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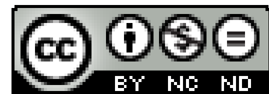

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OXFORD DOCTORAL COURSE IN CLINICAL PSYCHOLOGY

Exploring the theoretical and empirical foundations of a 'radical normalisation' approach to psychosis

Charles Heriot-Maitland

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requirements of the degree of Doctor of Clinical Psychology,
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Exploring the theoretical and empirical foundations of a ‘radical normalisation’ approach to psychosis

Abstract

Normalising psychotic phenomena is considered to be a useful tool in psychological interventions for psychosis as it reduces stigmatisation, improves therapeutic alliance, combats distress, and entails greater hope for recovery. However, while the usefulness of normalisation is acknowledged, there still remains the mainstream clinical view that psychotic experiences are the manifestations of abnormal brain function. Recently, this view has come under scrutiny with growing evidence for psychotic-like experiences in the ‘normal’ (non-clinical) population. Following these findings, the current thesis explores the case for developing a *radical normalisation* approach to psychosis, which goes beyond just clinical usefulness, and instead places psychotic experience within the realm of normal brain function. This exploration is comprised of both a theoretical and empirical component. The theoretical paper reviews multi-level models of information processing, and applies a multi-level framework to formulating core psychotic phenomena. The suggestion is that by illustrating the actions of different levels of processing, this formulation draws attention to the genuine emotional meaning of psychotic experiences; i.e. those aspects which are functional, healthy, and equivalent to the experiences of the non-clinical population. The empirical study approaches these explorative questions from a different angle by directly comparing the psychotic-like experiences of clinical and non-clinical participants. Twelve participants, six in each group, are interviewed about their initial psychotic-like ‘out-of-the-ordinary’ experience (OOE), and their data are analysed using the qualitative method of Interpretative Phenomenological Analysis (IPA). Inter-group comparisons of emergent themes reveal similarities in both contextual triggers and subjective nature of OOEs, but differences in the way these experiences are then incorporated in their personal and social contexts. This suggests that psychotic-like OOEs, themselves, do not determine the development of a clinical psychotic condition, and might therefore be recognised, both theoretically and clinically, as normal and meaningful aspects of psychological functioning.

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Paper A

Multi-level models of information processing, and their application to psychosis

Abstract

Multi-level models have been developed to illustrate the mind's processing of qualitatively different types of information, and therefore provide a useful tool for exploring the actions and interactions of different processing levels within a single theoretical framework. This paper firstly reviews a selection of multi-level models, and then constructs a detailed rationale for applying a multi-level framework to psychosis. The argument draws on a wide psychosis literature, in the areas of positive symptoms, subjective phenomena, risk factors, and cognitive phenomena. In doing so, the discussion highlights some limitations of current (single-level) cognitive models of psychosis, and argues that a multi-level framework not only offers enhanced explanatory power, but also facilitates an integration of the evidence accumulated in different areas of psychosis research. Implications of a multi-level approach are discussed with regards to understanding the 'psychotic-like' experiences of both clinical and non-clinical populations. In particular, the roles of emotional meaning and function of psychotic phenomena are emphasised, and the clinical therapeutic tenet of normalisation is encouraged.

Keywords

Psychosis; cognitive theory; multi-level; information processing

1. Introduction

All human experience comprises a complex combination of cognitive, emotional, biological and behavioural systems, and the history of mental health treatment has seen various shifts in focus between each system as a primary target for clinical intervention. Beck, who pioneered cognitive approaches to therapy (Beck, 1976), regarded the cognitive system as primary in that it "accounts for the functions involved in information processing and assignment of meanings" (Beck, 1997, p5). He suggested that each emotional state has a specific cognitive profile, and that because of its primary organising function, the modification of cognition is necessary for therapeutic change. Because Beck considered the cognitive system to be the mind's sole representation of meaning, cognitive therapy has typically encouraged a direct clinical focus on a single level of information processing, i.e. the cognitive level of thoughts, assumptions and beliefs.

Since its establishment as an effective treatment for depression and anxiety disorders, cognitive therapy has enjoyed considerable research interest, and has been adapted for use with a variety of mental health conditions. The umbrella-term, CBT (cognitive behavioural therapy), is now used to describe any psychological therapy that deals with the influence of thoughts, beliefs, and behaviours upon a negative emotional state. CBT has been demonstrated as effective through numerous research trials, and is consistently recommended as a treatment of choice in the NICE guidelines for mental health (e.g. NICE, 2004a & b; 2009).

Despite its wide usage and evidence base, the cognitive approach has still had its share of criticism. In particular, there is concern over its clinical emphasis on a single level of processing, and attention has been drawn to apparent clashes between different levels of meaning (e.g. the experience of *knowing* there is nothing to be frightened of, but nevertheless *feeling* frightened). Beck addressed some constraints of his original linear model by introducing the idea of "modes", which provide a higher-order organisational structure for distinct cognitive, affective, behavioural, and motivational schema (Beck, 1997). Although this marks a move away from the simplistic assertion that cognition causes emotion, in most CBT practice, there still remains the principle that emotional change is achieved through modifying cognition. The primary status of cognition is also reflected in the CBT research, where emotion is often relegated to dependent variable status (Mennin, 2006).

It is worth noting that questions over the relationship between cognition and emotion have been the source of much debate in scientific psychology: In particular, the so-called Zajonc-Lazarus debate is centred on whether affect or cognition is primary in the generation of emotion (Power & Dalgleish, 2008). To summarise, Zajonc (1980) promotes the primacy of affect, citing observations that some affective judgements are independent of cognitive operations: "we can like something or be afraid of it before we know what it is" (Zajonc, 1980, p 154). Lazarus (1984), however, favoured cognitive primacy, arguing that no emotion can arise without a cognitive appraisal attributing self-referential meaning to a situation.

This debate is now more commonly viewed as a semantic controversy over the definition of *cognition* (Leventhal & Scherer, 1987), in particular, whether the term should apply to *all* levels of meaning, including automatic, emotional ‘judgements’. Greenberg (2004) points out that at the start of the cognitive revolution, cognition used only to refer to thoughts that were accessible to consciousness, but has now “become so all encompassing as to become almost meaningless” (p 1). He argues that because cognition has now been used to refer to all information processing (including unconscious, preverbal or perceptual), it has become increasingly difficult to investigate the relationship between emotion and cognition.

The term *multi-level* (e.g. Leventhal & Sherer, 1987; Jones, 2001) has been used to describe cognitive models that incorporate the operations of at least two qualitatively different processing systems within one theoretical framework. Multi-level models therefore allow for the investigation of relationships and interactions between these systems without getting caught up with contentious definitions. Several multi-level theories have been proposed, and while each differs in focus and detail, what they all have in common is a fundamental contrast between a more rational, verbal, propositional processing system, without links to emotion, and a more holistic, automatic, rapid processing system, with extensive links to emotion.

This paper will firstly review three models, and extract from them a distinct multi-level framework to be used for the remainder of the discussion. It will then construct a rationale for applying this framework to psychosis, and finally discuss implications for understanding psychotic phenomena in clinical and non-clinical populations.

2. Multi-level models of information processing

It is beyond the scope of this paper to conduct a comprehensive review of all the multi-level literature, and therefore Table 1 contains a reference list for further reading on the major theoretical works that could be classed as multi-level.

Table 1
Multi-level references

Author(s)	**Model**
Brewin (1989)	Dual representation theory (DRT)
Epstein (1994)	Cognitive-experiential self theory
Johnson & Multhaup (1992)	Multiple entry memory system (MEMS)
Le Doux (1993)	Neurological model of different processing routes
Leventhal (1982)	Perceptual motor theory of emotion
Linehan (1993)	Reasonable mind and emotion mind
Philippot, Baeyens, Douilliez & Francart (2004)	Dual memory model (DMM)
Power & Dalgleish (1997)	Schematic, propositional, associative, and analogical representation systems (SPAARS)
Smith & Kirby (2000)	Process model of emotion elicitation
Teasdale & Barnard (1993)	Interacting cognitive subsystems (ICS)
Wells & Matthews (1996)	Self-regulatory executive function (S-REF) model

For the current purposes, three multi-level models will be reviewed: perceptual motor theory (Leventhal, 1982); ICS (Teasdale & Barnard, 1993); and SPAARS (Power & Dalgleish, 1997). The reason for selecting these is that Leventhal can be regarded

as pioneering the multi-level approach, and only ICS and SPAARS from Table 1 have been specifically applied in the psychosis literature. Also, between them, these theories cover all the key features of multi-level modelling that are required for bringing together different aspects of psychosis under one multi-level framework.

2.1. Perceptual motor theory

The perceptual motor theory (Leventhal, 1982; Leventhal & Scherer, 1987) proposes three levels of information processing: *sensory-motor*, *schematic*, and *conceptual*. The sensory-motor level is an innate processing system, which generates, from birth, simple (motor-based) emotions and motor reactions in response to environmental stimuli. These emotional states are not linked to any memories, conceptions, or expectations, and are therefore analogous to reflex reactions. The schematic and conceptual levels, which develop later on, are memory-based processing systems that incorporate learning into emotional life. These two systems differ from each other in the way memories are abstracted and stored.

Leventhal (1982) suggests that schematic memories (or schemata) are formed by linking the repeated experience of an emotion with the perception of its associated environmental stimuli and motor responses. Because schematic-level processing "integrates sensory-motor processes with image-like prototypes of emotional situations" (Leventhal & Scherer, 1987, p10), the schemata are essentially concrete representations of the perceptual, motor, and subjective sensations linked to an emotional episode. However, they do become more abstract over time by an averaging of different stimulus and response conditions associated with the

emotion. Because no conscious reasoning is required for one element of a schema to activate its associated elements, schematic-level processing is rapid and automatic.

This is in contrast to conceptual-level processing, which involves conscious reflection on emotional experience. As the conceptual system contains propositional memories *about* (rather than *of*) the emotional episode (Leventhal, 1982, p 827), it is more abstract than the schematic system, and can draw conclusions across a number of emotional episodes. The conceptual system can be used to talk about emotions, to deliberately evoke emotions by accessing the schemata, and it also provides a longer-term temporal framework for emotional episodes; i.e. in relation their antecedents and consequences (Leventhal & Scherer, 1987).

2.2. ICS

The ICS model (Barnard, 1985; Barnard & Teasdale, 1991; Teasdale & Barnard, 1993) proposes nine interacting cognitive subsystems, which each operate on a particular kind of mental representation or code, and store records of this information. The important subsystems for understanding cognition-emotion interactions are those which represent the two different levels of meaning: *propositional* and *implicational*. The essence of this distinction is between "knowing with the head (propositional) and knowing with the heart (implicational)" (Barnard & Teasdale, 1991, p 24).

Propositional codes represent specific meanings based on conceptual processing, which can be expressed verbally, and have a truth value that can be tested and verified with evidence. Implicational codes, however, represent a more general,

holistic, non-verbal meaning, which is linked to emotion, and cannot be evaluated as true or false in the same way. Patterns of implicational code are schematic, in that they represent a high-level synthesis of different features of experience: “constituents derived from the external world, the internal world of the body, and the conceptual world of meaning” (Teasdale & Barnard, 1993, p 66). By integrating information from these different sources, the so called, *implicational schematic models* comprise a more generic, implicit meaning. Whereas propositional meanings refer to aspects of the self-as-object, implicational meanings are said to be associated with different experiences of the self-as-subject (Teasdale, 1997, p 146).

On the face of it, the ICS propositional and implicational systems seem to correspond fairly closely to Leventhal’s (1982) conceptual and schematic systems. However, one major difference lies in the idea that implicational schematic models in ICS incorporate elements of conceptual meaning from the propositional level, whereas Leventhal’s schematic level specifically “does not require the participation of more abstract, conceptual-level processing” (Leventhal & Scherer, 1987, p10). In addition, ICS does not appear to account for the early development of schematic models, i.e. how the emotion was elicited in the first place when the affect-related schematic models were being formed. In perceptual motor theory, the sensory-motor level provides an innate reflex system, from which schemata are subsequently formed.

2.3. SPAARS

In the SPAARS model, Power & Dalgleish (2008) argue that Leventhal’s conceptual level is “too verbally based” (p93), and would therefore not be dissimilar to Beck’s

cognitive schema, i.e. “no more than collections of (propositional) beliefs” (p108). Instead, they highlight the need for a structure that can represent higher-order ideational content, which integrates information from verbal and non-verbal sources. SPAARS therefore describes a *schematic model* system which resembles the ICS implicational subsystem. Similar to ICS, the schematic models receive input from a *propositional* representation system of ideas, beliefs and concepts; however, in SPAARS, it also receives information from an *analogical* representation system, which consists of visual, olfactory, gustatory, proprioceptive, tactile and auditory images. It is these analogical representations which give schematic models a higher-level quality of meaning to that of verbally expressible propositional concepts.

The fourth and final representation system proposed in SPAARS is an *associative* system, which represents automatic, low-level, or associative processes that do not require access to the schematic model level. Rather confusingly, the SPAARS associative level actually seems quite similar to Leventhal’s schematic level, not only because of its automatic operation, but also because of its marked separation from conceptual processing. The complications arising from various different uses of the word *schema* (and its derivatives) will be returned to at the end of this section.

In SPAARS, emotion can be generated by two routes. The first route is via the schematic model level of meaning, and involves a (schematic) appraisal of the (analogical and propositional) interpretation of an event. The second route is via the associative level, where no such appraisal occurs at the actual time of the event. Instead, Power & Dalgleish (2008) suggest that an appraisal needs to have occurred

"at some point in the emotional history of the individual's experience of that event or, for a small circumscribed set of events, in the evolutionary history of the species" (p 153). So although the schematic models have formed as usual, the repetition of similar events over time will gradually cause the emotion to become associatively driven. Essentially, the schematic model level of meaning is "short circuited" (p 153).

2.4. Discussion and synthesis

Having introduced multi-level modelling as an effective way to avoid the potential minefield of defining cognition and emotion, it seems that reviewing these three models has highlighted the fresh challenge of how to structurally arrange the multiple processing levels. Indeed, it seems that much of this challenge lies, once again, with terminology; in this case, how to define the nature of *schemata*. As we have seen, the schemata described by Beck (1976) were initially criticised for being purely propositional; however, in the ensuing multi-level models, schemata are said to be comprised either of purely sensory information (Leventhal, 1982), or of both sensory and propositional information (ICS and SPAARS). Furthermore, Leventhal regards schematic processing as automatic and associative, whereas SPAARS places automatic and associative processing at a separate level to that of schemata.

Clearly these structural differences will have implications for how multi-level models are clinically applied, and since the purpose of this paper is to apply a multi-level approach to psychosis, it is necessary to firstly synthesise the most useful aspects of the differing models into a single coherent multi-level framework.

The first step, we suggest, is to abandon the term *schemata*, in the same way that multi-level theorists abandoned the cognition–emotion terminology. The term has been used in many different ways, and is therefore only likely to confuse the useful distinctions found in multi-level models. One important distinction is between sensory and propositional information, and another is between the two subjective levels of meaning: i.e. the implicit, emotional, meaning of an event, and the declarative, conceptual, knowledge about an event. ICS and SPAARS would argue that for implicit meaning to have its ideational (*meaning*) content, it must involve both propositional and sensory elements, even if its sensory elements provide it with a very different *meaning* to that of (purely propositional) conceptual meaning.

This paper, however, argues that an integrated schematic structure is unnecessary, and that the structural distinction between sensory and propositional information should be retained (as in perceptual motor theory). Therefore, instead of having a central schematic system that integrates, processes, and stores information, we believe it is more useful to conceive two separate systems that process and store two types of information, that arrive in awareness independently. The propositional information arriving from one system will have conceptual meaning, and the sensory information arriving from the other will have perceptual meaning.

The proposed framework (Fig. 1) retains Leventhal's (1982) distinction between conceptual and schematic systems, but names them *conceptual* and *perceptual* to represent the nature of meaning generated.

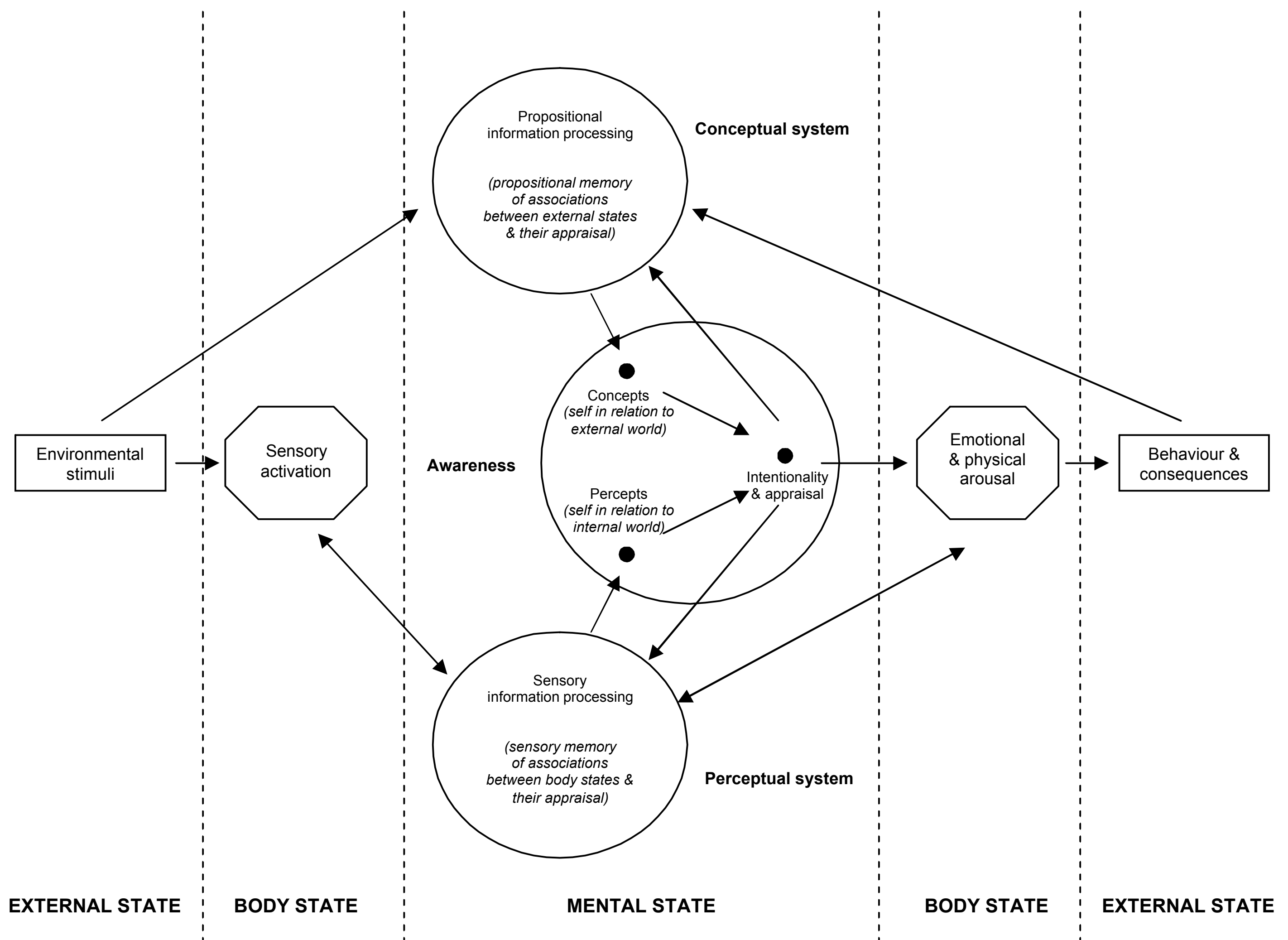

Fig. 1. A model of the balanced mind. Depicts the relationship and interaction between conceptual and perceptual processing systems

The conceptual system generates meaning from propositional information, and is governed by the laws of reason (in the interests of learned rules and beliefs). The perceptual system generates meaning from sensory information, and is governed by the laws of emotion (in the interests of innate survival). Each system has its own memory store and a filtering mechanism that operates according to its laws or goals. The perceptual system is pre-attentive and automatic, and similar to the SPAARS associative system, allows for some innate 'memory' from the evolutionary past (thus relinquishing the need for a third level).

In appreciation of the schematic-like qualities of memory (i.e. how a sensory element can instantly trigger a propositional element into awareness, and vice versa), we suggest that the sensory store of the perceptual system contains the *sensory* components of conceptual events: e.g. the sounds of spoken words and the images of written words. These sensory elements have no meaning in themselves. However, once activated into awareness, they convey a perceptual meaning, and are instantly recognisable to the conceptual system, which then activates associated elements from its propositional information store. The idea that qualitatively different information is stored separately, and arises in awareness independently, not only seems to make biological sense (e.g. Le Doux, 1993), but also brings an important focus on the role of *awareness* in regulating the whole system.

In the proposed framework, awareness performs some of the roles characteristic of schemata in other models, e.g. integrating sensory and propositional information, producing implicit, perceptual meanings, and generating appraisals. However, the crucial difference is that, unlike schemata, awareness is a transient mental state with no long-term storage or structural models (it only has working memory). This leads to a more transient view of cognitive and emotional states, similar to that advanced in mindfulness-based therapies: i.e. thoughts, sensations, emotions are experienced as passing events in the mind, as opposed to central components of the self (Segal, Williams & Teasdale, 2002). Another possibility arising from the proposed framework is that the conceptual and perceptual systems, being independent, may actually become dissociated or desynchronised from each other. This point will form a major part of the impending rationale for applying a multi-level approach to psychosis.

3. Applying a multi-level framework to psychosis

Multi-level approaches have so far been applied to a number of clinical conditions, such as PTSD (Brewin, Dalgleish & Joseph, 1996), depression (Teasdale & Barnard, 1993) and personality disorders (Linehan, 1993), and it is claimed that they are especially useful for the more severe end of mental health conditions, where basic cognitive restructuring is not always effective (Williams, 1994). However, mainstream cognitive approaches to psychosis still typically adhere to a single-level framework focussed on conceptual-level appraisal, as described below.

3.1. Current cognitive approach to psychosis

Garety, Kuipers, Fowler, Freeman & Bebbington's (2001) cognitive model postulates two routes to the development of positive psychotic symptoms: one in which cognitive changes give rise to an anomalous experience (accompanied by an emotional response), which is then appraised in a particular way; and a second in which affective changes alone lead to a particular appraisal. In the first route, a pre-existing bio-psycho-social vulnerability can be triggered to produce a "disruption of cognitive processes", giving rise to an anomalous experience. The cognitive disturbance can be viewed as a "weakening of the influences of stored memories", leading to "ambiguous, unstructured sensory input" (p189). Importantly, the authors state that at this point, however, these experiences have not been transformed into psychotic symptoms. It is not the anomalous experience *itself* which directly leads to psychosis, but rather the event that inevitably follows, i.e. the *appraisal* of experience.

The all-important appraisal of experiences is believed to depend upon cognitive biases, and if an *externalising* appraisal is reached, psychotic symptoms are likely to develop. Cognitive styles such as jumping to conclusions and externalising attributional biases are found to be elevated among people with psychosis (Garety & Freeman, 1999), and therefore may influence this appraisal process. Morrison (2001) similarly identifies the misinterpretation of experiences in the development of symptoms, suggesting that the nature of an individual's misinterpretation will be "determined by a combination of their experience, beliefs and knowledge" (p260).

3.2. Previous multi-level applications to psychosis

The only known authors to have explicitly applied a multi-level framework in the psychosis literature are Gumley, White & Power (1999), Clarke (2001; 2002), Barnard (2003) and Jones (2001). The first three apply ICS to psychosis, and the fourth applies SPAARS to bipolar disorder. These applications are briefly summarised below.

Gumley et al. (1999) argue that the ICS distinction between two different levels of meaning is needed to account for the initiation, acceleration and maintenance of relapse in psychosis. They suggest that psychotic relapse involves the activation of higher-level (implicational) meaning structures, which are derived from multiple information sources during previous experiences of psychosis. Psychotic symptoms are therefore thought to be maintained by the "continuing regeneration of implicational meaning" (p274). They propose that the whole process is driven by attempts to reduce the discrepancies between current and intended states, which, at the implicational level, will be comprised of information from multiple sources.

Clarke (2002) elaborates on these ideas by suggesting that the discrepancies will be experienced as threats to self, thus activating the body's threat arousal system. She proposes that schemata activation, accompanied by increased arousal, will cause a breakdown of communication between the propositional and implicational levels, leading to a dominance of the implicational subsystem. Clarke (2002) not only believes that this can explain the qualitative discontinuity between psychotic and everyday experience, but also that it can account for the wider realm of spiritual / mystical experience as well. Clarke suggests that "the everyday, scientific state is one where the propositional and implicational subsystems are working nicely together in balance, whereas the spiritual/psychotic state is one where the two are disjoint, and the system is essentially driven by the implicational subsystem" (Clarke, 2001, p136).

Barnard (2003) hypothesises that the symptoms of schizophrenia arise as a result of *asynchronous* processing between the two ICS levels of meaning. ICS stipulates the need for a transformation process in the interchange of information between subsystems (e.g. transforming propositions into implicational meanings). Barnard says that propositional information arrives in the implicational subsystem later than sensory information, and in the event of disruption to the system, this delay would result in the abnormal formations of implicational meaning: "When exchanges between two levels of meaning become asynchronous, the immediate products of sensory and body state processing are also going to be misaligned with ideational and affective correlates in the feedback stream" (p135). This, Barnard claims, is the basis for the misinterpretation of sensory and emotional events found in psychosis.

Jones (2001) argues that SPAARS can help to explain the coexistence of mania and depression in bipolar disorder, through its conception of two routes to emotion. He suggests that significant circadian disruption (e.g. alteration of sleep routine) will create analogical representations of increased energy, stamina, and alertness, due to the preceding life events and external environmental changes. If, however, these analogical representations are attributed to internal characteristics, they may trigger a cycle of positive propositional thoughts and positive schematic beliefs about the self, leading to erratic behaviours that exacerbate the initial mood changes. This link between elated mood and circadian disruption will eventually become driven by the associative system. However, Jones states that this associatively generated elation will come into conflict with the schematically generated low mood and depression from later appraisals of the negative consequences of erratic, risky behaviour.

These authors have applied multi-level models in different ways, and for different reasons. Gumley et al. (1999) use the approach to describe relapse and maintenance among those who have already had a psychotic episode. Clarke similarly uses it to describe maintenance of psychotic experiences among vulnerable individuals (via threat-related arousal), but also to explain the discontinuity in their subjective nature. There is overlap between Clarke's and Barnard's ideas of desynchronised communication between two subsystems; however, Barnard does not propose a psychological cause for this, only the psychological mechanisms accompanying it. Therefore, similar to Gumley et al., this does not provide a cognitive account of how an initial episode is caused. Indeed, both Barnard and Jones explicitly place biological disruptions at the heart of their cognitive operations (Barnard: "disruption in the

production of a neurotransmitter such as dopamine" in schizophrenia (2003, p134); Jones: "disruption of circadian rhythms" in bipolar disorder (2001, p1193)). Clarke (2001), meanwhile, views the pattern of cognitive processing in psychosis as underlying a *universal* area of human experience that is linked to benign spirituality.

3.3. Rationale for multi-level approach to psychosis

The previous multi-level applications provide useful insights into the maintenance of psychosis, as well as some aspects of its manifestation. Building on these ideas, this paper will now outline its own detailed rationale for applying a multi-level framework to understanding the onset and core features of psychosis: (1) positive symptoms; (2) subjective phenomena; (3) risk factors; and (4) cognitive phenomena.

The aim is to demonstrate how the multi-level framework can offer a deeper understanding of each aspect than current cognitive models, and to show how psychosis formulations could benefit if the different aspects were brought together under one comprehensive framework, as cannot be achieved with any one single-level framework. This is not to suggest that single-level models are inaccurate, but rather that their descriptive and explanatory powers are limited, and could be enhanced by a multi-level approach. The following proposals are speculative at this stage, but they are firmly grounded in the existing theoretical and empirical literature, and are certainly open to more direct empirical testing in the future.

3.3.1. Positive symptoms

In medical diagnostic terms, the main positive symptoms of psychosis are delusions, hallucinations, and thought disorder. Delusions have traditionally been viewed as irrational or “false” beliefs, “based on incorrect inference about external reality” (DSM-III, APA, 1987). While, on the surface, delusional content may be irrational or false to the onlooker, psychological formulations of psychosis have increasingly recognised the personal significance of delusions in relation to an individual’s unique circumstances and experiences. One important clinical observation is that delusional content typically shares the main themes of an individual’s predominant emotions (Freeman & Garety, 2004), suggesting that delusions may actually be expressing emotional concerns. Current single-level models rightly acknowledge the crucial role of emotion in delusion formation; however, as the delusions are described as attempts to make sense of the emotion (Garety et al., 2001), they are seen more as conceptual *responses to*, rather than direct *expressions of*, emotional experience.

A multi-level framework can offer a slightly different perspective of delusions, with regards to the levels of meaning they represent. While at the conceptual level, the delusions express something objectively irrational (fixed false beliefs), at the perceptual level, they express something subjectively valid (genuine emotions). In single-level models, emotion is involved with delusion formation, but subsequent delusional meaning is conveyed at a purely conceptual level. The problem with this is not so much in understanding why the delusional content was formed, but rather why the delusional system is maintained with such adamant conviction, in spite of all the evidence. A multi-level framework, however, would explicitly convey the

emotional validity of a delusional system, thus highlighting its continuing appeal to the individual. By conceiving a level of processing that is concerned solely with perceptual meaning and survival, we can better recognise why a belief system might be upheld, even if it creates problems for an individual in the objective, conceptual world. Perhaps if both levels of meaning were explicitly and routinely incorporated into delusion formulations, more attention would be paid to the emotional motivation which *drives* a delusional system, not just that which precedes it.

Hallucinations are explained in current cognitive models as being the individual's externalising appraisal of their own internal mental events (auditory, visual, and somatic). Therefore, again, it is the making sense or appraisal of experience that is the focal problem; in this case, the conceptual response to a perceptual experience. The single-level approach accordingly centres its formulation on the maladaptive nature of conceptual processing. A multi-level approach, however, would offer a single framework that incorporates both the conceptual and perceptual elements of hallucinations. The framework adopted in this paper would see the internal mental events as being the products of the (sensory-based) perceptual processing system. These percepts would therefore be seen as having meaning in their own right; i.e. perceptual meaning generated in the interests of survival. As with delusions, this framework would present a more complete picture of hallucinations, with both their subjective validity and objective invalidity. Again, the likelihood is that this may encourage closer attention to the emotional, perceptual meaning of hallucinations; e.g., what the 'voices' are expressing in terms of the individual's emotional life.

In a similar vein, thought disorder can be readily understood under the multi-level framework as being the valid expression of something at a subjective perceptual level of meaning, but which comes across as nonsensical or illogical at an objective conceptual level of meaning. This is very much in line with how thought disorder is currently viewed in the cognitive literature: For example, Kingdon & Turkington (2005) state that "the thoughts (or at least what they are trying to convey) beneath the conversation may be quite logical (once they can be understood), but their expression seems not be" (p24). So, although there seems to be an allusion to the operation of two different levels of meaning, what is currently lacking in the literature is a formal multi-level framework with which to explain this phenomenon.

3.3.2. Subjective phenomena

The subjective phenomenology of psychotic experience was once the primary source of information for early theories of schizophrenia, with key subjective phenomena identified as being a loss of *ego boundaries* (Schneider, 1959) and a disturbance in the *sense of self* (Jaspers, 1913). However, while there continues to be theoretical interest in self-experience in the information processing models of psychosis (Gray, Feldon, Rawlins & Smith, 1991; Hemsley, 2005), contemporary empirical research seems to have "systematically neglected" the subjective aspects of self-experience (Parnas & Handset, 2003, p121). Therefore, in order to convey a sense of the subjective phenomena in psychosis, we aptly turn to self-reports:

> *"I feel strange, I am no longer in my body ... I hear my voice when I speak, but the voice seems to originate from some other place"* (Case 4 in Parnas & Handset, 2003, p126)

> *"what scared me most was a sense that I had lost myself, a constant feeling that myself no longer belonged to me"* (Kean, 2009, p1034)

> *"my first personal life is lost and is replaced by a third-person perspective"* (Case 2 in Parnas & Handset, 2003, p125)

> *"the boundary between within and without is dissolved"* (Chadwick, 2009, p5)

These subjective experiences of ego-loss and depersonalisation seem to suggest an awareness that is not contained by one's previous contextual boundaries. Hemsley (2005) describes this disturbance as a lack of integration "between current sensory input and contextually appropriate stored material" (p979). As we have seen, such phenomena also form the basis of Clarke's (2001; 2002) argument for two different types of experience: one framed within the contextual (propositional) boundaries of space, time, etc., and one that involves participation in the unbounded *whole*. We agree that these phenomena involve a departure from one's usual context and boundaries, and argue that this is best described within a multi-level framework, where the conceptual system becomes dissociated from, or weakened in its association to, the perceptual system. The triggers for this separation, and the wider psychological consequences, will become clearer as the argument unfolds.

3.3.3. Risk factors

A recent review of psychosis risk factors highlighted trauma, drug use, isolation, social adversity, life events, and migration (Dean & Murray, 2005).

In multi-level theories of trauma (e.g. Brewin, 1989; Ehlers & Clark, 2000), dissociative states are brought about when conceptual processing of a traumatic event becomes separated from "data-driven" processing (Ehlers & Clark, 2000). This occurs because the event provides information to the individual that is, on the one hand, highly salient and, on the other hand, incompatible with their pre-existing conceptual models of the world (Dalgleish, 1999). Dissociation is a way of preventing threatening information from reaching consciousness; however, by dissociating conscious (conceptual) processing of the event, there becomes a monopoly of unconscious (perceptual) processing of its sensory aspects. This is because the perceptual system functions in the interests of survival, and the trauma presents a threat to survival. So although the dissociation of conceptual processing may be protective in the short term, the simultaneous heightening of perceptual processing is likely to cause problems later on, through an increased risk of sensory intrusions.

Applying a similar multi-level framework to psychosis is appealing as it acknowledges the trauma-psychosis links (Steel, Fowler & Holmes, 2005), it accounts for trauma-like dissociative phenomena in psychosis, and it also offers an understanding of how sensory intrusions may be linked to positive symptoms. As the traumatised individual becomes more engaged at the perceptual level and less engaged at the conceptual level, the connections between the two systems, and memory stores, will be

weakened. When future sensory memories then arise in awareness (sounds, images, emotions etc.) the individual will have less conceptual context to make sense of them. This raises the possibility of contextually misinterpreting the intrusions, which, as we know, is central to cognitive models of delusions and hallucinations.

Another risk factor is drug use, in particular illicit drugs with dissociative and hallucinogenic qualities (e.g. cannabis, LSD, ketamine). In multi-level terms, the dissociative effect can be seen as a loosening of the influence of one's previous conceptual framework; and the hallucinogenic effect, as the perceptual system's triggering into awareness of "new combinations of sensations, ideas and memories" that create "the potential for seeing oneself and one's world differently" (Batson, Schoenrade & Ventis, 1993, p121). Similar to trauma, the drugs essentially cause a weakening of the conceptual system, together with a heightening of the perceptual system, thus creating a conscious experience of sensory percepts with no immediate context. These percepts will be experienced as novel and creative, and while this is the desired effect for many recreational users, it still creates a risk of misinterpreting the experience as *more* than just the entertaining effects of the drugs.

Prolonged periods of isolation also increase the risk of psychosis. To explain this in multi-level terms, we should first recall that the perceptual system is concerned with self-as-subject processing (i.e. the self in relation to internal body states), and the conceptual system is concerned with self-as-object processing (i.e. the self in relation to the external world). When an individual is isolated, there becomes reduced need for self-as-object processing. This is because the social and environmental context is

not changing, and therefore the conceptual rules of how to navigate oneself within the external world are not required. Instead, the individual's processing becomes increasingly inward, focussed more on internal body events than external events. This is not likely to be intentional, but simply the result of having minimal external cues to process and conceptualise. However, the cognitive implications are similar to that of trauma and drug use, whereby the perceptual system becomes dominant and its connections to the conceptual system are weakened. As the individual becomes more detached from their previous environment, they also become more detached from the conceptual framework that was designed to navigate around that environment. Again, the consequence is a de-contextualised, unbounded awareness of sensory-emotional events and memories, with multiple appraisal possibilities. Furthermore, the opportunities for reality testing of these appraisals will be reduced.

For the purposes of this discussion, the remaining risk factors of social adversity, life events and migration will be broadly grouped under the category, *'existential crisis'* (a term borrowed from Batson et al., 1993). The suggestion is that some of the more extreme or emotionally-infused life experiences could be so radically different to an individual's previous experiences, or expectations/beliefs of what life should be, that their existing conceptual system is inadequate or unequipped to deal with them. This would then trigger a psychological problem-solving process, whereby one's existing conceptual system is deconstructed to allow for a new conceptual system to take its place. This is analogous to the creative problem-solving process described by Wallas (1926), except that the *problem* is existential rather than intellectual, and the *solution* involves a metaphysical rather than a theoretical paradigm shift (Jackson,

2001). During this process of cognitive restructuring, the redundant conceptual system will become dissociated from the perceptual system, which will dutifully assume the dominant processing role in the interests of survival. This, again, creates a situation (in awareness) whereby unstructured, uncontextualised sensory and emotional events are vulnerable to the misattributions that characterise psychosis.

3.3.4. Cognitive phenomena

We now apply our multi-level framework to the distinctive cognitive features of psychosis, in the domains of attention, memory, and reasoning.

With regards to attention, Frith (1979) argues that "ambiguous and multiple interpretations" (p228) arise from the disruption of inhibitory processes that keep most irrelevant material from entering awareness. Indeed, research has shown that psychotic symptoms are associated with poor cognitive inhibition (Minas & Park, 2007). The multi-level framework can explain this as increased perceptual processing at the expense of conceptual processing. Because the perceptual system processes information automatically, its filtering mechanism will not prevent material from entering awareness on the basis of reason and intentionality alone; or indeed, because that happens to be the instruction of a psychological experiment. By considering psychotic symptoms as sources of current threat, either Clarke's (2002) *threat to self*, or the threat inherent to command hallucinations, persecutory delusions etc., we can understand why the survival-led perceptual system might override the conceptual system, allowing more sensory percepts into awareness.

With regards to memory, the most consistent impairment found among people with psychosis is in episodic memory (Herbener, 2008), which refers to the recollection of experiential episodes with a context of time and place. Because episodic memory depends on a combination of perceptual processing (the experience) and conceptual processing (the context), communication between the two systems is essential for both encoding and retrieval. In psychosis, the threat-related dissociation between the systems will disrupt both stages, leaving experiential memories with no context. Neumann, Blairy, Lecompte & Philippot (2007) found that people with psychosis were less likely to *remember* seeing a picture shown the day before, but more likely to report *knowing* that the picture had been shown, without having a specific memory of it. Control participants displayed the opposite pattern. Philippot et al. (2004) use this as evidence for a multi-level model of memory, because *knowing* (what they call "noetic awareness") only requires conceptual processing, whereas *remembering* ("autonoetic awareness") requires communication between the perceptual and conceptual systems.

The reasoning biases most often associated with psychosis are *jumping to conclusions*, *externalising attributional style*, and *poor theory of mind* (Garety et al., 2001). Dudley & Over (2003) propose that jumping to conclusions is a normal threat-related reasoning process, which is only increased among people with psychosis because they perceive threat in objectively non-threatening situations. We agree with this principle, and suggest that a multi-level framework can complement and advance its explanatory power. Jumping to conclusions can be seen as the result of a less engaged conceptual (reason-based) system, and a more engaged perceptual

(survival-based) system, and decisions favouring survival will always be more rapid and impulsive than those favouring reason (in evolutionary terms, it would have been safer to act on the first suspicion of threat, rather than hanging around to weigh up further evidence). The lack of belief flexibility also found in psychosis could then be explained as the continuing dominance of survival-based processing, even in the face of new reason-based evidence.

An externalising attributional style would be described psychodynamically as a defence to avoid negative emotion; for instance, Freud states that "the purpose of paranoia is ... to fend off an idea that is incompatible with the ego, by projecting its substance into the external world" (Freud, 1966, p209). The same defence process, or cognitive "self-serving bias" (Bentall, 2003, p243), also applies to incompatible auditory intrusions that are appraised as external voices. The multi-level framework can take these ideas further by explaining how the conditions for externalising appraisals are created in the first place. With a weakened or dissociated conceptual system, and being unable to interpret events in the context of one's previous life, an individual's appraisal possibilities could transcend personal laws and boundaries, perhaps into higher-order transpersonal or supernatural laws. The conceptual self-as-object is dissolved, and there is no clear distinction between what is internally and externally generated. The self, others, and the world essentially become one, which *depersonalises* thoughts and actions, and *externalises* their appraisal.

Following on from this, a theory of mind deficit can also be understood as the individual's detachment from self-as-object processing, and engagement with self-

as-subject processing. Theory of mind is the ability to understand the mental states of others, and it is argued that people with psychosis make invalid attempts at inferring these states (Frith 2004). In terms of the multi-level framework, we can recognise how perceptual-dominated processing will be primarily concerned with the significance of events in relation to self (again, in the interests of survival). By having a self-as-subject processing focus, people with psychosis are more likely to appraise the actions and intentions of other people in terms of what personal meaning they hold for their self, as opposed to the meaning they hold for the other people; essentially a misrepresentation of the other people's intentions.

Although current single-level models do acknowledge many of the cognitive phenomena outlined above, they present them more as vulnerabilities, biases, or traits associated with psychosis, rather than actually detailing their precise causes and operations. What the multi-level framework brings, however, is a description of the mechanisms underlying how these phenomena are generated, manifested, and maintained. This amounts to a more complete formulation, emphasising the circular relationship between the cognitive phenomena and psychotic experiences.

4. Implications for clinical and non-clinical populations

The main argument emerging from the previous section, and the central thesis of this paper, is that current single-level approaches are no longer adequate to integrate all of the knowledge accumulated in different areas of the psychosis literature, and that a multi-level approach, with greater descriptive and explanatory

power, is now required to collate these understandings into a single theoretical framework. Multi-level models have been successfully adapted for formulations of other clinical conditions, such as PTSD, depression, and personality disorders, and the previous section highlights good reason for the same to be done for psychosis formulations. Some implications of this approach will now be discussed, with regards to understanding psychotic phenomena in both clinical and non-clinical populations.

As we saw in the section on positive symptoms, the multi-level formulation of clinical psychotic experiences would focus on those aspects that carry a genuine, valid emotional meaning, which is generated automatically by the perceptual level of processing. The conceptual level would be formulated as temporarily dissociated from the perceptual level, for reasons of either protective dissociation or adaptive problem-solving. Throughout this formulation, the psychological meaning and function of delusions, hallucinations, and thought disorder would be conveyed.

This explicit focus on genuine meaning and psychological function highlights the aspects of psychotic phenomena that are shared with the non-clinical population. There has been much interest in the incidence of psychotic-like experiences in the non-clinical population (Poulton, Caspi & Moffit, 2000; van Os, Hansen, Bijl & Ravelli, 2000; Verdoux et al., 1998), and the multi-level framework may be in a unique position to explain their similarities and differences with those of the clinical population. Clarke's (2002) theoretical ideas on the spiritual-psychotic experiential realm have already been noted, and there is now growing research interest in the

interface between psychotic and spiritual/religious phenomena (Jackson & Fulford, 1997; Day & Peters, 1999; Brett et al., 2007; Lovatt, Mason, Brett & Peters, in press).

Jackson & Fulford (1997) reported that psychotic-like experiences are triggered in both psychotic and spiritual groups by intense stress in the context of existential crises, and that the subsequent distinction between groups depends on “the way in which psychotic phenomena are embedded in the values and beliefs of the person concerned” (p 41). The group difference is therefore not in the psychological processes involved, which are adaptive, but rather in how the experiences are subsequently incorporated; i.e. how they are processed conceptually. We can see that the triggers are similar in both groups, and would therefore hypothesise that the subjective and cognitive phenomena are also similar. In multi-levels terms, the experiences of both groups have similar perceptual meaning, and involve a similar dissociation of the old conceptual framework in response to an existential crisis. The subsequent differences in conceptual meaning and clinical consequences arise when the new conceptual framework is implemented to replace the old one, and will be primarily influenced by contextual factors (i.e. self in relation to the external world).

With regards to appraisal, having similar perceptual meanings would imply that people in both groups have similar appraisal possibilities, scopes, or styles, even if their appraisal content (conceptual meaning) is different. It is not hard to notice the similar appraisal styles in clinical and non-clinical populations; e.g. as with psychotic experiences, spiritual/mystical/religious experiences often involve a sense of being guided by an external power, a perception of meaning in events, and a special

mission or purpose in life. Both kinds of experience are also accompanied by the appraisal style of adamant conviction (Jackson, 2001). However, these similar appraisal possibilities and styles can still lead to different appraisal content, depending on the context of experience. In a religious context, for instance, a sense of destiny or fate may be conceptualised as God's guidance, whereas in psychosis, there may be no such context immediately available, and a sense of fate may be conceptualised as a *special mission* from aliens, government agencies, etc. (Heriot-Maitland, 2008). In addition to these similar cognitive phenomena, there are similar subjective phenomena, such as loss of self-object boundaries, time distortion, and an initial moment of euphoric revelation (Buckley, 1981; Jackson & Fulford, 1997).

The multi-level approach not only has implications for formulating psychotic experience, but also for bringing it into the realm of normal experience. If clinical formulations routinely incorporate the conceptual system, the perceptual system, and the communication between these systems, they will closely match non-clinical experiences in terms of both aetiology and function. The subjective and cognitive phenomena associated with psychosis will also be acknowledged as the normal manifestations of these functional processes. With regard to positive symptoms, their meaning will be recognised as valid at the emotional (perceptual) level, but misrepresented at the conceptual level. Overall, this will entail what could be termed a more '*radical normalisation'* approach to formulating psychotic experiences; i.e. normalising them not just because it's therapeutically useful, but because it's intrinsic to multi-level formulations.

5. Conclusion

This paper has demonstrated the need for a multi-level approach to integrate our advanced psychological understandings in different aspects of psychosis into a single theoretical framework. Not only will this bring cognitive formulations of psychosis more into line with those of other clinical conditions, but will also guide clinical practice in a more comprehensive and meaningful way. Single-level models of psychosis have historically been very useful in directing our clinical focus on the role of cognitive appraisal; however, we now recognise the complexities involved with mapping cognition onto other entities such as emotion, memory, and information processing, and it is no longer acceptable to define cognition as simply a collection of propositional thoughts and beliefs.

The multi-level framework adopted in this paper has a clear structural distinction between conceptual and perceptual systems, which helps us describe how the mind processes different kinds of information (sensory and propositional), and allows us to explore the relationship and communication between the systems. Being able to formulate psychosis in this way opens the door to a greater understanding of how psychosis develops, how it is manifested and maintained, and how it can be treated psychologically. The argument outlined above in no way contradicts the existing cognitive literature on formulating and treating psychosis; rather, it complements and advances it by providing a theoretical framework to propel it into the new generation (or *'third wave'*, Hayes, 2004) of CBT.

At present, the psychological research and treatments for psychosis are already quite advanced, and we now need theoretical advancement to tie them together, and to build the foundations for future scientific and clinical developments. One crucial research development would be to explore more carefully the similarities and differences between the experiences of clinical and non-clinical populations. The implied *radical normalisation* of psychosis is likely to be one of the most positive outcomes of adopting this proposed approach in modern clinical practice.

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Paper B

A qualitative comparison of psychotic-like phenomena in clinical and non-clinical populations

Abstract

Objectives
To explore the nature and context of psychotic-like phenomena in clinical (C) and non-clinical (NC) participants; and by comparing the two groups, to explore whether the factors involved with triggering a psychotic-like 'out-of-the-ordinary' experience (OOE) can be distinguished from those determining its clinical consequences.

Design and methods
Data were collected by semi-structured interviews, and analysed by the qualitative method of Interpretative Phenomenological Analysis (IPA). A total of 12 participants, who all reported OOEs starting in the last five years, were split into C and NC groups depending on whether they were involved with mental health services as a result of their experiences. Each interview was recorded, transcribed, and analysed as per IPA recommendations, and inter-group comparisons of emergent themes were made.

Results
A range of similarities were found in the triggers and subjective nature of experiences in both groups, with more clear group differences in the inter-personal and background personal contexts of participants, and how the experiences were incorporated into their lives. In particular, the inter-personal theme of validation was found to be an important factor in distinguishing the clinical consequences of OOEs.

Conclusions
The findings suggest that it is not the OOE itself that determines the development of a clinical condition, but rather the wider personal and interpersonal contexts which influence how this experience is subsequently integrated. Theoretical implications for the refinement of psychosis models are outlined, and clinical implications for the validation and normalisation of psychotic-like phenomena are proposed.

6. Introduction

6.1. Background

Many people displaying symptoms of psychosis will be diagnosed with a psychiatric condition, will be in some distress, and will require clinical treatment. However, there are also people who have 'out-of-the-ordinary' experiences (OOEs) that resemble positive psychotic symptoms, but which do not cause distress, do not entail a need for treatment, and hence do not receive a diagnostic label (Verdoux & van Os, 2002). The most commonly studied OOE in non-clinical populations is voice hearing, which has an estimated prevalence of 10-15% (Tien, 1991), and is found to be associated with lower levels of distress than in clinical populations (Lawrence, Jones, & Cooper, 2010; Daalman et al., in press). This suggests that some OOEs do not inevitably lead to psychiatric conditions, and that many people can experience psychotic-like phenomena while continuing to function effectively in day-to-day life.

The empirical literature has identified a range of contextual risk factors for psychosis (e.g. social adversity, life events, drug use, isolation, migration, and trauma (Dean & Murray, 2005)), and characteristic cognitive phenomena (e.g. jumping to conclusions externalising attributional style, and poor theory of mind (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001)). In an attempt to incorporate these different findings, the theoretical literature has begun to produce integrative models, which indicate *bio-psycho-social* vulnerabilities in the development of psychosis. However, because the research has typically only studied clinical populations, these models are unable to distinguish between which *bio-psycho-social* factors are involved with

having an OOE in the first place, and which are involved with the subsequent development of clinical psychosis. For example, in Garety et al.'s (2001) model, which highlights the importance of *appraisal* of anomalous experience in determining whether psychosis develops, it is unclear as to which contextual factors trigger the experience and which influence its appraisal. Indeed, with evidence from only clinical populations, it cannot be disproved that the same cognitive appraisal *styles* are also present in the non-clinical OOE population.

To address the issue of disentangling experiences from appraisals and consequences, Brett et al. (2007) and Lovatt, Mason, Brett, & Peters (in press) have recently employed a new sampling strategy to study non-clinical participants with psychotic-like OOEs. By having similar experiences, this population is likely to share some risk factors with the clinical population, but may also have some protective factors that allow them to continue functioning without the need for clinical intervention. With information from this population, it may be possible to establish which vulnerability factors apply to which stage of psychosis development, and also to establish what factors constitute a protective appraisal, both of which would be useful in guiding clinical interventions.

Brett et al. (2007) designed an in-depth interview (called the "AANEX") to compare appraisals of diagnosed (D) and undiagnosed (UD) populations reporting anomalous experiences. They found that while the D group were more likely to appraise their experiences as external and caused by other people, the UD group made more psychological, spiritual and normalising appraisals, and reported higher perceived

understanding from others. Lovatt et al. (in press) later replicated these findings, and made further specific explorations into the role of trauma and social support. They found no group differences in traumatic life events, but did find trauma levels in both groups to be higher than in the general population. This could be an example of how something generally believed to be a risk factor for clinical psychosis (Mueser et al., 1998) might more appropriately be seen as a risk factor for psychotic-like OOEs (i.e. disentangling experiences from their appraisals and clinical consequences).

The quantitative methods used in these two studies are likely to have slightly compromised the richness of data. Since experiences and appraisals were recorded into pre-defined categories on the AANEX, information may have been lost regarding the personal meanings and feelings surrounding experiences, and the context in which they occurred. Without these aspects, it may be difficult to establish, e.g., why a similar situation was experienced by one individual as highly distressing, but by another as emotionally neutral; data that may be crucial in understanding why an OOE was triggered at a particular time, and appraised in a particular way.

The only known published qualitative study of clinical and non-clinical populations with OOEs was by Jackson (see Jackson & Fulford, 1997), although some qualitative elements of Brett's (2004) original thesis are also being prepared for publication. Jackson gathered information about the context, phenomenology, effects, and interpretations of psychotic-like experiences (Jackson, 2001). The results suggest that experiences are triggered in both groups by intense stress in the context of existential crises, and that the subsequent distinction between groups depended on

"the way in which psychotic phenomena are embedded in the values and beliefs of the person concerned" (Jackson & Fulford, 1997, p 41). This implies that there are certain contextual factors involved with triggering experiences (i.e. creating an existential crisis), and certain *different* contextual factors involved with how these experiences are appraised and incorporated (i.e. prior beliefs, knowledge etc).

Unlike the two quantitative studies, Jackson's study elicited contextual information about how OOEs arose from, and were incorporated into, someone's unique life narrative. It was therefore more sensitive to personal meanings, feeling, goals etc. However, as the research was designed as a "descriptive case study comparison", the data were not analysed within a structured methodological framework, i.e. one characterised by its own explicit set of epistemological assumptions and techniques. As a result, it would appear to lack some of the methodological and interpretive "rigour" that is typically used to evaluate qualitative research (Fossey, Harvey, McDermott, & Davidson, 2002).

6.2. Aims

This study aims to build on the previous research by exploring the nature and context of primary OOEs using Interpretative Phenomenological Analysis (IPA), which is a qualitative method that is becoming increasingly applied to psychosis populations (e.g. Rhodes & Jakes, 2000; Knight, Wykes, & Hayward, 2003; Perry, Taylor, & Shaw, 2007; Nithsdale, Davies, & Croucher, 2008). In doing so, the hope is to elicit a similar richness of data to Jackson & Fulford (1997) for making clinical and non-clinical group comparisons, but with a more structured analytic procedure, and

with the additional benefit of more recent findings from the quantitative work of Brett et al. (2007) and Lovatt et al. (in press), such as the importance of inter-personal factors in distinguishing groups.

The current study also differs from the previous research in that it only includes participants whose OOEs started within the last five years. In contrast, Jackson's clinical participants had all been through a substantial period of recovery since their psychotic episode, and participants in the quantitative studies all had OOEs ongoing for at least five years to avoid the possibility of recruiting *prodromal* participants in the non-clinical group. The problem with exploring phenomena which started so long ago is that much of the original emotional, cognitive and contextual information surrounding their onset may have been lost, or distorted by subsequent experiences and appraisals. These effects are minimised in the current study, and there is a more specific focus on the very first OOE. Regarding the issue of *prodromal* participants, this study is more interested in the non-clinical group's protective factors around the initial OOE and up until the time of the research, regardless of whether contextual changes or re-appraisals may precipitate a psychotic episode after the research.

6.3. Research questions

1) What are the phenomenological and contextual similarities and differences between the psychotic-like OOEs of clinical and non-clinical participants?

2) By comparing the two groups, is it possible to distinguish the factors involved with triggering an OOE from those determining its clinical consequences?

7. Method

7.1. Design

This study was exploratory in nature, using semi-structured interviews for the data collection, and Interpretative Phenomenological Analysis (IPA) for the data analysis.

7.2. Participants

Twelve participants were included in the study, with six in the clinical (C) group and six in the non-clinical (NC) group. All participants reported psychotic-like OOEs commencing in the last five years, and were split into C and NC groups depending on whether they had mental health service involvement as a result of their experiences.

The C group were recruited from two psychosis teams in the South East of England, one of which held a register of people who had agreed to be contacted for research participation. The NC group were recruited by advertising through a number of UK organisations and networks involved with religious, spiritual, mystical or psychic phenomena. There was also a small NC group register that could be accessed if and when other sources dried up. (See recruitment documents in appendices 3, 4 and 5).

All participants underwent a screening process to determine the eligibility of their experiences against the Schneiderian First Rank Symptoms (SFRS), which are commonly used for diagnostic purposes (DSM-IV, APA, 1994). The screening tool (appendix 6) was adapted from the AANEX inventory probe questions (Brett et al., 2007), which was similarly adapted by Lovatt et al. (in press) as a screening tool.

A total of 28 people were invited for the C group by letter from their clinical teams, of which 10 did not reply, eight declined, and four were excluded for OOEs over five years ago. Of 60 people responding to NC adverts, two lived abroad, two declined, three were excluded for non-eligible OOEs, 24 were excluded for OOEs over five years ago, and 23 responded late. Most non-eligible participants were excluded at the screening stage, however two NC participants were excluded after the interview when it emerged they had OOEs over five years ago. The six eligible people in each group were interviewed between October '09 and January '10. Table 2 introduces these participants, with a brief outline of the OOE that established their eligibility.

Table 2
Participants and their OOEs

Participant		Out-of-the-ordinary experience (OOE)	Group
Holly[1]	(26F)	Receiving visions from God	C
Omar	(24M)	Body taken over by spirits	C
Beth	(25F)	Telepathic communication and speaking with God	C
Tom	(24M)	Receiving symbolic messages from other realms	C
Nessa	(24F)	Hearing voices, and thoughts of being watched / filmed	C
Leroy	(27M)	Hearing voices when nobody is there	C
Jenny	(27F)	Body taken over by spiritual energy	NC
Clive	(53M)	Visions of people who have died and religious figures	NC
Maria	(63F)	Receiving words directly from God	NC
Daniel	(30M)	Spiritual calling, and developing intuitive perception	NC
Flora	(20F)	Visions and voices of spirits (mediumship skills)	NC
Stefan	(23M)	Body taken over by an external force	NC

Note. [1]Participants' names have been changed for confidentiality

7.3. Interview procedure

After reviewing the information sheet, participants had the chance to ask questions about the interview and confidentiality before signing a consent form (appendix 7). The semi-structured interview, which lasted about an hour, was based on a series of open-ended questions designed to gather retrospective accounts of the initial OOE, with regards to both its context and phenomenology (appendix 8). These questions had previously been agreed with the IPA research supervisor and piloted with an IPA research colleague. The interview schedule was used to guide the interview, rather than dictate it, and so the ordering of questions was flexible. However, each interview started with the more general questions to invite participants to *tell their story* before more specific details were elicited. The first two interviews were run as pilots so that the reliability and appropriateness of the schedule could be verified with the IPA supervisor. As no amendments were needed, these pilot interviews were included in the final sample. All participants were remunerated for their time.

7.4. Analytic procedure

IPA is a systematic qualitative methodology primarily concerned with the personal meanings an individual holds for particular events (i.e. their lived experience of events). The main theoretical underpinnings of IPA hold that humans are not passive perceivers of an objective reality, but rather they come to interpret and understand their world by formulating their own biographical stories into a form that makes sense to them (Brocki & Wearden, 2006). Because of its marked focus on subjective experience, IPA is particularly well suited to exploring how life events are perceived, experienced, and understood by individuals. Also, by acknowledging the researcher's

own position in the analytic process, the IPA method can appropriately detect the two levels of interpretation involved: (i) the participant making sense of their experience, and (ii) the researcher making sense of how the participant is making sense of their experience (Smith & Eatough, 2007).

Once the interviews had been transcribed, the analysis followed recommended IPA procedures (Smith, Flowers, & Larkin, 2009), which can be broadly grouped into three stages:

1) On each of the 12 transcripts, *exploratory comments* (descriptive, linguistic and conceptual) were noted in the right-hand margin, and *emergent transcript themes* were developed in the left-hand margin (appendix 9).

2) Each participant's *emergent transcript themes* were organised into clusters, leading to the development of 12 tables of *single case themes* (appendix 10).

3) A master table was produced, in which *single case themes* were organised into clusters, leading to the development of *group themes* and *super-ordinate group themes*. To facilitate inter-group comparisons, the recurrence of group themes among C and NC participants was noted (appendix 11).

Each of these analysis stages was conducted by the researcher, and was checked for credibility by the IPA supervisor. Further checking by an external researcher with IPA expertise and an IPA research group was also carried out to enhance the credibility

of analytic interpretations (appendix 12). To help acknowledge how the researcher's own experiences and beliefs could influence the interpretative process, as is essential in IPA (Smith et al., 2009), a reflexivity commentary was compiled, which covered all phases of the study, from its conception to completion (appendix 13).

7.5. Ethical procedure

The study proposal was reviewed and approved by the University of Oxford Research Sub-Committee (appendix 14), and ethical approval was granted by the Oxfordshire NHS Research Ethics Committee B (appendix 15). NHS Research and Development approval was obtained from the two separate sites used for C group recruitment (appendix 16), and finally, indemnity and sponsorship were provided by Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust (appendix 17).

8. Results and discussion

Exploratory comments and emergent transcript themes of the 12 interviews generated a total of 85 single case themes. From these, 16 group themes were developed, which were further organised into five super-ordinate group themes, according to which aspect of the OOE they related. The results will now be presented and discussed under these theme titles, using illustrative participant quotes, and paying particular attention to the similarities and differences between C and NC groups. The overall structure and recurrence of themes is displayed in Table 3 (and an additional master table of group themes *and quotes* is included in appendix 18).

Table 3
Structure and recurrence of group themes

1. Immediate situational context[1]
a) *Emotional suffering*[2] *(6C, 5NC)*[3]
b) *Existential questioning (2C, 6NC)*
c) *Isolation (4C, 4NC)*
2. Subjective nature
a) *Emotional fulfilment (3C, 4NC)*
b) *Loss of ego boundaries/control (3C, 2NC)*
c) *Fearful absorption (4C, 3NC)*
d) *Insight into deeper meaning (3C, 5NC)*
e) *New way of thinking (3C, 3NC)*
3. Inter-personal context
a) *Awareness of others' views– pathologising (6C, 6NC) or normalising (3C, 6NC)*
b) *Validation from others– validating/accepting (1½*[4]*C, 5NC) or invalidating (5C, 2NC)*
4. Background personal context
a) *Previous knowledge/understanding (3½C, 6NC)*
b) *Attitude of experiential openness (0C, 3NC)*
5. Appraisal / incorporation
a) *Considering multiple appraisal possibilities (2C, 5NC)*
b) *Desirability– desirable (4C, 5½NC) or undesirable (2C, ½NC)*
c) *Transiency– temporary process (2C, 5NC) or permanent state (2C, 0NC)*
d) *Acknowledging spirituality-psychosis link (4C, 6NC)*

Note. [1]Super-ordinate group themes; [2]Group themes; [3]Recurrence of group theme among C and NC participants; [4]Recurrence value of ½ indicates that group theme only partially reflects the experience of a participant

8.1. Immediate situational context

This super-ordinate group theme comprises three group themes relating to the situational context of participants' OOEs, immediately preceding the first experience.

a) Emotional suffering (6C, 5NC)

Nearly all participants in both groups reported a period of emotional suffering before their first OOE. This was either due to immediate issues (e.g. physical illness, grieving, stressful events / transitions, social problems), or to the processing or re-emergence of unresolved past issues (e.g. childhood family breakdown). Beth (C) and Clive (NC) gave typical reports of the kind of emotional difficulties experienced:

> "I was depressed... I was not really having a good sort of life at those times, so I guess that's where the voice came in" (Beth, C, 51)
>
> "My experiences with my ex-partner were very strange and stressful. There was nothing pleasant happening to me during that period of time" (Clive, NC, 284)

There was a clear link noticed between the nature of emotional suffering and the nature of OOE. For instance, Leroy (C) had a period of "anger and resentment" (76) towards his parents, which preceded the OOE of hearing his father's voice saying "nasty things" (79) in his mind. Similarly, both Clive (NC) and Flora (NC) had visions / visitations from spirits, who were initially identified as the person for whom they were grieving (although when Flora's spirit returned another time, she re-identified him as someone she hadn't met). There was a sense, therefore, that the first OOE was a direct expression of emotional concerns at the time. This was also true for

those processing past emotional issues; for instance, Holly (C), who was "bringing up all this tar and sort of darkness, and sort of negative feelings towards [her] family" (217), had an OOE that involved visual templates (presented to her by God), which were "related very much" (262) to these family-based emotional concerns.

b) Existential questioning (2C, 6NC)

This theme refers to the cognitive process of deep personal thinking and questioning about the meaning and/or direction of life. This may be partly linked to emotional suffering because it seemed that, in most cases, it was prompted by a sense among participants that they had reached some kind of *dead-end* in their lives:

> "I wasn't getting anywhere, and er, lots of the values and things I had, and the way I looked at the world, I began to question" (Daniel, NC, 54)
>
> "suddenly I was back at home thinking, you know, where's my life going to now, kind of thing, feeling really ill, not seeing a way out" (Jenny, NC, 167)

In Daniel's (NC) and Jenny's (NC) cases, this was very much an internal problem-solving process; i.e. searching for personal meaning and direction in a situation that seemed meaningless and directionless. In other cases, however, e.g. Tom (C) and Stefan (NC), there was a clear external influence of existential philosophies:

> "I was given a book... supposedly spiritual book about a particular way of thinking about things, and a particular way of living, which is all to do with, um, your ego, and you should try to dissolve your ego, and live your life in the present moment and things like this, and um, I basically really hooked into that whole philosophy" (Tom, C, 44)

Whether the existential questioning was internally or externally driven, the participants' OOEs appeared to have implications for the type of questions being contemplated. Clive (NC), who thought that his life had reached a dead-end ("I'd got to the end of it" (541)), spoke about the implications of his OOE: "there's more meaning, there's more purpose, and there's more direction" (547). Therefore, similar to emotional suffering, there also seemed to be some direct relevance of OOEs to the context of participants' existential questioning. From this, it could be interpreted that the OOE actually emerged as a direct expression of, or indeed solution to, some kind of psychological crisis. The finding that existential questioning was a more recurrent feature of the NC group might reflect that the psychological crises of NC participants had both emotional and intellectual components, whereas those of (most) C participants were more emotionally-based.

c) Isolation (4C, 4NC)

The immediate contextual theme of isolation, which was reported equally across C and NC groups, was either caused by an intentional withdrawal from people, or by a private pre-occupation with other activities:

> "I cut myself off like completely from my friends, like I didn't speak to them hardly ever" (Nessa, C, 187)
>
> "I was really really focussed only on reading, I was reading all day long and was getting involved with only a few persons, but was really like self-centred" (Stefan, NC, 47)

Isolation has been widely acknowledged in theories of psychosis, largely as it is thought to reduce access to reality testing and more normalising appraisals of experiences (Garety et al., 2001). However, the current data suggests that isolation may have been a factor in both C and NC participants in the lead up to an OOE, i.e. before the appraisal stage. It may therefore be that isolation has more of a causal role in triggering the experience itself, perhaps because it encourages introspective focus on the kinds of emotional and/or existential concerns mentioned above.

8.2. Subjective nature

This super-ordinate group theme comprises five themes relating to the subjective nature of OOEs. These provide an insight into what it was like for participants to actually *live* their experiences, and what subjective meanings they conveyed.

a) Emotional fulfilment (3C, 4NC)

One of the most striking findings was the powerful language used by participants to describe the emotionally fulfilling and euphoric qualities of their experiences:

> "I was feeling it in my body, and it was giving me a lot of joy" (Maria, NC, 307)
>
> "really sort of profound sense of love... deeper and more magnificent than sort of anything else I'd ever felt" (Holly, C, 614)
>
> "I got this terrific warm feeling, this very warm, loving feeling, and it was amazing. And I wanted it to go on. I didn't want it to stop" (Clive, NC, 114)

The experience of emotional fulfilment, which was expressed by both C and NC participants, would appear to tie in with previous speculations about the OOE being some kind of 'solution' to a psychological crisis. For instance, Holly's (C) visions brought a "sense of relief" (322) after a long period of depression, and Beth's (C) voice provided her with "company" (357), as well as with love and guidance:

> "God saw my suffering and he wanted to use me... to help me, you know, Yeah, that's why he gave me a guardian, which is the voice" (Beth, C, 140)

b) *Loss of ego boundaries / control (3C, 2NC)*

Another subjective phenomenon reported by both C and NC participants was the sensation of ego loss, what essentially seemed to be a breakdown of the normal psychological relationships between mind-body and / or self-others:

> "I didn't feel like I existed any more. I couldn't feel myself in my body. I had to keep pinching myself... I felt like my body was dissolving" (Jenny, NC, 421)
>
> "feelings of people potentially being able to read your thoughts, or, you know, potentially just having your kind of whole internal world really much externalised" (Holly, C, 1098)

Stefan (NC) and Omar (C) reported a complete mind-body disconnection, manifested by their bodies being controlled independently from their perception of ego or *self*:

> "I went through a period where my body, which I felt was being taken over by something else, and screams used to come out of my mouth... it was uncontrollable, it was out of my hands" (Omar, C, 81)

Stefan (NC) remained in his *out-of-body* state for about two weeks, during which time he was merely an observer of his body's sensations and behaviours: "it was belonging to [Stefan], not to me" (228). Again, this OOE could be directly traced to Stefan's existential questioning beforehand, which was driven by an Indian philosophy that promotes "denying the body completely" (257).

c) Fearful absorption (4C, 3NC)

There was a sense among participants in both groups that, although some aspects of their OOE were scary and confusing, they were still quite compelling and absorbing:

> "at the beginning I started to be afraid of him, but then, yeah, I kind of got attached to him... I started to miss him" (Flora, NC, 149)

The fear reaction is likely to have largely come from the unfamiliarity of experience, and although some initial absorption may be due to a natural, instinctive attention towards fear-inducing stimuli (Öhman, 2000), it is possible that more prolonged absorption was caused by the emotionally fulfilling role of the OOE in a psychological problem-solving process. In both groups, there was certainly evidence of some underlying emotional motivation surrounding participants' experiences, which often defied or contradicted their rational/logical motivations:

> "it felt something that was very unfamiliar, and quite alien, I suppose... something I naturally had quite a lot of resistance towards, um, but at the same time it was really innately familiar as well" (Daniel, NC, 191)

d) Insight into deeper meaning (3C, 5NC)

This theme consistently emerged from both groups, and refers to a cognitive tendency (or style) of perceiving a different level of meaning in events; deeper than the surface level of reality.

> "I was hearing everything on a completely different level of awareness than everyone else, like I sort of entered into this world of symbolic meaning" (Tom, C, 267)

> "moments of quite radical, striking, kind of intuitive perceptions of things, and being encountered by other peoples' really very striking intuitive perceptions of me. You know, the ability to look really deeply into someone" (Daniel, NC, 131)

This symbolic, deeper meaning perhaps reflects a quality of awareness that is not filtered or confined by the conceptual boundaries of ordinary day-to-day experience. There is a connection here with ego loss, because it is likely that one's conceptual framework for experiencing the world is concomitant with one's sense of ego or *self*. If the ego breaks down, then it may be that perception of the world becomes unbounded and limitless (Clarke, 2001), and becomes driven by emotional intuition rather than conceptual reasoning. Holly provided an account of this subtle perceptual difference:

> "you're so conditioned, just from life, of being taught what a chair is that you can expect to see the shape of a chair and all this stuff. I was seeing the object in its own right, without labels and, from every angle, and like, in its splendour, kind of thing (laugh), like without the kind of attachments, and like any conditioning" (Holly, C, 566)

e) New way of thinking (3C, 3NC)

Following on from the previous theme, which conveys an awareness that is free from the influences of a "conditioned" conceptual framework, this theme suggests the implementation of a new conceptual framework, or a new way of looking at the world. This was expressed by half of the participants in both groups:

> "this just did something to my consciousness that just started a process that meant that I was really never going to be the same again" (Jenny, NC, 318)
>
> "everything else that I used to think or I used to know just totally changed" (Tom, C, 149)
>
> "the way I see things changed" (Beth, C, 169)

This cognitive shift may be an important key to understanding the role of OOEs in the lives of both C and NC participants. It could be that the initial psychological crisis arose in many participants due to an inadequacy of their existing conceptual framework in making sense of their emotional experience. The analysis has already indicated that 11 of 12 participants were experiencing an intense emotional experience, and that this was accompanied by deep existential questioning in eight participants. Perhaps a new way of thinking was the necessary, adaptive 'solution' to this crisis? Perhaps the old conceptual framework had to be replaced by a new conceptual framework in order for the emotional experience to become integrated?

This portrayal of a conceptual-emotional crisis, leading to ego breakdown and new fulfilling insights appears to be suggestive of an adaptive psychological problem-

solving process, similar to that hypothesised by Jackson (2001). Also, the fact that, apart from existential questioning, there has been no notable difference up to this point in the OOEs of C and NC groups implies that this problem-solving process is neither pathological nor indicative of clinical psychosis. It is only when we move onto the following super-ordinate themes that inter-group differences start to emerge.

8.3. Inter-personal context

This super-ordinate group theme comprises two group themes that concern the participants' views and experiences of relating to other people about their OOEs.

a) *Awareness of others' views– pathologising (6C, 6NC) or normalising (3C, 6NC)*

All participants in both groups showed some awareness of the pathologising views of other people towards their OOEs, whether this was people they knew personally, or just the public at large. However, regarding normalising views, there was more awareness among NC participants. In the C group, it was only Omar's mother who initially took a spiritual view, although she later sought medical advice. Holly had no initial awareness of others' normalising views, but later found some Christian followers who could relate to her experiences. Beth was aware that people had religious experiences, but didn't know anyone personally to whom she could relate. In the NC group, there was recognition of both extremes for viewing experiences, and what seemed to be a more considered approach to negotiating these extremes:

> "I wouldn't share it with anybody, because if something is important to me, I don't want somebody else to laugh at it" (Maria, NC, 655)

b) Validation from others– validating (1½C, 5NC) or invalidating (5C, 1NC)

This theme refers more to participants' actual interactions with people; i.e. the views that were imposed, or otherwise received, from people they had direct contact with. This reveals more substantial group differences, in that more of the NC participants received validating/accepting responses from others, and more of the C group received invalidating responses, as these quotes illustrate:

> "[I] relayed this experience to psychiatrists in the [hospital] and was sent for EEG tests, was told that I was hallucinating, was, this guy just didn't listen to, just obviously hadn't heard anything really that I'd said, and at the end of time was like, "so you think your Jesus?", and I was like, "er, no"... I just felt that this really positive experience was just scrutinised and just not, just like mocked. I didn't feel offended, I just thought they were being really stupid, and disregarding this kind of, yeah, really important thing" (Holly, C, 984)

> "somebody came up to me and said "well, you know, we really need to hear from you. That's a very powerful message to people, and they need to hear that message". And that did matter to me" (Clive, NC, 440)

For the individual who is, perhaps, already slightly hesitant about how best to incorporate their experience into their social worlds, the difference between these two social interactions could be immense. This seems to be the first major difference between C and NC groups, who until this stage of the report have generally reported quite similar experiences (in both triggers and subjective nature). Daniel (NC) neatly summed up why he believes inter-personal context is so important:

> "I needed affirmation, that's what I needed, er, to help me contextualise it and make sense of it... I suppose I did need kind of affirmation from other people that it was all ok" (Daniel, NC, 236)

8.4. Background personal context

This super-ordinate group theme comprises two themes about personal background, concerning participants' prior knowledge of, and attitudes towards, OOEs.

a) Previous knowledge / understanding (3½C, 6NC)

All NC participants demonstrated some prior understanding or interest in their OOEs. The same was true for just half of the C group, with two participants specifically saying that they had no knowledge whatsoever (e.g. Leroy (C): "I didn't know that what I was experiencing had been like experienced by anybody else ever" (162)). Flora (NC), whose OOE was being visited by spirits, spoke of her childhood interests:

> "I always believed in ghosts when I was little, but I was terrified from them. But I wanted, I always wanted to know if they were true or not, so I used to watch ghost programmes" (Flora, NC, 437)

Jenny (NC) also reported some previous knowledge, and highlighted the difference between having a concept *about* something, and having direct experience *of* it:

> "I kind of knew it more intellectually maybe before, and like from my Buddhist stuff, I started to believe in the concept of enlightenment and waking up, being a more awake human being and stuff, so I did kind of believe it... but this was more profound and more strong" (Jenny, NC, 370)

Previous knowledge is likely to facilitate the process of incorporating an OOE into one's life because of the meaningful context it provides. In the same way that inter-

personal context was found to be so important in accommodating OOEs, background personal context is likely to have played a crucial role in conceptual meaning-making. Although, at an emotional / perceptual level, the meanings conveyed by an OOE were very similar in both groups (symbolic insights, unbounded awareness, etc), at the conceptual level, the meanings attached to the OOE were greatly dependant on contextual factors. It may therefore be the lack of suitable context, either through no prior understanding, or through invalidating interactions with others, which left C participants more vulnerable to maladaptive appraisals and inter-personal conflicts.

b) Attitude of experiential openness (0C, 3NC)

This theme was only identified in the NC group, and refers to a general attitude of openness and readiness for OOEs. Because this attitude seemed to precede the experience, it may represent a personality feature rather than a transient state:

> "it was almost like part of me knew that I would allow myself to really open in that way" (Jenny, NC, 632)
>
> "I was very open to, um, strange experiences, what synchronicities or the idea that there were kind of nature spirits or fairies" (Daniel, NC, 456)

This is essentially a form of preparation for the experience. So, in addition to having a prior general concept of OOEs, the suggestion is that some NC participants actually had a prior concept of their own personal relationship to OOEs. This amounts to a more *tailored* contextual framework with which to integrate their experiences.

8.5. Appraisal / incorporation

Having already speculated about how contextual factors influence the integration of OOEs into participants' lives, the discussion now moves onto the final super-ordinate theme, which comprises four themes on the subject of appraisal / incorporation.

a) Considering multiple appraisal possibilities (2C, 5NC)

There was a sense, especially among NC participants, of there being more than one appraisal option for their OOE. Stefan (NC), for example, relayed a whole list of possibilities: "schizophrenia"; "bad trip"; "meditation"; "higher natural being"; "magic"; "overloading my brain" (134-370). Clive (NC), who described himself as a "complete non-believer" (52), explored rational explanations before accepting that there must be some spiritual dimension that he doesn't understand. Daniel (NC) felt that he was presented with a choice between a religious appraisal and a personal-growth appraisal: "I was kind of caught between these two different ways of looking at it" (256). In the C group, Omar seemed to adopt parallel explanations, choosing to seek help for his "evil gin" possession through both the spiritual and medical routes:

> "I think, personally, that both things helped me: the spiritual side and the medical side" (Omar, C, 237)

The group difference in theme recurrence may relate to the earlier finding of fewer C participants having prior conceptual knowledge, because a fear of uncertainty might encourage *jumping to conclusions* or fully accepting the first explanation that

becomes available. For instance, Leroy (C) and Nessa (C), who both lacked a prior conceptual context, instantly adopted a medical appraisal from their first GP contact.

b) *Desirability– desirable (4C, 5½NC) or undesirable (2C, ½NC)*

In the NC group, five participants wholeheartedly embraced their OOE as desirable and enhancing to their lives, and just one remained ambivalent about its desirability. In the C group, four described their OOE as enhancing, although three of these only arrived at this view after a period of experiencing it at undesirable and debilitating. The remaining C participants viewed it as purely negative; these were the ones that had adopted a medical explanation. Interestingly, in some cases, the perceived life-enhancing qualities seemed to determine which appraisal option was chosen:

> "there's been a lot of positive effects, whereas I'd expect, um, if it was a sign of a mental illness or a disturbance, that I would be having the opposite effects" (Clive, NC, 263)

> "it was such a positive thing, and was such a, kind of, enlightening thing... just full of these realisations that were kind of setting me free from this darkness, that it just, yeah, I would definitely ascribe it to God now" (Holly, C, 799)

However, in other cases, it seemed to be the other way round, whereby the reflective appraisal process determined the perceived desirability of OOEs:

> "It happened at a point where I was considering what to do, and this experience gained me the time to reflect... it helped me a lot to like order my thoughts about how I should proceed... somehow it fitted in the moment" (Stefan, NC, 475)

These life-enhancing qualities, which were reported by the majority of participants, add further support to the psychological problem-solving hypothesis. Not only did the OOEs provide many participants with relief from emotional suffering, but they also added a dimension that enriched other life-domains:

> "It generally tends to add an enrichment to what I'm doing, and a dimension, and a sense of meaning... the consequences of it, in the sense of psychological benefits and stability in life, are fantastic" (Daniel, NC, 346)

The medical (illness) explanation clearly presented barriers to similar reflections in the C population, and even if this explanation was resisted (e.g. Holly and Beth), the stigma and conflicts of opinion with professionals, families etc. created inter-personal difficulties that affected the perceived desirability of OOEs.

c) *Transiency– temporary process (2C, 5NC) or permanent state (2C, 0NC)*

More NC than C participants viewed their experience as a temporary stage or process. Stefan (NC) even considered how he might go about re-experiencing his *out-of-body* state: "I do think that I could get in this state again if I let go of myself, and like read a lot, and start to evade social contact" (513). In contrast to this, there were participants in the C group who conveyed an unwelcome sense of permanency:

> "I'm told that they might never go away... I read somewhere that mental illnesses never go away, um, but so, going forward is quite difficult because I'm still living with the effects of the mental illness that I've had. And basically the most salient fact is that it might never go away. In fact, it probably won't. That's the problem" (Leroy, C, 417)

Again, the influence of the medical explanation can be implicated here. For Leroy, it seemed that it was not so much the OOE that was "the problem", but the fact he had been told that his "illness" was permanent. The way that Leroy's OOE had been incorporated begs the question if there is any scope at all for desirability, growth, and future well being. Holly (C) described how her attempts to take something positive out of her temporary OOE were directly hampered by medical opinions:

> "It was very frustrating for me because I felt like it was a stage, and I knew for myself that it was a stage. But it was like they [services] didn't accept that it was just a stage, like a process, that it was very much the end" (Holly, C, 1190)

It could be interpreted from these findings that medical advice might, paradoxically, be a hindrance to positively incorporating OOEs. However, it is also probable that those participants receiving medical advice are the ones who were struggling to positively incorporate their experiences in the first place. Either way, if the causes and subjective nature of OOEs are no different between NC and C groups, then it seems misleading for professionals to inform one group that their OOEs signal "the end", while the other group continue with their (enhanced) lives. Indeed, this is precisely the time that professionals should be facilitating the incorporation process.

d) Acknowledging spirituality–psychosis link (4C, 6NC)

Nearly all participants gave some acknowledgment of the link between psychotic and spiritual experience. This was either in reference to the earlier theme of considering multiple appraisal possibilities, or was in their more general reflections on this

experiential realm. Jenny (NC) felt that she was "balancing a really fine line" (426) between spiritual and psychotic experience, and emphasised that what helped her through was *trust*: "just trust that you're ok and that everything's ok, and the universe is, just trust" (522). Like other participants, Jenny (NC) also contemplated the idea that perhaps the two phenomena are actually one and the same:

> "I remember going back and saying to my Dad, "you know Dad, do you think sometimes when people are in mental hospital, they're actually undergoing some sort of spiritual phenomena?"" (Jenny, NC, 626)

9. Summary and implications

9.1. Summary of findings

If the table of participants and their initial OOEs (Table 2) were to be mixed up, it would be impossible to identify which six participants belonged to the C or NC group. This, of course, was the intention of screening: to control for the experiences themselves, so that phenomenological and contextual comparisons could be made. The results revealed five super-ordinate themes of phenomenological and contextual interview data, within which group comparisons were carried out. In the super-ordinate themes of *immediate situational context* and *subjective nature*, there were many clear similarities between the two groups, and in the super-ordinate themes of *inter-personal context*, *background personal context*, and *appraisal / incorporation*, there were more noticeable group differences emerging from the data.

Regarding similarities, the OOEs of both groups were found to have occurred during a period of significant negative emotion, which in most cases, was accompanied by isolation and deep contemplation about the meaning and direction of life. The initial OOEs typically provided emotional fulfilment to participants in both groups, and the deep insights revealed by them were subjectively meaningful in the context of their emotional concerns. Because the OOEs of all participants seemed, at some level, to fulfil a psychological purpose, they were interpreted as being part of an adaptive psychological problem-solving process, which frequently involved the breakdown of conceptual ego boundaries, and the formation of a new conceptual outlook.

Regarding group differences, there was a sense that NC participants were better able to incorporate their OOEs into their personal and social worlds. This was partly due to more NC participants having prior conceptual knowledge of, and in some cases, open attitudes towards, their OOEs; however, the more prominent reason seemed to be that more NC participants received validation and acceptance from others. There was awareness among all participants in both groups about how their OOEs *could* be invalidated or pathologised, but more C participants were directly subjected to this invalidation, and had less access to those who could validate and accept their experiences. Another protective factor among NC participants was the perceived desirability and transiency of their OOEs, which might also have been influenced by the differences in inter-personal validation. Finally, while most participants in both groups recognised a link between clinical and non-clinical OOEs, more NC participants demonstrated an ability to consider multiple appraisal options, and conveyed a sense of less urgency in considering which appraisal 'option' to adopt.

9.2. Implications and limitations

The findings of this study are consistent with those of Jackson & Fulford (1997), in that the contextual factors involved with triggering the experience are different to the contextual factors involved with incorporating the experience, and that it is the latter which are implicated in the development of psychosis. As the NC participants have demonstrated, the OOE itself is not pathological; to the contrary, it is adaptive and generally enhancing. The 'pathology' seems to be a separate matter altogether; i.e., when the purpose and *meaning* of the OOE is failed to be acknowledged through a lack of integration with the inter-personal and background personal contexts. The particular emphasis emerging on inter-personal context for positively incorporating OOEs reinforces the previous work of Brett et al. (2007) and Lovatt et al. (in press).

One finding of Brett et al. and Lovatt et al. that did not feature in the current study was that of C participants being more likely to appraise their experiences as external and caused by other people. In the current study, the majority of participants in both groups adopted appraisals that could be described as spiritual; i.e. OOEs were appraised as externally generated by spiritual beings, rather than by other people. Unlike previous studies, this suggests that an externalising attributional style was present in both groups, and may therefore be more closely linked to the OOE phenomena themselves, rather than being a predictor of their clinical consequences.

The main theoretical implication of these findings is that integrative *bio-psycho-social vulnerability* models are not suitably precise, and that psychosis may be better understood if the OOE vulnerabilities are separated from the clinical vulnerabilities.

It would seem that the more OOEs are associated with clinical psychosis, the less chance people have of recognising their desirability, transiency and psychological benefits, and the more chance they have of detrimental clinical consequences.

Following on from this, an important clinical implication is that psychotic experiences should be normalised, and people with psychosis should be helped to re-connect the meaning of their OOEs with the genuine emotional and existential concerns that preceded them. A normalising rationale is already recognised as a useful therapeutic tool as it reduces stigmatisation, improves therapeutic alliance, combats distress, and entails greater hope for recovery (Kingdon & Turkington, 1991). However, the current findings suggest that the argument for normalisation goes far deeper than clinical usefulness. The results imply that a more '*radical normalisation'* approach is needed, where normalising OOEs becomes an intrinsic treatment principle, rather than something that is included in some therapies because it is thought to be useful.

Linked to normalisation is the therapeutic tenet of validation, which was found to be a key protective factor in the NC group. Clinically, this might involve identifying the subjectively valid emotional expression underlying the delusional / hallucinatory content. Treatment could then be geared towards accepting this emotional validity, and conceptualising it in a way that is not so detrimental to the individual's well-being. Unlike antipsychotic drugs, which suppress the emotional expression, this approach would validate and encourage the emotional expression, whilst working on building a more helpful conceptualisation or narrative about the emotional concerns.

One of the limitations to this study is that the findings cannot be generalised to the entire clinical and non-clinical populations with OOEs, and the best that can be hoped for with such a small, select sample is that the results and discussion can build a platform for future quantitative research and theoretical developments. Another limitation is that qualitative designs are clearly not as well suited to inter-group comparisons as quantitative designs. However, while IPA is most typically applied to single homogenous groups of participants, its flexibility for comparative and multi-perspectival research has been demonstrated (e.g. Clare, 2002; Larkin & Griffiths, 2004). Indeed, Smith et al. (2009) state that “the exploration of one phenomenon from multiple perspectives can help the IPA analyst to develop a more detailed account of that phenomenon” (p52). In this study, a fair amount has been revealed about the phenomenon of OOE by exploring C and NC perspectives, even if the group comparisons are more arbitrary than in a quantitative, statistical analysis.

For future research, measures will need to be developed to tap the perceptual and conceptual phenomena revealed in this study. The AANEX (Brett et al., 2007) is a well constructed tool for measuring the appraisal-related phenomena surrounding OOEs, but additional measures are required to access the more subjective aspects identified, such as ego breakdown, dissociative states, and intuitive perception. These aspects appeared to play an equally important role in participants’ appraisal processes in that they conveyed a subjective meaning that influenced appraisal *style*, as opposed to the objective, conceptual meanings that influenced appraisal *content*. It may therefore be an idea for future quantitative research to explore these subtle appraisal differences, so that further refinement of psychosis models is encouraged.

9.3. Conclusion

This study used the qualitative method of IPA to explore the phenomenology and context of psychotic-like OOEs in both clinical and non-clinical participants. In comparing the groups, it was found that many triggers and subjective elements of the OOEs were similar, suggesting that the OOE itself was not determinative of a dysfunctional clinical condition; instead, the OOE was interpreted as a functional, adaptive aspect of psychological experience. The clinical consequences of OOEs were discussed in terms of the influence of inter-personal and background personal contextual factors, which were found to differ between the groups. The implications and limitations of these findings were noted, and it was proposed that a more validating and normalising approach be adopted towards psychotic-like phenomena.

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British Journal of Clinical Psychology

Notes for Contributors

The **British Journal of Clinical Psychology** publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations
- Theoretical papers, provided that these are sufficiently related to the empirical data
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications
- Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words (excluding abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via our online peer review system. The Journal operates a policy of anonymous peer review.

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and

shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi.

- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions. Please see the document below for further details:

Structured abstracts

Authors should note that all papers submitted to the British Journal of Clinical Psychology must include structured abstracts. Papers will not be considered for publication unless they have a structured abstract in the correct format.

Articles containing original scientific research should include a structured abstract with the following headings and information:

Objectives State the primary objectives of the paper and the major hypothesis tested (if appropriate).

Design Describe the design of the study and describe the principal reasoning for the procedures adopted.

Methods State the procedures used, including the selection and numbers of participants, the interventions or experimental manipulations, and the primary outcome measures.

Results State the main results of the study. Numerical data may be included but should be kept to a minimum.

Conclusions State the conclusions that can be drawn from the data provided and their clinical implications (if appropriate).

Review articles should include a structured abstract with the following headings:

Purpose State the primary objectives of the review.

Methods State the method used to select studies for the review, the criteria for inclusion, and the way in which the material was analysed.

Results State the main results of the review.

Conclusions State the conclusions that can be drawn from the review and their clinical implications if appropriate.

- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

6. Publication ethics

All submissions should follow the ethical submission guidelines outlined in the documents below:

Ethical Publishing Principles – A Guideline for Authors

Code of Ethics and Conduct (2006)

7. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

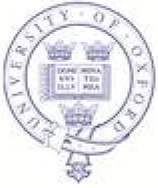
8. Copyright

On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form. To find out more, please see our Copyright Information for Authors.

Table of organisations for NC recruitment advertising

Organisation contacted	Outcome
The College of Psychic Studies	Advert on notice board
Spiritualists Association of Great Britain	Advert on notice board
UK Spirituality	Initial reply, but declined advertising
The Spiritual Crisis Network	Agreed to email circulation, but not used
Society for Psychical Research	Advert on website & in magazine
Quakers	Advert in ‘The Friend’ (£13.16 fee)
Heythrop College, University of London	Email circulation & advert on notice board
St Marlyebone Healing Centre	Advert taken to meeting
The Esoteric Experience	Advert taken to meeting
The Theosophical Society in England	No reply
Psychics & Mediums Network	Advert on web forum
ShahMai Network	Initial reply, but then no contact
The Miracle Network	Advert in magazine (£10 fee)
Living Spirituality Network	No reply
Sea of Faith Network	Email circulation & advert in newsletter
The Spirit Guides Network	Advert on website (£12 fee)
Alistair Hardy Society	Poster & announcement at open day

The recruitment adverts / posters that were sent to the above NC organisations are shown on the following two pages:



Oxford Doctoral Course in Clinical Psychology
an NHS Course validated by the University of Oxford

Isis Education Centre, Warneford Hospital, Headington, Oxford OX3 7JX
Tel: +44 (0) 1865 226431 Fax: +44 (0) 1865 226364
Web-site www.hmc.ox.ac.uk/clinicalpsychology

Have you had a mystical/spiritual/religious experience in the last five years?

I am looking for individuals who have had any of these experiences to take part in my doctoral research project for the University of Oxford.

If you are interested in talking about your experiences as part of a research study, or would like any further information please contact me on:

Tel: 07505 243638
Email: charlie.heriot-maitland@hmc.ox.ac.uk

Charlie Heriot-Maitland
Trainee Clinical Psychologist
Oxford Doctoral Course in Clinical Psychology

If you do not have a pen to hand, please tear off one of the slips below with my contact details on:

07505 243638 charlie.heriot-maitland@hmc.ox.ac.uk

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Tel: +44 (0) 1865 226431 Fax: +44 (0) 1865 226364
Web-site www.hmc.ox.ac.uk/clinicalpsychology

Have you had a mystical/spiritual/religious experience in the last five years?

My name is Charlie Heriot-Maitland and I am a Trainee Clinical Psychologist studying at the University of Oxford. For my doctoral research study, I am interested in talking to people who have had what they might describe as a mystical, spiritual or religious experience.

The Study:

Many people describe having experiences that are different to ordinary day-to-day experience in that they involve extra-sensory communication, awareness of an alternative reality or a different dimension to life. For some, these experiences can be very positive, but other people find them more distressing and may need support in understanding and coping with them.

I am interested to try and understand why different people have different responses to their experiences.

I am especially interested in finding out about the nature of people's experiences, the way they make sense of them, and the context in which they occur.

What will it involve?

If you would like to take part in the study I will arrange to meet you for a one-off interview about your experiences that should take about 1-1½ hours.

All of the information that you give will be strictly confidential and no one other than myself will be able to identify your details.

Participation in the study is entirely voluntary and you may like to take some time to think about it. You will be remunerated £15 for your time, on top of any travel costs you incur.

If you have any questions or would like to take part in the study, please contact me on:

Tel: 07505 243638 or Email: charlie.heriot-maitland@hmc.ox.ac.uk

07505 243638 charlie.heriot-maitland @hmc.ox.ac.uk

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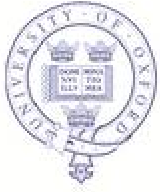

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Web-site www.hmc.ox.ac.uk/clinicalpsychology

Charlie Heriot-Maitland

Tel: 07505 243638
Email: charlie.heriot-maitland@hmc.ox.ac.uk
1st Sept 2009

Dear

My name is Charlie Heriot-Maitland and I am a trainee clinical psychologist studying at the University of Oxford. I am writing to invite you to take part in a research study entitled:

'Out-of-the-ordinary experiences in clinical & non-clinical populations'

I am interested in speaking to people who have had what they might describe as a mystical, spiritual or religious experience. Many people report having experiences that are different to ordinary day-to-day experience in that they involve extra-sensory communication, awareness of an alternative reality or another dimension to life. For some these experiences can be very positive and enriching, but others can find them more distressing and they may need help in coping and understanding them.

I am interested in trying to understand why people respond differently to their experiences, and would therefore like to find out about the nature of people's experiences, the way people make sense of them, and the context in which they occur. All participants for this study will be interviewed by me for about 1-1½ hours, and will be reimbursed £15 for their time.

Participation is entirely voluntary and you may withdraw from the study at any time without the need to justify your decision. Any information that you provide is confidential and will not be able to be identified by anyone other than myself.

I have enclosed an information sheet with further details. If you require any further details or would like to take part, please do not hesitate to contact me (see above).

Yours sincerely,

Charlie Heriot-Maitland
Trainee Clinical Psychologist

PICuP Clinic

«Title» «FirstName»
«LastName»
«Company»
«Address1»
«Address2»
«City»
«State»

1st Sept 2009

PICuP RESEARCH REGISTER

Dear «Title» «LastName»,

We are currently supporting a research study on "out-of-the-ordinary experiences in clinical & non-clinical populations", being carried out by Charlie Heriot-Maitland, University of Oxford. Since you are currently registered with our Research Register, we are enclosing an information sheet on the study. **If you would like to participate in this study, please contact Charlie Heriot-Maitland directly at the number or address provided on the information sheet.** If, however, you do not wish to participate in this study, you don't need to do anything, unless instructed otherwise in the information sheet.

If you would like to be removed from the PICuP research register, you can do so by calling PICuP on **020 3228 3524**, e-mailing picup@slam.nhs.uk, or completing and returning the slip below, without giving a reason.

We would like to take this opportunity to thank you for your support of the PICuP Research Register so far,

Yours sincerely,

Dorothy Abrahams
PICuP Administrator

NAME: ……………………………………………… DATE: ……

Please remove my name from the PICuP Research Register until further notice.

Send to: Dorothy Abrahams, PICuP, PO79, Maudsley Psychology Centre, Maudsley Hospital, Denmark Hill, LONDON SE5 8AZ

Berkshire Healthcare NHS
NHS Foundation Trust

Slough Early Intervention Service (Tel: 01753 690950)
New Horizons, Pursers Court, Slough, Berks SL2 5BX

1st Sept 2009

Dear

The Slough Early Intervention Service are currently supporting a research study on "out-of-the-ordinary experiences in clinical & non-clinical populations", being carried out by Charlie Heriot-Maitland, University of Oxford. Enclosed with this letter is an information sheet, which gives an outline of what this study involves, and details of how to contact the lead researcher.

If you would like to participate in this study, please contact Charlie Heriot-Maitland directly at the number or email address provided on the information sheet.

If, however, you do not wish to participate in this study, you do not need to do anything.

Yours sincerely,

Dr Eve D'Souza
Consultant Psychiatrist
Slough Assertive Outreach & Early Intervention Services

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Web-site www.hmc.ox.ac.uk/clinicalpsychology

INFORMATION SHEET (non-clinical participants)

'Out-of-the-ordinary experiences in clinical & non-clinical populations'

We would like to invite you to take part in a research study, the title of which is shown above. However, before you decide, we would like you to understand a bit about why the research is being done, and what it would involve if you were to take part.

What is the purpose of the research?
Many people describe having experiences that are different to ordinary day-to-day experience in that they involve extra-sensory communication, awareness of an alternative reality or a different dimension to life. These experiences can be pleasant or unpleasant, confusing or inspiring. This research hopes to help us understand the range of unusual experiences people have, and how some of their features relate to other life factors. We are particularly interested in exploring the nature of people's experiences, the way they make sense of them, and the context in which they occur.

Why have I been invited?
By receiving this information sheet, you have either responded to an advert or signed a research register for people reporting 'out-of-the-ordinary' experiences. These experiences might be described by you or others in mystical / spiritual / religious terms, or in some other way. For this study, it is not important how you describe or explain your experiences, but the fact that they are different to ordinary day-to-day experience makes you a suitable research candidate. Also, because your experiences have not directly resulted in your involvement with clinical treatment services, you would be included in the 'non-clinical' population of this study.

Do I have to take part?
This study is entirely voluntary, and if you agree to take part, we will ask you to sign a consent form. Before signing this, we will go through the information sheet with you and give you the opportunity to ask questions. You also have the right to withdraw from the study at any time without having to give a reason. If you decide to withdraw, any information you have given will be destroyed and you will not be contacted again.

What will happen to me if I take part?
You will be asked to meet with the lead researcher on one occasion to complete an interview. This should take about 1-1½ hours, and with your permission, will be audio recorded. This meeting will be at a time and place that is convenient for you.

Expenses and payments
We can offer you £15 to remunerate you for your time. Also, if you have to travel to the interview, please keep a receipt so that we can reimburse your travel expenses.

What will I have to do?
We will want to ask you questions about your first 'out-of-the-ordinary' experience, what you think and feel about it, and about what events and circumstances were happening in your life at the time. All participants will follow the same procedure.

What are the possible risks and benefits of taking part?
As this study only involves a one-to-one interview about your experience, there are unlikely to be many significant risks or benefits. However, if the conversation touches on some emotionally sensitive issues for you, there may be a risk of you becoming distressed. Because the interviewer is a trainee clinical psychologist, they already have experience of working with people in distress, and will try to help you manage these feelings by talking. There is also a possibility that talking about sensitive issues may have a therapeutic benefit, although this is not the intention of the research.

Will my taking part be confidential?
All information which is collected during the course of the research will be kept strictly confidential. The data will be collected and stored in accordance with the Data Protection Act 1998, secured against unauthorised access. The recordings of the interview will be anonymised and stored in a locked filing cabinet.

What will happen to the results of the study?
Overall results of the study will be available to all participants, if they want them, after completion of the study in July 2010. The results will be written up as an internal report that will be submitted as part of an educational qualification at the University of Oxford. It is also intended that the results of the study will be published in a peer reviewed journal. Although interview quotes may be used to illustrate the results, these will be anonymised to ensure that no individual participant is identifiable.

Who is organising and funding the study?
This study forms part of the doctoral clinical psychology training at the University of Oxford. It is organised by the Oxford Doctoral Course in Clinical Psychology, and is funded by the Oxfordshire and Buckinghamshire Mental Health NHS Trust.

Who has reviewed the study?
This study has been reviewed and approved by the University of Oxford Research Sub-Committee and the Oxfordshire NHS Research Ethics Committee B (ref: 09/H0605/93). It has also been registered with the R&D departments of South London and the Maudsley NHS Trust, Berkshire Healthcare NHS Trust, and Oxfordshire and Buckinghamshire Mental Health NHS Trust.

What if there is a problem?
If you have a concern about any aspect of this study, you should speak to the named researchers (below) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the Oxford Doctoral Course in Clinical Psychology on telephone number 01865 226431.

Further information and contact details
If you would like to participate in this study, please call or email the lead researcher:

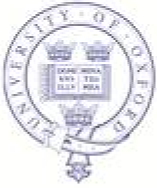
Charlie Heriot-Maitland
(Trainee Clinical Psychologist)
Tel: 07505 243638
Email: charlie.heriot-maitland@hmc.ox.ac.uk

If you have any additional questions relating to this study, or concerns about participation, please contact the lead researcher or one of the research supervisors:

Dr Emmanuelle Peters
(Consultant Clinical Psychologist)
Tel: 020 7848 0347

Dr Matthew Knight
(Clinical Psychologist)
Tel: 01753 477 092

Thank you for taking the time to read this sheet and considering whether to take part in the research study.



Oxford Doctoral Course in Clinical Psychology
an NHS Course validated by the University of Oxford

Isis Education Centre, Warneford Hospital, Headington, Oxford OX3 7JX
Tel: +44 (0) 1865 226431 Fax: +44 (0) 1865 226364
Web-site www.hmc.ox.ac.uk/clinicalpsychology

INFORMATION SHEET (Slough EIS clinical participants)

'Out-of-the-ordinary experiences in clinical & non-clinical populations'

We would like to invite you to take part in a research study, the title of which is shown above. However, before you decide, we would like you to understand a bit about why the research is being done, and what it would involve if you were to take part.

What is the purpose of the research?
Many people describe having experiences that are different to ordinary day-to-day experience in that they involve extra-sensory communication, awareness of an alternative reality or a different dimension to life. These experiences can be pleasant or unpleasant, confusing or inspiring. This research hopes to help us understand the range of unusual experiences people have, and how some of their features relate to other life factors. We are particularly interested in exploring the nature of people's experiences, the way they make sense of them, and the context in which they occur.

Why have I been invited?
By receiving this information sheet, you have been identified by the Slough EIS team as someone who has reported 'out-of-the-ordinary' experiences. These experiences might have been described by you or others in spiritual / mystical terms, in psychiatric terms, or in some other way. For this study, it is not important how you describe or explain your experiences, but the fact that they are different to ordinary day-to-day experience makes you a suitable research candidate. Also, because your experiences have resulted in your involvement with Slough EIS, you would be included in the 'clinical' population of this study.

Do I have to take part?
This study is entirely voluntary, and if you agree to take part, we will ask you to sign a consent form. Before signing this, we will go through the information sheet with you and give you the opportunity to ask questions. You also have the right to withdraw from the study at any time without having to give a reason. If you decide to withdraw, any information you have given will be destroyed and you will not be contacted again.

What will happen to me if I take part?
You will be asked to meet with the lead researcher on one occasion to complete an interview. This should take about 1-1½ hours, and with your permission, will be audio recorded. This meeting will be at a time and place that is convenient for you.

Expenses and payments
We can offer you £15 to remunerate you for your time. Also, if you have to travel to the interview, please keep a receipt so that we can reimburse your travel expenses.

What will I have to do?
We will want to ask you questions about your first 'out-of-the-ordinary' experience, what you think and feel about it, and about what events and circumstances were happening in your life at the time. All participants will follow the same procedure.

What are the possible risks and benefits of taking part?
As this study only involves a one-to-one interview about your experience, there are unlikely to be many significant risks or benefits. However, if the conversation touches on some emotionally sensitive issues for you, there may be a risk of you becoming distressed. Because the interviewer is a trainee clinical psychologist, they already have experience of working with people in distress, and will try to help you manage these feelings by talking. There is also a possibility that talking about sensitive issues may have a therapeutic benefit, although this is not the intention of the research.

Will my taking part be confidential?
All information which is collected during the course of the research will be kept strictly confidential. The data will be collected and stored in accordance with the Data Protection Act 1998, secured against unauthorised access. The recordings of the interview will be anonymised and stored in a locked filing cabinet.

What will happen to the results of the study?
Overall results of the study will be available to all participants, if they want them, after completion of the study in July 2010. The results will be written up as an internal report that will be submitted as part of an educational qualification at the University of Oxford. It is also intended that the results of the study will be published in a peer reviewed journal. Although interview quotes may be used to illustrate the results, these will be anonymised to ensure that no individual participant is identifiable.

Who is organising and funding the study?
This study will form part of a doctoral degree in clinical psychology at the University of Oxford. It is organised by the Oxford Doctoral Course in Clinical Psychology, and is funded by the Oxfordshire and Buckinghamshire Mental Health NHS Trust.

Who has reviewed the study?
This study has been reviewed and approved by the University of Oxford Research Sub-Committee and the Oxfordshire NHS Research Ethics Committee B (ref: 09/H0605/93). It has also been registered with the R&D departments of South London and the Maudsley NHS Trust, Berkshire Healthcare NHS Trust, and Oxfordshire and Buckinghamshire Mental Health NHS Trust.

What if there is a problem?
If you have a concern about any aspect of this study, you should speak to the named researchers (below) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the local NHS complaints procedure by contacting:

Complaints
Berkshire Healthcare NHS Foundation Trust
2nd & 3rd Floors, Fitzwilliam House
Skimped Hill Lane
Bracknell
Berkshire
RG12 1LD

Tel: 01344 415600
Email: BHCT.Complaints@berkshire.nhs.uk

Further information and contact details
If you would like to participate in this study, please call or email the lead researcher:

Charlie Heriot-Maitland
(Trainee Clinical Psychologist)
Tel: 07505 243638
Email: charlie.heriot-maitland@hmc.ox.ac.uk

If you have any additional questions relating to this study, or concerns about participation, please contact the lead researcher or one of the research supervisors:

Dr Emmanuelle Peters
(Consultant Clinical Psychologist)
Tel: 020 7848 0347

Dr Matthew Knight
(Clinical Psychologist)
Tel: 01753 477 092

Thank you for taking the time to read this sheet and considering whether to take part in the research study.

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INFORMATION SHEET (PICuP clinical participants)

'Out-of-the-ordinary experiences in clinical & non-clinical populations'

We would like to invite you to take part in a research study, the title of which is shown above. However, before you decide, we would like you to understand a bit about why the research is being done, and what it would involve if you were to take part.

What is the purpose of the research?
Many people describe having experiences that are different to ordinary day-to-day experience in that they involve extra-sensory communication, awareness of an alternative reality or a different dimension to life. These experiences can be pleasant or unpleasant, confusing or inspiring. This research hopes to help us understand the range of unusual experiences people have, and how some of their features relate to other life factors. We are particularly interested in exploring the nature of people's experiences, the way they make sense of them, and the context in which they occur.

Why have I been invited?
By receiving this information sheet, you have been identified from the PICuP research register as someone who has reported 'out-of-the-ordinary' experiences. These experiences might have been described by you or others in spiritual / mystical terms, in psychiatric terms, or in some other way. For this study, it is not important how you describe or explain your experiences, but the fact that they are different to ordinary day-to-day experience makes you a suitable research candidate. Also, because your experiences have resulted in your involvement with PICuP, you would be included in the 'clinical' population of this study.

Do I have to take part?
This study is entirely voluntary, and if you agree to take part, we will ask you to sign a consent form. Before signing this, we will go through the information sheet with you and give you the opportunity to ask questions. You also have the right to withdraw from the study at any time without having to give a reason. If you decide to withdraw, any information you have given will be destroyed and you will not be contacted again.

What will happen to me if I take part?
You will be asked to meet with the lead researcher on one occasion to complete an interview. This should take about 1-1½ hours, and with your permission, will be audio recorded. This meeting will be at a time and place that is convenient for you.

Expenses and payments
We can offer you £15 to remunerate you for your time. Also, if you have to travel to the interview, please keep a receipt so that we can reimburse your travel expenses.

What will I have to do?
We will want to ask you questions about your first 'out-of-the-ordinary' experience, what you think and feel about it, and about what events and circumstances were happening in your life at the time. All participants will follow the same procedure.

What are the possible risks and benefits of taking part?
As this study only involves a one-to-one interview about your experience, there are unlikely to be many significant risks or benefits. However, if the conversation touches on some emotionally sensitive issues for you, there may be a risk of you becoming distressed. Because the interviewer is a trainee clinical psychologist, they already have experience of working with people in distress, and will try to help you manage these feelings by talking. There is also a possibility that talking about sensitive issues may have a therapeutic benefit, although this is not the intention of the research.

Will my taking part be confidential?
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Complaints Office
Maudsley Hospital
111 Denmark Hill
London
SE5 8AZ

Tel: 020 3228 2444/2499
Email: complaints@slam.nhs.uk

Further information and contact details
If you would like to participate in this study, please call or email the lead researcher:

Charlie Heriot-Maitland
(Trainee Clinical Psychologist)
Tel: 07505 243638
Email: charlie.heriot-maitland@hmc.ox.ac.uk

If you have any additional questions relating to this study, or concerns about participation, please contact the lead researcher or one of the research supervisors:

Dr Emmanuelle Peters
(Consultant Clinical Psychologist)
Tel: 020 7848 0347

Dr Matthew Knight
(Clinical Psychologist)
Tel: 01753 477 092

Thank you for taking the time to read this sheet and considering whether to take part in the research study.

SCREENING TOOL

I need to ask you a few questions to find out a little more about you and your experience/s. This will help me to know whether you meet the criteria to take part in this study.

The following are descriptions of experiences that other people have reported. Please read each one, and circle the number matching the response which you feel is the most accurate one for you.

Please base the number you choose on the following definitions:
1) Have you 'Never', 'Possibly', or 'Definitely' had the experience described?
2) If you have definitely had that experience, has it occurred 'Rarely' (once or twice), 'Occasionally' (no more than twice a month), and 'Frequently' (more than three times a month)? Your decision should be based on the period of time when the experience occurred most frequently.

1	2	3	4	5
Never experienced	Possibly experienced (unsure)	Definitely experienced (rarely)	Definitely experienced (occasionally)	Definitely experienced (frequently)

SECTION 1

1a)
- Have you had any experience of your thoughts being read or picked up by other people?
- Have you ever had the experience of people reacting to thoughts you have had, so that you wonder if they are aware of what you are thinking?

1	2	3	4	5

1b)
- Have you ever had the experience of feeling emotions or thinking thoughts that were actually those of other people?
- Have you ever thought that other people or agencies were putting thoughts in your head, or making you feel certain things?
- Have you had the experience of picking up on other people's thoughts?

1	2	3	4	5

1c)
- Have you ever experienced your thoughts being taken out of your mind, blocked or stopped by something or someone else?

1	2	3	4	5

1d)
- Have you ever experienced your bodily movements being controlled by someone or something outside of you?

1	2	3	4	5

1e)
- Have you ever had an experience of having your thoughts, feelings or movements influenced by other people? Through their thoughts, or gestures alone?
- Have you ever had an experience in which you felt your body moving automatically, or felt urges to move into certain postures or make certain movements, when you didn't seem to be controlling this?

1	2	3	4	5

1f) • Have you had experiences in which things you read or heard people say seemed to reflect or resonate with your own thoughts?
- Have you had experiences in which things in the world around you seemed to contain messages or hints, perhaps in a metaphorical or symbolic way?
- Have you had the experience of people seeming to be communicating with you in a special way, like with double meanings or significant words or hints?
- Have you had the experience of feeling as though events in your environment, such as the actions or comments of other people, are in reference to you, or are directed at you, even though you know that this is unlikely?

1	**2**	**3**	**4**	**5**

1g) • Have you had the experience of influencing or controlling people with your thoughts or gestures?
- Have you had the experience of watching something happen and feeling as though you had caused it in your mind?
- Have you had the experience of causing things to happen by thinking about it, when the effect happened some time later?

1	**2**	**3**	**4**	**5**

1h) • Have you ever experienced your own thoughts being very loud, so that you could hear them being spoken in your head?

1	**2**	**3**	**4**	**5**

1i) • Have you ever had the experience of hearing things, like voices talking, or music playing, when there hasn't been anyone around?

1	**2**	**3**	**4**	**5**

SECTION 2

2a) • Did the above experience/s commence in the last five years?

YES	**NO**

2b) • Have you had the above experience/s in clear consciousness and in the absence of any drug use?

YES	**NO**

2c) • Are you aged 18 years or above?

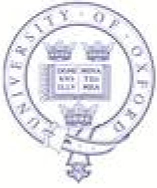
YES	**NO**

2d) • Have you had contact with health services regarding your experiences?

YES	**NO**

Thank you for taking the time to answer these questions. I can confirm that you DO / DO NOT meet the criteria for this study.

Potential participants will meet the criteria for this study if they answered 'Definitely' to any question in Section 1 and 'YES' to questions 1, 2 and 3 in Section 2. Answering 'YES' to question 4 will meet criteria for the clinical group, and answering 'NO' will meet criteria for the non-clinical group)



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CONSENT FORM (non-clinical participants)

Title of Study: *'Out-of-the-ordinary experiences in clinical & non-clinical populations'*

Name of Researcher: *Charlie Heriot-Maitland*

	Please initial box
I confirm that I have read and understand the information sheet dated 1st Sept 2009 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
I understand that relevant sections of my data collected during the study, may be looked at by the researcher, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individual to have access to my records.	☐
I understand that interviews will be tape recorded and that these recordings will be destroyed after the data is anonymously coded.	☐
I give permission for anonymised quotes from my interview to be included in the write-up of results for illustration purposes.	☐
I agree to take part in the above study.	☐

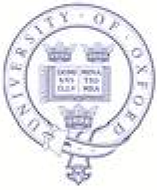
Full Name in Capitals:……………………………………………………………………….

Signed:………………………………………………………………Date:…………………..

Full Name of Researcher:…………………………………………………………………..

Signed:………………………………………………………………Date:…………………..

When completed, 1 copy for participant, and 1 copy for research site file.



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CONSENT FORM (clinical participants)

Title of Study: *'Out-of-the-ordinary experiences in clinical & non-clinical populations'*

Name of Researcher: *Charlie Heriot-Maitland*

	Please initial box
I confirm that I have read and understand the information sheet dated 1st Sept 2009 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
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I agree to take part in the above study.	☐

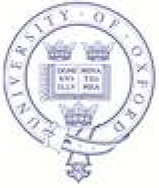
Full Name in Capitals:……………………………………………………………….

Signed:………………………………………………………Date:…………………..

Full Name of Researcher:…………………………………………………………..

Signed:………………………………………………………Date:…………………..

When completed, 1 copy for participant, and 1 copy for research site file.



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INTERVIEW SCHEDULE

1. How are you today?
   Can you tell me a little bit about yourself?

2. Can you tell me what was happening in your life just before had your (first) experience?
   What was your home life like?
   What was your social life like?
   What was your work life like?
   Had there been any significant events or changes in your life?
   How had you been feeling in the weeks and months before?

3. Can you describe your experience?
   Do you remember how you felt at the time?
   Did you notice any unusual or different body sensations?
   How did you feel afterwards?

4. How did you make sense of the experience?
   What did you think had caused it?
   Did it stand out as a significant moment in your life? In what way?
   Did it lead to any changes in the way you see the world? In what way?
   Has anything changed in the way you think about it now?

5. Were you aware that these kinds of experience could occur before you had yours?
   Did you intend it to occur? For what reason?
   Did you expect it to occur? For what reason?

6. Did you think that your experience would be understood by those around you?
   Was there anyone with similar experiences to share it with?
   What did you think was the general public's view on these experiences?
   Do you think differently about how others view these experiences now?

Transcript excerpt – Holly (C group)

	441	And at the same time I was seeing these figurines which were infiltrated with negativity, I, on	
	442	the left hand side was like a burning white light, um, that was just this pure white light, and	
	443	um, and again I felt like intrinsically like I had a choice, I was being shown this choice, and I	- shown this choice
	444	had this choice within me to basically choose more-or-less the dark or the light, and um, and	interesting dynamic between
	445	I phoned my brother (laugh). It sounds like 'Who Wants to be Millionaire' (laugh)	'out-of-control' aspects and
	446		'in control' aspects (choice)
	447	I: Phone a friend, yeah (laugh)	
	448		
	449	R: And it's weird that I still felt like integrated enough with normal life to kind of phone my	
Sharing experience	450	brother, because he's not religious, but we both get on really well, we have a really good	
with understanding	451	connection. And we've both been through, psychological experiences and we can support	- good connection / understanding
and support	452	each other, and we seem to go through quite similar experiences, so I feel really connected	with brother.
	453	with him. I phoned him, and for some reason, he knew what I was talking about, or like,	Shared experiences & support
	454	could understand what I was talking about, and he said, um... We didn't talk that much, but	
	455	he kind suggested that I only have... he thought that there was only one choice that I could	
	456	really make in this context. So I put down the phone slightly bemused, and not really	
	457	knowing... like not feeling concrete about anything or, you know, just quite bemused by it	
	458	all, not sure about what I was going to do. But the visual experience was still very strong, and	
	459	whenever I closed my eyes, it was still very much present, and um, I basically decided to dive	- Choice firmly taken
	460	internally, like headfirst into the light, kind of thing. (pause). And it was strange that I	
	461	actually felt a sense of fear. I was surprised that I felt, like, as I jumping into the white light, I	
	462	thought in reflection later on, I was thinking how weird the light should have also made me a	- fear of breaking away from
	463	little bit afraid, because I would have thought that the light was only good. There was a kind	roots? Choosing the lone path
	464	of like sense of fear. I think I so much fear in my life at that time that I was like I just had to	
	465	get over that, and kind of, anyway... The point was that I, basically I dived in my head, I dived	- very bold decision,
	466	into this white light and I kind of went through it, um, and having gone through the white	motivated by desire to
fulfilled psychological	467	light, the negative, all my negativity that I'd been experiencing for like two years	overcome emotional problems
purpose	468	disappeared. All of this kind of physical symptoms, this feeling of darkness, of like drudgery	
	469	of like tar, and all this stuff just went, and just lifted, and was gone. Um, and, yeah (laugh)	PSYCHOLOGICAL PURPOSE
	470		FULFILLED.
	471	I: So powerful	
	472		
joyful	473	R: It was really powerful. And it was weird though because I remember like I experienced it	
	474	in my room, and it all kind of happened, and I remember feeling so joyful, and so kind of like	
	475	surprised that this negativity had gone, and I remember just like.. I think I stayed with it on	
	476	my own, but not for very long, and I ran downstairs and I like told my flatmate, the one	
	477	who'd suggested to me that I write everything down, I was like, I don't think anyone else	

13

sharing experience	478	really understood the significance of what I'd experiences, like no one else was really	
with no	479	operating, as far as I know, on this level, and so I was just like "I've just seen the light! I feel	- others didn't understand
understanding	480	better! I feel light!", and everyone was kind of "ah cool! Well done!" (laugh), and I found	
	481	like... It wasn't... It didn't take this kind of weight, it didn't take this kind of like, I'm now	- not significant to others.
	482	going to... I just felt quite light and joyful and kind of surprised by what had happened. And	
	483	the weirdly realistic, like "ah I feel light, I feel better, like, the (?)'s gone", or whatever...	
	484		
	485	I: And what did you... So you tried to share your experience, and you didn't get much of a	
	486	reaction by sounds of it. Were you expecting more of a reaction?	
	487		
	488	R: I think so yeah. I think... One thing I remember was, because I was feeling so much better,	
	489	and I think, I had this feeling of wanting to... like another flatmate i was sharing with, we	
	490	were doing something together, and I had feeling of like wanting to tap him on the shoulder,	
	491	and be like "I'm back!" like "I'm here! I'm back again!" And no one seemed to sense this	
	492	huge change that I'd like gone through internally, and no one was like... and for me it was so	- internal experience, not
	493	significant, and I felt so much more alive and rejuvenated, and um, and um, yeah, so that	externally noticeable
	494	was quite weird for me, that was quite sad in a way, but, you know...	
	495		
	496	I: So, you know, internally, you felt alive and rejuvenated, light, and just sort of joy and	
	497	things like that...	
	498		
	499	R: Yeah, and it was amazing because this light stayed with me, um, for quite a few days.	- residual effects
	500	What I mean is that whenever I closed my eyes, like, it was almost like I could bring back	
	501	this... whenever I sort of... almost like I could kind of access this place where this light was.	
	502	The first few days I didn't have to try very hard, it felt like it was very present with me, like	
	503	almost holding me up, like buoying me up in my centre, because it felt very much like I'd	
reaching a deeper	504	reached my true self and my core, and my... and it felt like from this place, if I kind of like	- true self, core – peeled
level of truth	505	spoke from this place, that whatever I said was truthful, that like accessing that place and	away layers of negative
	506	speaking from that place, that truth only came from that place, and that... or rather that only	learning etc from family?
	507	truth came from that place.	
	508		
	509	I: So this was... So I guess, sort of metaphorically, kind of way, this was your truth, this was	
	510	your...	
	511		
	512	R: Yeah, my core, my truth...	
	513		
	514	I: And, um, now you had it, it was inside you, and you can access it for truth	

Transcript excerpt – Jenny (NC group)

	Line	Transcript	
	367	I: So you realised that something different about what it is to be human, really, that human	
	368	potential naturally is different to what you had originally thought	
	369		
	370	R: Yeah, I think I kind of knew it more intellectually maybe before, and like from my Buddhist	- previous knowledge of ↓ direct experience of
prior conceptual framework	371	stuff, I started to believe in the concept of enlightenment and waking up, being a more	
	372	awake human being and stuff, so I did kind of believe it, and I had certain little taste like	
	373	sense of it from these little glimpses that I'd had in meditation before, but this was more	- did having a previous conceptual framework help her to contextualise her experience
	374	profound, and more strong, and more kind of like, yeah	
	375		
	376	I: Yeah, it's a whole different thing, like knowledge about something and experiencing	
	377	something,	
	378		
	379	R: Yeah	
	380		
	381	I: and it's, you know, a whole different meaning to it, I see what you mean, and so that was	
	382	the point where you thought, "actually, I've now experienced it"	
	383		
	384	R: Yeah, it's not that I'd say (?), no not that I'd say that I was there, but it was like I really	
	385	really had a taste of it, and what could become possible in the future or whatever	- potential
	386		
	387	I: So what happened to the Buddhist explanation, you said that you're now not a Buddhist,	
	388	so what's happened since?	
	389		
	390	R: Well two years after that, um, I went through this up and down massive sort of, lots of	
	391	strange (?), two years after that I was really desperate to be healed of ME, well I kept seeing	- explaining it as ME and now explains it as a spiritual process. flexible interpretation
	392	it as ME then, I mean I don't even know what, I think for me a lot of it was just this spiritual	
necessary process for spiritual growth	393	process I was going through, this was just what I had to go through, but anyway at the time I	
	394	was still desperate to be healed of ME, so I did lots of different training, I was training in reiki	- search for cure by spiritual means rather than medical means.
	395	healing and, um, I can't remember what else, but anyway, I did lots of different things and	
	396	later on I did loads of stuff, I'd also done my Bowen training by then as well. I mean even in	
	397	my Bowen training for example one time someone did a (?) of my coccyx, which is (?) round	
	398	there, which is where the kundalini is supposed to come from, and I did feel this energy just	- Is ME preferred because of its non-psychiatric connotation (i.e. thought to be physical by the lay person)
self help practices	399	shooting up my spine, I didn't realise at the time that it was probably because it was active	
	400	(?) in my system, which is probably why I had such a strong sense of it then, um, but anyway	
	401	so I was doing various training, um, and then I got involved in this thing called 'the journey',	
	402	which is like a process developed by someone called Brandon Bays, and later I realised that	
	403	essentially a lot of NLP techniques, but really it doesn't call it that, but anyway, it's where	

11

	Line	Transcript	
	404	you kind of drop, there's different processes, but one where you drop into different	
	405	emotional states and you get to the core of them, which is really peace, and then also	
	406	resolve old memories, you know, have ways of resolving old memories like dialoguing with	
	407	family members or whatever was involved with it, and anyway, that process had quite a	
	408	powerful effect on me as well, I started doing that quite a lot as well, on my own and with	- friends with people involved in alternative therapies
• friends with shared interests/ goals	409	friends, and with a friend I went on her course and that was all quite intense and then I went	
	410	on her second course, um (pause) and um, then I just remembered just being so desperate	
	411	to be healed of ME, and so desperate to really know who I was, I really wanted to just, I	- spec... in a very passionate way
• desperate search for answers	412	mean I allowed myself in a way to just completely disintegrate at quite a young age, later I	
	413	thought this was quite daft really, anyway so I did that, so that was ok, I just had this sense	
	414	of sort of allowing myself to completely surrender, and just surrender to this whatever was	- need to feel better outweighed the need for ego-integration ∴ surrender
• surrendering of ego	415	going on in a way, I just surrendered. But what it felt like in a way was more like surrendering	
	416	to God (laugh). It used to be Buddha nature (laugh), and er, allow myself to be healed of ME,	
	417	and be completely free in a way, just wake up in a way. But then after that, I was totally un-	
	418	integrated and in a way, if I had gone to a psychiatrist, I would probably have been	- awareness of similarity to psychiatric condition
	419	diagnosed as psychotic. I broke up with my partner who I was with for two years, my	
	420	Buddhist teacher, and that was all traumatic, and oh, my life just felt like a complete mess in	
ego loss	421	a way, and I didn't know who I was, and I didn't know, I didn't feel like I existed any more, I	- EGO LOSS for purpose of healing
	422	couldn't feel myself in my body, I had to keep pinching myself and wind myself up, it just got	
	423	so intense, and I felt like my body was dissolving and just yeah, but then at times there	- was this discarding the old 'injured' self
	424	would be just total stillness and peace, and everything would be fine, but then so much	
fine line with psychosis	425	chaos at another level as well, and it was just like I thought I was going mad, felt like I was	- Feeling that there was an option: either hospital or trust
	426	balancing a really fine line and I could have just like fallen into the like psychiatric, going to	
	427	see a psychiatrist route, and end up in hospital or something, or I could just really start to	
	428	trust, and know that everything will be ok, and it just felt like I was just sort of ... (pause)	
	429		
	430	I: Did you have anyone to talk to about these things, because it's a difficult thing to do on	
	431	yourself, to make these decisions	
	432		
social support and understanding	433	R: Well, I was lucky, I was really lucky because I started to be friends with someone, this guy	- support gladly accepted
	434	who had been a friend for a while actually, but we started to be friends and he lived out in	
	435	the countryside near Sheffield, and I'd go and see him, um, and when I was with him, I'd	
	436	laugh and we'd have a good time, but we'd also talk about spiritual things, we'd talk about	- provided time and understanding
	437	what was special, what was going on for me. At the time, I felt like I was better from ME, so I	
	438	thought right I've got to get off benefits, I'd also just signed off benefits, (laugh) (?) I could	- joking that could have met criteria for psychosis
	439	have just changed it I should just get it for psychotic symptoms, psychosis instead (laugh).	
	440	Anyway, so I'd signed off benefits, and I'd started working, yeah, I'd started my therapy work	

Table of single case themes – Tom (C group)

THEMES	LINES	KEYWORDS
New life direction & stress[2]		
Changing life direction & ambitions[1]	157	Want to quit course, pursue music
Environmental stress	423	Stress uni and strained relationship
Existential philosophising		
Connecting with a spiritual philosophy	45,48,426	Book, hooked into whole philosoph.
New existential outlook	79	Wake up to spiritual dimension
Symbolic, deeper meanings		
Looking for deeper meanings	132	Deeper meanings, coincidentally
Operating outside laws of rationality	334	That's a sign, not a rational way of
Immersed in symbolic meaning	268	Different level, world of symbolic m
Personally significant deeper meanings	274	Read into, meant me to do someth.
Radically different perspective	149	Everything I know totally changed
Following non-rational impulses	467-471	Follow awareness, random impulses
Following bodily impulses	344	Detect subtle signs within my body
Absorbing & confusing		
Similar to drug exps (subjective & cognitive)	411-418	High on weed, hidden meanings
Enlightening and enthralling	147,354	So much sense, totally hooked, big t
Powerful, addictive emotional high	278	Cool, powerful, want to get it back
Emotionally magical and meaningful	290	Magical, infused with meaning, cool
Adamant conviction	319-323	Hundred percent, strong believing
Confusion in decoding signs	491	Really confusing, not clear message
Spiritual healing mission		
Higher purpose	106,111	What supposed to do, the right way
Positive healing mission	83,205,337	Healing by being, heal the world
Mission of global existential significance	240	Lofty goal, raise consciousness, guru
Directed by supernatural/external forces	351	Magnetic poles, spiritual direction
Destiny	427	Great big plan for me, destined
Interpreting signs for direction	129,139	Reading signs, interpreting, always
Tapping spiritual energy	87,91	Focus my energy, to heal them
Spiritual guidance	120,329	In touch with universe, follow signs
Previous interest in Buddhism & ego dissolution		
Previous interest in Buddhism	67-72	Previously read about Buddhism
Intentional ego-loss	47	Try to dissolve ego, break throu ego
Pathologising views & interpersonal difficulties		
Pathologising and invalidating reactions	200	Labelling me as ill, unwell or manic
Intense emotional interactions with parents	208,457	They didn't respond well, hatred
Stress	197-209	V stressed out, v upset with rents
No understanding from others (x2)	215,382	Rubbish and crazy talk, didn't get it
Intentional isolation	174	Wanted to remove from all contact
Resistant to medical approach	534	Really resisted treatment, drugs
Limitations of medical explanation	431	Supposed brain chemistry, don't kn.
Not feeling ill or crazy	543-548	Felt normal, see & hear clearly
Others would be scared	454	Worried, scared, psycho, dangerous
Later incorporation into life goals		
Finding positive use for experiences	487,505-522	Fun journey, good material, stories

Note. [1]Emergent transcript themes → [2]Single case themes

Table of single case themes – Clive (NC group)

THEMES	LINES	KEYWORDS
Multiple stresses, isolation & existential crisis[2]		
Unresolved circumstances of mother's death[1]	80	No explanation, violent, son ran off
Multiple stresses	82	Awful lot of stresses, depressed
Poor physical state	85	Blood, cholesterol, not eating, sleep
Isolation	91	Alienated, others not understanding
Nobody to talk to	321	Nobody, there wasn't anybody
Reached a dead end	541	I'd got to the end of it really
Heading towards serious illness	286	Gradual worse, heart attack, stroke
Heading towards major breakdown	297	Stressors cause... major breakdown
Either the experience or death	572,575,555	Either I would have died that night
Pleasant, euphoric, overwhelming		
Pleasant, warm, comfortable feeling	101,114	Comfortable, warm, fascinated
Overwhelming positive emotion	110	Awe-inspiring, blew me away
Feeling at peace	141	Completely at peace, absolutely
Visual content directly counteracted main stressor	106	Mother, wonderful time, power
Pleasant feeling in aftermath	176	Extremely pleasant, sense wellbeing
Non-rational meaning & direction		
Experience brought meaning, purpose & direction	547	More meaning, purpose, direction
Experiential meaning overriding rational meaning	233	Having it's different, cant rationalise
Explanation transcends natural laws of reason	240,244	I've accepted, I couldn't have put it
Emotional fulfilment overriding rational fulfilment	590	I don't attempt now, I accept
Willing on deeper significance of experience	115,125	Wanted it to go on, not intention
Choosing spiritual over psychosis explanation due to life enhancement		
Search for rational explanation	146,130	Looking for a rational explanation
Linked spiritual phenomena with mental illness	58	Hallucinating, what are they taking?
Positive emotional changes in 3-month business trip	157-162	In touch with something, relaxed
Health, social & lifestyle improvements	349,366	Significantly healthier, better vibes
Compliment about physical appearance	164	Have you looked in the mirror?
Appraised as spiritual experience (James' criteria)	181	Ticked all the boxes for criteria
+ve effects favoured spiritual over psychosis explanat.	188,212,231,	253, 264) Lasting effts astronomical
Sharing & understanding, but aware of pathological views		
Comfortable sharing experience with others	193	Not worried talking, doesn't bother
Sharing experience regularly	408-413	AA, NA meetings, share experience
Receiving understanding from others	263	Understanding, found it comforting
Positive responses from sharing experience	440-441	They need to hear that message
Aware of others' pathological views	415,423	He's away with the fairies
Prior scepticism & unplanned		
Prior scepticism towards spiritual phenomena	57,334	Very sceptical, non-believer, atheist
Experience was unplanned	186	The unplanned nature of it
Interest in spiritual phenomena		
Some prior knowledge of spiritual experiences	201	Read *'Varieties'* many years earlier
Some prior intellectual curiosity in spiritual exps	488	I've sort of explored things
Prior influence of Quaker attitudes	464	Quaker stuff in way I was thinking
Prepared with attitude of validating experiences	474	There was something to draw on

Note. [1]Emergent transcript themes → [2]Single case themes

Master table of group themes

	1: Immediate situational context[3]		
	C		**NC**
Holly	*Suffering, isolation & despair*[1] *Personal & existential problem-solving*	Jenny	*Physical & emotional suffering* *Quest for deep personal understanding*
Omar	*Period of emotional suffering*	Clive	*Multiple stresses, isolation & existential crisis*
Beth	*Emotional suffering & isolation*	Maria	*Seeking insights through isolated, focussed contemplation*
Tom	*New life direction & stress* *Existential philosophising*	Daniel	*Emotional processing & personal development*
Nessa	*New environment, stress & isolation*	Flora	*Grieving in period of self discovery*
Leroy	*Stress, anger & isolation*	Stefan	*Distress and isolation* *Deep inward contemplation*
Group themes	*a) Emotional suffering² (HOBTNL, JCDFS)* *b) Existential questioning (TH, JCMDFS)* *c) Isolation (HBNL, CMSD)*		

	2: Subjective nature		
	C		**NC**
Holly	*Fulfilling & joyful* *Boundary loss* *Insight into deeper meaning*	Jenny	*Loss of ego & bodily control* *Emotional extremes* *Insight into deeper meaning*
Omar	*Loss of bodily control*	Clive	*Pleasant, euphoric & overwhelming* *Non-rational meaning & direction*
Beth	*Fulfilling emotional needs* *Scary, then absorbing* *Loss of ego boundaries*	Maria	*Joyful, powerful & enriching* *Insights with deep existential significance*
Tom	*Absorbing & confusing* *Symbolic, deeper meanings*	Daniel	*Powerful & infused with deeper meaning*
Nessa	*High anxiety & paranoia*	Flora	*Fearful curiosity*
Leroy	*Confusion & disorientation* *New awareness / expression of emotion*	Stefan	*Loss of bodily control and dissociation* *Scared but interested*
Group themes	*a) Emotional fulfilment (BTH, JCMD)* *b) Loss of ego boundaries/control (HOB, JS)* *c) Fearful absorption (BTNL, DFS)* *d) Insight into deeper meaning (THB, JCMDS)* *e) New way of thinking (TBL, JSD)*		

	3: Inter-personal context		
	C		**NC**

Holly	*Initial sense of Christian belonging* *Later invalidation & pathologising*	Jenny	*Understanding & acceptance*
Omar	*Understanding from mother, but not from others*	Clive	*Sharing & understanding, but aware of pathological views*
Beth	*Pathologising views & avoiding interaction*	Maria	*Access to shared experiences, but aware of pathologising opinions*
Tom	*Pathologising views and interpersonal difficulties*	Daniel	*Both positive and negative interpersonal experiences*
Nessa	*Invalidated & pathologised*	Flora	*People with similar experiences, but aware of others' scepticism*
Leroy	*Initially reluctant to share, but now finds helpful*	Stefan	*Think others might pathologise, but aware of shared experiences*
Group themes	*a) Awareness of others' views – pathologising (HOBTNL, JCMDFS) or normalising (HBO, JCMDFS)* *b) Validation from others – validating (H½O, JCMDF) or invalidating (HOBTN, JC)*		

4: Background personal context			
	C		**NC**
Holly	*No prior conceptual framework or intentionality*	Jenny	*Prior knowledge, openness & willingness for spiritual experiences*
Omar	*Prior knowledge of spirit possession*	Clive	*Prior scepticism & unplanned Interest in spiritual phenomena*
Beth	*Prior knowledge of Christianity & religious experience*	Maria	*Previous explanatory context, openness & readiness*
Tom	*Previous interest in Buddhism & ego dissolution*	Daniel	*Prior interest & openness towards supernatural realm*
Nessa	*A-level knowledge of psychosis*	Flora	*Family & childhood belief in ghosts*
Leroy	*No prior explanatory framework*	Stefan	*Prior study of existential Philosophy*
Group themes	*a) Previous knowledge/understanding (OBT½N, JCMDFS)* *b) Attitude of experiential openness (–, DJM)*		

5. Appraisal / incorporation			
	C		**NC**
Holly	*Transient & given by God for personal growth*	Jenny	*Normal, transient & necessary for spiritual growth* *Fine line between spiritual & psychosis understandings*
Omar	*Alternating between spiritual & medical explanations* *Evil gin possession, leading to spiritual & personal growth*	Clive	*Choosing spiritual over psychosis explanation due to life enhancement*
Beth	*A unique, positive gift from God*	Maria	*Normal & generated by God*
Tom	*Spiritual healing mission (initial)* *Later incorporation into life goals*	Daniel	*Exploring psychological & spiritual appraisal possibilities* *Beneficial & enriching*

Nessa	*Medical ('not real') explanation* *Viewed as negative & undesirable*	Flora	*Exploring spiritual & psychosis explanations* *Exploring multiple ways to make sense of experience*
Leroy	*Medical explanation adopted* *Permanent, undesirable & interfering*	Stefan	*Positively incorporated for understanding self & world* *Viewed as a transient state*
Group themes	*a) Considering multiple appraisal possibilities (OH, JCDFS)* *b) Desirability–* *desirable (HOBT, JCMDS½F) or undesirable (NL, ½F)* *c) Transiency–* *temporary process (HO, JCMDS) or permanent state (NL, –)* *d) Acknowledging spirituality-psychosis link (HOBT, JCMDFS)*		

Note. [1]Single case themes → [2]Group themes → [3]Super-ordinate group themes

Credibility checking

Interview

- The interview schedule was developed in supervision between the researcher and the IPA supervisor. Key pieces of supervisory advice included: "emphasis on a fluid and coherent narrative, funnelling through the topics"; "focus on immediate context, then phenomenology, then conceptual / social context"; "questions to be simple (as far as possible), active and open".

- The researcher carried out a pilot interview with an IPA research colleague. The main feedback was that it might need to be more explicit that the interview focus is on the very first OOE, so that participants are clear about what they should be talking about.

- The final interview schedule was agreed by the IPA supervisor, and was then checked and approved by the Oxford research sub-committee, the NHS research ethics committee, and the relevant NHS R&D departments.

- The first two transcripts of participant interviews were examined in detail by the IPA supervisor, with both written and verbal feedback provided. It was agreed that the interview schedule and the interview technique were consistent, reliable and appropriate for the collection of data, and that no further amendments were required before the remaining interviews.

Analysis

The interview transcripts were analysed by the researcher following recommended IPA techniques suggested by Smith et al. (2009). Also, all tables of themes produced by the analysis were modelled on the examples given by Smith et al. (2009).

- *Analysis stage 1 – exploratory comments and emergent transcript themes*
  The IPA supervisor checked the credibility of the researcher's exploratory comments and transcript themes on two individual transcripts through a process of paper trailing and interpretative questioning. It was established that the "emergent themes are grounded / based within the text".

- *Analysis stage 2 – single case themes*
  The IPA supervisor checked the credibility of the researcher's single case themes developed from the emergent themes of three different participants. The researcher's first attempt produced single case theme titles that were too neutral / bland, and not representative enough of the thematic content contained within. The researcher was encouraged to produce more interpretative theme titles at the second attempt. The researcher presented

both the first and second attempts at an IPA workshop, which was attended by an external IPA expert and a number of IPA research colleagues. The group discussion was around how neutral or interpretative to make single case themes, using the researcher's two attempts to guide this discussion. The feedback from this was that the first attempt was indeed too bland, but the second attempt was too interpretative, and that being too interpretative at this stage could greatly restrict the later stages of analysis. The IPA expert's advice was "don't commit too early". The researcher's third attempt at single case themes therefore integrated the different pieces of advice by finding the middle ground. This third attempt was agreed by the IPA supervisor, and then used as a model for analysing the remaining individual transcripts.

- *Analysis stage 3 – group themes and super-ordinate group themes*
  The IPA supervisor checked the credibility of the researcher's group themes and super-ordinate group themes by ensuring that they represented the single case themes within. The IPA supervisor used paper-trailing to track certain themes back through to the original source material. This ensured that the final master table of group themes was still appropriately grounded in the interview data, either in direct transcript quotes or in direct interpretations of original text. The researcher was encouraged to conduct similar paper-trails outside of supervision. It was finally established that the group themes were grounded within the text, and that the super-ordinate group themes best represented the data to which the group themes applied.

Write up

- A draft write up was sent to the two research supervisors and the research tutor, and was checked by them before the final version was submitted.

Reflexivity commentary

Background information

- PERSONAL:
  I lived with someone with acute psychotic experiences (2000). There were clear religious themes in his delusions/hallucinations, and because we were good friends, I became very much a part of his perceived special mission. This was before my undergraduate psychology degree, and I knew nothing about psychosis. I have also personally known other people with non-clinical out-of-the-ordinary experiences, which were mainly drug-induced, but also had spiritual / mystical content.

- ACADEMIC:
  I did a masters degree in Psychology of Religion, and in the first term gave a seminar presentation on 'Alister Hardy and Religious Experience' (2004). This is where my academic interest in the overlap between spiritual and psychotic phenomena began. I wrote my MA dissertation on 'Mysticism and madness' (2005/06), which was later published as a theoretical review paper (Heriot-Maitland, 2008). My Paper A of this DClinPsych dissertation (2009/10) explores a new theoretical approach to psychosis, which has implications for the normalisation of psychotic phenomena.

- CLINICAL:
  I worked clinically with people with psychosis as an assistant psychologist, both in an early intervention (EI) team (2006), and in inpatient psychiatric units (2007). I am currently working in another EI team as part of my third year training placement, and will be employed as a specialist clinical psychologist in psychosis after training.

- RESEARCH:
  I did qualitative research on an inpatient ward for my service-related project in the first year of training (2008).

Conception of research idea

- I wanted to build on the theoretical groundwork from my MA dissertation on 'mysticism and madness', i.e. take the step from academic interest to empirical research. I already had experience working with psychosis, and this research seemed to be the perfect opportunity to bring together my academic and clinical interests.

- I began looking for potential research supervisors on the topic of psychotic and spiritual experiences, so contacted Emmanuelle Peters (March 2008) to discuss the possibility of supervision. Emmanuelle had been previously

contacted by me when I was writing my MA dissertation in 2005/06, and had read my paper. She accepted.

- I wrote a letter to Emmanuelle (May 2008) with some possible ideas and hypotheses for quantitative research into clinical and non-clinical populations with psychotic-like experiences. Also attached to this letter was my 'Model of the balanced mind' (Fig. 1 in Paper A). This demonstrates how far I had progressed with my own theoretical ideas by this early stage of the study.

- I had an initial meeting with Emmanuelle (June 2008) to discuss my hypotheses and research ideas. We explored a number of options together over the next couple of months (including an idea of Emmanuelle's to induce anomalous experiences by infrasound). It soon became clear that my main interests and ideas could not be investigated using quantitative methodology, and so we agreed that I instead start considering qualitative designs. IPA was by far the best fit for my interests.

- Because Emmanuelle's previous experience and expertise is in quantitative research methods, I needed to find an additional co-supervisor with IPA expertise, so I arranged an initial meeting with Matthew Knight (September 2008).

- I also had external meetings with Isobel Clarke (October 2008) and Caroline Brett (June 2009) to cultivate and consolidate ideas for my research proposal. Isobel's theoretical work is cited in Paper A, and Caroline's empirical work is cited in Paper B.

Proposal stage

- The biggest challenge for the proposal was in focussing my broad theoretical interests into a single research topic. However, with a qualitative methodology, I did now have the freedom to retain quite a broad, explorative attitude, which suited me. One of the best pieces of advice given to me by Emmanuelle was that I've got the rest of my career to research my interests, and I shouldn't try to cover them all at once. I was therefore happy to adopt a more curious, explorative approach for now, in the hope that the findings might create opportunities for more focussed quantitative research in the future. Indeed, the main reason why my ideas could not be contained within a quantitative method straight away was that this is still a fairly new area, and some explorative foundations are still needed to be put in place.

- My previous theoretical interests certainly played a role in the development of my research topic and proposal, and the IPA method acknowledges that this is an inevitable aspect of research. One important thing I had to recognise, in this regard, was that I had adopted (through various academic, clinical and personal routes) quite a normalising view of psychosis. For

instance, the abstract of my 'Mysticism & madness' paper reads, "the intention is not to pathologise mystical experience, but rather to normalise psychotic experience" (Heriot-Maitland, 2008, p301). I was also aware that I had specifically approached Emmanuelle Peters, Isobel Clarke and Caroline Brett for inspiration because I knew that they held fairly similar views.

- The luxury of having two supervisors and a tutor closely following each step of my proposal development ensured that my personal biases and beliefs did not reach an extent where they might compromise the usefulness of the research. Matthew was particularly tuned in to this matter due to his previous experience with IPA.

- The proposal was approved by the Oxford Research Sub-Committee (June 2009).

Ethics stage

- For me, the main ethical issue was how to not give the impression of pathologising the experiences of the non-clinical population. Terms like 'psychotic-like' may have given that impression, which was neither desirable nor the intention of the study. It was Emmanuelle who suggested the term 'out-of-the-ordinary' (OOE) to ensure that a more neutral position was retained in relation to people's experiences.

- Interestingly, my REC meeting (August 2009) brought to my attention a perspective that I had not yet fully appreciated. One of the committee members asked me: "Are you actually interested in the experiences of normal people as well?" There seemed to be an assumption in this question that my non-clinical group is 'abnormal' or pathological as well as the clinical population. Perhaps this committee member thought that my non-clinical recruitment method would just find more people with psychosis that had somehow slipped through the net. I don't personally share this view, but it did open my eyes to the fact that my interpretation is just one of many, and that my whole study could be interpreted differently by other people.

- After some minor amendments to the study information sheets, full ethical approval was received by the REC (September 2009), and this was shortly followed by full R&D approval from the two NHS recruitment sites.

Recruitment stage

- As expected, one of the main issues to come out of the recruitment stage was a suspicion among some non-clinical organisations and individuals about my intentions; i.e. was I looking to "debunk" their spiritual / mystical experiences, or would I accept them and take them seriously? Obviously,

because all my recruitment documents displayed that I was training in clinical psychology, there was some wariness that I might only be interested in the clinical nature of their experiences. Of course, this wariness was completely understandable and warranted when you consider the opinions of most other mental health professionals (and ethics committee members!) I ensured these people that the research would very much be conducted with an attitude of openness, acceptance and explorative investigation.

- In many ways, my own personal bias towards normalisation and validation of experiences is potentially far less restrictive on research than having a pathologising bias, which is the bias that drives the vast majority of psychosis studies. At least with my bias, the experiences can still be accepted and explored for what they are, and what they mean to people, rather than being cornered into diagnostic categories.

- An incredible 60 responses to non-clinical adverts came in less than four months. This was a very promising sign for any future quantitative research. 18 of them also signed up for Emmanuelle's non-clinical participant research register, indicating that they were happy to be contacted directly for future research in this area.

Interview stage

- The 12 interviews were carried out between October 2009 and January 2010. Most of the participants were extremely keen to talk, which demonstrated to me that the experiences had been particularly significant in their lives, and that perhaps they had not had many opportunities to discuss them at such length before. I got a sense in some of the non-clinical interviews that participants were looking for validation from me. I therefore had to be careful not to reveal any of my personal views, and to remain as objective / neutral as possible. I occasionally had to make it explicitly clear to participants that I would not be disclosing my views as they may interfere with the research. Thankfully, this was always accepted without question.

- My mind occasionally wandered back to what the ethics committee member had said. Did some of these non-clinical participants actually need clinical interventions? Am I really exploring what factors keep these people out of services rather than out of 'psychosis'? Is this more of an access-to-treatment issue? But then, when the participants started to reel off stories of how positive and beneficial the experiences had been in their lives, any inkling towards pathologising these experiences soon disappeared. If anything, the interviews made me even more frustrated and embarrassed that the dominant medical view in my employment field is one of basic ignorance and resistance towards the psychological role of these experiences in peoples' lives. I therefore wanted nothing more than to get the voices of these

participants into a journal, and into the consciousness of mental health professionals.

Analysis stage

- I will be forever thankful to Matthew for his guidance through the IPA analytic procedure. His rigorous credibility checking (appendix 12) both challenged and enlightened my interpretative processes. As someone more aware of my views about psychosis than most (having read my papers and shared my workplace), Matthew was ideally positioned to notice the extent of my analytic bias, and to redirect me if this bias started to overshadow the interview data. It took me three attempts at generating single case themes from the first two transcripts before Matthew and I were happy that I had found the right interpretative balance. With the help of this thoughtful supervision, I am satisfied that my analysis is an accurate and credible reflection of participants' views, as well as of my own.

Write up stage

- Does the fact that these results concur with some of the hypotheses I was brewing in 2006 reflect that I have presented a biased interpretation of the data, or that I have successfully managed to design a study to tap genuine issues that I had previously noticed? Perhaps this is a question that can only be answered with time, as (hopefully) more scientific efforts are directed towards the issues raised. I think the fact that I have illustrated all of my results with transcript quotes reassures me that at least my interpretations were not plucked out of thin air. There are actually many instances in the write up where the participants' quotes sum up a point far better than I could ever do. Their level of insight was remarkable, and I was fascinated to hear what they had to say. I certainly wasn't putting words in their mouths, and I was adamant about getting their first-hand views across to the reader.

- As an explorative piece of research, I believe that this study has been successful in raising interesting issues for future studies. Of course, as a scientist, I would be equally appreciative of studies that seek to confirm *or* disconfirm these findings.

Oxford Doctoral Course in Clinical Psychology

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1st June, 2009

Charlie Heriot-Maitland
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Dear Charlie,

Thank you for submitting your dissertation proposal to the Research Sub-Committee. It is a well thought out project, and you now have full approval for the study.

We wish you all the best with your project.

With best wishes.

Dr Myra Cooper
Chair, Research Sub-committee

c.c. Alexis Berry
Matthew Knight
Emmanuelle Peters, IOP

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APPENDIX 14 – Approval letter (Oxford research sub-committee)

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30 September 2009

Mr Charlie Heriot-Maitland
Trainee Clinical Psychologist
Isis Education Centre
Warneford Hospital
Oxford, OX3 7JX

Dear Mr Heriot-Maitland

Study Title:	**A qualitative comparison of phenomenology and context of 'out-of-the-ordinary' experiences reported by individuals from clinical and non-clinical populations**
REC reference number:	**09/H0605/93**
Protocol number:	**1**

Thank you for your letter of 17 September 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is

available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

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

Document	*Version*	*Date*
Response to Request for Further Information		01 September 2009
Advertisement	2	01 September 2009
Advertisement	2 (x2)	01 September 2009
Letter of invitation to participant	2	01 September 2009
Letter of invitation to participant	2 (picUp	01 September 2009
Letter of invitation to participant	2 (Slough EIS)	01 September 2009
Indemnity letter		09 July 2009
Approval letter (research sub-committee)		01 June 2009
Reflexivity info & commentary	1	12 July 2009
Screening tool	1	12 July 2009
Interview Schedules/Topic Guides	1	12 July 2009
Letter from Sponsor		09 July 2009
Covering Letter		13 July 2009
Protocol	1	12 July 2009
Investigator CV	Charlie Heriot-Maitland	
REC application		15 July 2009
Investigator CV	Matthew Knight	
Participant Consent Form: Clinical	4	29 September 2009
Participant Consent Form: Non-Clinical	4	29 September 2009
Response to Request for Further Information		17 September 2009
Participant Information Sheet: non clinical	3	17 September 2009
Participant Information Sheet: Slough EIS	3	17 September 2009
Participant Information Sheet: PICuP	3	17 September 2009

Statement of compliance

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

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

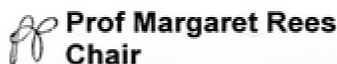
- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0605/93	**Please quote this number on all correspondence**

Yours sincerely



Prof Margaret Rees
Chair

Enclosures: "After ethical review – guidance for researchers"

Copy to: Jan Newell, R&D Dept, OBMH Trust

Berkshire Healthcare NHS
NHS Foundation Trust

R&D Department
Fitzwilliam House
Skimped Hill
Bracknell
RG12 1LD
Tel: 01344 415825
Fax: 01344 415666

Charlie Heriot-Maitland
Trainee Clinical Psychologist
Isis Education Centre
Warneford Hospital
Oxford
Ox3 7JX

30 September 2009

Our Ref: 2009/16

REC Ref: 09/H0605/93

Study title: **A qualitative comparison of phenomenology and context of 'out-of-the-ordinary' experiences reported by individuals from clinical and non-clinical populations**

Start date: 30/9/2009 End date: 30/9/2010

Dear Charlie

Confirmation of Trust Management Approval

On behalf of Berkshire Healthcare NHS Foundation Trust, I am pleased to confirm Trust Management Approval for the above research on the basis described in the application, protocol and other supporting documents.

If there are any changes to the study protocol, the R&D Department must be informed immediately and supplied with any amended documentation as necessary, including confirmation that the amendments have been favourably reviewed by the Sponsor and the Ethics Committee.

If the end date changes from that shown above, then please inform BHFT R&D Manager. Trust approval will cease on the end date above and you will be requested to submit a final report. Please contact the R&D Manager to discuss and request any extension.

The R&D Department is required to monitor the progress of all research in the Trust under the Department of Health's Research Governance Framework. You will be contacted in due course with a request for reports of progress, and for a brief final report of research findings.

If you have any questions about the above, or you require any other assistance, then please contact the R&D Department.

I wish you every success with the study.

Yours sincerely

Dr Justin Wilson, Medical Director

Institute of Psychiatry

at The Maudsley

Research and Development Office

Box P005
De Crespigny Park
Denmark Hill
London SE5 8AF
Tel +44 (0)20 7848 079
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KING'S College LONDON Founded 1829

Mr Charlie Heriot-Maitland
Trainee Clinical Psychologist
Isis Education Centre
Warneford Hospital
Oxford OX3 7JX

1 October 2009

Dear Mr Heriot-Maitland,

Trust Approval: R&D2009/055 A qualitative comparison of phenomenology and context of 'out-of-the-ordinary' experiences reported by individuals from clinical and non-clinical populations

I am writing to confirm approval for the above research project at South London and Maudsley NHS Foundation Trust. This approval applies work in the Specialist National directorate and relates only to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including the extension to other Trust Directorates, will require further approval from this Trust and where appropriate the relevant Research Ethics Committee. Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached but is also available on the R&D Office website.
(http://admin.iop.kcl.ac.uk/randd/downloads/RD_Approval_Amendment_Form.doc)

I note that Oxfordshire and Buckinghamshire Mental Health NHS Partnership Trust will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health's Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.
- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework

- (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122427.pdf).

- Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework. In particular the Trust Confidentiality Policy. (http://admin.iop.kcl.ac.uk/randd/downloads/Confidentiality_Policy_080219.pdf).

- Co-operating with the Trust R&D Office's regular monitoring and auditing of all approved research projects as required by the research governance framework, including complying with ad hoc requests for information.

- Informing the Trust's Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.

- Sending a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.

- Honorary Contracts must be in place prior to patient contact for all relevant members of the research team. Advice on this will be provided by the R&D Office at the point of obtaining R&D approval and on an ongoing basis for new members of staff joining the research team.

- Sending a copy of the annual reports and end of project notification submitted to ethics.

Failure to abide by the above requirements may result in the withdrawal of the Trust's approval for this research.

If you wish to discuss any aspect of this research approval with the R&D Office, please contact Jenny Liebscher jennifer.liebscher@kcl.ac.uk in the first instance.

I wish you every success with this study.

Yours sincerely

SCannon.

pp **Jenny Liebscher**
R&D Governance and Delivery Manager
SLaM/IoP R&D Office

Enc. R&D Approval Amendment Form

Institute of Psychiatry
at The Maudsley

Research and Development Office

Box P005
De Crespigny Park
Denmark Hill
London SE5 8AF
Tel +44 (0)20 7848 079
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KING'S College LONDON Founded 1829

1 October 2009

Dear Mr Heriot-Maitland

Letter of access for research

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that such checks as are necessary have been carried out by your employer and that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. This letter confirms your right of access to conduct research through South London and Maudsley NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on 1 October 2009 and ends on 15 July 2010 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to South London and Maudsley NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through South London and Maudsley NHS Foundation Trust, you will remain accountable to your employer Oxford and Buckinghamshire Mental Health Partnership NHS Trust but you are required to follow the reasonable instructions of your nominated manager Emmanuelle Peters in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with South London and Maudsley NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with South London and Maudsley NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on South London and Maudsley NHS Foundation Trust. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

South London and Maudsley NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Jenny Liebscher
R&D Governance and Delivery Manager
South London and Maudsley NHS Foundation Trust

cc: **HR department of the substantive employer (and provider of honorary clinical contract, where applicable)**

Professor Tom Burns
Research & Development Lead
Department of Psychiatry University of Oxford
Warneford Hospital
Oxford OX3 7JX

Tel: 01865 226474
Fax: 01865 793101
e-mail: tom.burns@psych.ox.ac.uk

9th July 2009

Ref: TB/jrn

Mr Charlie Heriot-Maitland
Trainee Clinical Psychologist
Oxford Clinical Psychology Doctoral Course
ISIS Education Centre
Warneford Hospital

Dear Mr Heriot-Maitland

Research Study Name: Out of the Ordinary Experiences in Clinical & Non-Clinical Populations

This letter confirms that indemnity will be provided for you by the Trust for the above study, according to the information you have provided within the application form. This confirmation is also subject to the formal approval of the National Research Ethics Service and on the understanding that you have a contract of employment with this Trust.

I wish you every success with the study
Yours sincerely

Professor Tom Burns
Research & Development Lead Director
Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust

Jan Newell
R&D Manager
Nursing and Clinical Governance Department
4000 John Smith Drive
Oxford Business Park South
Oxford
OX4 2GX

Tel 01865 782103
jan.newell@obmh.nhs.uk

9th July 2009

Ref: R&D/jrn

To Whom It May Concern:

Re: PI: Mr Charlie Heriot-Maitland
Research Study Name: Out of the ordinary experiences in clinical & non-clinical population

I can confirm that Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust will act as research sponsor for the above study and will comply with the Department of Health Research Governance Framework for Health and Social Care 2005. As sponsor, the Trust will also provide indemnity for the above study.

Sponsorship is confirmed subject to formal approval from a Research Ethics Committee and the understanding that should any substantial amendments be submitted to the Ethics Committee, these would also be copied to the Trust R&D office.

Yours sincerely

Jan Newell
R&D Manager

Master table of group themes and quotes

C group	NC group
Holly (H) Beth (B) Nessa (N)	Jenny (J) Maria (M) Flora (F)
Omar (O) Tom (T) Leroy (L)	Clive (C) Daniel (D) Stefan (S)

1. Immediate situational context[1]

a) Emotional suffering² (6C, 5NC)

B51	*"I was depressed... I was not really having a good sort of life at those times, so I guess that's where the voice came in, you know. Yeah, it's not like I was living a happy life... I was going through a lot of problems before the voice came"*[3]	C284	*"My experiences with my ex-partner were very strange and stressful. There was nothing pleasant happening to me during that period of time, and I should have got, in degrees, gradually worse, probably had a heart attack or stroke"*
H217	*"I was kind of bringing up all this tar and sort of darkness, and sort of negative feelings towards my family that I probably wouldn't normally want to accept or experience... that I hadn't consciously realised that I felt"*	J123	*"lots of difficulties in the flat and people's relationships, and one trying to commit suicide, and another one getting pregnant, and two falling out, one leaving (laugh). It was all a bit mad really... about the worst it could've been in a way"*
O60	*"I started getting depressed, very badly I mean... I was suicidal"*	D98	*"I was dealing with unresolved issues"*
L72	*"at that time, in my personal life, I wasn't best pleased with my parents... anger and resentment between me and my parents... when I started having these people [voices] commenting on what I was doing, it was often my father was a key person in doing that, and he was saying nasty things"*		

b) Existential questioning (2C, 6NC)

T44	*"I was given a book... supposedly spiritual book about a particular way of thinking about things, and a particular way of living, which is all to do with, um, your ego, and you should try to dissolve your ego, and live your life in the present moment and things like this, and um, I basically really hooked into that whole philosophy"*	D54	*"I wasn't getting anywhere, and er, lots of the values and things I had, and the way I looked at the world, I began to question quite a lot"*
		J167	*"suddenly I was back at home thinking, you know, where's my life going to now, kind of thing, feeling really ill, not seeing a way out"*
T78	*" it's [book] got a lot of strange stuff in there, like about how the whole purpose of your life is to wake up to the*	F99	*"I started a new school and I started to become myself again"*

spiritual dimension of existence”

H179 *“I was almost like solving this mystery... all these thoughts were really culminating in my head, and it just, it was like I had my own private project going on while operating within normal lifestyle. I was, you know, I was still suffering, but I kind of felt like this was leading somewhere, and so I wanted to pursue this”*

S60 *“I would assume, from my perspective, that it had a lot to do with this introspective, but also from not knowing how my life would go on, because I'd finished my bachelors before that, before I went there, and I was thinking a lot about how my, I think how I see myself in the future, what I want to do, and then I was interested in like a lot of philosophical background theories and stuff like this”*

c) Isolation (4C, 4NC)

N187 *“I cut myself off like completely from my friends, like I didn't speak to them hardly ever. I think like in the whole time I was there, I think I went to the house like once, which is not like me at all”*

B87 *“I was isolated. I just kept being by myself”*

T174 *“I decided basically to remove myself from all contact with pretty much everyone”*

S47 *“I was really really focussed only on reading, I was reading all day long and was getting involved with only a few persons, but was really like self-centred”*

D85 *“I'd gone through a period of some isolation”*

2. Subjective nature

a) Emotional fulfilment (3C, 4NC)

H321 *“It very much felt like a little realisation, or it kind of gave me a sense of relief and, kind of, epiphany... I think it brought a sense of relief because I was kind of unravelling all this stuff about my family, and this was, kind of, confirming what I'd found, in a way... a fully fully good thing... like three small epiphanies that were kind of leading on from what I'd been thinking about ”*

H414 *“I think the fact that I was being shown these truths was also helping me to become free from them, in a way”*

H467 *“all my negativity that I'd been experiencing for like two years disappeared”*

H614 *“this really sort of profound sense of love and um, yeah, that was kind of*

M307 *“It was been given to me, and I was feeling it in my body, and it was giving me a lot of joy”*

C114 *“I got this terrific warm feeling, this very warm, loving feeling, and it was amazing. And I wanted it to go on. I didn't want it to stop”*

C110 *“it was absolutely awe-inspiring, you know, it just completely blew me away”*

J210 *“having loads of energy and feeling amazing”*

deeper and more magnificent than sort of anything else I'd ever felt"

B357 *"I was just interested in the voice at the time because it was just keeping me company. I wouldn't even think of having anybody with me"*

b) Loss of ego boundaries/control (3C, 2NC)

O81 *"I went through a period where my body, which I felt was being taken over by something else, and screams used to come out of my mouth... it was uncontrollable, it was out of my hands"*

H1098 *"feelings of people potentially being able to read your thoughts, or you know, potentially just having your kind of whole internal world really much externalised"*

B37 *"I was hearing people's minds. It's like I'm just sitting down here, I'd be talking to you, but talking to each other mind to mind"*

S227 *"I was aware of my hands and my limbs and my body and my hands, but it was unattached. It was belonging to [Stefan], not to me"*

S288 *"I didn't feel anything. That was as if someone had put me in a nutshell with glass walls, but no sensations. I had no smell, I had no touch feeling, I had no touch and no. I could see, I could somehow see what [Stefan] was seeing, and I could sense what he is experiencing, so sense that he was smelling a nice flower, and that it's nice and comforting feeling for him. But for him"*

J421 *"I didn't feel like I existed any more. I couldn't feel myself in my body. I had to keep pinching myself and wind myself up. It just got so intense, and I felt like my body was dissolving"*

J413 *"I just had this sense of sort of allowing myself to completely surrender, and just surrender to this whatever was going on in a way"*

J653 *"I had quite a lot of out-of-body experiences and just feeling like I'd died and didn't exist, and was really kind of questioning who I was, kind of profoundly, I mean, really existential"*

c) Fearful absorption (4C, 3NC)

B35 *"when it first started it was a bit scary because you've never heard a voice before"*

B112 *"I just found it interesting, so I couldn't think of telling everyone, like that, or finding help, thinking that it's a*

F149 *"at the beginning I started to be afraid of him, but then, yeah, I kind of got attached to him in one way, so if you're gone too long, I started to miss him"*

S148 *"it scared me a lot"*

	problem. So I was just listening to it, like a command"	S271	*"I think during the two weeks I was more like "oh, that's weird stuff; this is really weird stuff". Afterwards, I found it brilliant. I found it really interesting to have a notion of me acting without me being the one who acts... as I said, I wasn't like bad. I was just scared that I couldn't interact, that was the only scary thing. The rest was just weird and interesting"*
T105	*"I think I was quite confused about it as well in many respects, because, no I'm not sure, um, I kind of felt that I knew what I was supposed to be doing for once, even if I didn't quite know what it was"*	D191	*"it felt something that was very unfamiliar, and quite alien, I suppose, or quite (?), something I naturally had quite had quite a lot of resistance towards, um, but at the same time it was really innately familiar as well... so it was kind of just straight down the middle, between very unexpected and almost unpleasant actually, with actually everything's been leading towards this moment at the same time"*
N121	*"I used to get really like scared and stuff. Well my heart used to beat really fast like, you know, when you hear people talking about me"*		
L190	*"I once remember I was having my racing thoughts, my daydreams etcetera, and I was sitting, just sitting straight in front of my computer for four hours having these daydreams. Cos I remember what time it was when I sit down, I was intending to do some study, and then the next time I looked up at my clock, it was four hours later"*		

d) Insight into deeper meaning (3C, 5NC)

T266	*"I was like reading into everything that anyone ever said. I thought that I was hearing everything on a completely different level of awareness than everyone else, like I sort of entered into this world of symbolic meaning"*	D131	*"moments of quite radical, striking, kind of intuitive perceptions of things, and being encountered by other peoples' really very striking intuitive perceptions of me. You know, the ability to look really deeply into someone"*
T129	*"I was always trying to read the signs that were going on around me that would sort of be coincidentally all linked together, that were trying to tell me something about what I should do next... interpreting them in a way that, um, that had a deeper meaning"*	J689	*"I remember feeling like that all I ever wanted was to have more sort of insight into reality, and the suddenly it was like spilling over, but I felt like I couldn't contain it"*
T289	*"everything was magical, and um, kind of, it was almost as if like something was in the air or something, you know, um, that the whole of life had suddenly become infused with some spiritual kind of meaning"*	M377	*"I am aware, if you want, of resurrection in daily life much more... in the flower blossoming, in drops of water... all this for me is resurrection... it is enveloping my daily life, if you want. My eyes enable me to see and to vibrate much more with whatever life around me"*
H527	*"I had this feeling of being able to see through situations, and to get to what was really going on"*		

H566 *"you're so conditioned, just from life, of being taught what a chair is that you can expect to see the shape of a chair and all this stuff. I was seeing the object in its own right, without labels and, from every angle, and like, in its splendour, kind of thing (laugh), like without the kind of attachments, and like any conditioning that can kind of drive you down into what you can, kind of, expect"*

H625 *"connected as well with these quite like trivial, if you like, things that I was doing, and they just became really profound"*

H749 *"feeling that I had discovered loads of answers, and had kind of discovered this answer that felt, like, really important, and kind of like a key into life, if you like. Um, and I remember feeling quite smug about the fact I would sort of become this prophet"*

e) New way of thinking (3C, 3NC)

T149 *"everything else that I used to think or I used to know just totally changed"*

B168 *"I'm not the person I used to be. I'm totally changed. Even my thoughts changed. The way I see things changed"*

L290 *"it changed the way I thought"*

J318 *"this just did something to my consciousness that just started a process that meant that I was really never going to be the same again"*

S388 *"this challenged my worldview. I needed to challenge my worldview a lot"*

D180 *"it changed, yeah, the way I related to the world, alone, every day, at a mundane level"*

3. Inter-personal context

a) Awareness of others' views– pathologising (6C, 6NC) or normalising (3C, 6NC)

O271 *"the reason why I stayed away from my friends was because I didn't want them to know what was actually going on with me. Because if I'd told them, then, you know, it would make me feel like, you know, my friends might think I'm crazy or something"*

N330 *"[general public's] lack of understanding, and they just like bundle*

M655 *"I wouldn't share it with anybody because if something is important to me, I don't want somebody else to laugh at it"*

M739 *"I believe that everybody has experiences... but they don't know about it, and they don't need them, and that is sad. I believe a lot in it"*

	all mental illness into one thing"	J503	*"Well it's in everyone. I think it's the life force energy in a way, because it's like, I mean it's just part of being human"*
		C193	*"I'm not worried about talking about it. I doesn't bother me"*
		S324	*"I think my parents would think I'm mad or something, and say "maybe philosophy's not for you""*
		S340	*"if I could search for someone who could have had a similar experience, I would go to like Buddhists, like monks who mediate and try to detach their, um, 'I', or whatever they call this from their body, so yeah. I think they would sense some similarity to this"*
		D311	*"I think there's quite a deep-rooted suspicion and resistance towards religion"*

b) Validation from others– validating (1½C, 5NC) or invalidating (5C, 2NC)

H984	*"[I] relayed this experience to psychiatrists in the [hospital] and was sent for EEG tests, was told that I was hallucinating, was, this guy just didn't listen to, just obviously hadn't heard anything really that I'd said, and at the end of time was like "so you think your Jesus?", and I was like, "er, no", and just not, and very, I just felt that this really positive experience was just scrutinised and just not, just like mocked. I didn't feel offended, I just thought they were being really stupid (laugh) and disregarding this kind of, yeah, really important thing"*	C440	*"somebody came up to me and said "well, you know, we really need to hear from you. That's a very powerful message to people, and they need to hear that message". And that did matter to me"*
		J433	*"I was lucky. I was really lucky because I started to be friends with someone... and when I was with him, I'd laugh and we'd have a good time, but we'd also talk about spiritual things. We'd talk about what was special; what was going on for me"*
N167	*"I said to Mum like "what's been happening?", and she was like "I think you might need to go to the doctor, because I don't think it's actually really happening, I think it might be like all in your mind"... I felt like no one believed me about what was happening"*	J559	*"I was friends with [name] then, and he had already been through something quite similar, and he was very helpful. But yeah, having people I could talk to about it that could understand, or at least were trying to understand, or that could nearly understand, was really vital"*
T215	*"I did try to explain things to my parents in various different ways, but they thought it was all rubbish and crazy talk"*	J723	*"I did have enough people that kind of understood. And then the internet, you know, once that stuff was printed off and I started to explore it, and started to*

H651	*"I remember also still feeling like strong rejection from people. I still have diary entries of like really days after this experience of going up on the train to visit my friends in [place], of still feeling strong waves of rejection and of darkness... I think it was really hard for them to kind of accept or integrate, and I remember my friend (laugh) falling asleep while I was like explaining to her what had been happening to me"*		*read more, and started to get books in it, and to understand it, it was like I could have a context for it all"*
H1119	*"I knew that I needed to build a network, and I knew that in order to survive and whatever, I needed a network"*	F 326	*"I have tried to ask several mediums how I can stop it if it's possible, and everybody's saying "yeah, it's possible", but they never say to how I can stop it, they just say "oh don't you want to develop your skill?""*
H1161	*"relating this experience, these experiences, to these Christian people did suddenly find me these friends on quite a deep level, and um, I never really felt stable, but I had found some sense of belonging"*	C261	*"we talk on a much more spiritual plain with some understanding. She has some understanding of what I'm talking about, and I found that very comforting"*
O575	*"when I stopped communicating, that made things worse"*	D236	*"I needed affirmation, that's what I needed, er, to help me contextualise it and make sense of it... I suppose I did need kind of affirmation from other people that it was all ok"*

4. Background personal context

a) Previous knowledge/understanding (3½C, 6NC)

L160	*"I had no clue about what mental illness meant... at one point I thought there was something wrong with my brain, and, but that was the shocking thing about it, I didn't actually know. I didn't know that what I was experiencing had been like experienced by anybody else ever"*	F437	*"I always believed in ghosts when I was little, but I was terrified from them. But I wanted, I always wanted to know if they were true or not, so I used to watch ghost programmes when I was little"*
B182	*"I knew that pastors were called. Some of them were called with voices.... usually they call then they start working for God"*	J370	*"I kind of knew it more intellectually maybe before, and like from my Buddhist stuff, I started to believe in the concept of enlightenment and waking up, being a more awake human being and stuff, so I did kind of believe it... but this was more profound and more strong"*
T67	*"it sort of seemed to tie in with what I read previously about Buddhism"*	C463	*"there was a little bit of osmosis in, if you like, there that the Quaker stuff started to move into the way that I was actually thinking, but I hadn't acknowledged it"*
O295	*"he [my uncle] went through hell in his life because of gins"*	C474	*"so when the big one came up there was*

			something to draw on"
		S255	*"the continuous philosophy I was studying at that time was Indian philosophy, and Indian philosophy is only about minds, like it's denying the body completely"*
		D446	*"I had an upbringing where, I mean, my father and step-mum were born-again Christians in an evangelical context... so obviously that did affect me on many different levels... I was always very interested in the idea of sort of transcendent meaning, thinks like that, and would naturally reflect on it"*
b) Attitude of experiential openness (0C, 3NC)			
		D456	*"I was very open to, um, strange experiences, what synchronicities or the idea that there were kind of nature spirits or fairies. I'd love to read everything like that"*
		J628	*"I want to experience this level of consciousness, I want to experience, I don't care the consequences... it was almost like part of me knew that I would allow myself to really open in that way"*
		M108	*"to know God more, and to get closer to him, and to, well to listen to what he has to guide you... so my senses, if you want, become more attuned to the communication"*
		M359	*"when I am on retreat... I don't talk. It means I am, all my senses are open to nature much more, to, I think to what God wants to say to me"*
5. Appraisal / incorporation			
a) Considering multiple appraisal possibilities (2C, 5NC)			
O237	*"I think, personally, that both things helped me: the spiritual side and the medical side"*	S134	*"maybe some sort of schizophrenia or something" (134); "the first thing I thought was well I've taken something which gave me quite a bad trip" (145); "like a sort of meditation" (155); "some higher natural being or something, I don't know, magic or something, that*
O281	*"some people don't know too much about gins, and because they don't have the knowledge about the gins,*		

	they could interpret it as something, as a mental illness, or something else, you know, cos I didn't want my friends to think I'm crazy (laugh), so I never said anything to them about gins (laugh)"		*was controlling me" (177); "maybe I was just ill, maybe it wasn't even some special experience, it was just overloading my brain, and therefore something in my brain said "I'm out"" (370)*
		J214	*I remember saying to my Dad, "Dad, is there an illness where you can feel completely high and in love all the time?""*
		F186	*"I started to look around on the internet if I was schizophrenic, or. I got a bit scared, yeah, starting to see people [spirits]. That's not normal"*
		C233	*"I'm always looking and attempting to rationalise out the problem now, but I can't... I don't know where I could have put that scenario together"*
		D256	*"I was kind of caught between these two different ways of looking at, understanding these experiences in our society: understanding them in quite a strict religious way, and other people that would understand them more in a sense of human self realisation and self expression. Um, and I found that I could explain it more easier in the latter... as time's gone on, I've kind of found, I suppose, it doesn't fit neatly into the categories of sort of human development..."*
b) Desirability– desirable (4C, 5½NC) or undesirable (2C, ½NC)			
H735	*"part of my journey... the first, sort of, unfolding of myself, like my kind of introduction to personal growth... I'd never really experienced sort of personal growth, like consciously, um, and I think it felt to me just like something that needed to happen"*	M400	*"somebody will tell me I'm imagining, but I don't mind, it's still making me happier"*
		M558	*"it touches something beautiful in me, something special in me... I am enriched by my experiences"*
H796	*"I just felt like, yeah, I was given it by God, more or less, and I think that's why it makes sense to me, that it kind of appeared, you know, that it just came, because I didn't invite it and I didn't expect it on any level at all. Like I was one million percent surprised, so, and it*	S420	*"I'm glad that I had these experiences, and I'm really glad to take out what I'm taking out of this"*
		C263	*"there's been a lot of positive effects, whereas I'd expect, um, if it was a sign of a mental illness or a disturbance, that I*

was such a positive thing, and was such a, kind of, enlightening thing, and was such a, kind of, just full of these realisations that were kind of setting me free from this darkness, that it just, yeah, I would definitely ascribe it to God now"

B140 *"I just believe that God saw my suffering and he wanted to use me... to help me, you know, Yeah, that's why he gave me a guardian, which is the voice... I just believe I have a gift from God"*

B377 *"An important part of my life. A very very important part of my life... what I've achieved now that I've got the holy spirit, I didn't achieve it when I didn't have him. So that makes me sort of happy with my life"*

N383 *I: "any positive things coming out of it?" N: "No. None at all"*

O115 *"I want to get rid of this, um, evil that's inside me"*

O432 *"a lot of angels have helped me, um, get through this terrible time"*

O600 *"it's changed me. It's made me a better person than I used to be"*

would be having the opposite effects"

J342 *I did wonder if it just (?) unbalancing or unhealthy way or something. I did have times of wondering that (pause), but yeah, but generally I just felt that it was a positive process"*

J468 *"we can go through a dark period, but it can be taking us somewhere... more in touch with who we are and happier"*

F571 *"they're not here to guide us, they're just here to help us, yeah. So if someone says "you have to murder that person", then I know I'm crazy"*

C547 *"there's more meaning, there's more purpose, and there's more direction"*

C572 *"I think either I would have died that night, or I would have had the experience"*

S475 *"It somehow seems that it happened at the right point of my life. It happened at a point where I was considering what to do, and this experience gained me the time to reflect, not only on work, not only on Marcuse, or not only on (?), or someone I'm reading, but also on myself... also that it was so scary, and that it was so not natural for me to have this experience, um, at that particular moment, it helped me a lot to like order my thoughts about how I should proceed... somehow it fitted in the moment"*

D346 *"It generally tends to add an enrichment to what I'm doing, and a dimension, and a sense of meaning... the consequences of it, in the sense of psychological benefits and stability in life, are fantastic"*

c) Transiency– temporary process (2C, 5NC) or permanent state (2C, 0NC)

L417 *"I'm told that they might never go away... I read somewhere that mental illnesses never go away, um, but so, going forward is quite difficult because I'm still living with the effects of the*

S513 *"I do think that I could get in this state again if I let go of myself, and like read a lot, and start to, evade social contact, and read a lot, and, or do some like yoga or something like this. Maybe I could get*

	mental illness that I've had. And basically the most salient fact is that it might never go away. In fact, it probably won't. That's the problem"		*through to this state again, but I'm not sure if I want to (laugh)"*
H1190	*"It was very frustrating for me because I felt like it was a stage, and I knew for myself that it was a stage. But it was like they [services] didn't accept that it was just a stage, like a process, that it was very much the end"*	J522	*"a lot is to do with just getting out there, you know, doing stuff, being a service to others, allow this energy to kind of reach out to others, rather than, kind of, almost like if it's just too caught up in yourself, it's just aaahh, you can drive yourself crazy with it. Be a service to others. Trust. Trust. Just trust that you're ok and that everything's ok and the universe is, you know, just trust really, just trust. And those things just really helped to get me through, I mean, very up and down for a while, with periods of really dark depression in a way. It was almost like it would just kind of go, then it would lift, it would be like lightness. When I go through the darkness period, it would be like afterwards there would so much more light, it was like, "oh that was just another layer", because when you're in that (?) place, you think that you'll always be like that, you'll always be like that. But you're not, it's some sort of process"*
d) Acknowledging spirituality-psychosis link (4C, 6NC)			
B264	*"they just think you are mad, you know, but obviously you'd know yourself that it's not like you are mad. You have something in you that is real, that you know is real, because it shows you spiritually. You know when it is spiritual, the eyes, the human eyes cannot be able to see it"*	J425	*"it was just like I thought I was going mad, felt like I was balancing a really fine line and I could just like fallen into the psychiatric, going to see a psychiatrist route, and end up in hospital or something, or I could just really start to trust, and know that everything will be ok"*
		J626	*"I remember going back and saying to my Dad, "you know Dad, do you think sometimes when people are in mental hospital, they're actually undergoing some sort of spiritual phenomena?"*

Note. [1]Super-ordinate group themes; [2]Group themes; [3]Illustrative quotes

Dissemination of findings

Oxford Doctoral Course in Clinical Psychology

- Five minute presentation to clinical psychology training colleagues on 31st August 2010 in Harris Manchester College, University of Oxford

Berkshire Healthcare NHS Foundation Trust

- One hour presentation to NHS staff and service users at the Berkshire Research Club on 2nd September 2010 in Prospect Park Hospital, Reading

South London and Maudsley NHS Foundation Trust

- Abstract publication in the 2010 PICuP research newsletter, which is circulated among NHS staff and service users

Division of Clinical Psychology, British Psychological Society

- Poster submission for the DCP annual conference on 1st-3rd December 2010 in Manchester (including entry for the 2010 DCP trainee poster prize)

Peer reviewed journals

- Paper A submission to *'Clinical Psychology Review'* by the end of 2010
- Paper B submission to *'British Journal of Clinical Psychology'* by the end of 2010

Research participants

- All participants have been invited to contact the researcher if they wish to be informed of the publication details. As most of them have already expressed this wish, they will contacted by the researcher if and when the details are confirmed