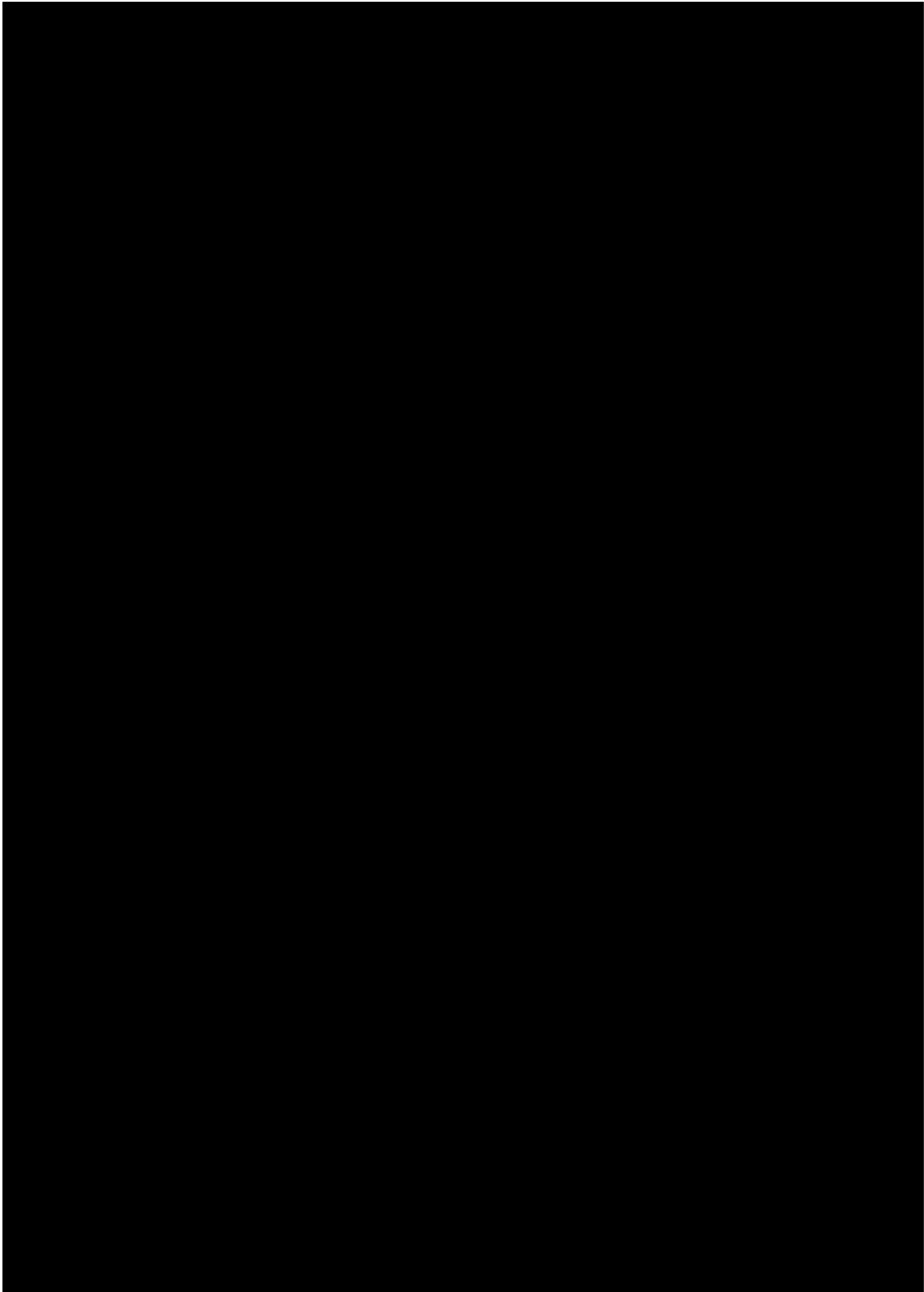


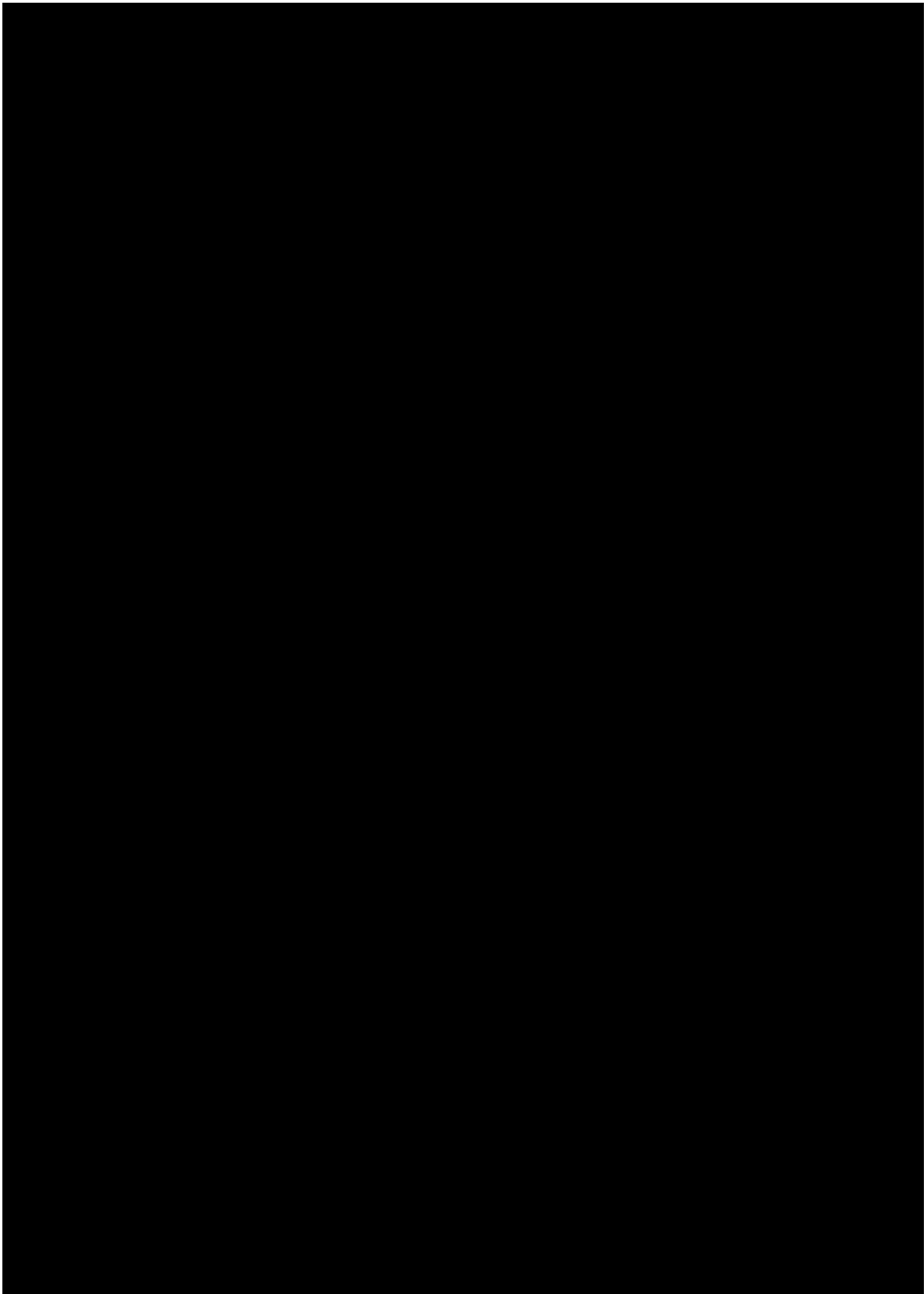


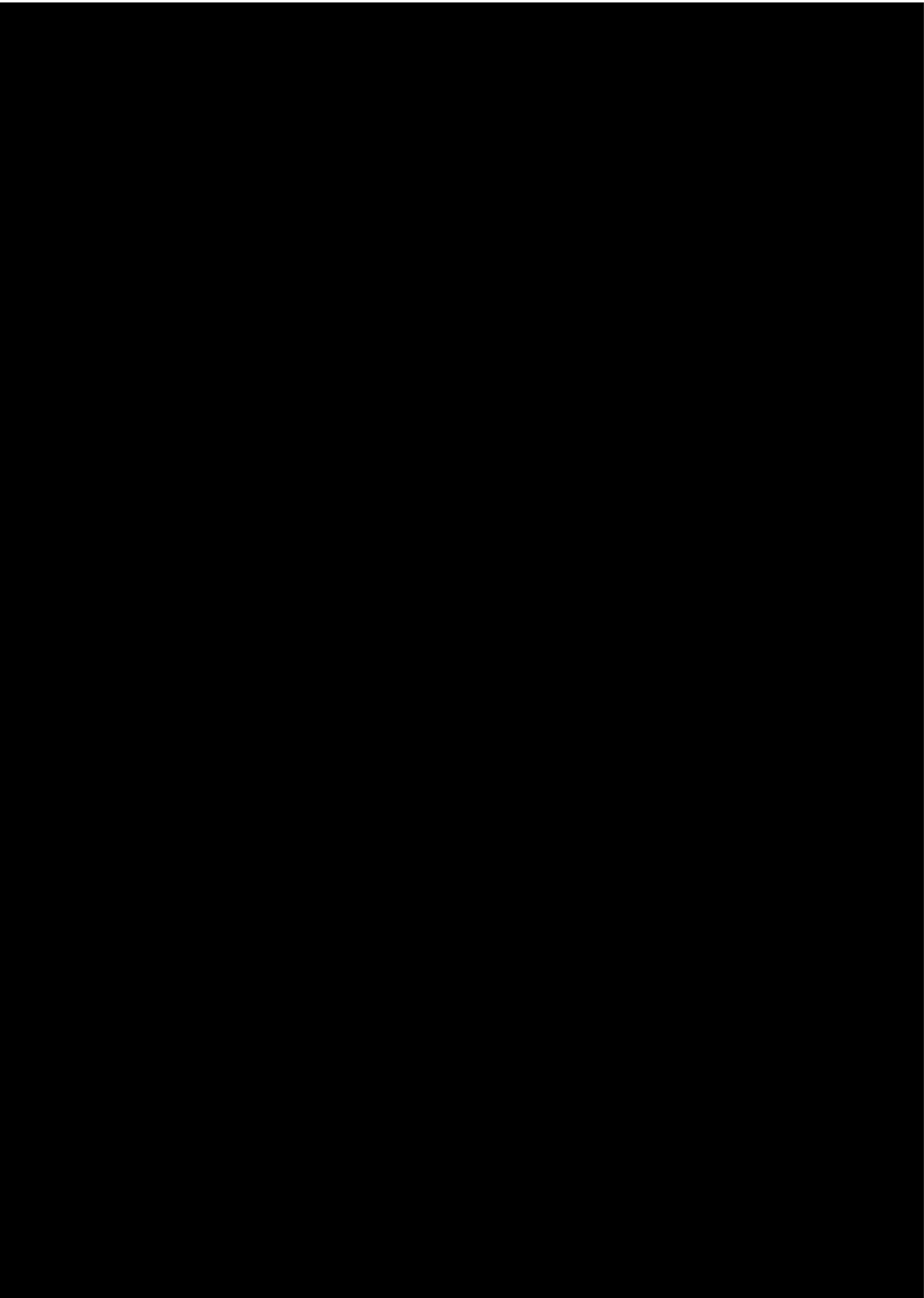


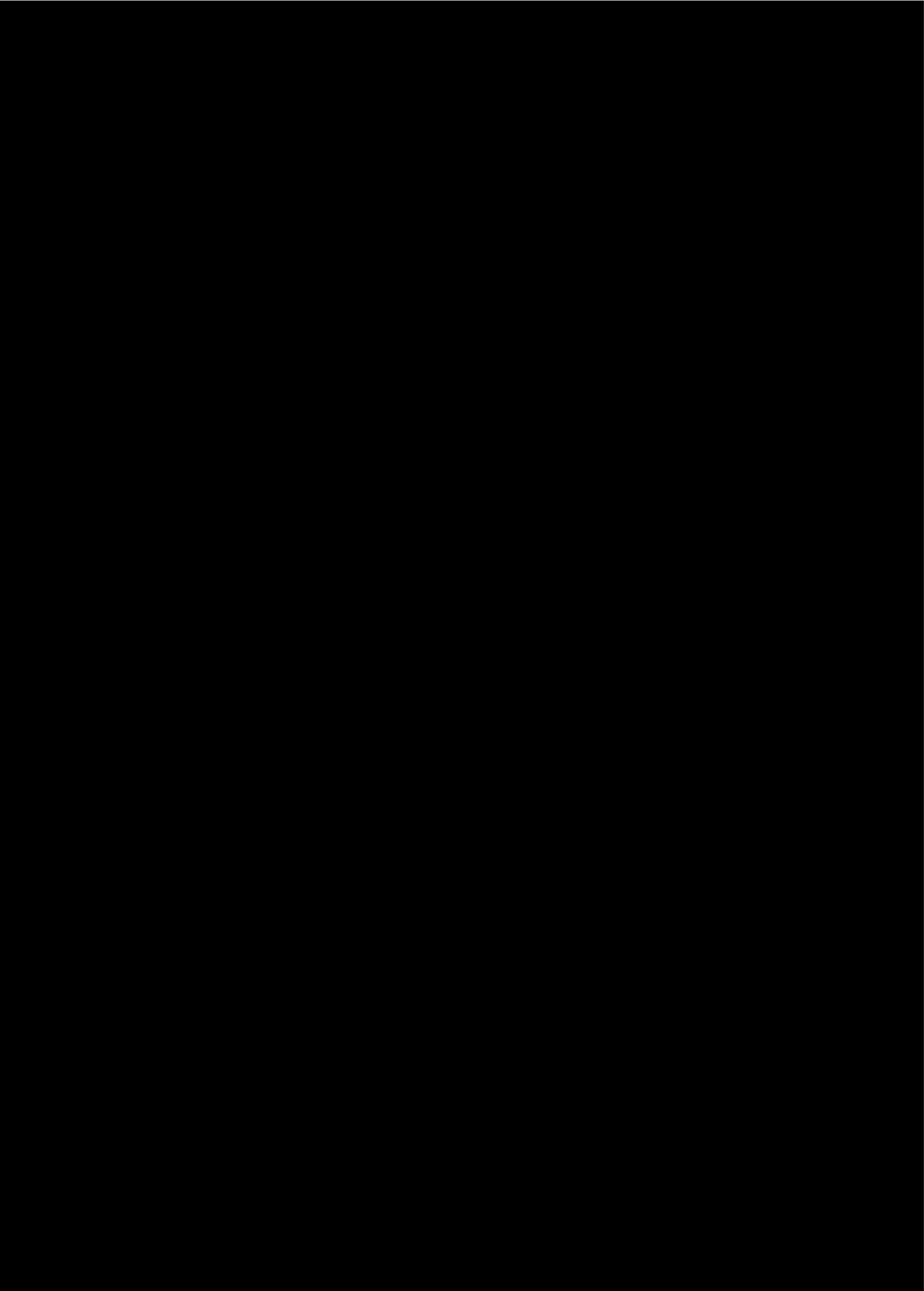


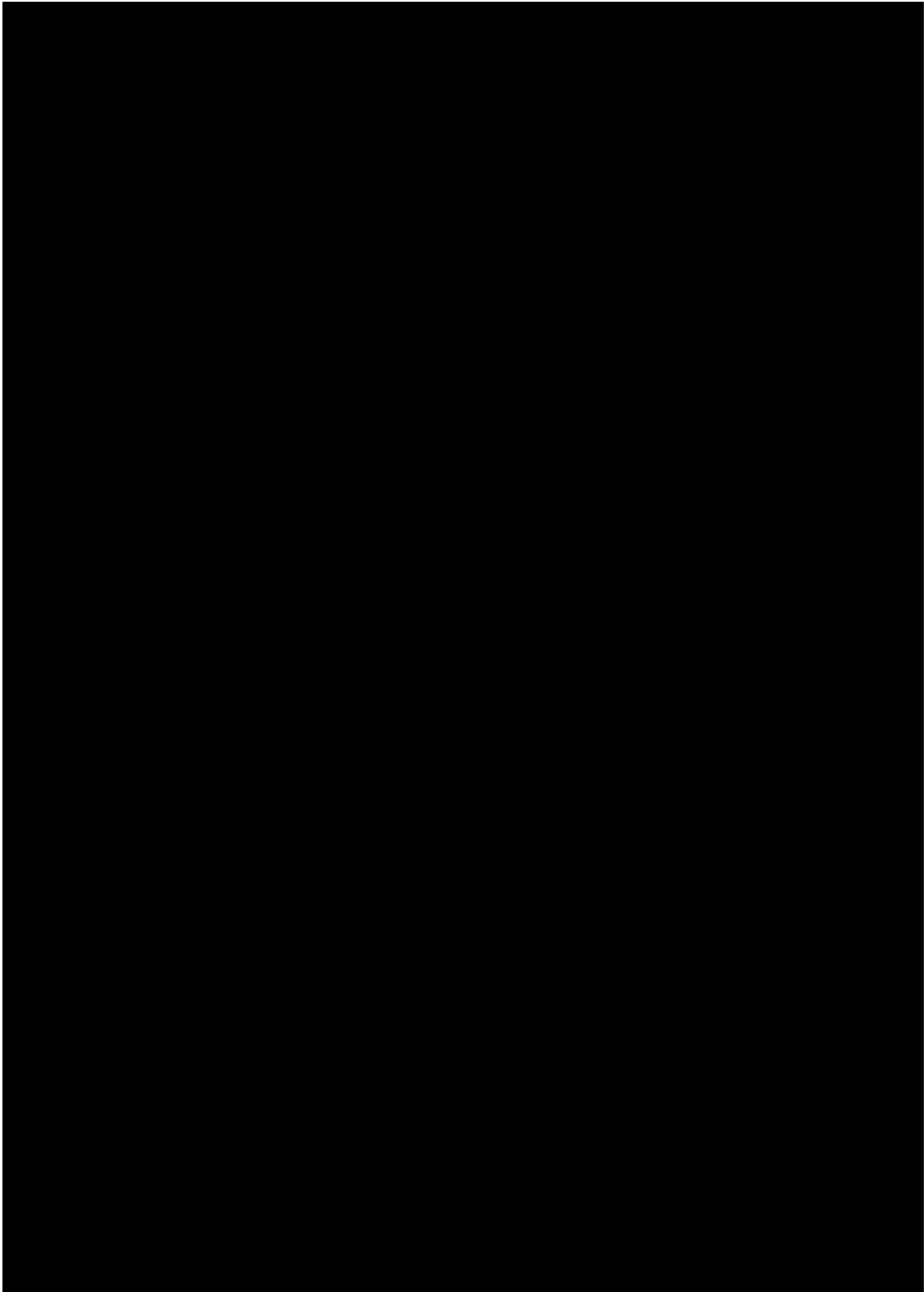


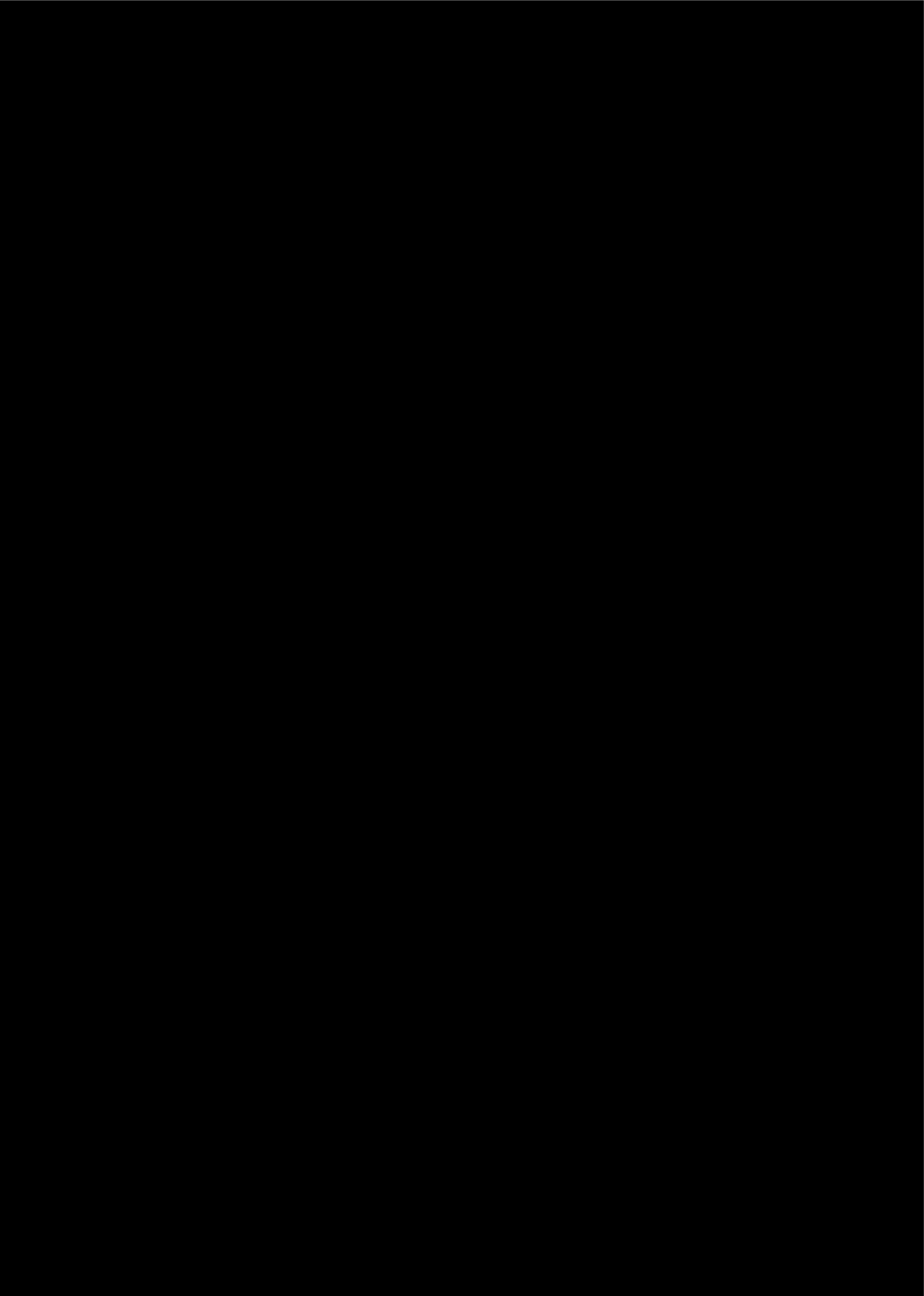


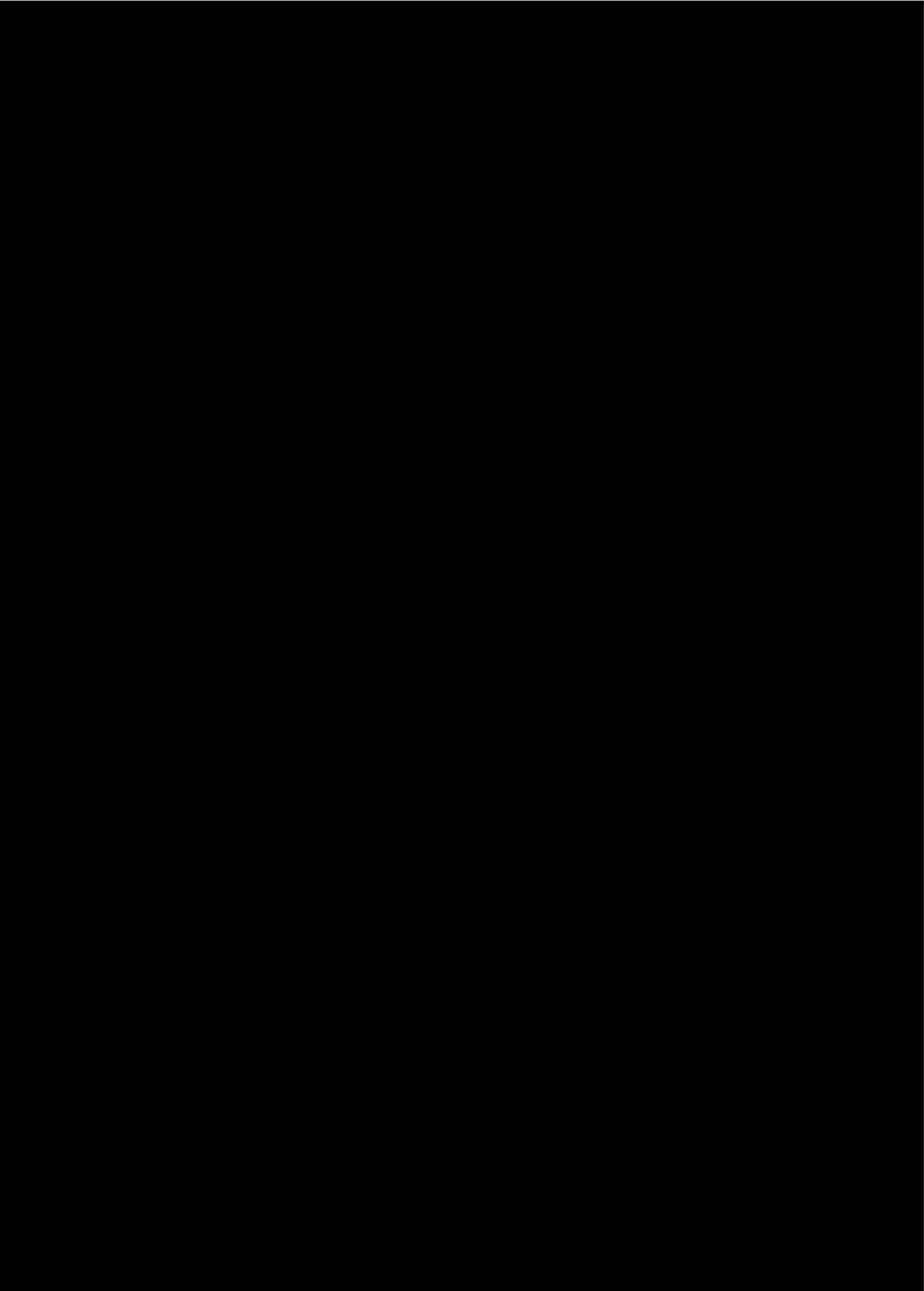


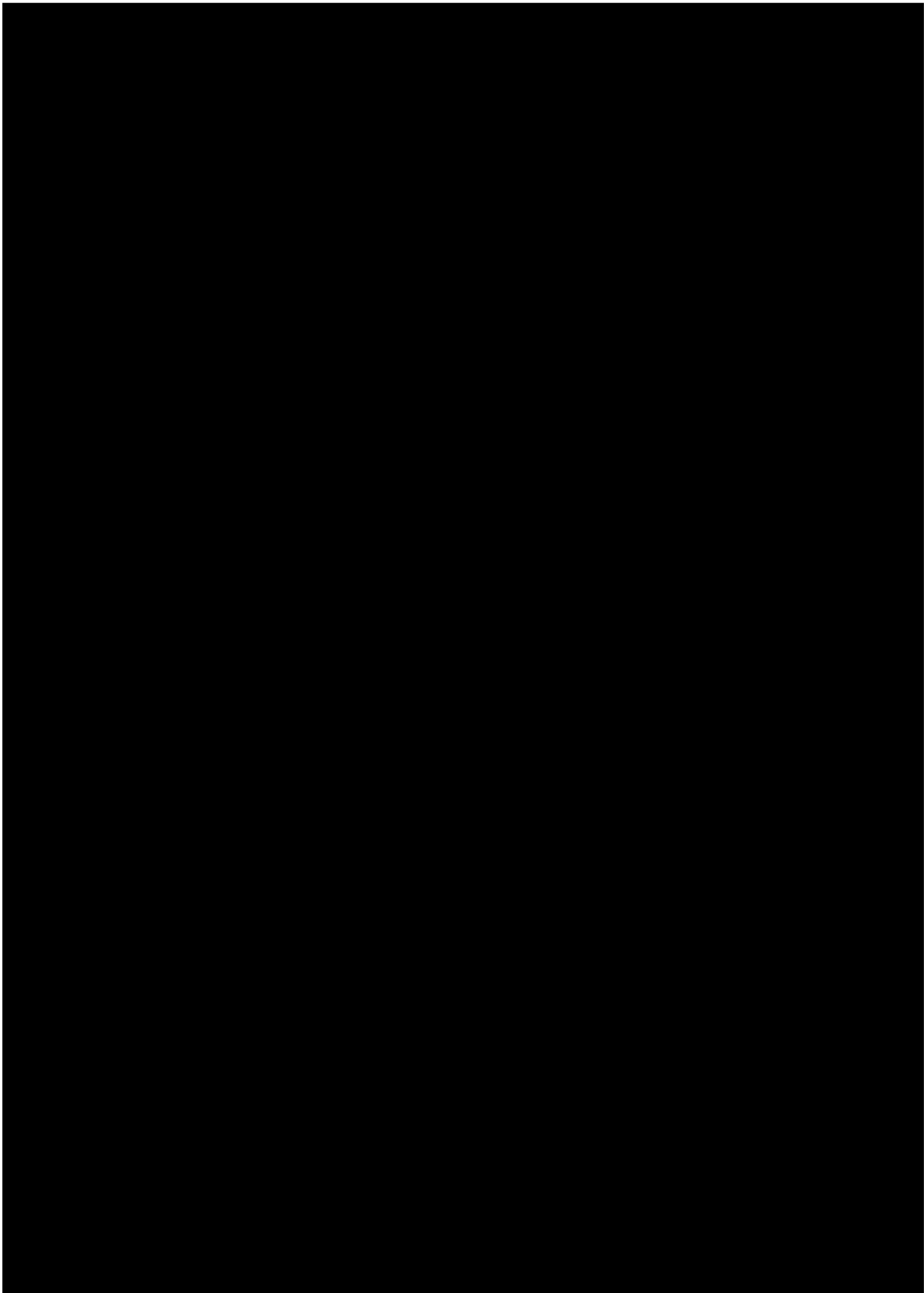


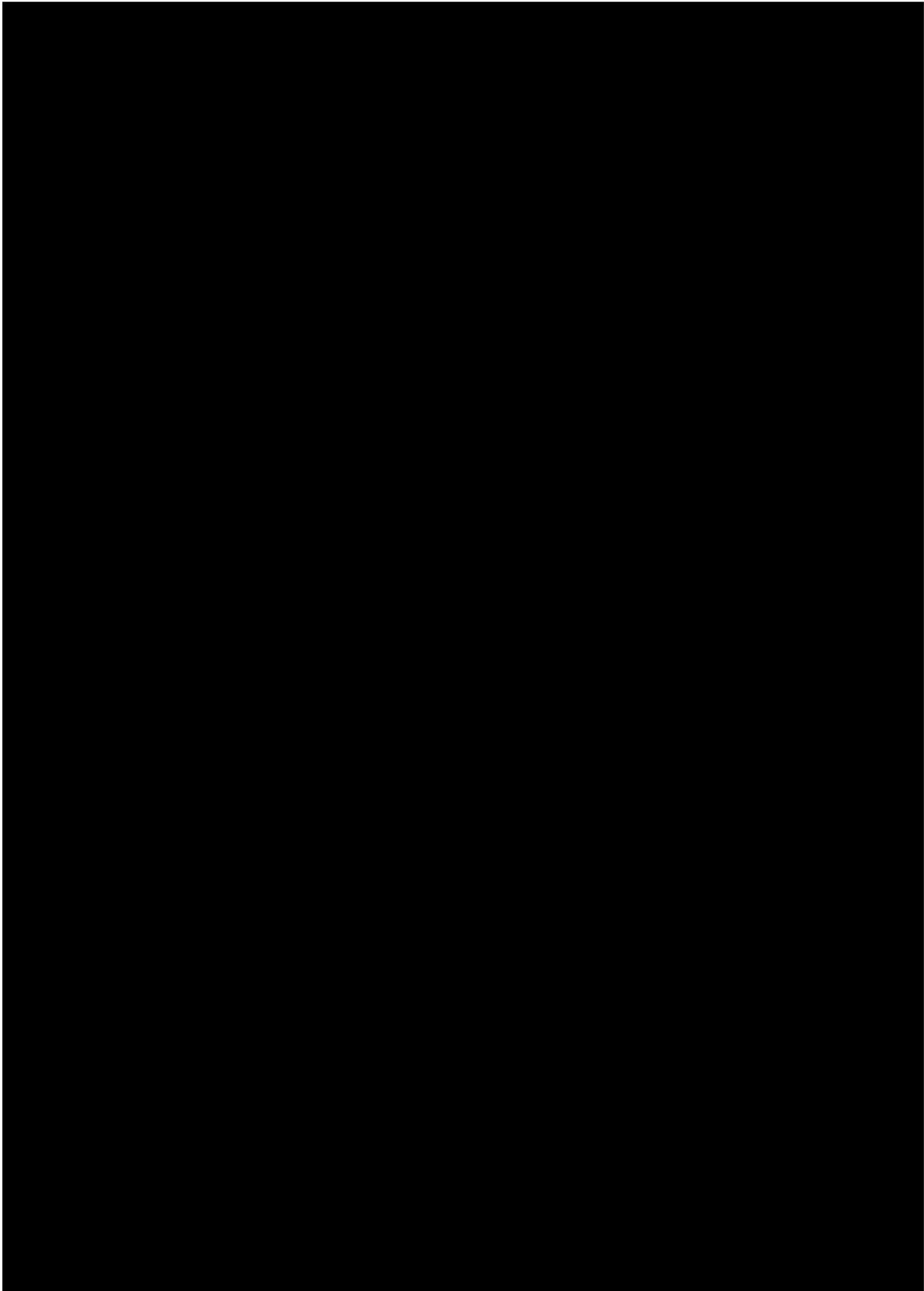


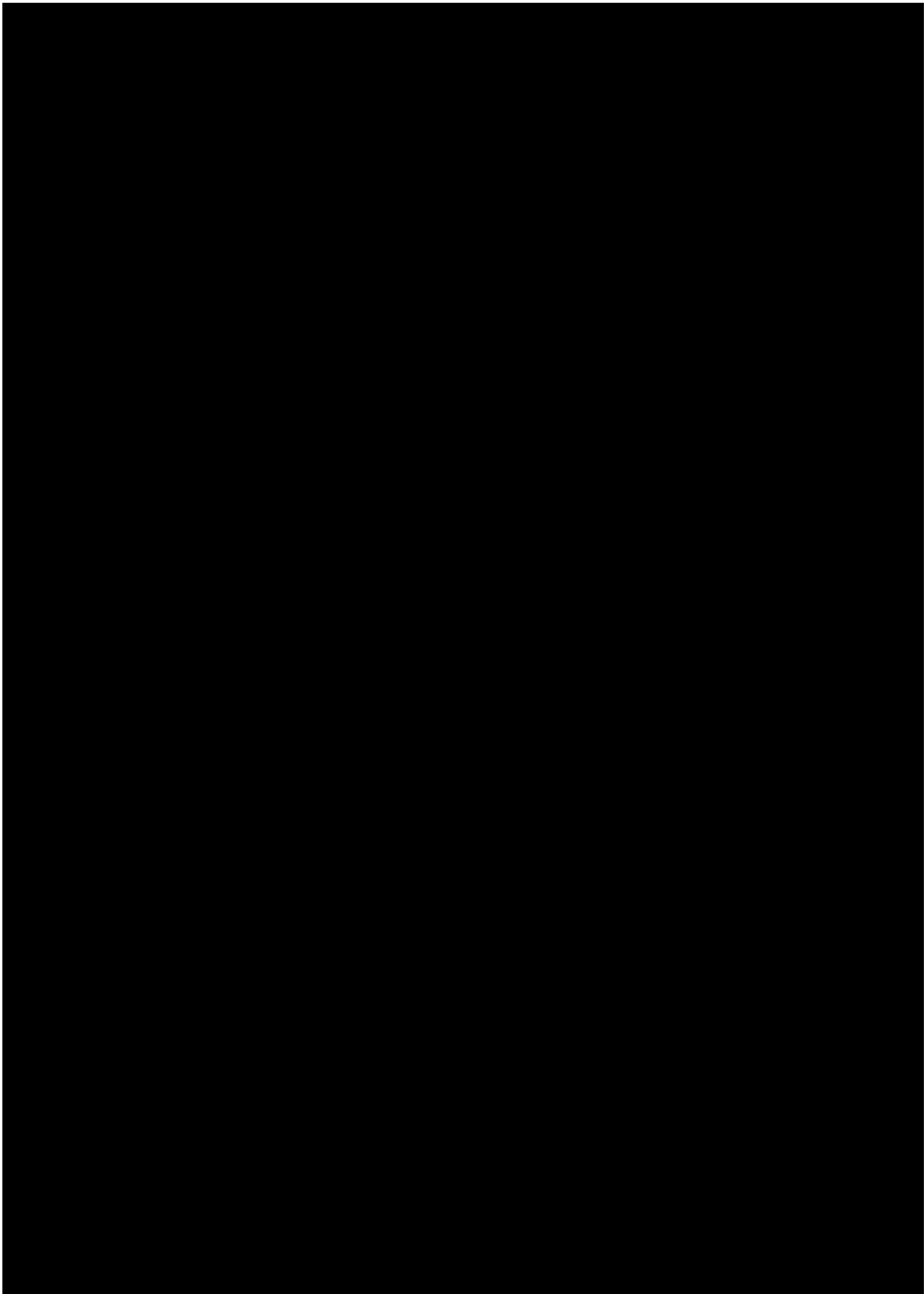


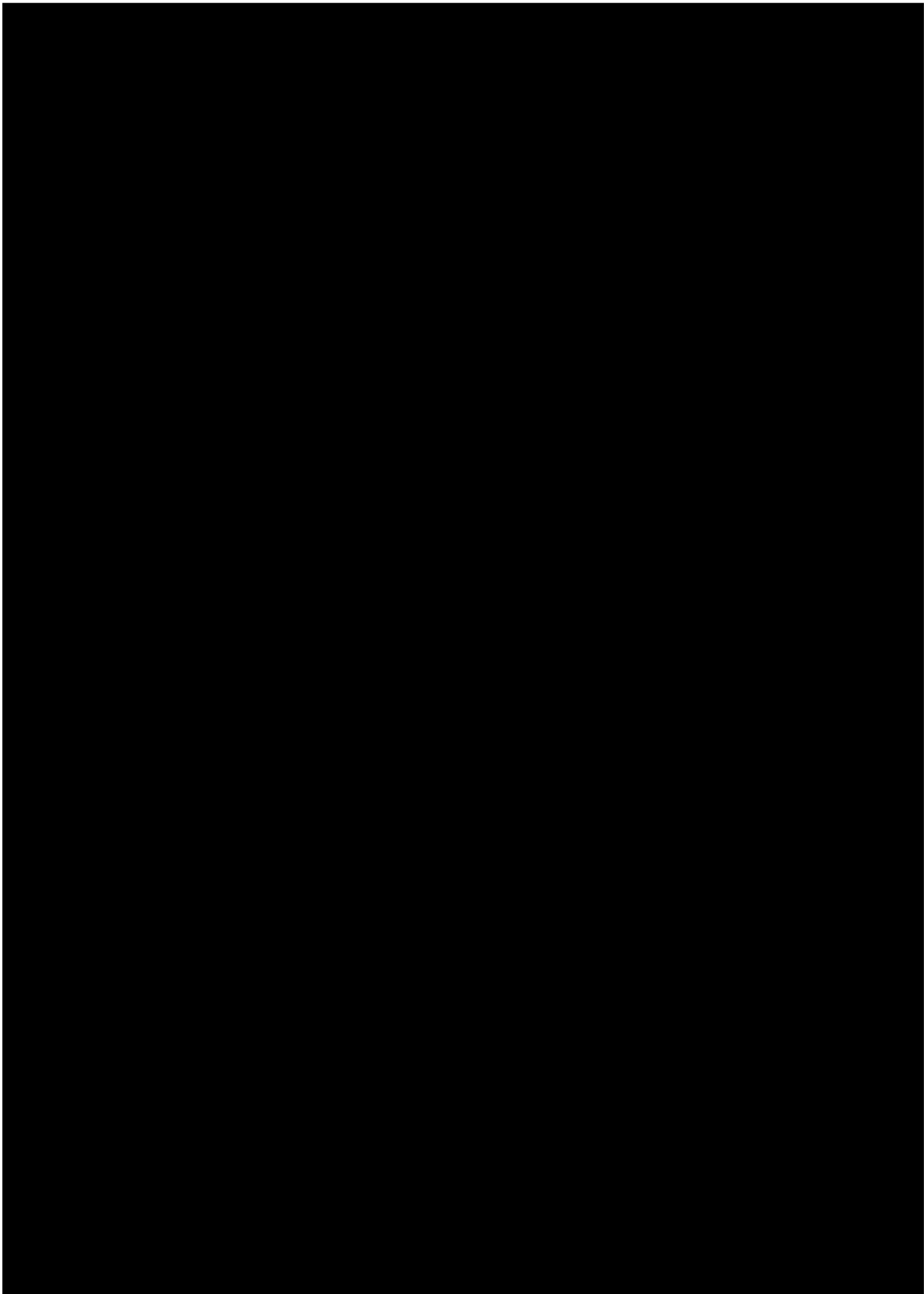


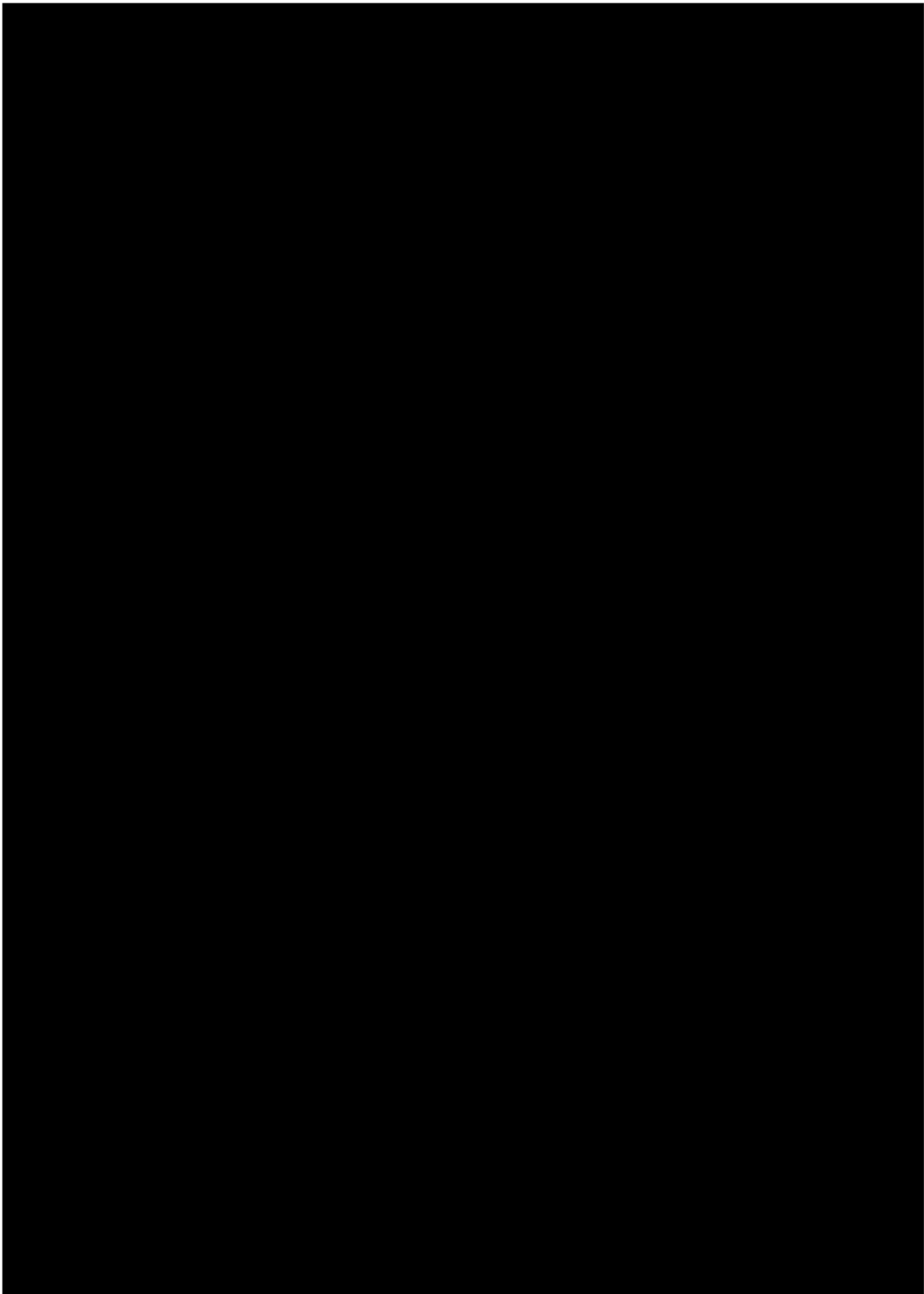


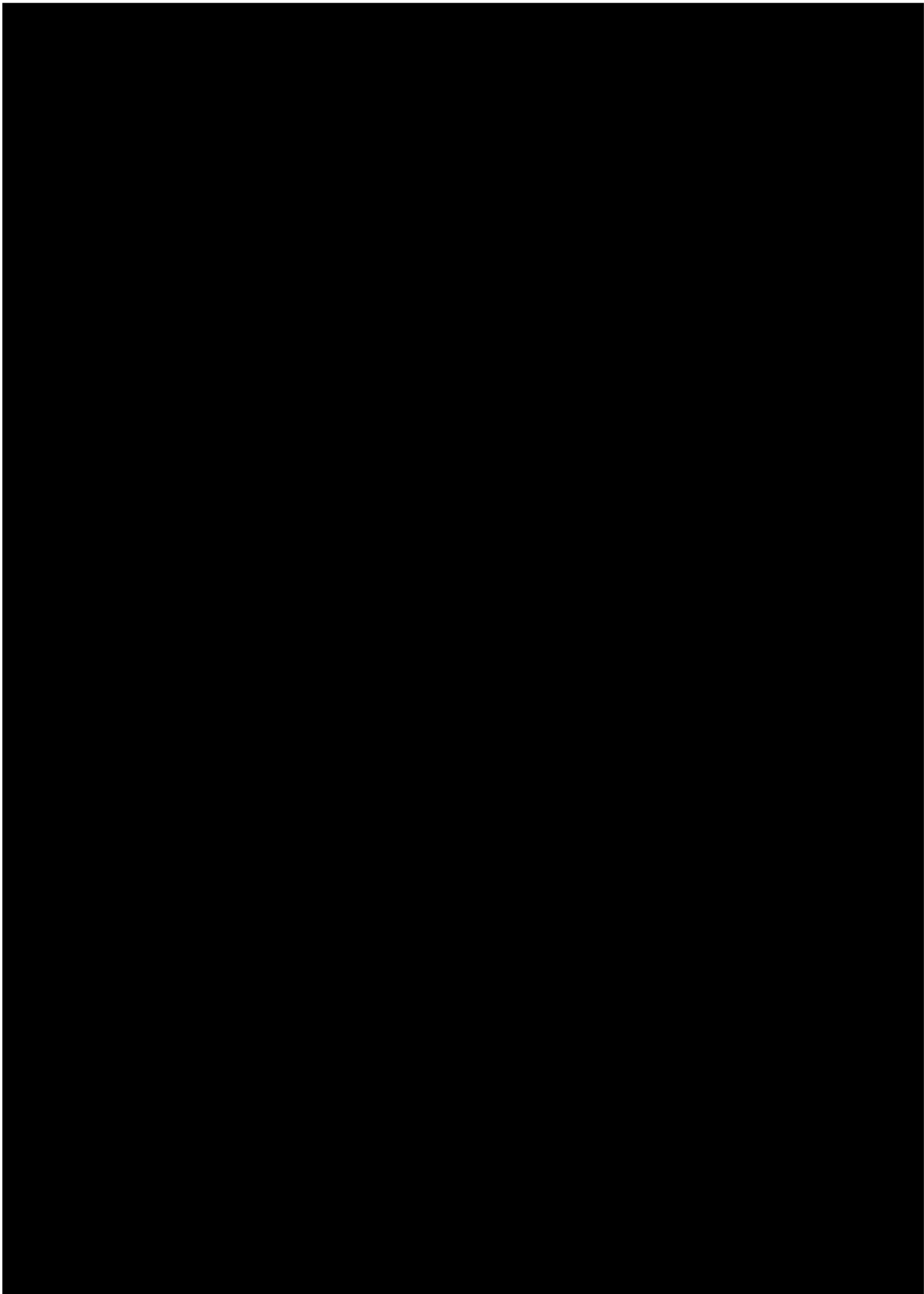


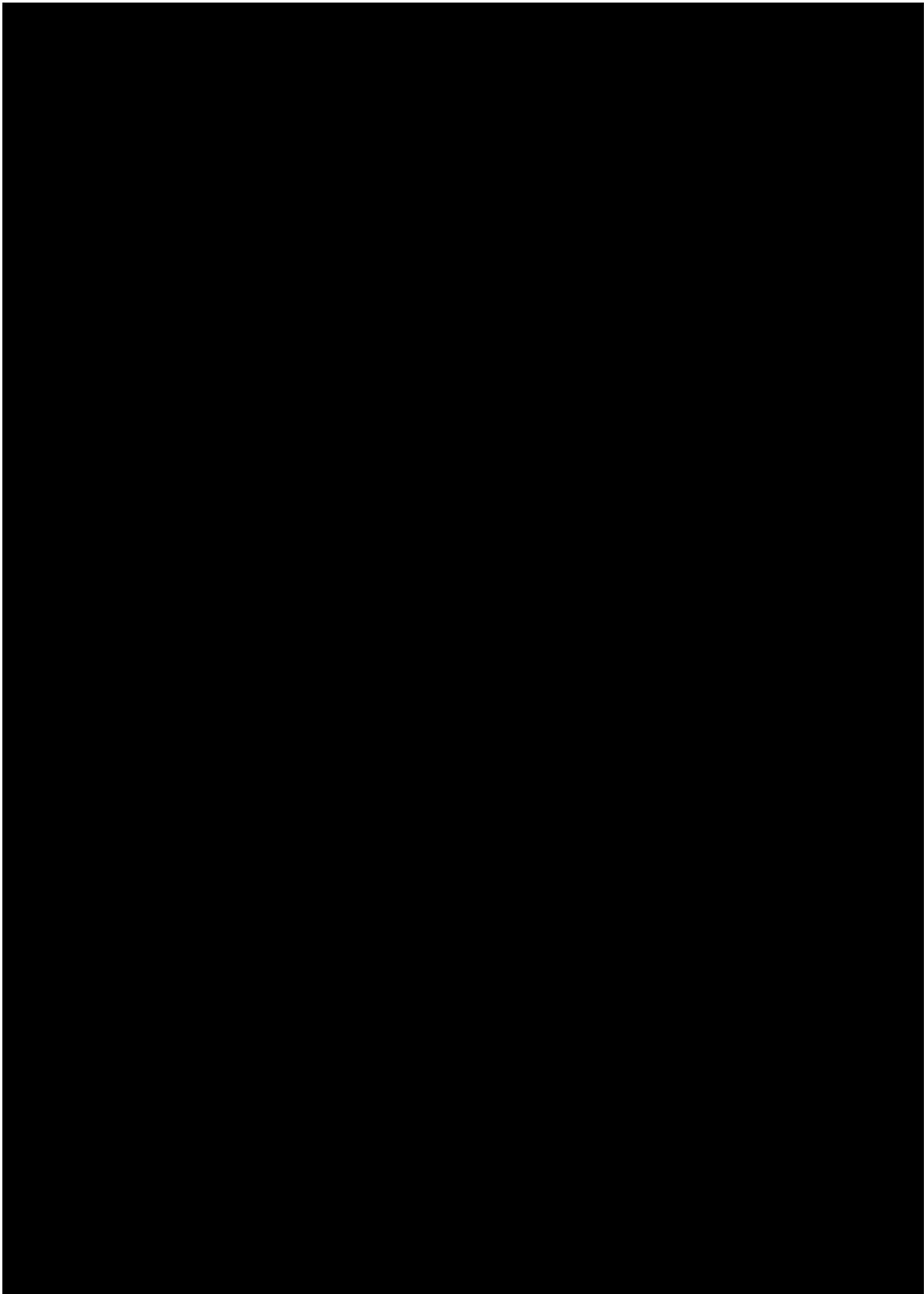


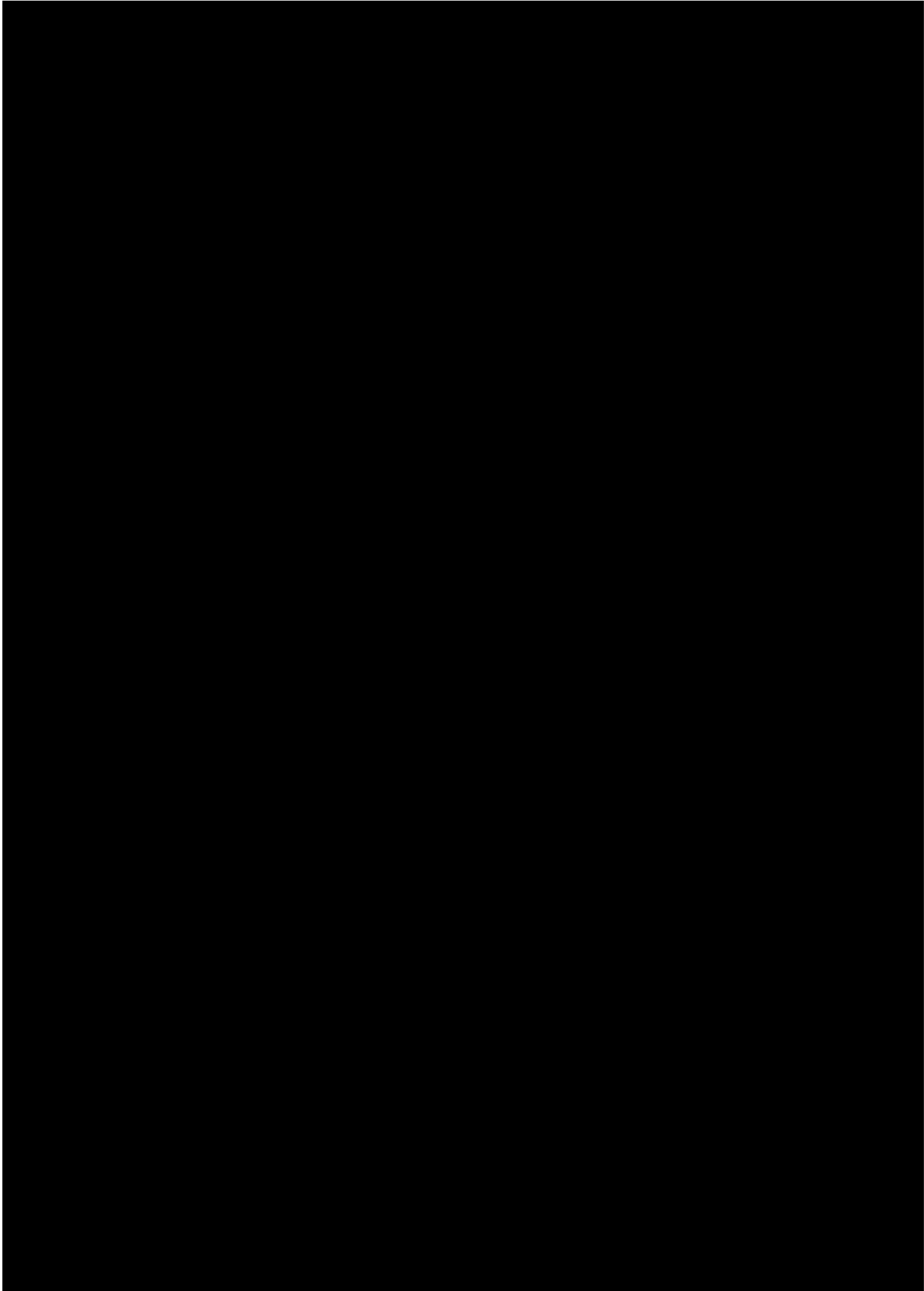


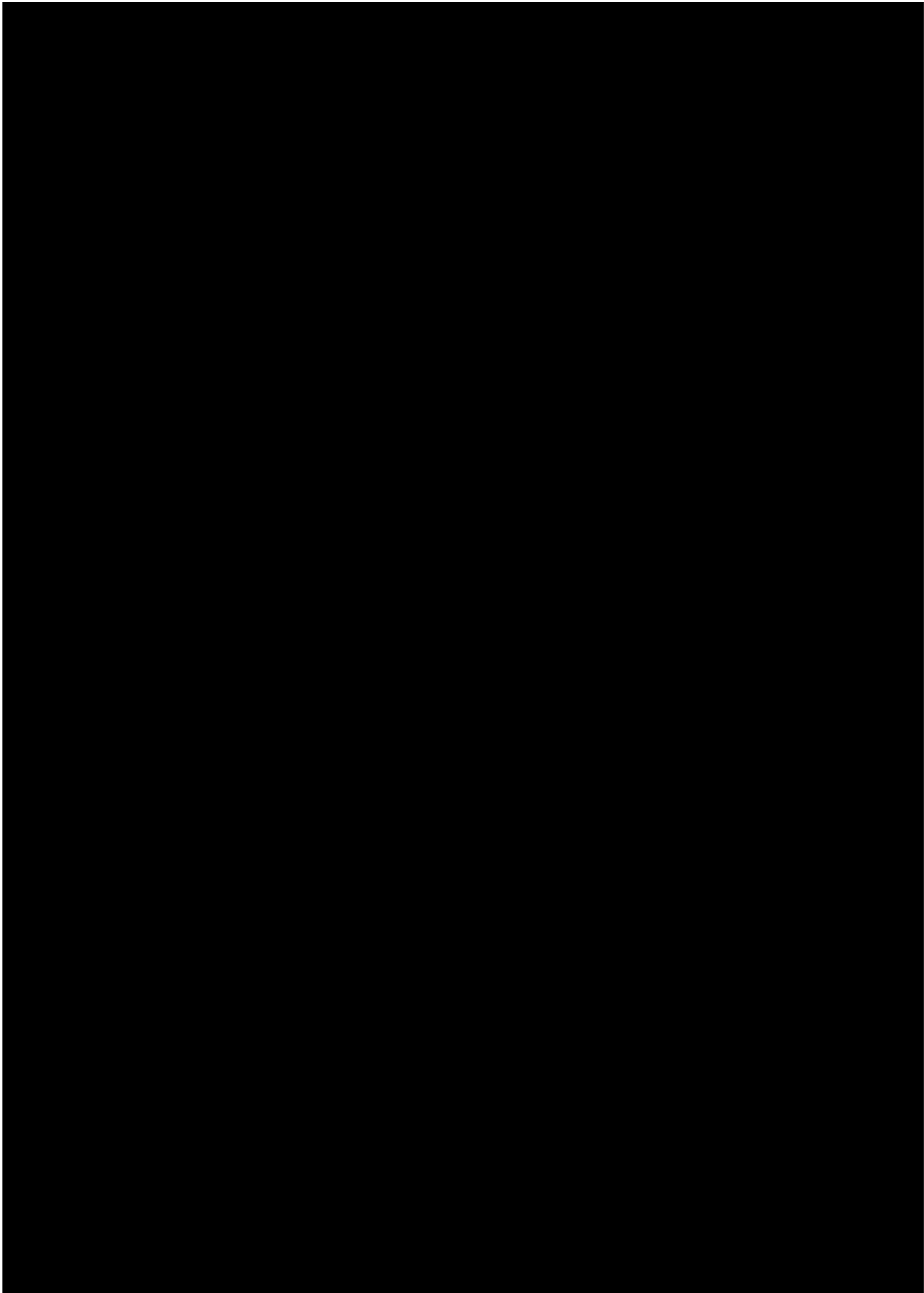


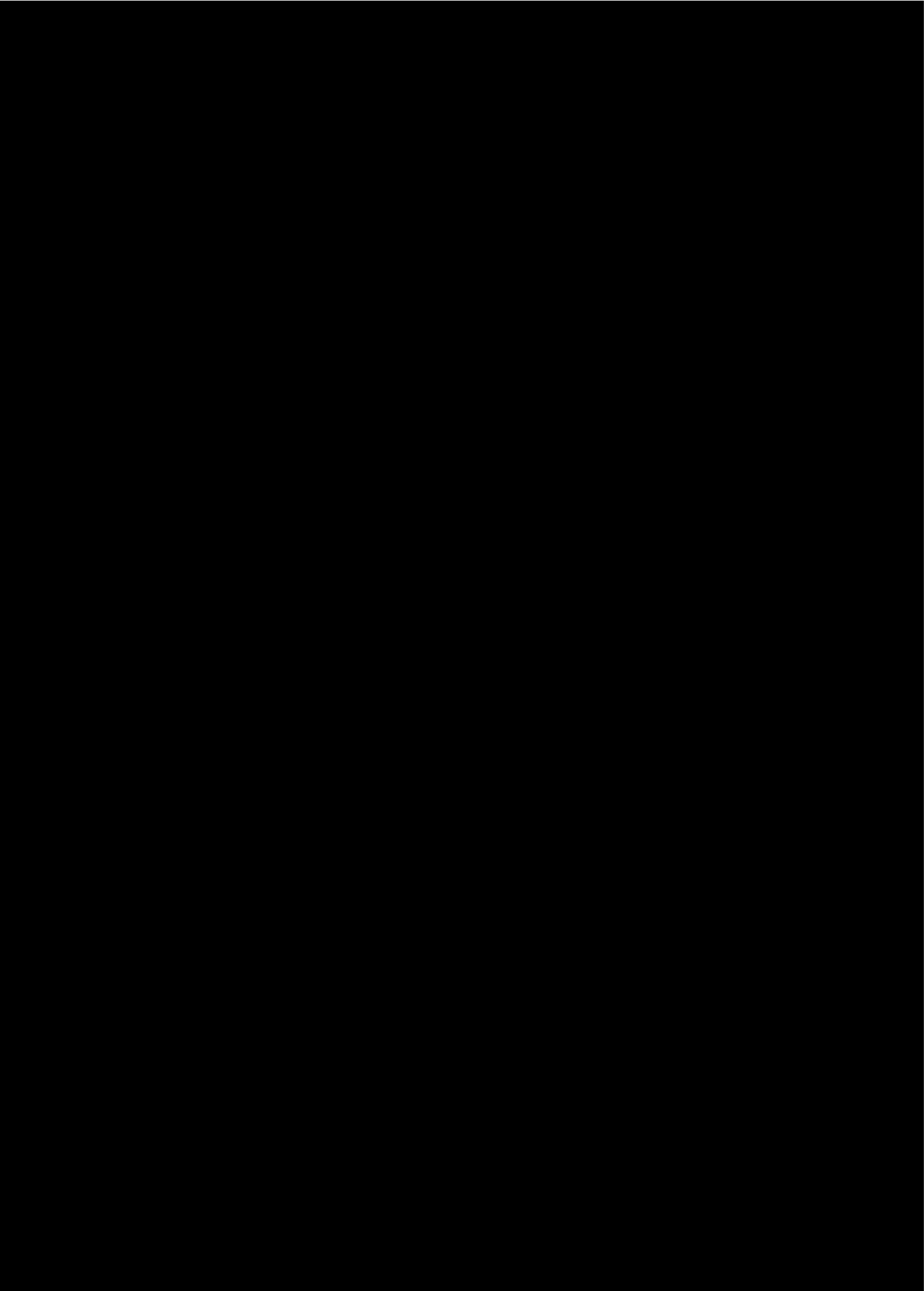


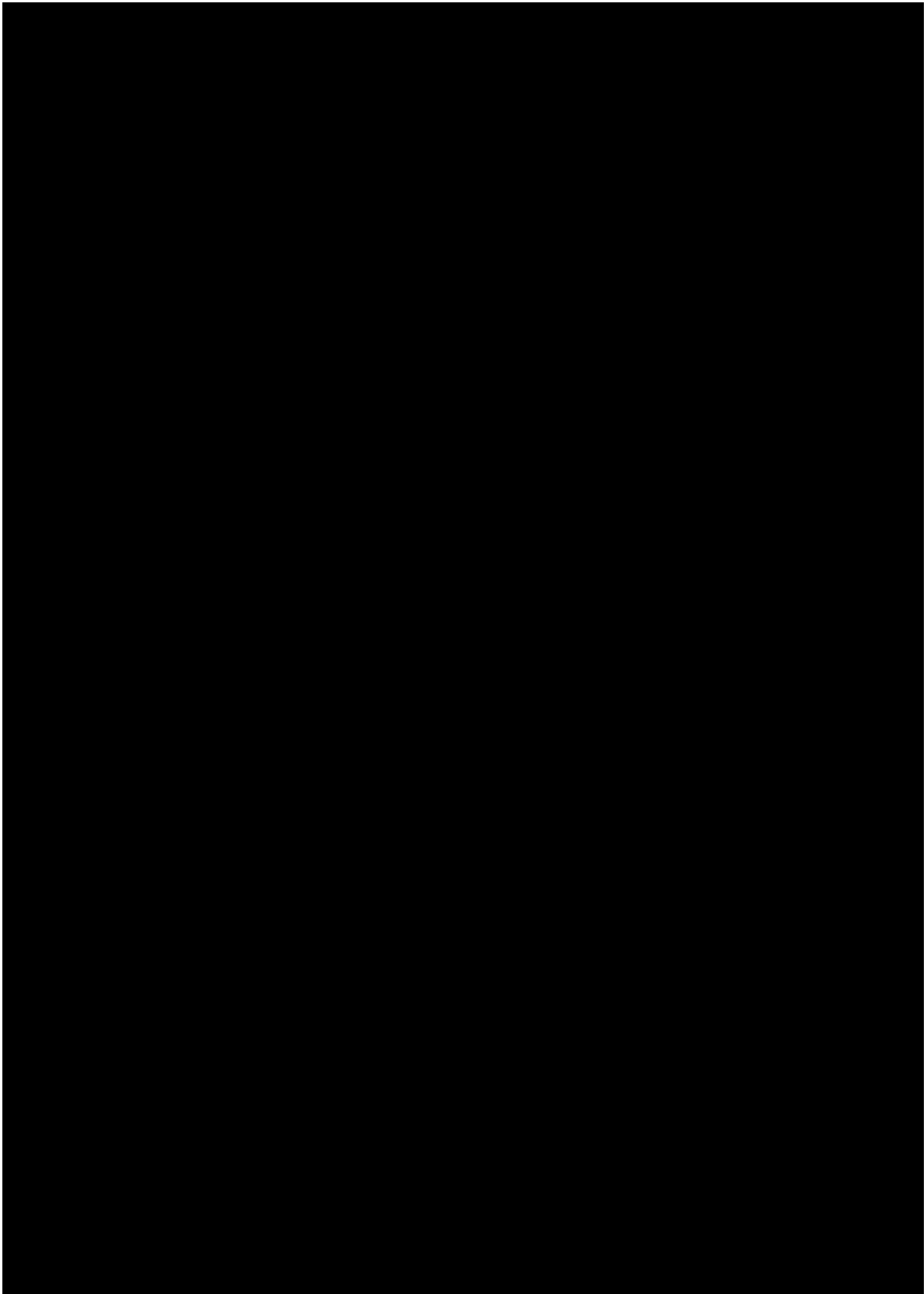


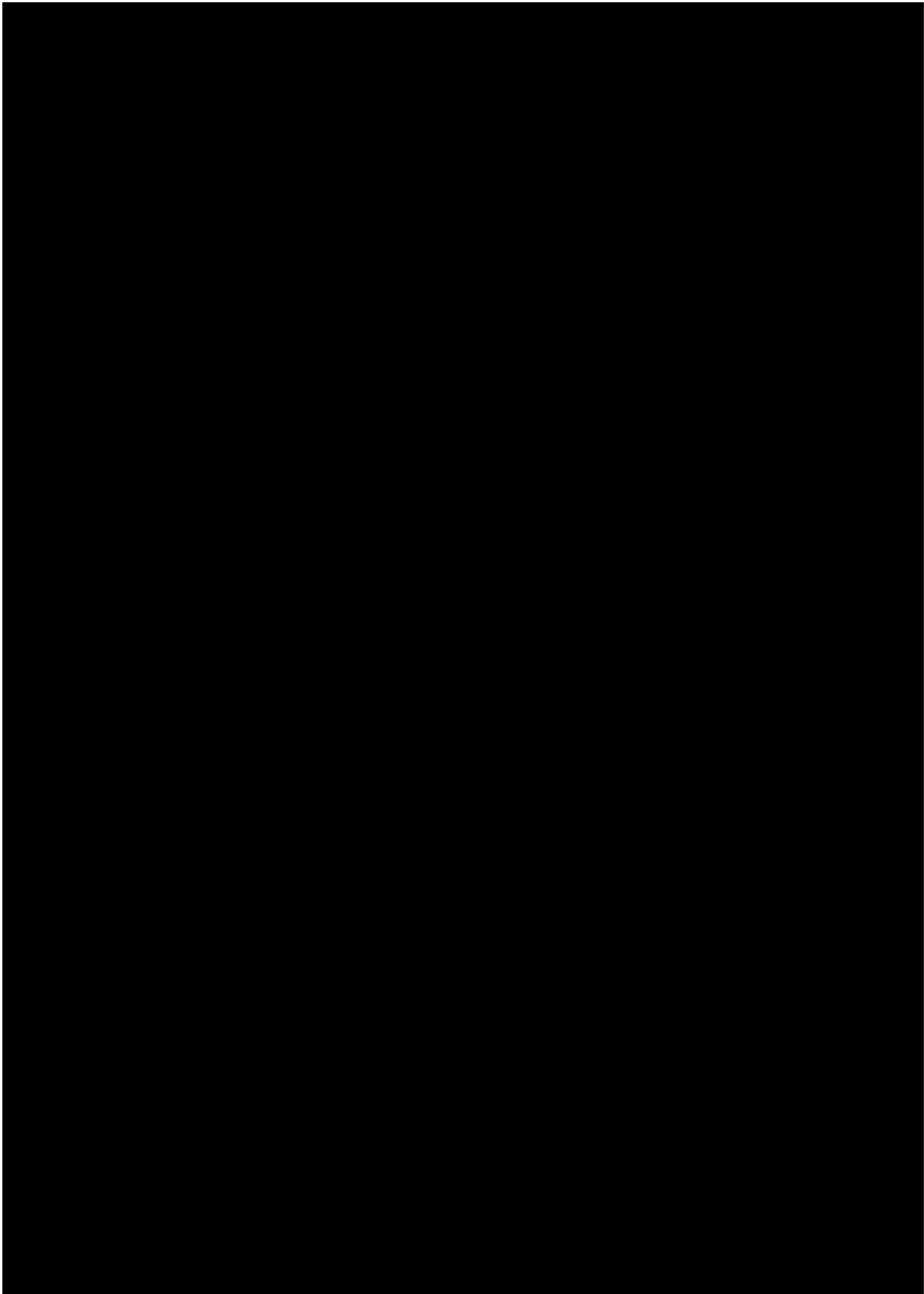


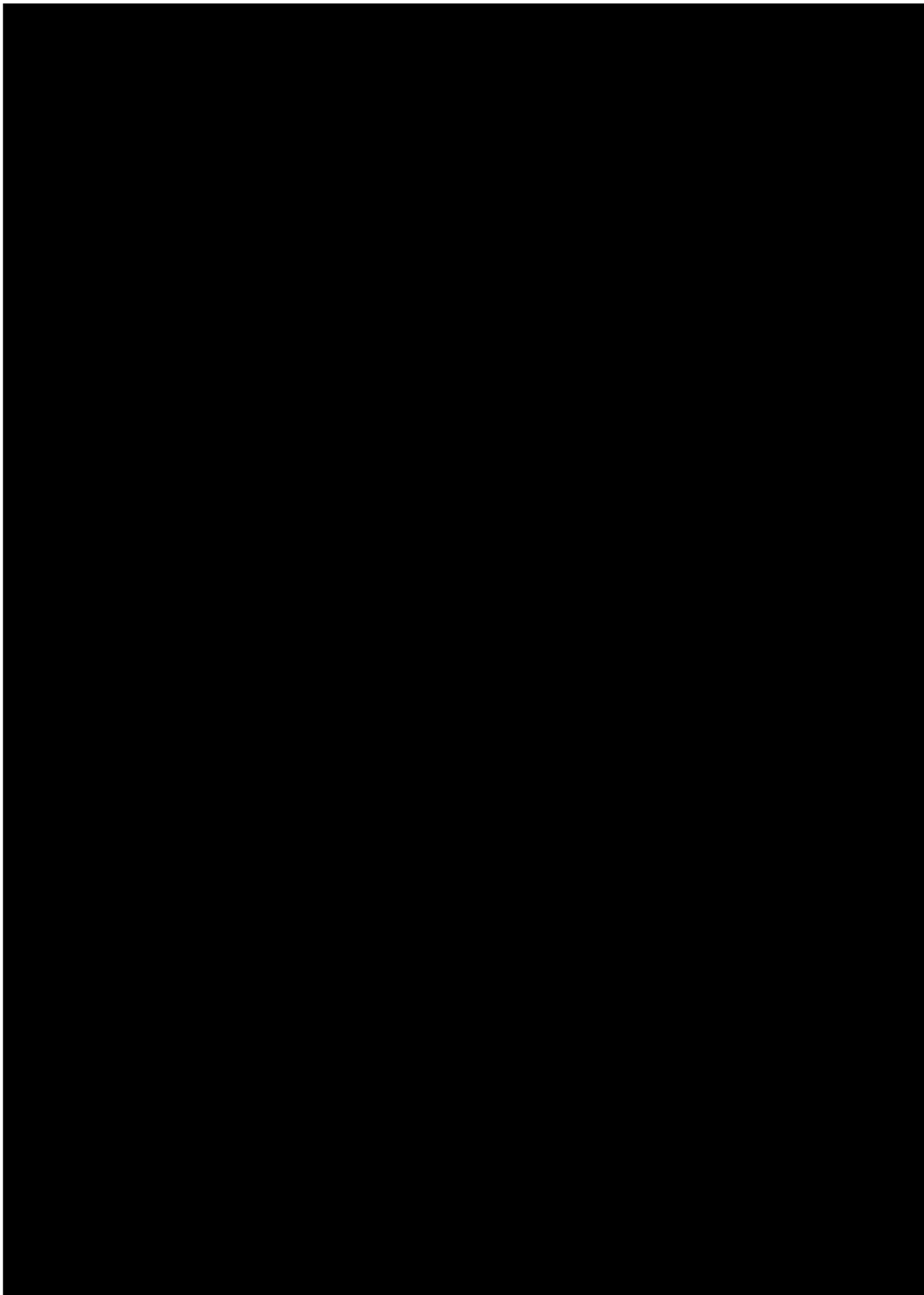










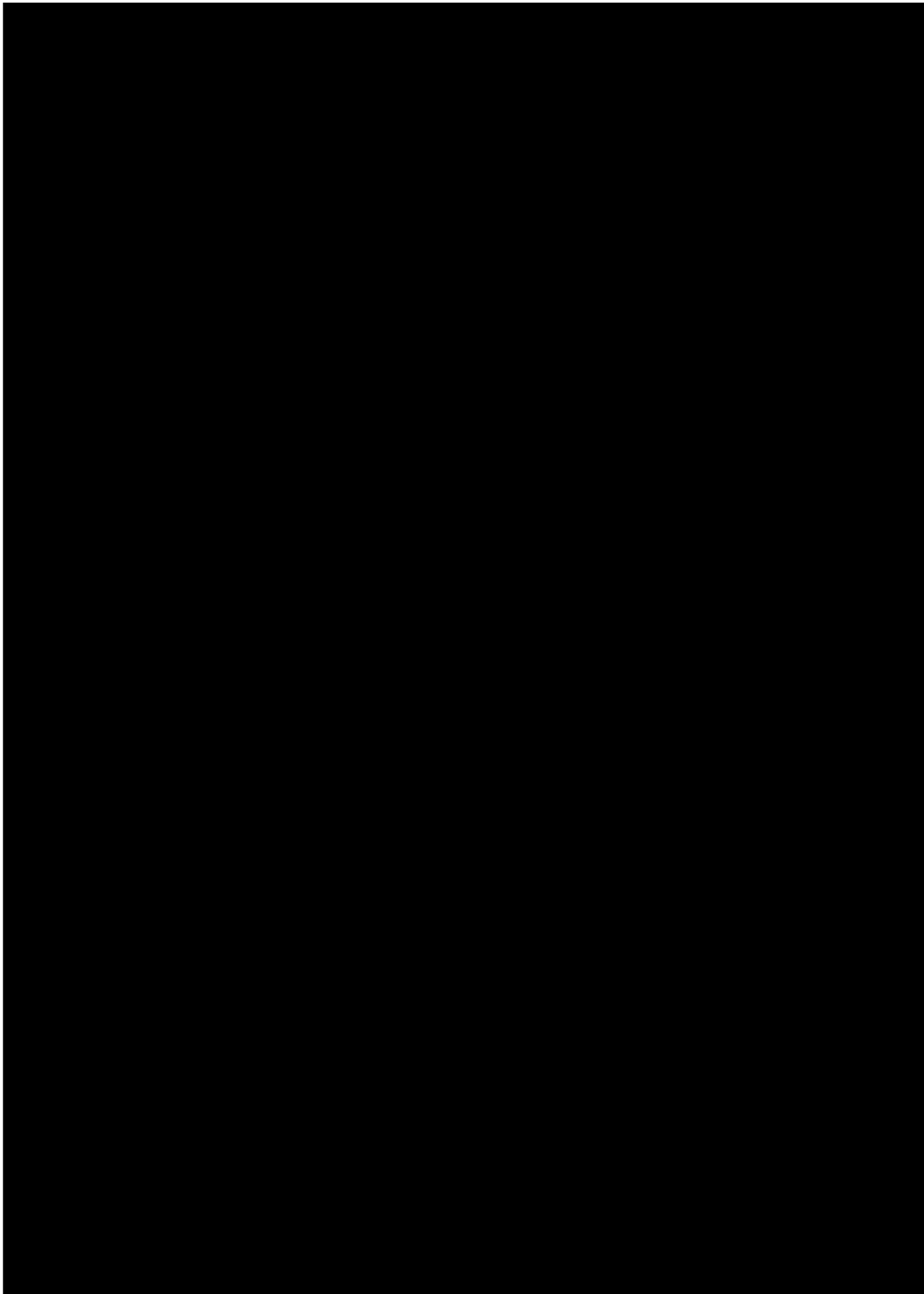


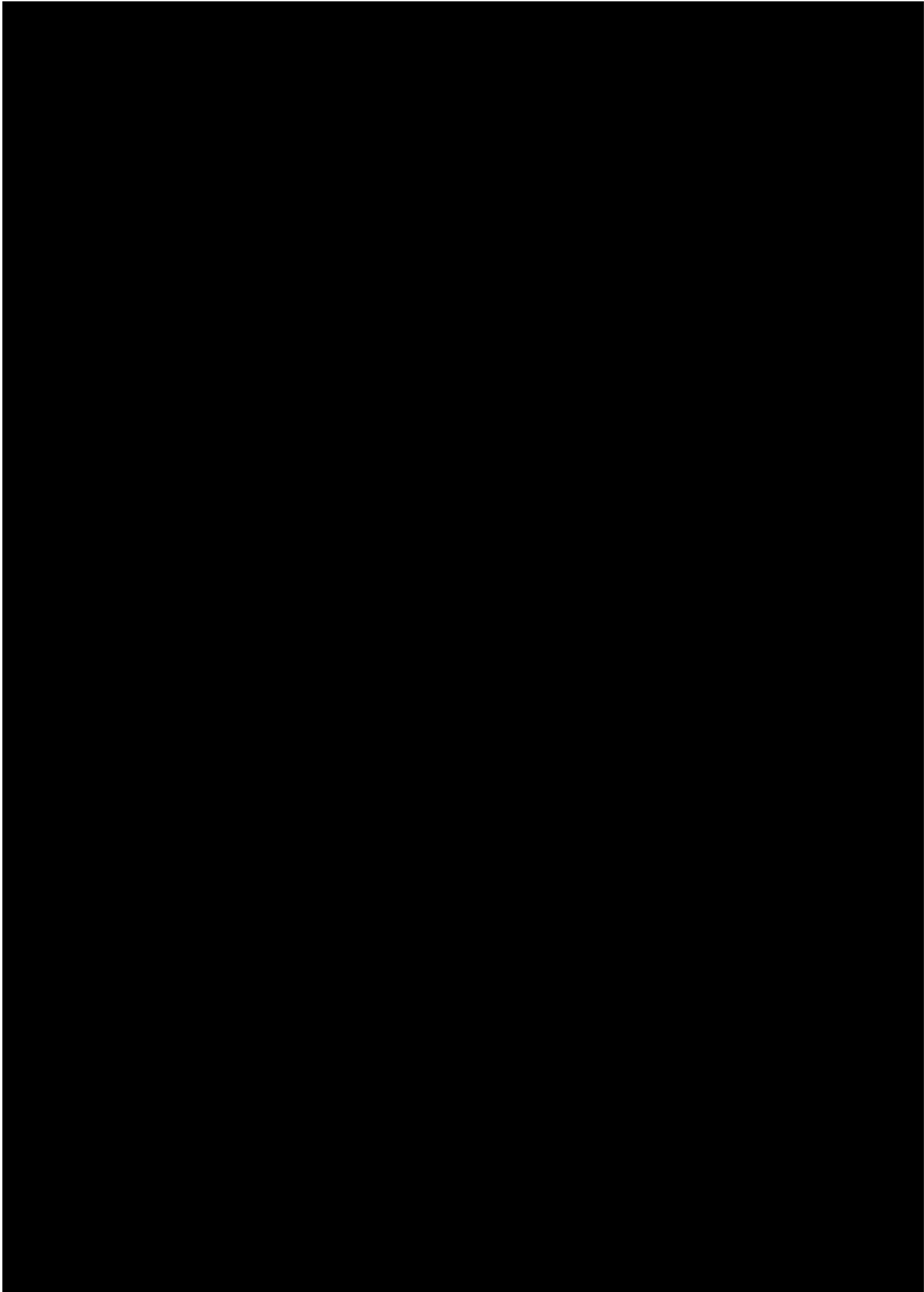
Section C: Combined Case Study and Process Report

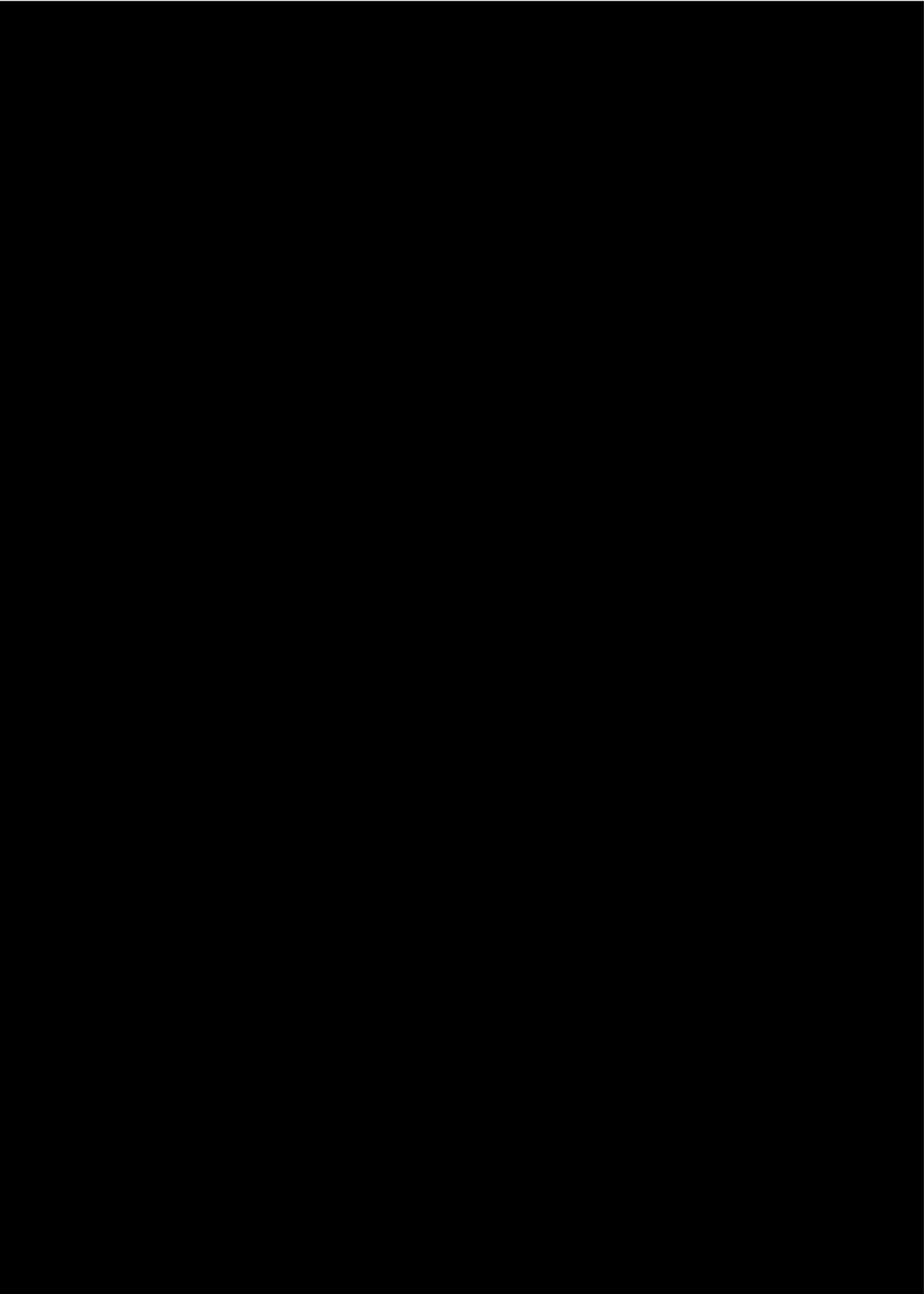
The Cyclical Relationship Between the Spiritual and the Mental

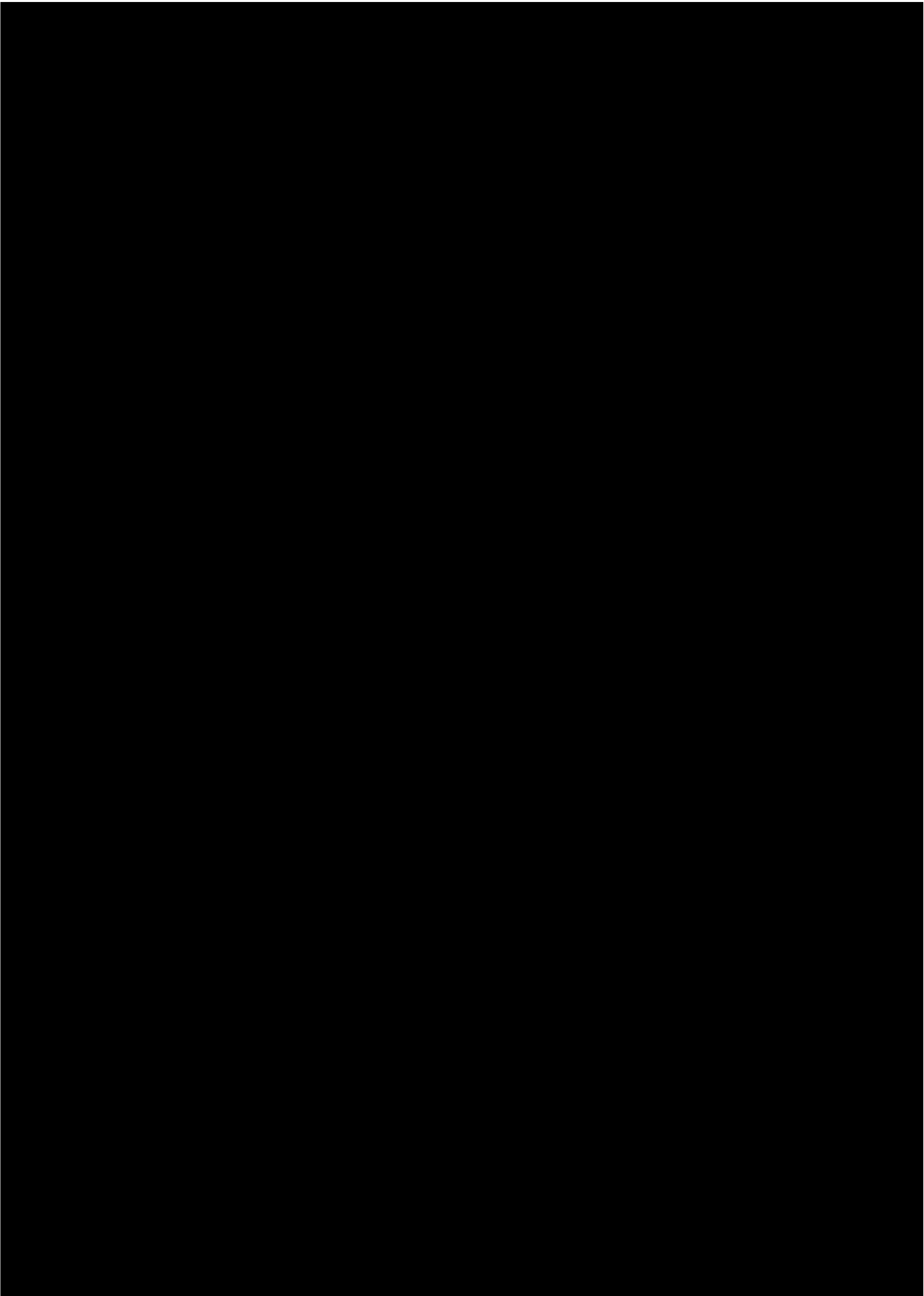
A CBT & Systemic Assimilative Integration

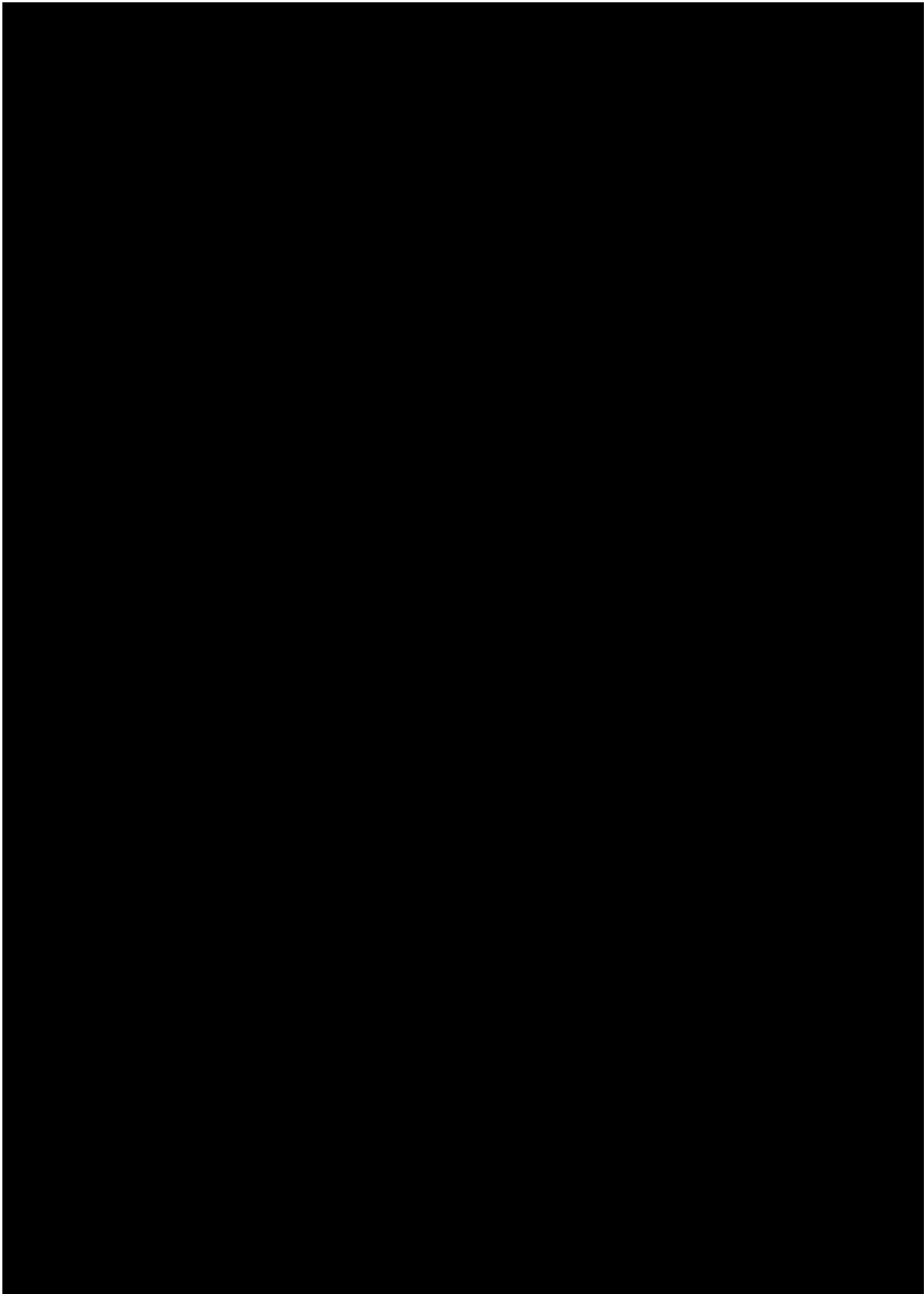
Nikita Fofie

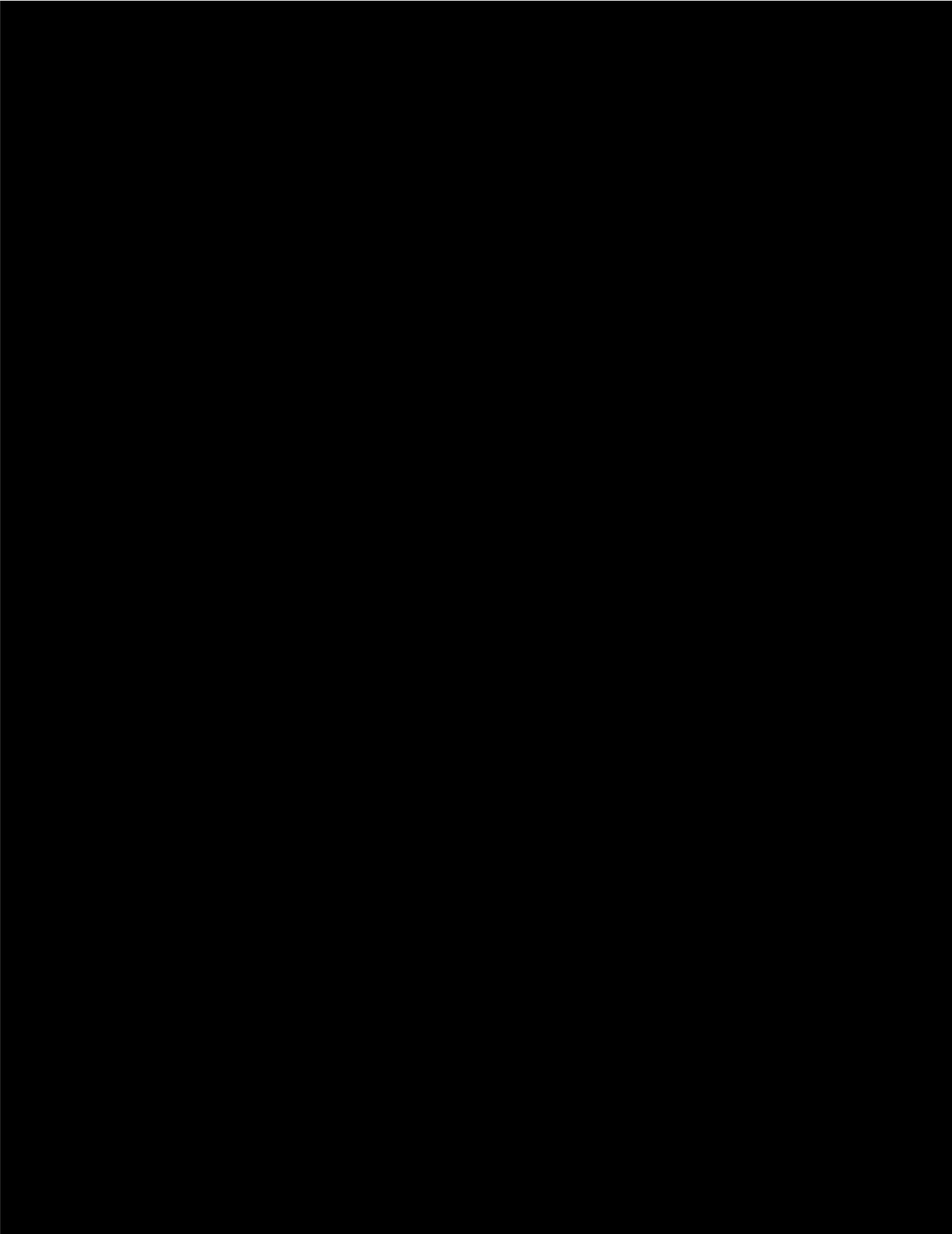


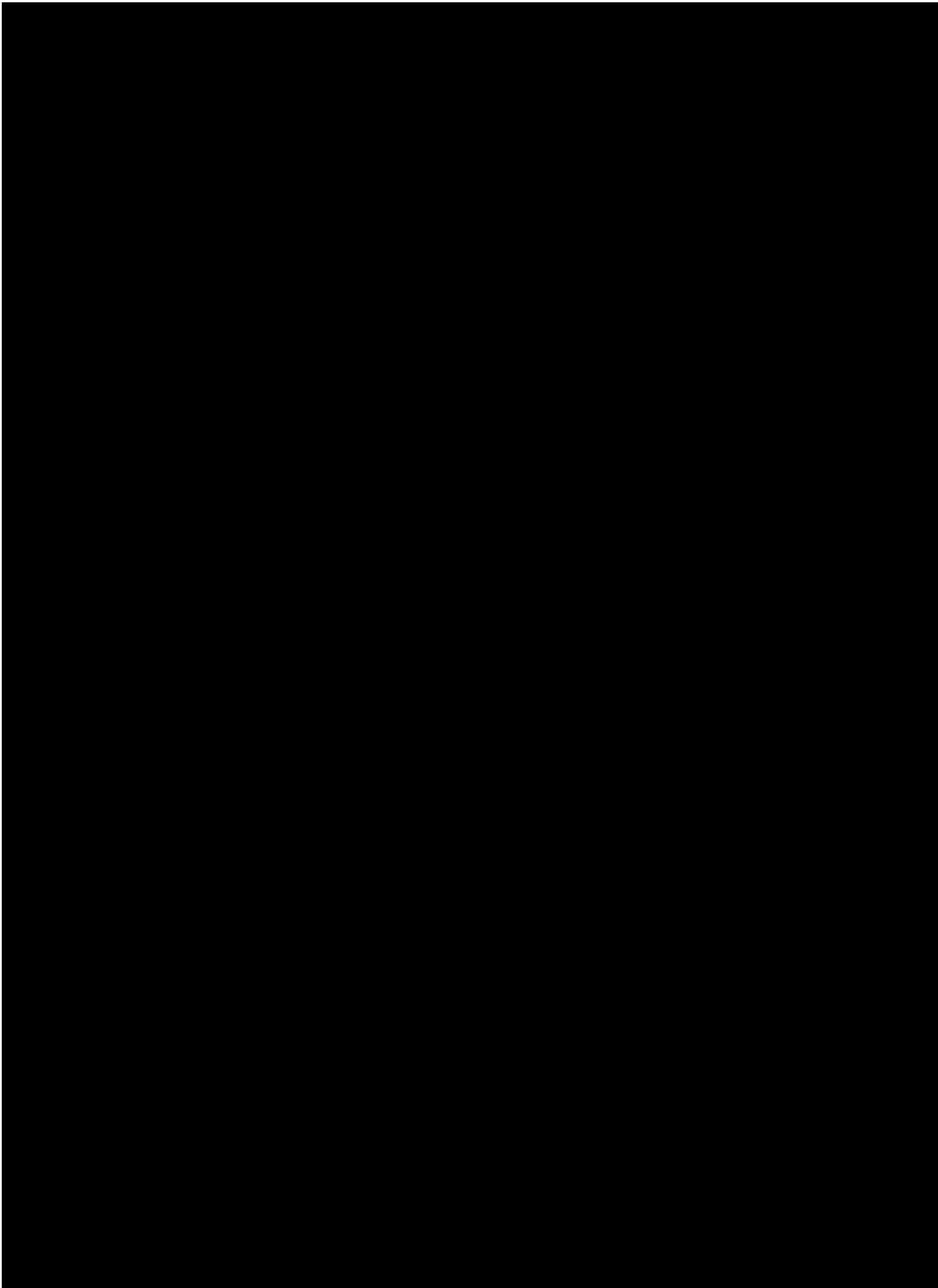












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