“Did I look at the blackness, or did I look at the stars?”

The role of spirituality in mental health and recovery

Katja Milner

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Abstract

Spirituality in both religious and non-religious forms is an important component of mental health and recovery. Research demonstrates that many people would like to have their spiritual needs addressed within mental healthcare services. However a 'spirituality gap' exists in the difference in value placed on spirituality by professionals compared with service users, often resulting in people's spiritual needs being neglected or poorly understood within clinical practice. A recovery approach to mental health care seeks to value and better understand lived experience. Supporting clinicians to better understand spirituality from the perspectives of people who experience mental health difficulties could help to bridge the spirituality gap and improve spiritual care within mental health services.

This thesis aims to address the gap in knowledge in two stages. First, exploring the experiences of spirituality among adults with mental health difficulties in published qualitative research through a qualitative systematic review. An electronic search of seven databases identified thirty-eight published studies which met the inclusion criteria. A thematic synthesis of the study findings identified six key themes: Meaning-making, Identity, Service-provision, Talk about it, Interaction with symptoms and Coping, which is presented as the acronym MISTIC. This is the first qualitative systematic review to explore the experiences of spirituality among adults with mental health difficulties and offers an evidence-based framework for developing holistic, strengths-focussed and person-centred approaches to mental health care.

The second approach employed within this thesis is an empirical study using a narrative methodology to explore the role of spirituality in the stories of adults who have current or previous experiences of mental health difficulties. An additional focus is employed, informed by systematic review findings, in exploring the way people use spirituality to find meaning in their experiences and how this process may develop over time. Thirty participants were interviewed and asked to share their stories of spirituality, mental health and recovery. A pluralistic emergent narrative thematic analysis approach was developed to explore superordinate themes of: Meaning making, Psychospiritual development and Spiritual connection.

Participant stories contained wisdom, challenge, beauty and a striking willingness and ability to articulate a dimension of life that can sometimes be considered taboo,

nebulous or too overly subjective to have value. A salient finding not adequately addressed within empirical research was the articulation of meaning making for some participants as an internalised form of spiritual guidance. Another key finding was the importance of authenticity within the context of their psychospiritual growth. An emergent integrative factor relating to all superordinate themes was the concept of spiritual functionality. This highlighted how spirituality operated within participant experiences both to support and sometimes challenge or damage their mental health and recovery. Spiritual functionality could therefore be a useful concept within mental health and clinical contexts to advance understanding of sometimes highly subjective and nuanced spiritual and mental health experiences.

The outcomes of this thesis provide a number of knowledge contributions. These include the production of an original conceptual framework highlighting key themes pertinent to people who experience spirituality in the context of mental health and recovery. It also provides novel insights into the ways in which meaning making, psychospiritual development and spiritual connection may function within this context. It contributes towards the development of evidence, theory and training resources for clinicians and mental health services to enable better understanding and reduce stigma of people's spiritual experiences in the context of mental health. A paradigm of healthcare delivery is highlighted which validates and integrates the spiritual dimension into an evolving recovery approach.

Acknowledgements

This PhD has been a huge personal journey for me, and it has been one which would not have been possible without the ongoing support of others, something for which I will always be extremely grateful.

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I would like to give a heartfelt thank you to my mother, Renate Milner, who stepped in like an Angel to provide me with a home and nurturing at a difficult period of transition of my PhD journey when I had to move house. I would not have been able to complete this project without your help so thank you for putting up with me and looking after me when I needed it the most!

I would also like to thank my amazing friend Tonya Bathe for being there for me unwaveringly throughout my PhD journey, as an amazing support as well as listening ear to allow me to talk through anything I needed to about my experiences and learning. There are many other friends, family members, companions, fellow travellers along the PhD journey and academic colleagues who have also been amazing in their support. They have provided a listening ear, practical help, tips and useful cathartic chats which helped me feel like I was not traversing this alone. Thank you to you all!

Some people who provided specific assistance to my thesis who I am extremely grateful for are: Dr. Laurie Hare-Duke, Dr. Snigdha Dutta, Emma Young, Dr. Ada Hui and the Research Recovery Team. In addition, Jane Titterton, Eleanor Shipman, and all members and contributors to my PPI (Patient and Public Involvement) group.

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Last, but not least, I am extremely grateful to the thirty participants who courageously and generously contributed their personal and heart-felt stories to this project. I hope this work does some justice to their beauty and importance.

I dedicate this thesis to all those who struggle with mental health difficulties, including those I met, worked with and had the honour to hear something of their stories – which ultimately has been the inspiration for this work.

In particular I dedicate this work to Des Haigh, a former colleague, friend and PPI member for this thesis; and Stefan Finnis, a family friend, who both sadly passed away during completion of this PhD. They both inspired me in relation to this topic and were wise beautiful souls who struggled greatly, at least in part because of an on-going lack of awareness and understanding about mental health difficulties and their potential impact upon the deepest aspects of being.

Thesis-related outputs and knowledge mobilisation

Publications

Milner, K., Crawford, P., Edgley, A., Hare-Duke, L., & Slade, M. (2020). The experiences of spirituality among adults with mental health difficulties: a qualitative systematic review. Epidemiology and psychiatric sciences, 29. https://doi.org/10.1017/S2045796019000234

Conference presentations and posters

I have delivered 13 conference presentations across a broad range of contexts and organisations including internationally, in person and online, focussing upon the MISTIC study and clinical applications. Some examples include:

'ECRSH' European Conference on Religion Spirituality and Health and 'BASS' British Association for the Study of Spirituality Conference, Coventry, 17/05/18 – 19/05/18 – Oral Presentation: 'Qualitative systematic review on the role of spirituality amongst adults with mental health difficulties'.

'ENMESH' European Network for Mental Health Service Evaluation Conference, Lisbon, Portugal, 06/06/19 - 08/06/19 - Oral presentation: 'The experiences of spirituality among adults with mental health problems: A qualitative systematic review.'

Nottingham Refocus on Recovery Conference, 03/09/19 – 05/09/19 - Oral presentation: 'Experiences of spirituality among adults with mental health problems: Qualitative systematic review findings and the MISTIC framework.'

'INSS' International Network for the Study of Spirituality Conference, Online, 07/06/21 – 08/06/21 – Online live oral presentation: 'An evidence-based approach towards understanding, assessing and working with the experiences of spirituality among adults with mental health problems: The MISTIC framework and its clinical applications.'

British Psychological Society Transpersonal Psychology Section, Online Conference, 11/09/21 – 12/09/21 – Online live oral presentation: 'The MISTIC

Framework: An evidence-based conceptual framework and resource to improve understanding and conversation around spirituality and mental health.'

'ECRSH' European Conference on Religion, Spirituality and Health, Amsterdam Netherlands and Online, 02/06/22 – 04/06/22 – Poster presentation: 'The MISTIC Framework: Supporting conversations around spirituality and mental health.'

Teaching and training

I have developed teaching and training presentations based upon the MISTIC framework and delivered these in person and online, in academic contexts at the university and for clinicians at the NHS. These include:

Nottinghamshire Healthcare NHS Foundation Trust 'Let's Talk Wellbeing Service IAPT Therapy Service', 20/06/19 and 05/10/19 - Two invited in-person training presentations: 'The experiences of spirituality among adults with mental health problems: A qualitative systematic review.'

University of Nottingham Faculty of Medicine and Health Sciences 'Mental Health Masterclass', 01/11/19 - Oral presentation: 'Addressing the religiosity gap: Spirituality as a key dimension in mental health and recovery.'

University of Nottingham, School of Health Sciences, Undergraduate Psychiatric Nursing School, 21/01/20 – In-person teaching presentation; and February 2021 online teaching presentation: 'Spirituality, Mental health and Recovery.'

Media and public engagement

Invited webinar: Trinity College Dublin, Trinity Spirituality Research and Innovation Group 'Re-imagining Spiritual Healthcare' Seminar Series 2021-2022, 03/02/22 – Online Seminar: 'The MISTIC Framework: An evidence-based conceptual framework and resource to support understanding and conversation around spirituality and mental health.'

'Hearing the voice' multidisciplinary project with Durham University, 2019 – Invited to contribute towards this project and include the MISTIC study and clinical recommendations on their website: https://understandingvoices.com/exploring-voices/voices-and-spirituality/putting-it-into-practice-information-and-advice-for-clinicians/

Interviewed for an online news article by Mental Health Lead in Melbourne, Australia for 'Spiritual Health Association', 2021 –
Invited to discuss the MISTIC study after gaining interest from an Australian mental health professional working in spiritual healthcare. The MISTIC resource is now available on their website and has been promoted within their service: https://www.spiritualhealth.org.au/mental-health-list/mental-health-and-spirituality-resources

Articles published in University of Nottingham Online News Bulletins, 2021 –

Published in the Institute of Mental Health:

https://institutemh.org.uk/images/9134_IMH_News_September_2021_FINAL.pdf

Published in the School of Health Sciences Research Bulletin:

https://sway.office.com/73anP7Ib79WC3bIY?ref=email

Invited to contribute a blog piece for the Institute of Mental Health Blog:

https://www.institutemh.org.uk/news/blog/it-s-ok-to-talk-about-spirituality

Design and creation of 'Toolkit' resource

I obtained ESRC funding to work with a designer and illustrator, Eleanor Shipman, to co-create a user-friendly and evidence-based 'Toolkit' resource based on the MISTIC framework. The aim of this resource was to make the findings more accessible to both clinical audiences and to a more general public wellbeing audience in the creation of two online 'Toolkits'. The clinical toolkit presents the 'Clinical implications' table and some basic information about the MISTIC framework in an attractive and user-friendly way. The leaflet for the general public presents the MISTIC themes in a less clinical way and utilizes some reflective questions to encourage people to consider how the themes may apply to their own lives and wellbeing. This resource can be accessed here:
https://www.researchintorecovery.com/research/mistic/

Abbreviations

BME	Black and Minority Ethnic
CASP	Critical Appraisal Skills Programme
LGBTQ+	Lesbian, gay, bisexual, transgender, queer and more
MISTIC Study	Abbreviation for thesis qualitative systematic review study
MHP	Mental Health Practitioners
NHS	National Health Service
PGR	Postgraduate Research
PIS	Participant Information Sheet
PPI	Patient and Public Involvement
UK	United Kingdom

Table of Contents

Tables

Figures

Chapter 1: Introduction

1.1 Introduction

There is a story written by a First Nation person derived from the teachings of the Plains People in North America. The author, Hyemeyohsts Storm (1972, p.14 -15) utilises capital letters to highlight words which have importance within their cultural and spiritual telling:

> *"It seems that at One time the People were Living Scattered Out all Over the World, and Each of them had Heard about a very Powerful person who Lived in the River. It was Said that this Person could Settle any Problem, no matter what it was.*
>
> *Because no one really Wanted to Admit to Anyone Else that they Possessed Problems, Everybody had to Sneak Down to the River Alone when they Wished to Hear this Powerful Person Speak. And Everybody did Sneak Down to the River to Hear about the Powerful Person, but No One ever Spoke to Anyone Else About it.*
>
> *Then One Day a Little Boy and a Little Girl Returned from the River. The Little Boy and the Little Girl began to Talk to Everyone About their Journey.*
>
> *"It was a very Strange thing," the Children said.*
>
> *"What was it that was so very strange?" the People asked as they Gathered Around the Children, Pretending they did not Know.*
>
> *"Have you not Seen what is at the River?" the Children asked.*
>
> *"No." the People All answered. "What was it that you saw there?"*
>
> *"Have All of you not Sneaked Down to the River, just as we Did?" the children asked in Surprise?*
>
> *"Who ever Said such a silly thing?" The People asked Angrily.*
>
> *"We did," the Children answered, Becoming Frightened.*

"Never say such an Awful thing again," the People told them Accusingly.

The Children Became even more Frightened. They Perceived that they were Strangers even to their Own Mothers and Fathers.

This Caused All the People to Move Away, Leaving the Little Boy and the Little Girl Alone Upon the Prairie. That Night they were all Alone and Frightened. They Cried because Everything seemed to be so Terrible."

The story goes on to depict a journey the little boy and the little girl make to learn about some key spiritual teachings within their tradition which they finally bring back to share with their people. The author explains about the being that the children meet in the river that can solve problems:

"This powerful person is our spirit. But we never really want to admit to anyone, or even to ourselves, that we actually have a problem. So every one of us sneaks down many times to the river inside ourselves. This river is the spirit of the power of the universe. But when we go there to hear the powerful person, we usually are afraid to speak about it. That is, until one day the little boy and the little girl within each of us speaks to us about it. This little boy and little girl begin to make themselves known in our minds."

The rejection the children experience from speaking openly about their experiences, the author explains, teaches them something. That they, or we, cannot trust ourselves and there is a disconnect and inability to communicate about these aspects with others. And so they are put out of mind and left alone, on the prairie, which symbolises everyday life. At this point of fear and isolation however, the children hear a voice speaking to them and they find comfort from some Elders who make a fire to warm them. The author says this symbolises the illuminating nature of the spirit within.

I share this story from a published accessible book with great respect for the spiritual teachings across all traditions including indigenous and First Nation peoples. I do it with awareness of the issues of Western cultural appropriation and with knowledge from a lineage which specifically chose to open up a proportion of their teachings to Westerners for the benefit of the spiritual growth of humanity as a whole. I also have a personal interest in such teachings in relation to my own

spiritual journey as they resonate deeply in a way that I have struggled to find within my culture.

I was brought up in a non-religious household and it was not until leaving university and living and working in Japan for three years in my early 20s that my interest in exploring spirituality began, and then continued throughout the rest of my adult life. Different kinds of spiritual teachings, traditions or practices would hold interest for me at different times in my life. They seemed to offer me something distinct in terms of helping me gain a deeper understanding of myself, others and the world around me, or they offered support or healing. I noticed that it was often at those times that life seemed most challenging or transformatory, when I felt the strongest sense of spiritual calling. By that, I mean a yearning to connect more deeply with a spiritual aspect of myself, even if I did not quite know what that was at the time.

Alongside my personal spiritual interests, I was also drawn to working across various mental health contexts after studying psychology at university. I remember working in psychiatric mental health wards and noticing that many patients spoke about the importance of spirituality but that there was almost no provision for this aspect within the mental health service. Later, when working in a new NHS role as Spirituality Lead, I had the opportunity to consider people's diverse spiritual needs and how the mental healthcare service could best provide for these across multiple contexts. This included co-creating an educational course for the NHS Recovery College on spirituality and recovery. This gave me the opportunity to listen to groups of people sharing their experiences with one another across a variety of beliefs and mental health challenges, and they, along with other people I worked with, taught and inspired me a great deal.

I found the experiences shared with me by Recovery College students and service users humbling and wise, informative and illuminating, challenging and frustrating, painful and beautiful. A recurring theme across these stories was that these individuals were not being heard (like the little boy and the little girl in the earlier story), or they were met with silence, confusion, judgment or pathologisation. There seemed to be a need for an authentic sense of safety and respect when people did share their experiences. Service users often admitted that the nature of spirituality and mental health was not straight-forward and may be challenging. In particular, the way that this topic was dismissed by others often led to experiencing confusion, isolation and sometimes an exacerbation of mental health difficulties.

These experiences became the motivation for this PhD. Having an awareness of mental health clinical practice and having started to explore spiritual research in completing an MSc, I grew aware of gaps in the literature and areas requiring further research. What seemed most pertinent to me was to explore this topic from the perspective of lived experience. What if, rather than shunning or silencing them, we asked the little boy and the little girl what happened at the river, and what they saw, felt and perceived? What could be learned from that?

This chapter outlines and explores the key concepts, approaches and rationale underlying this thesis: spirituality, mental health and lived experience, mental health recovery and adopting a psychospiritual approach. It includes salient theoretical perspectives and research, including in relation to healthcare practice.

1.2 What is spirituality?

1.2.1 Definitions and characterisations

Like many complex concepts, 'spirituality' and 'religion' lack a universally agreed definition. However they are both broadly concerned with symbolic systems and cultural factors which give structure and meaning to human values, behaviours and experiences (Hanegraaff, 2000; Lukoff et al., 1995). They often include a search for meaning and purpose, and connection with self, others, God or the transcendent (Gilbert, 2011b; Mueller et al., 2001). Although spirituality and religion are often used interchangeably in the literature, spirituality can be understood in a broader and more personally-defined, individual and experiential way than religion, although it does have a social and traditional dimension (Royal College of Psychiatrists, 2011). Religion is understood more in terms of systems of beliefs and is defined in this thesis as:

> *'A tradition of beliefs, experiences and practices that are related to the sacred, common among a group of people, and capable of being experienced experientially, institutionally and/or socially' (Kao et al., 2020, p. 2).*

A useful definition of spirituality used by the Royal College of Psychiatry is:

> *'Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values'* (Cook, 2004).

The word religion is derived from the Latin *religare* which means 'to bind together' whilst spirituality is from the Latin *spiritualitas*, which means 'breath' (Gove, 1961). Spirituality and religion can be synonymous or overlapping as well as contrasting or opposed concepts (Royal College of Psychiatrists, 2011).The similarities and distinctions between religion and spirituality are complex (Kao et al., 2020) and there is much scope and variability in the application of both terms. Following other contemporary authors and researchers, spirituality and religion in this thesis are viewed as overlapping concepts (Holland et al., 1998; Miller & Thoresen, 2003). Although each may have distinct aspects (e.g. public vs private, institutional vs individual) these are not mutually exclusive and may be expressed slightly differently by each person (Ouwehand et al., 2014). As spirituality is often considered the broader of the two concepts, inclusive of religion, following other authors such as Koenig et al. (2001), spirituality is used in this thesis as an over-arching term which includes both religious and non-religious expressions, depending on the personal meaning to the individual. Exceptions to this are where it is relevant to distinguish between the two terms, to use both terms (e.g. within research contexts) or when studies or participants specifically highlight the concept of religion.

David Tacey (2012) argues that spirituality as a term has radically changed its meaning in the last few decades. He points out that it used to refer to those who were 'very religious' such as monastics, but is now often used by people who are not necessarily religious. For Tacey (2012) spirituality is positioned within a historical, social and developmental context which challenges both traditional religious perspectives and secularised society. Summarising the contrary perspectives within the spirituality discourse, he states:

> *'Contemporary spirituality is defined by the contrary voices and movements expressed within it. The fact that there are so many conflicting views, and a number of contested positions, is a sign that the field is dynamic and alive'* (Tacey, 2012, p. 474).

Tacey (2004) identifies a renewed interest in spirituality and its healing effects on life, health, community and wellbeing as a 'spirituality revolution'. He argues that we are seeing a return of the spiritual impulse along with a need to integrate a new spiritual understanding of life and health into existing models and approaches.

There are several key difficulties and complexities around characterisations of spirituality, particularly when considering integration and application into healthcare and practice. These include its subjectivity, highly personal nature and the lack of a universally agreed definition. The challenge of finding definitions which transcend specific religious and cultural contexts has been highlighted, which some authors suggest is virtually impossible (McSherry & Cash, 2004). Additionally, the multidimensionality of the concept can highlight differing core components such as meaning, transcendence, values, connectedness, transformation, growth, beliefs, awareness or experience (e.g. King & Koenig, 2009; King, 2011). Consequently different definitions may describe varying aspects of spirituality and highlight the 'language challenge' that occurs when people attempt to define this concept from differing personal, cultural and professional backgrounds (Gatmon, 2015). Ways forward are suggested to include use of qualitative research and conceptual discussion to explore how the term spirituality is used by people in everyday life rather than focussing upon restrictive arguments of definition (King & Koenig, 2009; McSherry & Cash, 2004).

John Swinton, a key authority on the subject, reflects upon the wide definitions that emerge from the literature. Within a context of healthcare and research which '*loves precise concepts and accurate descriptions*' this is often perceived as a problem that is indicative of the meaninglessness of the concept (Swinton, 2014, pp. 162-163). He argues that the fact that a concept may be vague, multi-vocal and imprecise does not mean it is not important (Swinton & Pattison, 2010). He states:

> *'Spirituality is unabashedly a fluid and deeply pragmatic concept that shifts and changes according to the context within which it is constructed and the needs it is attempting to meet'* (Swinton, 2014, p. 163).

In that way, the question ‘what is spirituality?’ is probably unanswerable and even misleading. Swinton conceptualises spirituality in a way that recognises its inherent fluidity and subjectivity, and yet emphasises its practical applications within contexts such as healthcare practice. He says:

> *‘Spirituality does not get its meaning from dislocated intellectual reflection alone. Rather, its meaning emerges from the impact that it has on practice. We come to know what spirituality feels like in action as we engage with it in particular contexts and in specific ways… Action is the place where one learns what spirituality is’* (Swinton, 2020, pp. 6–7).

A different yet useful perspective for understanding spirituality in relation to health and wellbeing emerges from indigenous First Nation teachings. One central component of such teachings across different specific cultures is the ‘medicine wheel’. This is a map used as a basis for understanding the world and different systems of knowledge which overlap and interconnect. The wheel as a map also highlights a non-hierarchical and relational nature of viewing knowledge. The map for understanding the human condition, health and wellbeing highlights four aspects – the physical, the emotional, the mental and the spiritual, as shown in Figure 1.1.

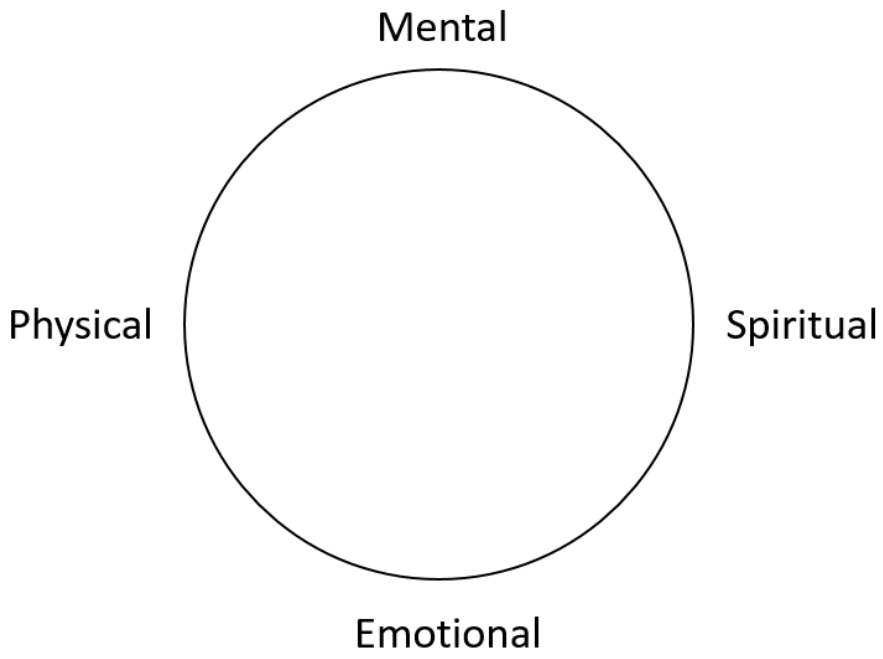


Figure 1.1 Medicine wheel of four aspects of human nature and wellbeing

From this perspective, an individual's needs in each of these areas must be met for optimal health and wellbeing and the development of human potential (Graham & Martin, 2016). Although this is one of many ways to understand spirituality and could be viewed as culturally-specific, the simplicity of this model is informative because it places spirituality in a similar form of relationship to human experience as mental, emotional and physical aspects. From this perspective spirituality is not reified or separate from human life, or seen as having value merely in a dualistic sense (is it good or bad, is it real or not?). If spirituality is seen as an aspect of being human and as a part of holistic health and wellbeing, this can provide a helpful tangible viewpoint from which to approach spirituality in relation to healthcare.

Although there are an array of definitions and extensive literature exploring the concepts of spirituality and religion, a key aspect of how spirituality is characterised in relation to this thesis is as 'personally defined.' This is because this thesis focusses on researching lived experience and how participants themselves understand spirituality and its potential relationship with their mental health and recovery (defined in Sections 1.3 and 1.4). Although spirituality could be understood as a dimension of human nature alongside physicality, mentality and emotionality, it is perhaps distinguished by its degree of subjectivity, including in relation to how it can be researched. The subjective is central to spirituality and therefore the stance I take is that it is a field of study that cannot be judged in terms of its validity. Attempts can be made to understand, interpret and analyse experience within relevant frameworks, but not to make value-judgements about whether someone's experience is genuinely spiritual, or how 'good' (whatever that means) their spirituality is. In this light, what this thesis aims to contribute is to understand in greater detail the nature of people's spiritual experiences in relation to mental health and recovery, and delineate patterns and tendencies within this context. Spirituality is not then, from this perspective, something to be judged in and of itself. It is a dimension of human experience that demands exploration and attention within a contemporary context and in relation to mental health and recovery.

1.2.2 Prevalence and beliefs

Despite the assumption that secular attitudes prevail in contemporary Britain, experiences of the sacred or spiritual remain widespread (Cobb & Robshaw, 1998). Although there has been an overall decline in people identifying as religious,

spiritual beliefs and practices have diversified, and the curiosity and search for the spiritual, mystical and transcendental remains strong (Swinton, 2001).

The 2011 and 2021 England and Wales census indicate that there has been a decline in religious affiliation in England and Wales, with an increase in the population reporting no religion from 25.2% in 2011 to 37.2% in 2021. There has been a drop in the population reporting to be Christian - from 59.3% in 2011 to 46.2% in 2021, and an increase in other main religions. For example, the number of people describing themselves as Muslim rose from 4.9% in 2011 to 6.5% in 2021, and there were small increases in Buddhist, Hindu and Sikh populations. There was also a small increase in those who identified as 'Other religion', with the largest group within this category being Pagan (Office for National Statistics, 2012, 2022). Similar findings were highlighted in a survey conducted in 2016 by BSA (British Social Attitudes) on religious affiliation which found that 53% of respondents indicated they affiliated with 'no religion' and 41% were Christians, while 6% affiliated with non-Christian religions (Clery et al., 2016). The issue with these surveys however, including the most recent 2021 census, is that they only ask about religious affiliation and not spirituality. This means that the growing number of people who consider themselves as spiritual but not religious (Fuller, 2001) would likely be recorded as 'not religious'. This misses potentially vital information about non-religious spiritual beliefs as well as how beliefs may be changing within today's society.

The conceptualisation of spiritual belief as 'spiritual but not religious' seems to be an increasingly popular self-designation for people when asked about their beliefs. Diversity and ambiguity in how individuals understand this designation are evident within the literature and seem to be influenced by cultural and demographic factors (Wixwat & Saucier, 2021). Because of this, research exploring spirituality more broadly can be less concrete, measurable and constant than religion, and research findings focussing specifically on one conceptualisation may not always extrapolate to the other (Kao et al., 2020; Koenig, 2008). The term 'spiritual but not religious' may still be somewhat limiting as it seems to pit spirituality against religious belief when for some people spirituality may be both distinct from and informed by religious traditions or practices. Tacey's (2004) conceptualisation of 'contemporary spirituality' captures the way in which such beliefs seem to be related to societal change. He argues that contemporary beliefs are moving away from traditional or organisational forms towards those which are chosen by the individual, and that

they can be fluid and changing. Ouwehand and colleagues (2018, pp. 33–34) use the term *'new spirituality'* to coin this evolving form of belief which they describe as:

> *'a broad term for different emerging forms of religion, where the focus is on individual experience and a "true inner self", a holistic and cyclic perspective on transformation and history, the immanence of the divine, and syncretistic tendencies.'*

Although there is less up-to-date information regarding rates of broadly spiritual rather than specifically religious beliefs, an ICM (Independent Communications and Marketing) survey in Europe in 2004 revealed that 67% of the population of the United Kingdom held beliefs in God or a higher power. Hay & Hunt (2000) found that over 75% of respondents in a British national survey claimed they were personally aware of a spiritual dimension to their experience. They said:

> *'Something extraordinary appears to be happening to the spiritual life of Britain… after a first look at the findings of the 'Soul of Britain' survey… results show that more than 76 per cent of the population would admit to having had a spiritual experience. In hardly more than a decade, there has been a 59 per cent rise in the positive response rate to questions about this subject'* (Hay & Hunt, 2000, p. 846).

A similar picture was highlighted in the United States by theologian Sandra Schneiders (Schneiders, 2000, p. 1):

> *'Spirituality has rarely enjoyed such a high profile, positive evaluation, and even economic success as it does among Americans today. If religion is in trouble, spirituality is in the ascendency and the irony of this situation evokes puzzlement and anxiety in the religious establishments, scrutiny among theologians, and justification among those who have traded the religion of their past for the spirituality of their present.'*

In relation to surveys of beliefs in the United States, successive Harris polls have indicated that around 90% of the population say they have a belief in God (King, 2014). Within a more global context, reports have identified that 84% of the world's population is religiously affiliated and that 68% of unaffiliated individuals believe in a higher power (Pew Research Center, 2012; Rosmarin et al., 2021). Although the

nature of people's spiritual beliefs may be changing within the contemporary world, both religion and spirituality appear salient to the majority of the population.

1.3 Mental health and lived experience

Mental health is defined in various ways, for example by the World Health Organisation (2004) as '*a state of wellbeing in which the individual realises his or her abilities*' and as:

> *'Essentially about how we think and feel about ourselves and about others and how we interpret the world around us… it also affects our capacity to cope with change and transitions such as life events… Mental health may be central to all health and well-being'* (Rankin, 2005).

It is increasingly recognised that mental health is integral to health and wellbeing, including physical health as reflected by the World Health Organisation that there can be *'no health without mental health'* (World Health Organization, 2013). In many societies, mental health problems are of increasing concern with higher rates of mental illness and suicide. People with mental health problems experience disproportionately higher rates of disability, stigmatisation, discrimination, poverty, disease and mortality leading to huge economic consequences (World Health Organization, 2013). In the UK, mental health problems are common, with one in six adults reporting a mental health disorder, and around half a million adults diagnosed with a severe mental illness. Issues of mental health and wellbeing have worsened since the Covid-19 pandemic, a global outbreak of the infectious respiratory disease, coronavirus, starting in 2019 and leading to instituted lockdowns, huge loss of life and disruptions worldwide. Declining mental health issues include social risk factors such as poverty, extreme stress, exposure to violence, low social support, social isolation and poor housing (Public Health England, 2022).

Mental health issues are sometimes referred to as 'mental illness' which is distinguished from physical illness essentially in that there is no established physical cause (Slade, 2009). A number of models of mental illness exist such as the 'medical model' that privileges the biological and chemical basis of mental illness and often dominates within psychiatric and clinical contexts. Other social or psychological models are concerned with life events, family dynamics, belief systems and social aspects. Often these frameworks of understanding will interact

and require a range of social, cultural, spiritual, medical and cognitive approaches (Gilbert, 2011a; McCulloch, 2006).

Clinical models developed to inform clinical practice have been problematized and subject to interrogation over the last twenty years or so. These include medical, biopsychosocial and cognitive approaches which tend to label and thereby de-individuate people by assuming homogeneity within a group regarding diagnostic features. This can also lead to a negative bias in relation to labelling the person which tends to highlight risk factors, problems and deficits at the expense of protective factors, strengths and abilities. Such clinical models also tend to neglect social and environmental factors (Slade, 2009).

In contrast to this, disability approaches to mental illness emphasise the barriers and exclusion a person may experience as a result of lost functionality (Sayce, 2000). Here the focus moves away from illness to a more holistic view of the person and what they might need to adapt within a socially inclusive and accessible context. Finally, 'diversity' models challenge both clinical and disability approaches and the psychopathological assumptions related to them. Such models focus on emancipatory changes needed in society rather than the treatment of or adaptation by the individual. They highlight the need to integrate all aspects of human experience and challenge the idea that mental illness is a wholly negative or dichotomous phenomenon as well as negative values and language associated with such views (Slade, 2009).

Because of the controversy about the use of language in relation to mental health which may emphasise psychopathology, and which some object to or see as irrelevant to their own experiences, the term 'mental health' is used as a general concept for this thesis. Other terms are used when specifically described by participants or studies, otherwise mental health is used generically to refer to mental health experiences, and terms such as 'difficulties' or 'distress' are used to highlight particular challenges in mental health.

Understanding mental health as a subjective experience emphasises approaches and models that may focus upon personal perspectives rather than solely clinical ones. The idea that individual 'lived experience' is important in the consideration of mental health and treatment has gained traction over the last few decades. This has led to the idea of 'experts by experience', in contrast to clinical, scientific or

psychiatric expertise. This development involves the professional acknowledging and affirming the expertise of the person they work with, in assessing and agreeing a way forward (McLaughlin, 2009). Glasby and Berresford (2006) argue that a new understanding of what constitutes valid knowledge or 'evidence' is required. They suggest that the practice wisdom of practitioners and the lived experience of service users should be increasingly deployed as 'knowledge-based practice' and is an important way of understanding the world.

Some areas in which lived experience is increasingly utilised include training, evaluation, research, consultation and service planning. There are many considerations however if these developments are to be effective and meaningful rather than merely tokenistic. For example, the term 'lived experience' has been criticised for connoting representation of a homogenous group. Morgan (2008) argues that the notion of lived experience has been adopted uncritically with the implication that it is somehow individually owned, transparent and easy to give an account of. Other issues highlighted which can limit the potential impact of lived experience are institutionalised oppressions that may restrict complexity and diverse perspectives to preserve the status quo (Trivedi, 2010). On the other hand, the promotion of open, inclusive dialogue between service users and healthcare practitioners is a potentially powerful tool for change, particularly within the context of creating safe environments which encourage honest self-expression (Carr, 2007).

This study seeks to align with the emerging trend in mental health research, policy and practice to highlight and prioritise subjective and lived experiences. There is increasing acknowledgment that this can provide a form of particular expertise that contrasts with traditional models of understanding mental health biologically or psychologically in which psychopathology is emphasised. This approach to understanding, researching and practicing mental health is encapsulated by the phrase 'mental health recovery' and is described and explored below.

1.4 Mental health recovery

The concept of mental health recovery has gained prominence in mental health service user writing since the late 1980s (Ralph, 2000). The emergence of the voice of service users could be seen as one of the most powerful developments in mental health worldwide (Buchanan-Barker & Barker, 2008). Their experiences have

highlighted themes of resiliency, growth and transformation within the context of a deficit- and pathology-oriented mental health system (Onken et al., 2007).

The term ‘recovery’ was coined as a way of acknowledging that people with mental health problems can successfully build full, productive and meaningful lives. Recovery thinking has generated ideas within an emerging movement or paradigm with a distinct philosophy, values, beliefs and terminology which have promoted change and become central to the mental health field over the last few decades (Bonney & Stickley, 2008).

There have been numerous ways of conceptualising recovery from mental illness but most distinguish between two key aspects; clinical ‘recovery from’ mental illness and personal ‘being in’ recovery. The concept of clinical recovery relates to the conventional idea of a cure, restoration to former health and the eradication of symptoms (Davidson et al., 2009). The notion of personal ‘being in’ recovery refers to the process of healing and rebuilding a meaningful life and of reclaiming a sense of identity beyond the effects of mental illness (Davidson & Roe, 2007). Personal recovery is a deeply personal process, a ‘journey of discovery’ and a way of life involving the development of new meaning and purpose (Anthony, 1993; Repper, 2006).

Personal recovery, which is the focus of this thesis, is ultimately personally defined with no ‘one size fits all’ definition or approach (Slade, 2009). It is seen as a journey in life, rather than an outcome to be arrived at, and as a process requiring active engagement and personal responsibility in contrast to a more passive patient role emphasised in traditional clinical approaches (Watts & Higgins, 2016). To clarify the meaning of personal recovery, Leamy et al. (2011) conducted a systematic review which showed that recovery can be thought of as a journey which varies over time and from one person to another. They identified five over-arching recovery processes comprising Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment (giving the acronym CHIME). This research highlights an overlap between the concepts of spirituality and recovery.

Along with the increasing prevalence of the concept within practitioner, policy and research discourses (Stickley & Wright, 2011), throughout the last few decades the language of recovery has been absorbed into the heart of mainstream healthcare policy in the United Kingdom and internationally. For example, the policy document

‘No Health Without Mental Health’ (Department of Health, 2011) depicts service users as being at the centre of their own care, and utilises terms such as ‘choice’ and ‘control’ and ‘no decision about me without me’. In addition, following the Francis report (2013) the Department of Health endorsed a number of regulatory changes to cultivate more humane services consistent with the recovery approach including employment of peer support workers and development of educational rather than medical discourses in Recovery Colleges (Newman-Taylor et al., 2015; Speed & Harper, 2015). More recently, the World Health Organization’s Comprehensive Mental Health Action Plan 2013–2030 emphasises expansion of knowledge and promotion of recovery approaches within mental health systems globally (World Health Organization, 2021).

Various recovery-focussed approaches and models have been proposed for improving mental health care. For example, the Tidal Model (Barker & Buchanan-Barker, 2004) emphasises ten philosophical ‘commitments’ central to recovery-focussed practice which help practitioners support people to make their own life changes. These include valuing the voice, respecting their language, developing genuine curiosity and being transparent. Although there is some evidence that the Tidal Model can bring about positive results in adult acute mental health units, such as improving patient satisfaction and perceptions of care, adoption has been limited to specific locations or providers (Kusdemir et al., 2022). In addition, large-scale studies of its evaluation and implementation are required (Ramage et al., 2018). Fundamental changes may be needed within clinical practice for the effective implementation of such recovery-focussed approaches, including a values-based shift from clinical preoccupations to the priorities and aspirations of the individual (Slade, 2009).

Despite the positive innovative ideas suggested by the recovery approach, its implementation within the mental health system has not been straightforward. For example, it may not always be clear what the term recovery means in relation to transforming the mental health system and professionals sometimes highlight concerns that it can add to their burden of care already stretched by demands that exceed their resources (Davidson et al., 2006). In addition, research has identified that some professionals view recovery as happening for very few people and not applying to ‘their patients’, that recovery is about making people ‘independent and normal’ or that it is just a passing fad (Davidson et al., 2006; Slade et al., 2014). Recovery could also be viewed as counter-cultural in that it could be seen to

threaten power structures which have been in place much longer than the recovery movement (Pilgrim, 2008).

Other criticisms of recovery include that it has been co-opted by mental health systems and used in government policy as ‘another optimistic rhetorical device’ (Spandler & Stickley, 2011) which positions service users as individual consumers, rather than investing in the hope-inspiring contexts necessary for these kinds of services to evolve (Spandler, 2004). Trivedi (2010) argues that service user concepts too often become distorted, tokenistic or even tyrannical when taken up by mental health systems and questions whether recovery can retain its authenticity when used in this way. The recovery paradigm may therefore struggle to embrace the diversity and plurality of human experience (Edwards, 2015). In addition, there are questions regarding whether the recovery movement is prepared to address the systematic social-economic disadvantages that many users of mental health services are burdened with (Arenella, 2015). Beresford (2015) questions how likely it is that people experiencing distress will be able to overcome exclusion and regain their confidence whilst rising levels of fear, stigma and anxiety are being created by service and welfare cuts in the United Kingdom.

Other authors highlight that people may not only be recovering from the life circumstances that gave rise to their mental distress, but the impact of coercive, oppressive practices and disempowering effects of an illness-based model of psychiatric care (Coleman, 2011). In addition, consequences of discrimination and the loss of rights and voice that can result from being labelled ‘mentally ill’, can often be more challenging than dealing with the initial distress (Perkins & Repper, 2003; Watts & Higgins, 2016). The recovery process therefore crucially involves the transformation from an illness-dominated identity to one that encompasses personal agency and a process of re-engagement and meaningful integration into community life (Mancini, 2007).

Although there has been a lack of detailed guidance on the implementation of effective recovery-focussed transformational initiatives within mental health services (Poole, 2011), an understanding of service change is emerging. Empirically validated recovery-oriented interventions have been identified including peer support workers, recovery colleges, supported housing, wellness recovery action planning and working with a strengths model (Winsper et al., 2020). Greater challenges may come from tackling organisational issues such as a transformation

away from a ‘treat and recover’ view and reducing the barriers which prevent individuals from experiencing full entitlements of citizenship (Slade et al., 2014).

Some authors urge for a transformational ideology marked by political and social justice goals and a ‘radical transformation’ of how mental distress is conceptualised and responded to, including a move beyond professional-centric psychiatric services and embracing less hierarchical models of support (Watts & Higgins, 2016, p. 25). Longden et al. (2016) call for a ‘radical reappraisal’ of how biomedical theory and practice are used within mental health services, arguing that a conceptual shift in mental health is not only necessary but also feasible and inevitable. They identify the need for a paradigm shift which addresses the real causes of human distress, develops treatments which support people’s needs in humane and effective ways and which acknowledges the political, relational and cultural components in which mental health difficulties are embedded. Blanch (2007) takes this a step further saying that what may hold the key to a new recovery paradigm is to open up to and integrate the wisdom which comes from religious and spiritual frameworks of understanding. This is based upon the burgeoning research highlighting the effects of spirituality on mental health and recovery, as explored in the next section.

1.5 Spirituality, mental health and recovery: A research context

The emergence of the voice of the mental health service user has highlighted the central importance of spirituality for some people in coping with the pain and struggle of mental distress and in facilitating wellbeing and recovery (Basset & Stickley, 2010). There has been a corresponding growing interest and increasing number of publications in spirituality research including within the context of mental health and recovery.

Research indicates a high prevalence of spirituality and religiosity among adults experiencing mental illness with some studies finding higher rates than in the general population (Bussema & Bussema, 2007; Russinova & Cash, 2007). Some researchers note that the understanding of religion and spirituality for this population might be complex and nuanced (Russinova & Cash, 2007), for example because of the overall loss of hope, control and purpose that mental health difficulties can engender. Tepper et al. (2001) found that more than 80% of participants in their study used religious beliefs or activities to cope with their symptoms of mental illness. D’Souza (2003) found that 79% of participants identified that spirituality was

important to them and 67% stated that their spirituality had helped them to cope with the psychological pain associated with mental health problems.

Empirical findings in the last few decades have fairly consistently reflected the beneficial effects of spirituality and religion on mental and physical health (Wong-McDonald, 2007). In a meta-analysis of more than 3000 published studies on religion, spirituality and health by Koenig et al. (2012) substantial evidence was found to support the idea that spiritual and religious beliefs are used to cope with illness and result in positive outcomes. For example, spirituality was associated with fewer symptoms of depression, lower incidence of suicide and lower severity of alcohol and substance use. Research has also shown positive effects of spirituality and religion on various indicators of recovery from mental illness. These include greater empowerment and involvement in recovery enhancing activities (Yangarber-Hicks, 2004), lower suicide rates (Jarbin & von Knorring, 2004; VanderWeele et al., 2016), lower levels of depressive symptoms (Bosworth et al., 2003) and greater levels of emotional wellness, self-esteem and life satisfaction (Baetz et al., 2002; Rosmarin & Koenig, 2020).

The means by which spirituality and religion facilitate recovery is varied and complex (Fallot, 2007; Webb et al., 2011). Spirituality has been found to give people hope when very little else provides this (Bussema & Bussema, 2000), to cultivate personal identity beyond the 'sick role' (Wilding, May and Muir-Cochrane, 2005) and to support beliefs which promote meaning making, self-esteem and recovery (Bassett et al., 2008; Bussema & Bussema, 2007). Religion and spirituality can offer a way to cope with symptoms, frustrations and difficulties by providing a cognitive framework, guidance, support and hope for managing events that might otherwise seem overwhelming (Bussema & Bussema, 2000; Corrigan et al., 2003; Pargament, 2001). Pursuing new meaning and purpose in life is seen as a core component of the recovery model (Anthony, 1993), and religious coping has been highlighted as a frame of reference to facilitate understanding of difficulties, especially those associated with loss of control and endangered meaning (Bussema & Bussema, 2007; Rogers et al., 2002). Religion and spirituality may also help enhance self-esteem through beliefs and practices that connect people to the idea of a force greater than themselves (Webb et al., 2011).

Spirituality and religion can also support coping in the context of mental health and recovery through spiritual practices such as prayer and meditation, which can serve

as a stress-buffering function (Webb et al., 2011). Borras et al. (2007) found that 71% of participants in their studies utilised religious resources for coping, including support with depression and anxiety, suicide prevention, reduction in substance use and a greater sense of self-fulfilment. Such resources included practices of prayer, meditation, attending church services and worship. The faith community can further provide supportive social networks, practical or emotional aid, and a sense of security or belonging (Stone et al., 2003). Research has also demonstrated the positive impact of Buddhism-based mindfulness practices upon health and wellbeing and their efficacy as evidence-based treatments for psychiatric disorders including the treatment of stress, depression and anxiety (Goldberg et al., 2018; Rosmarin et al., 2021).

Whilst there is a great deal of literature pointing to the positive impact of religion and spirituality on mental health and recovery, research also demonstrates some negative or harmful effects and associations. For example, whilst some studies highlight spirituality as a protective factor against suicidal behaviour, others have indicated that anger against God, disillusionment with one's faith, or the destruction of relationships in the religious community were risk factors for suicide (Huguelet et al., 2007). Similarly, while some people describe their mental illness as a 'gift from God to help me grow', others have portrayed their mental illness as 'punishment sent by God for my sins' (Borras et al., 2007, p. 1242). Spiritual struggles such as feelings of excessive guilt, 'spiritual despair' (Mohr et al., 2006), disillusionment following religious abuse scandals or anger towards God (Rosmarin et al., 2021) can contribute towards emotional distress and exacerbate mental health difficulties. Experiences of religious communities can also be challenging. For example, the attitudes of some religious groups in Fallot's (2007) study regarded mental illness as a sign of moral or spiritual weakness or failure, and would therefore contribute to an additional source of stigma. In a recent systematic review, Eillis et al. (2022) found that religious and spiritual abuse and trauma, which can include a misuse of power by spiritual communities, can result in a variety of negative outcomes including emotional, psychological, physical and spiritual harm.

King (2014) argues that research on religion and spirituality is often complex and challenging to interpret due to problems of measurement and definition. In another critical perspective on the field of spirituality research, Holloway (2014, p. 122) suggests that spirituality scholars can sometimes overlook the contexts of socio-economic hardship, chronic ill-health, discrimination and oppression. She urges

resisting the temptation to equate spirituality with a positive 'sweetness and light' model and instead highlights the need to grapple with challenges which may be part of the spiritual experience. In his book 'The Darkening Spirit', Tacey (2013b) argues that if spirituality is neglected or repressed, as it often can be within the rational context of modernity, it can be expressed in toxic, disruptive or dangerous ways. Tacey suggests these are distorted expressions of spirituality which have not been integrated sufficiently with care, education, insight or discernment, and can give rise to religious violence and fanaticism. He argues that this aspect, as well as the 'numinous' and mystical nature of spirituality can lead to fear and resistance from a rationally-focused culture. This could include clinicians and healthcare practitioners who may have had negative experiences in relation to religion or spirituality, or find it triggering in some way. However, Tacey argues that the spiritual dimension and its psychological and social impact does not go away when it is ignored, and in fact may be prone to toxic or disruptive effects when not sufficiently given awareness and understanding. Holloway (2014) suggests that 21st-centuary health care may not yet feel familiar or comfortable dealing with challenging spiritual experiences. Such healthcare contexts in relation to spirituality, mental health and recovery are explored in the following section.

1.6 Spirituality, mental health and recovery: A healthcare context

Over the last few decades there has been a greater emphasis on spirituality within professional contexts, healthcare discourse and policy, with attention being paid to spirituality as an ethical obligation of professional care (Vermandere et al., 2011). A UK Government publication on this topic states that:

> *'Local NHS trusts are responsible for determining, delivering and funding religious and spiritual care in a way that meets the needs of their patients, carers and staff'* (NHS England, 2015, p. 5).

Within psychiatry there have been some changes in attitudes over the last few decades as the profession has become more accepting of the spiritual and religious concerns of patients (Sims & Cook, 2009). In 2015, the Executive Committee of the World Psychiatric Association accepted a position statement that the consideration of patients' spirituality, religious beliefs and practices and their relationship to the diagnosis and treatment of psychiatric disorders should be considered as essential

components of psychiatric history taking, training and professional development (Moreira-Almeida et al., 2016; Verhagen, 2017).

Within the context of nursing in the UK, the Nursing and Midwifery Council expects newly qualified graduate nurses to make holistic and person centred assessments and treat people with kindness, respect and compassion. Although former codes of practice specifically highlighted taking into account a person's spiritual needs as part of their personalised care plan (Royal College of Nursing, 2011), later policy has omitted specific guidance around spiritual care (Nursing and Midwifery Council, 2018). A survey was commissioned by the Royal College of Nursing in 2010 to ascertain members' perceptions of spirituality and spiritual care. Although respondents recognised that attending to patients' spiritual needs enhanced the quality of nursing care, the majority said they required more education and guidance about effective spiritual care (McSherry & Jamieson, 2011).

Spiritual care is defined as recognising and responding to the needs of the human spirit in the context of trauma, illness or distress, which can include the need for meaning, self-worth and expression, faith support or for a sensitive compassionate listener (NHS Education for Scotland, 2009). Spiritual care is part of a holistic, person-centred approach to health care which attempts to embrace the whole person through the integration of various dimensions including the spiritual (Rogers et al., 2021). Various models of spiritual care exist (e.g. Govier, 2000) to support practitioners undertaking enquiries to ascertain potential spiritual needs (Eagger & McSherry, 2011). Spiritual needs are described as those needs and expectations to find meaning, purpose and value in life (Murray et al., 2004). These may include themes connected with hope, love, connectedness, spiritual struggles, loss and distress, belief systems and spiritual practices (Eagger & McSherry, 2011; Narayanasamy, 2001).

Research and service user narratives however repeatedly highlight themes about people's spiritual needs or faith being ignored, dismissed or pathologised by health professionals (Fallot, 1998; Halasz, 2003; Zinnbauer & Pargament, 2000). A 'religiosity gap' has been frequently identified in empirical studies of healthcare practitioners who often significantly undervalue the importance of spiritual factors in recovery (Dein et al., 2010). This has been found to be related to practitioners reporting a lack of knowledge, competence or clear practical guidance about spiritual care (McSherry & Jamieson, 2013; Mooney, 2009). These concerns can be

confounded by confusion about the great diversity of spiritual expressions, beliefs, practices and organisations (Fallott, 2007). In addition, spiritual needs may be interpreted as mental illness, thus shutting down engagement with services and further discussions about spiritual care (Dein et al., 2010; Mental Health Foundation, 2002). This may be partly because the boundary between some spiritual experiences such as visions, hearing voices and mystical experiences, and mental health symptoms including psychosis, remains unclear and can share phenomenological similarities (Dein, 2017). In line with the terminology utilised in this thesis, outlined in Section 1.2.1, which highlights 'spirituality' as an overall inclusive concept, the term 'spirituality gap' is used rather than the term 'religiosity gap' which could imply the exclusion of spirituality that is not grounded in religious experience.

The first task of mental health services, according to Fallott (2007, p. 268), is to become 'spiritually competent' by developing understanding of the role spirituality may play in mental health and recovery. Spiritual competence is described as the extent to which service providers are skilled in understanding and taking into account people's spiritual realities. Wattis et al. (2017, p. 3) describe spiritually competent practice as involving:

> *'compassionate engagement with the whole person as a unique human being, in ways which will provide them with a sense of meaning and purpose… accepting the person's beliefs and values.'*

Spiritual competence includes considerations of the person's relationship with their community and addressing coping strategies to support their quality of life. There have also been moves internationally to develop a European standard for spiritual care competency frameworks and spiritual education and training in general as part of the 'EPICC project' (Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care) (Giske et al., 2022). Nolan & Crawford (1997) argue that the nursing agenda for the 21st century must include the spiritual domain and that nurses need to re-introduce spirituality into the language of nursing. They suggest that it is necessary to change radically the metaphors governing nursing practice, calling for a rhetoric in spirituality to ensure that the spiritual is valued alongside the scientific.

Adopting a spiritual approach to recovery requires both an openness to new information and considerable courage to confront prevailing norms (Blanch, 2007). This may be a significant challenge for practitioners and for the development of mental health services. However, Russinova & Blanch (2007, p. 248) argue that:

> *'Emerging evidence about the beneficial impact of spirituality on recovery outcomes suggests that the successful incorporation of spiritual approaches into clinical practice has the potential to contribute to the next quantum leap in the development of effective person-centred systems of care… recognition of the spiritual dimensions of treatment can help to strengthen our understanding of recovery.'*

Similarly, Blanch (2007, p. 255) points out:

> *'introducing a spiritual framework could open the door to a new and deeper vision of recovery – one that has long been espoused by consumer/survivors'.*

Understanding mental health challenges in the context of spirituality could provide a powerful alternative to biological or psychological frameworks, and help people gain new meaning, motivation and direction in life (Wong-McDonald, 2007). Spirituality can inform a different kind of attention within mental healthcare contexts, one which aligns with the recovery paradigm and highlights approaches which may have previously been overlooked such as caring in humane and compassionate ways. Therefore, introducing spirituality into healthcare could be considered a culturally subversive practice as it urges reconceptualising some fundamental assumptions, requiring a cultural change and a revised world-view rather than simply adopting new policies or practices (Swinton, 2014). An example of an approach to support such reconceptualisations and the integration of spirituality within healthcare contexts is discussed below.

1.7 A psychospiritual approach

A psychospiritual approach was chosen for this thesis because it characterises the idea that an overlap and synthesis exists between psychological and spiritual experiences (Spittles, 2018). This includes, for example, belief systems, meaning making, personal development, emotional regulation, coping and identity. These are

central to both spirituality and psychological research which is interested in intrapsychic dimensions of human life. That is, internal experience and how a person may perceive and make sense of this.

Adopting a psychospiritual lens from which to view research and narrate this project has the potential to address some of the issues related to understanding this topic area outlined earlier. These include the subjective and sometimes unshared or insufficiently discussed nature of spiritual and mental health experiences, the taboo surrounding experiences of spirituality and mental health and the tendency to pathologise such experiences within clinical contexts. In addition, the highly specialised language and understandings within theological, philosophical or spiritual metaphysical schools of thinking can be difficult to translate into everyday or clinical understanding. Although these more specialist disciplinary approaches to thinking and spiritual beliefs fall outside this thesis, I consider their contribution as relevant to the fields of spirituality and mental health. The task within this research project is to integrate and build bridges between potentially contrasting and confusing topics as spirituality in the context of mental health and clinical service provision. A psychospiritual lens has the potential to offer language and understanding which may be accessible to and address both personal lived experience and clinical understanding.

The term psychospiritual has diverse scope and meaning and, according to the Encyclopaedia of Psychology and Religion:

> *'has entered psychological and religious discourse as a loose designation for the integration of the psychological and the spiritual… It is commonly used to describe a wide range of therapeutic systems which embrace a spiritual dimension of the human being as fundamental to psychic health and full human development and which utilize both psychological and spiritual methods… in a holistic, integrated approach to healing and inner growth' (Gleig, 2010, p. 738).*

The Oxford English Dictionary (2022) similarly broadly defines psychospiritual as that which is *'involving, or relating to the interrelation of the mind and spirituality'*. Neither source, however, attempts to delineate the point at which the psychological ends and the spiritual begins. This may be because these domains of human

consciousness can be viewed as intrinsically merged, intermingled or overlapping (Spittles, 2018; Wilber, 1975).

One of the earliest significant writers on the subject of psychology and spirituality and now considered one of the founders of modern psychology is William James (Culliford, 2011b). In his influential book 'The Varieties of Religious Experience' (1902), James discussed mostly Christian religious experience and its relationship to psychopathology and healing. He pointed out that:

> *'To the psychologist, the religious propensities of man must be at least as interesting as any other of the facts pertaining to his mental constitution.'*

James was interested in applying the scientific methods of the time: phenomenology, observation and analysis. He compiled numerous narrative accounts of religious experiences to document private thoughts and emotions associated with them. Prior to this, religious experiences had eluded social scientists, remaining a strictly theological phenomenon. James considered such experiences as a natural fact of human life rather than supernatural, and rather than asking if they were true, he asked 'what do they lead to?'. He was interested in their psychological outcomes including whether they led to distress or healing (Dein, 2017).

Despite the ground-breaking nature and influence of James' work, the discipline of psychology distanced itself from and largely pathologised spiritual perspectives of human nature and mental health experiences (Dein, 2017). A key example of this is Freud (1927, p. 227), who described religion as:

> *'A system of wishful illusions together with a disavowal of reality, such as we find nowhere else… but in a state of blissful hallucinatory confusion.'*

The discipline of psychology was later criticised as being ethnocentric, that is, formulated and promoted by Western materialist scientists who considered their own perspective superior to other groups. From their perspective matter is primary and spirituality reflects ignorance of scientific facts, self-deception, primitive magical-thinking and pathology (Grof, 2008; Harner, 1980).

Such biases in mainstream psychology have been addressed in the development of transpersonal psychology which emerged from research in the field of humanistic

psychology in the late 1960s (Maslow, 1969), as well as being influenced by Eastern spiritual traditions. The evolution of this branch of psychology responded to the prior inability of the discipline to account for the diverse variety of human experiences, including mystical, non-ordinary or altered states of consciousness. These include experiences induced by spiritual practices or which may go beyond established notions of identity and may be connected to personal crises and developmental changes. The prefix 'trans' in transpersonal denotes going 'beyond' or 'through' different experiences or states.

Carl Jung, who has been highly influential within the development of the psychospiritual approach to understanding human nature, coined the term *'transpersonal unconscious'* to mean *'an interior spiritual world'* (Jung, 1966, p. 66). Jung highlighted useful yet underutilised concepts within the field of psychology, such as the notion of a 'Self' which relates to the idea of a person having an intrinsically psychospiritual and developmental nature beyond the more everyday consciousness of what he described as the 'ego' (Jung, 1933). Related to this idea, the meaning of 'psyche' originates in Greek as initially 'breath' and then 'spirit' or 'soul'. Jung argued that by rejecting this fundamental aspect of humanity, academic psychology is a *'psychology without a soul'* (Jung, 1931, p. 649), thus betraying its own name which literally means the study of the soul. Tacey (2012) argues that the psyche has the potential to provide a platform which can bring together the seemingly opposed aspects of the spiritual and the rational.

Some authors highlight the psychospiritual as representing a paradigm shift involving a major conceptual change in both theory and practice that can contribute towards social evolution. Culliford (2011a, p. 46) argues that the earlier theoretical framework of psychology is correct within its limits but must now be considered incomplete. The same can be said for psychiatry and the understanding and practice of healthcare in general. He explains:

> '*The psychospiritual paradigm involves recognition that spirituality involves a universal yet deeply personal and essentially subjective dimension of human experience, about which it can be hard to communicate in words.'*

Victor Shermer (2003) is a leading proponent of a major shift in psychology to incorporate a spiritual dimension. He argues that despite the reductionism within psychology leading to many insights and applications, in response to the

renaissance of spirituality in contemporary culture a new paradigm is overdue. This perspective was informed by witnessing the healing of patients on spiritually oriented therapy programmes, discovering Eastern philosophy and meditation practices, and the burgeoning research which provides empirical evidence for the health benefits of spiritual practices. Schermer aims to develop a 'psychospiritual paradigm' that brings spiritual understanding into conjunction with science-based ideas regarding the mind and its development. He argues that a key premise of the paradigm is the unity of body, mind and spirit, viewing spirituality not as an 'add-on' to basic human drives and energies but an integral part of them, informing and structuring them (Culliford, 2011a). According to the new paradigm, Schermer (2003, pp. 108–109) says:

> *'It becomes possible to raise questions, formulate hypotheses and develop treatment strategies, so that we begin to think of the psychospiritual as a legitimate and systematic area of investigation and practice.'*

Although the understanding and concept of psychospiritual is complex and under development, it promises an exciting and helpful angle from which to research lived experiences of spirituality, mental health and recovery. It could inform an interpretive analysis of deep subjective meanings within personal experience and conceptualise them utilising language and frameworks of understanding relevant to diverse audiences including mental health clinicians.

1.8 Study rationale and research question

One of the reasons for the difficulty mental health practitioners and clinicians may have in working with and understanding service users' spiritual needs is because the relationship between spirituality and mental health is complex. Rather than being simply 'good' or 'bad' for health (Pargament & Lomax, 2013), the findings of research in this field indicate the need for a more refined understanding of the interplay between spirituality and mental health and the careful exploration of this subject with people with lived experiences (Moreira-Almeida et al., 2014).

Much of the existing research in this field has focussed on clinical outcomes and operational definitions of the concept of spirituality that can then be measured and quantified. However, such definitions and measurement scales are contested, with a lack of agreement amongst researchers. In addition, they tend to focus on the

assumptions of specific theories and narrow definitions, or opinions of the researchers, and may exclude participant or patient views on spirituality altogether (Oldnall, 1996).

Other research on spirituality and health has a tendency to be theoretical and opinion-based (Sinclair et al., 2006), or focused on the views of professionals and clinicians rather than experiences of those with mental health difficulties. To gain a better understanding of this topic from the perspectives of people with mental health difficulties, researchers have used qualitative designs which can be an important way of understanding people's lived experiences and the meanings they attach to them (Edwards et al., 2010; Holloway, 2005). Qualitative research has the potential to advance understanding over explanation by illuminating from a psychospiritual perspective important spiritual and mental health experiences that may otherwise be ignored, under-valued or unspoken. Such research is also in alignment with the recovery approach which highlights and values personal and subjective perspectives.

Gaining a better understanding of the lived experiences of spirituality and mental health from the perspectives of people with mental health difficulties could help to bridge the spirituality gap and deepen engagement between service users and clinicians. It could also help inform future mental health interventions that integrate the spiritual dimension as part of a holistic approach to care.

The research question addressed in this thesis, therefore, is: **What is the role of spirituality in mental health and recovery from the perspectives of people who experience mental health difficulties?**

1.9 Structure of the thesis

The thesis comprises of nine chapters as follows:

Chapter 2: Qualitative systematic review characterises the experiences of spirituality among adults with mental health difficulties in published qualitative research. It provides an evidence-based conceptual framework (the 'MISTIC' framework, Milner et al., 2020) derived from a thematic synthesis which has the potential to inform training and clinical practice. Results of this review inform the focus of the data-collection component of the study.

Chapter 3: Methodology describes an emergent pluralist approach to conducting a qualitative research project. It locates the inquiry within a critical realist epistemology and provides the rationale for using a narrative methodology approach.

Chapter 4: Methods details the methods and narrative thematic analysis approach utilised to collect and analyse thirty people's stories of their experiences of spirituality, mental health and recovery. It also addresses the issues of reflexivity and ethics.

Chapter 5: Findings preface and participant characterisations of spirituality briefly overviews the data, provides participant characteristics and a thematic analysis of their understanding and conceptualisations of spirituality.

Chapter 6: Findings – Meaning making presents narrative thematic analysis findings and a conceptual framework of the superordinate theme of 'Meaning making'.

Chapter 7: Findings – Psychospiritual development presents narrative thematic analysis findings and a conceptual framework of the superordinate theme of 'Psychospiritual development'.

Chapter 8: Findings – Spiritual connection presents narrative thematic analysis findings and a conceptual framework of the superordinate theme of 'Spiritual connection'.

Chapter 9: Discussion and conclusion critically evaluates and discusses the narrative study's findings in relation to the wider literature. Narrative and MISTIC study findings are integrated and implications for practice are identified. Strengths and weaknesses of the overall study are discussed and key knowledge contributions are highlighted.

Chapter 2: Systematic Review

2.1 Introduction

This chapter outlines a qualitative systematic review conducted to identify and synthesise existing qualitative research that explores the experiences of spirituality among adults with mental health difficulties. It builds upon Chapter 1, which explored spirituality within the context of mental health and recovery, research and healthcare. Here it was highlighted that there is a great diversity and overlap in definitions of 'spirituality' and 'religion' described within the literature. This systematic review includes all variations of these terms yet places particular emphasis, as with the entire thesis, on personal definitions, descriptions and narrated experiences of spirituality and mental health. It was also identified that one of the difficulties clinicians may experience when working with service users' spiritual needs is that the relationship between spirituality and mental health problems can be complex. Research findings indicate the need for a more refined understanding of the interplay between spirituality and mental health and the careful exploration of this subject with people who experience mental health difficulties (Moreira-Almeida et al., 2014).

To understand experiences of spirituality and mental health, researchers have used qualitative designs to explore the meanings people attach to their personal experiences (see also Chapter 3, Section 3.3). Although qualitative research has been conducted on this topic, there has been no attempt to bring this research together in the form of a qualitative systematic review which could bring more comprehensive insight and illumination into this area, thereby informing practice and highlighting knowledge gaps.

Systematic reviews of qualitative studies are an emerging methodology aimed at providing a comprehensive understanding of social phenomena across a diverse range of contexts and are increasingly viewed as high-level evidence to underpin clinical practice guidelines. They can also be used to elicit in-depth insights into people's attitudes, beliefs, emotions, experiences and preferences for treatment (Tong et al., 2016). Systematic reviews follow a specific methodology for searching for, appraising and synthesising findings of primary research and have become important in the development of evidence-based practice and policy. They can be

used to provide information about gaps in knowledge and inform clinicians and policy makers with the best available research evidence to support practice and policy (Bath-Hextall, 2014; Dixon-Woods et al., 2006; Shamseer et al., 2015).

This review aims to systematise the spirituality and mental health care literature by identifying and discussing emerging themes within qualitative research studies of the experiences of spirituality among people with mental health difficulties. This could contribute towards bridging the spirituality gap and promote better understanding and engagement between service users and mental health practitioners. It could also inform future mental health interventions, training and policy that integrate the spiritual dimension as part of a holistic approach towards mental health care. The qualitative systematic review reported in this chapter has now been published (Milner et al., 2020).

2.1.1 Systematic review question

What are the experiences of spirituality among people with mental health difficulties?

2.1.2 Systematic review objectives

1) To conduct a systematic review of qualitative evidence of the experiences of spirituality among people with mental health difficulties.

2) To develop knowledge that can be used by clinicians and mental health services to better understand service users' spiritual experiences and provide for their spiritual needs.

3) To highlight gaps in the existing knowledge field and ensure the proposed study represents a new contribution to knowledge.

2.2 Methods

2.2.1 Design

A qualitative systematic review was undertaken. The review protocol was pre-registered (PROSPERO:CRD42017080566). Protocol deviations were:

- Extending Medline to include exploded terms to increase sensitivity;

- Reducing duplicates in search terms;
- Extending the date range to capture recent research.

2.2.2 Eligibility Criteria

The inclusion criteria were:

- Qualitative design;
- Participants aged 18 year or over;
- Current or previously diagnosed or self-reported mental health difficulties;
- Self-defined spiritual or religious beliefs;
- Peer reviewed studies with a main focus on spirituality/religion;
- English language.

To address the broad scope of this systematic review and large number of studies found during an initial explorative search, studies were excluded which focussed upon particular conditions, contexts, phenomena or groups of people which might produce results specific to those situations and warrant study in their own right. These included staff, expert or carer perspectives on spirituality and mental health. A full list of exclusion criteria is outlined in Appendix 1.

2.2.4 Search strategy and information sources

A literature search strategy was developed using an initial exploratory search of MEDLINE followed by an analysis of the text words contained in the title and abstracts, and of the index terms used to describe the articles. A systematic search of seven electronic databases was then conducted from inception to 21st September 2018: MEDLINE, PsycINFO, AMED (all accessed via Ovid), ASSIA (Proquest), CINAHL and ATLA (both EBSCO) and Web of Science (1900 onwards). Further sources were forward and backward citation searching, expert consultation and hand-searching (as a supplement to online database searching) of the following four journals congruent with the search focus from 2000 to February 2018: Mental Health, Religion and Culture; Psychiatric Rehabilitation Journal; International Journal for the Psychology of Religion; and Journal for the Study of Spirituality.

Only published peer reviewed studies were considered for inclusion for the review. This was to increase the quality and rigour of the data reviewed and to provide refinement to a very broad topic. Following guidance from the Cochrane Qualitative

Research Methods Group (Harden et al., 2011), qualitative studies to be included were restricted to empirical studies with adequate descriptions of sampling strategies, methods, data collection and analysis. Due to time and resource constraints, the search was limited to English-language studies only. The search strategy was reviewed and developed with guidance from the University Director of the Centre for Evidence Based Healthcare, PhD supervisors and a Healthcare Information Specialist.

A full search strategy for MEDLINE (Ovid, In-Process & Other Non-Indexed Citations 1946 to Present) including search terms used is shown in Appendix 2. The search strategy was modified for each database. Following the search, all identified citations were collated and uploaded into Endnote and duplicates removed. Titles and abstracts were then screened for assessment against the inclusion and exclusion criteria. To reduce the possibility of excluding relevant studies two independent researchers screened a proportion (n = 400) of the titles and abstracts. Any disagreements were resolved through discussion. Full texts of selected citations were assessed against inclusion criteria, with 10% also screened by an independent reviewer.

2.2.5 Data extraction and quality appraisal

The data extracted for the analysis included the full text of the findings or results sections and those parts of the discussion sections that were relevant to the research question. The Data extraction table is shown below in Table 2.1. The quality of studies was rated using the CASP checklist for qualitative research (Critical Appraisal Skills Programme, 2017). This is a clear checklist comprising ten questions relating to the design of the study (see Appendix 3). A second independent reviewer assessed a selection (10%) of the papers and any disagreements were resolved through discussion. As there is little evidence about decisions to exclude studies on the basis of their quality (Thomas & Harden, 2008) all studies were included.

2.2.6 Data synthesis

There are a variety of methods for synthesising and analysing studies within a qualitative systematic review which continue to evolve and promote debate (Thomas & Harden, 2008). For this review, study findings were synthesised using a thematic synthesis approach based on Braun & Clarke's (2006) thematic analysis

which involves six phases of generating codes and searching for and refining themes. It is a method for identifying, analysing and reporting patterns (themes) within the data and provides a flexible and useful research tool which can provide a rich, detailed and complex account of the data (Braun & Clarke, 2006). Data synthesis was also informed by Thomas & Harden's (2008) thematic synthesis which is specifically designed for bringing together and integrating the findings within a qualitative systematic review. This involves coding the text and developing 'descriptive' themes which are then further interpreted to generate 'analytical' themes. This latter stage allows for interpretation beyond the primary studies in order to generate new interpretive constructs or explanations. This method of synthesis was preferred to the more descriptive meta-aggregation or the theory-developing focus of the meta-ethnography as it emphasises a balance between description and interpretation. It is also a form of synthesis well suited for assisting with making practical recommendations to practitioners and policy makers (Barnett-Page & Thomas, 2009).

The overall guidance for coding was obtained from Braun & Clarke's (2006) six-step method that includes familiarisation with the data, generating initial codes, searching for themes, reviewing themes and defining and naming the themes. This guidance was chosen for its attention to detail whilst remaining flexible to the particularities of different types of research. Thomas & Harden's (2008) thematic synthesis approach is a simplification of these stages into three steps and is useful because it is tailored specifically to the synthesis of studies for a qualitative systematic review. Initial stages of data coding followed Braun & Clarke's (2006) suggestion to code the selected data that relates specifically to the research question. To ensure a comprehensive approach, the whole data set was then worked through systematically, identifying aspects that might form the basis of themes across the data set (Braun & Clarke, 2006). The following stages of generating and analysing themes were informed by both Braun & Clarke (2006) and Thomas & Harden (2008) which took into account the specific research question and aims to inform policy and practice.

The final themes were reviewed by a second independent researcher and discrepancies were resolved through discussion. In addition, the analysis and theme framework were discussed with the supervisory team who have expertise in a range of research and scholarly backgrounds.

2.2.7 Reflexivity

Reflexivity is an important consideration when conducting all forms of qualitative research and involves reflection upon and awareness of the ways in which the researcher and research process shape the collected data (Mays & Pope, 2000). To address reflexivity and enhance the credibility and trustworthiness of the research, an audit trail and a reflexive journal were kept throughout the research process as recommended by Lincoln & Guba (1985). This enabled the clear documentation of methodological and technical decisions made and their rationale, and reflections about the process of interpreting the data. This included potential influences of researcher background upon interpretations, such as previous experience working in spiritual care in the NHS and the ways in which certain themes might resonate with past experiences working with patients, and personal spiritual beliefs.

2.3 Results

2.3.1 Study selection

Results of the search and screening processes are shown in Figure 2.1 below.

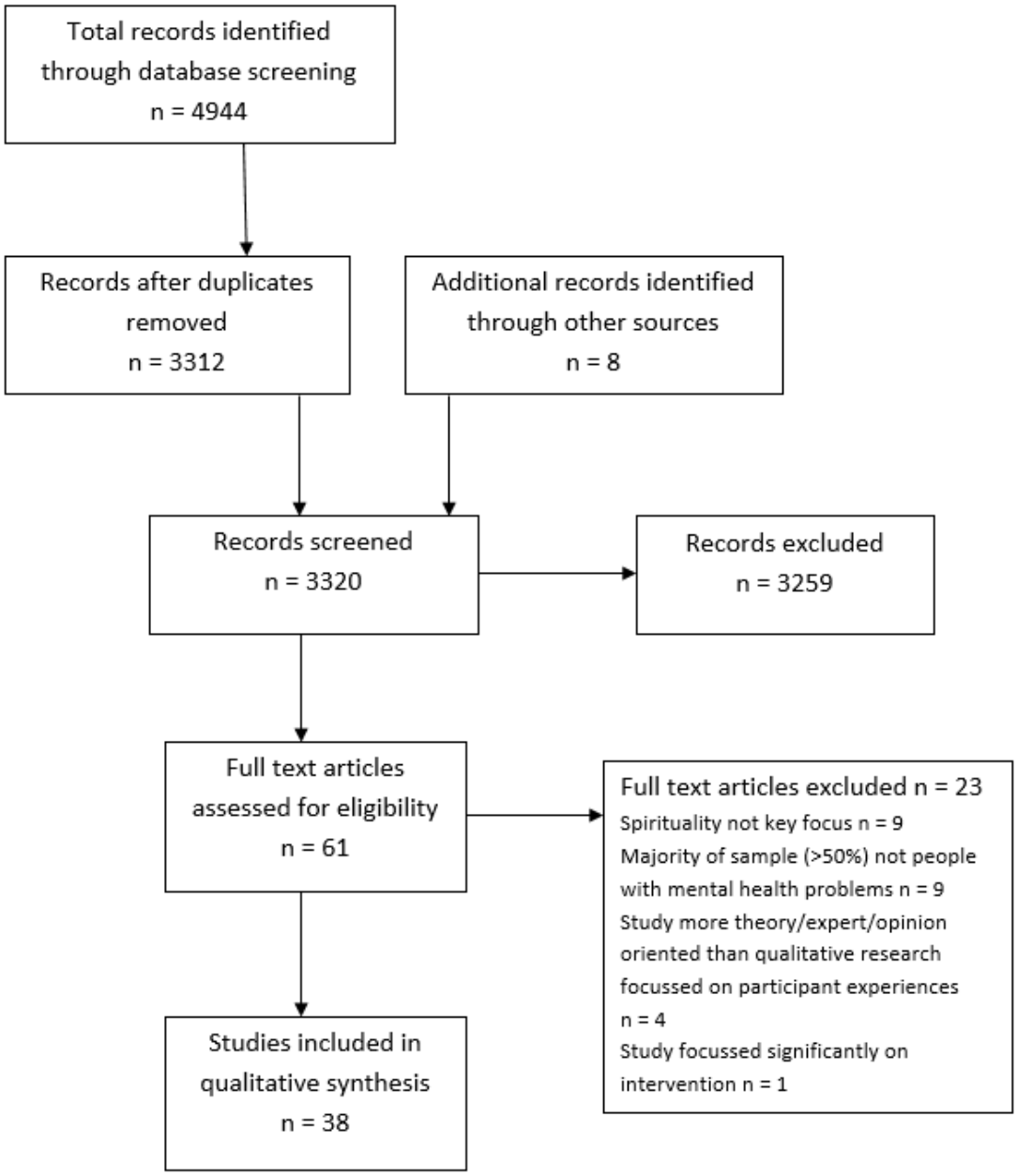


Figure 2.1 Flow diagram of study search and selection process

The data extraction table for the 38 included studies is shown in Table 2.1 below.

Table 2.1 Data extraction table of included studies (n = 38)

Study	Country	Participants	Religion or spirituality	Mental health issues	Design	Quality Appraisal rating	Key Findings
1. **Al-Solaim L, Loewenthal K** (2011). Religion and obsessive-compulsive disorder (OCD) among young Muslim women in Saudi Arabia. *Mental Health, Religion & Culture, 14*, 169-182.	Saudi Arabia	15 female participants. Arabic speaking, attending psychiatric clinics.	Muslim	Obsessive-compulsive disorder, onset before 21 years.	Semi-structured interviews. Thematic analysis.	Medium	Participants turned first to faith-healers for help and preferred MHPs (Mental Health Professionals) to be religious. Religion and prayer were the main sources of coping with symptoms. Disruption of religious rituals caused by illness led to distress.
2. **Baker M** (2010). How do service-users experience their local faith community and their mental health staff team? A UK perspective. *Journal of Psychology and Christianity, 29*, 240-252.	UK	8 participants (2 male 6 female). Recruited through UK national voluntary organisation for pastoral care and mental health.	Christian	All self-reported as having had previous though not current inpatient mental health admission in NHS.	Semi-structured interviews. Interpretive Phenomenolog-ical Analysis.	Medium-high	People sought refuge or 'sanctuary' within religious and healthcare contexts. They often experienced restriction or themes of 'imprisonment'. There was a lack of integration and understanding between faith and NHS contexts which impacted participants' experiences of recovery and meaning-making.
3. **Buser J, Parkins R, Buser T** (2014). Thematic analysis of the intersection of spirituality and eating disorder symptoms. *Journal of Addictions & Offender Counselling, 35*, 97-113.	US	12 participants (all female). Mean age 29.3 years. Mostly white; Caucasian (n=11) Middle-class (n=8). Enrolled in mid-Atlantic Universities.	Range of religious affiliations: Protestant, Catholic, atheist, agnostic, none.	Eating disorders: All reported struggling currently (n=8) or in the past (n=4).	Semi-structured interviews. Thematic analysis.	High	Spirituality imbues struggles with meaning, reduces symptoms and serves as an active agent for recovery. Spiritual uncertainty and feelings of guilt interacted negatively with symptoms. Participants shied away from requesting spiritual support.

4. **Corry D, Tracey A, Lewis, C** (2015). Spirituality and creativity in coping, their association and transformative affect: A qualitative enquiry. *Religions,* 6, 499-526.	Ireland	10 participants (5 male 5 female). Age 29 -70 years. From Ireland (Republic and Northern). Artists (n=3) From contemplative prayer group (n=3) Support group (n=4).	Catholic (n=9) Of those: 2 identify as spiritual but not religious, 1 no denomination, engages in meditation.	Anxiety (n=6) Depression (n=3) Suicidal ideation (n=2) Schizophrenia (n=2) PTSD (n=1) Bipolar disorder (n=1) Eating disorder (n=1) None (n=3)	Semi-structured interview. Interpretive phenomenolog-ical analysis.	Medium	Spirituality was a very important and integral part of participants' lives. They could not cope or imagine life without it. It played a role of positive transformation. Participants actively used spiritual beliefs to overcome symptoms, to enhance wellbeing and manage emotions/struggles.
5. **Drinnan A, Lavender T** (2006). Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions. *Mental Health, Religion & Culture, 9*, 317-331.	UK	7 participants (6 male 1 female). Age 30 – 53. White (mostly English) (n=6) Afro-Caribbean (n=1) Recruited from community mental health teams.	Christian (n=3) Mixed Christian (1 Jewish, 1 Hindu) (n=2) 'Idiosyncratic religious beliefs' (n=2)	All experienced beliefs that had been diagnosed as delusional.	Semi-structured interviews. Strauss & Corbin (1990) based qualitative methodology	Medium-high	Participants turned to religion to provide explanations for their psychotic experiences and negotiated identities which made sense of these. Religion had both positive effects (e.g. coping) and negative effects when interacting with symptoms.
6. **Eltaiba N, Harries H** (2015). Reflections on recovery in mental health: Perspectives from a Muslim culture. *Social Work in Health Care, 54*, 725-737.	Jordan	20 participants: 10 male (mean age 35), 10 female (mean age 34). Jordanian/Palestinian backgrounds. From Mental Health Centre in Jordan.	Muslim	Depression (n=7) Anxiety (n=5) Obsessive-compulsive disorders (n=4) Panic attacks (n=4)	Semi-structured interviews.	Low	Religion was viewed as central to recovery and Allah as the main source of hope and understanding. Mental illness led to meaning in life and participants' relationship with Allah became more prominent as they actively found ways to cope and find answers.
7. **Hanevik H, Hestad KA, Lien L, Joa I, Larsen TK, Danbolt LJ** (2017). Religiousness in First-Episode Psychosis. *Archive for the Psychology of Religion, 39,* 139-164.	Norway	18 participants (12 male 6 female). Recruited from Early Treatment and Identification of Psychosis Study, a clinical trial in Norway.	Most demonstrate religiousness at the present or in the past, majority engage in religious practices. Described subjectively for each participant.	First-episode psychosis	Semi-structured interviews and drawn images (though images not commented on in study). Mixed-method.	High	Participants attempted to make sense of their hallucinatory experiences through religious explanations. Many participants used religiousness for coping. Some experienced negative religious coping and struggled with a crisis of meaning.

8. **Heffernan S, Neil S, Thomas Y, Weatherhead S** (2016). Religion in the recovery journey of individuals with experience of psychosis. *Psychosis: Psychological, Social and Integrative Approaches, 8*, 346-356.	UK	10 participants (8 male 2 female). Age 25 – 35. From Early Intervention Services, Community mental health teams and voluntary services across NW England	Muslim (n=4) Christian (n=4) Jehovah's Witness (n=1) Religious but no denomination (n=1)	Had experienced psychosis.	Interview with flexible schedule. Social constructivist grounded theory.	High	Highlighted the essential role of a genuine reciprocal connection with a deity and an individually meaningful framework of understanding which assisted recovery (e.g. hope, self-esteem, emotional-wellbeing). Recovery was hindered when struggling with or lacking such a relationship.
9. **Hustoft H, Hestad K, Lien L, Moller P, Danbolt L** (2013). "If I didn't have my faith I would have killed myself!": Spiritual coping in patients suffering from schizophrenia. *International Journal for the Psychology of Religion, 23,* 126-144.	Norway	6 participants (3 male 3 female). Age 19 – 54. Selected from an original sample (Danbolt et al., 2011) to examine different spiritual characteristics.	Mostly Christian backgrounds but differ in current understandings and conceptualisations of spirituality. Believe in God (n=4) Believe in a 'higher power' (n=2).	Diagnosed with broad schizophrenia spectrum disorders: Paranoid schizophrenia (n=4) Schizoaffective disorders (n=2).	Interviews. Analysis with systematic text condensation.	Medium-high	Participants described their spirituality to have vital importance even if it met criteria for delusional. All showed spiritual struggles and attempts at spiritual coping. During illness they often searched to find new understanding.
10. **Jones N, Kelly T, Shattell M** (2016). God in the brain: Experiencing psychosis in the post-secular United States. *Transcultural Psychiatry, 53*, 488-505.	US	19 participants (9 male 10 female). Age 19 – 78. Predominantly Caucasian (n=13) African American (n=3) Other (n=3). High percentage advanced graduate degree or training. Recruited from fliers, clinical referrals and word of mouth.	Virtually all described childhood exposure to religion, majority identified as Christian.	Lifetime psychotic diagnosis, all reported at least one hospitalisation, past or present antipsychotic drug use, and repeated episodes of psychosis.	Unstructured interview with individually tailored questions for clarification. Constructivist-grounded theory.	High	Participants drew on and integrated concepts from competing and often contradictory explanatory frameworks (e.g. clinical/scientific and spiritual.) Personal uncertainty and doubt was created by tensions between individual idiosyncratic experiences versus awareness of social and clinical doubt or scepticism.

11. **Koslander T, Arvidsson B** (2007). Patients' conceptions of how the spiritual dimension is addressed in mental health care: a qualitative study. *Journal of Advanced Nursing*, *57*, 597-604.	Sweden	12 participants (6 male 6 female). Mean age 46 years. Strategically selected from six wards at different psychiatric clinics in southern Sweden.	No information provided.	Depression (n=4) Paranoid schizophrenia (n=3) Psychosis (n=3) Alcohol addiction (n=3)	Interview. Phenomenology	Medium-high	Patients wished to have their spiritual needs addressed. Patients perceived nurses to avoid talking about spirituality and that they had insufficient knowledge about addressing spiritual needs.
12. **Lilja A, DeMarinis V, Lehti A, Forssen A** (2016). Experiences and explanations of mental ill health in a group of devout Christians from the ethnic majority population in secular Sweden: a qualitative study. *BMJ Open, 6*, 1-9.	Sweden	17 participants (5 male 12 female). Age 30 – 73 . Mean age 50. Purposive sampling within congregations in different parts of Sweden.	All with Christian denominational affiliation. Lutheran Christian denominations (n=14).	Mixed range of mental health difficulties. Included: Depression (n=9) PTSD (n=4) Psychosis (n=3) Bipolar disorder (n=2) Panic disorder (n=2)	In-depth interviews. Systematic text condensation analysis.	High	Participants' relationship with God was often seen as the most important one in their lives, providing hope, protection, comfort and a life-line or prevention of suicide. Could also lead to disappointment, guilt, shame or fear of being unworthy. Illness sometimes impeded ability to connect with faith/religion. Explanations for illness included both medical and existential.
13. **Macmin L, Foskett J** (2004). "Don't be afraid to tell." The spiritual and religious experience of mental health service users in Somerset. *Mental Health, Religion & Culture, 7*, 23-40.	UK	27 participants (10 male 17 female). Age 20 – 70. Mean age 45. All white. British (23).	Christian (past or present) (n=22): Roman Catholic (n=7) Anglican (n=5) Methodist (n=5) Baptist (n=3) Quaker (n=2) Spiritual not religious (n=7) Pagan (n=6) Buddhist (n=1)	Many with more than one diagnosis: Depression (n=13) Schizophrenia (n=6) Manic depression (n=5) Acute affective disorder (n=4) Personality disorder (n=3)	Semi-structured interview. Grounded theory approach. Service-user lead research. Based on larger scale 'Somerset spirituality project'.	Medium-high	Vital importance that participants could safely explore their spiritual and religious needs and identify their spiritual resources in their search for meaning. Participants wanted to talk about spirituality to gain comfort from isolation and find meaning but struggled to reach out and were frustrated when ignored by MHPs.

14. **Mahintorabi S, Jones MK, Harris LM** (2017). Exploring Professional Help Seeking in Practicing Muslim Women with Obsessive Compulsive Disorder Washing Subtype in Australia. *Religions, 8*, 137.	Australia	5 female participants. Age 33 – 45. Not born in Australia – originally from Iran, Iraq, Turkey and Afghanistan. Recruited via convenience sampling in Australian city.	Muslim	All had current or previous diagnosis of Obsessive-compulsive disorder and had washing compulsions for more than 1 hour per day.	Semi-structured interviews. Thematic analysis within a 'scientific realist framework'.	Medium-high	Religion both exacerbated symptoms (e.g. fear of sin and guilt) and provided a supportive coping mechanism (e.g. through prayer) to help people tolerate their symptoms. All participants sought help from an Imam before seeking help from a health professional which they found helpful and sometimes unhelpful.
15. **Marsden P, Karagianni E, Morgan JF** (2007). Spirituality and clinical care in eating disorders: A qualitative study. *International Journal of Eating Disorders, 40*, 7-12.	UK	10 female participants. Recruited from eating disorder unit in Roehampton, UK.	All cited religion as important in questionnaire. All Christian: Roman Catholic (n=4) Orthodox (n=1) Congregational (n=1) Salvation army (n=1) Baptist (n=1) Evangelical (n=1) Pentecostal (n=1)	All diagnosed with DSM-IV anorexia nervosa (n=9) or bulimia nervosa (n=1).	Semi-structured 'depth' interviews.	Medium	Participants turned to their faith or new beliefs in a quest to resolve or understand difficulties. Beliefs matured during treatment and people utilised practices such as prayer and being seen by a chaplain to explore meaning and for protection from suicide. People experienced spiritual struggles such as feelings of shame and sin.
16**. Mental Health Foundation** (2002). *Taken Seriously: The Somerset Spirituality Project.* Mental Health Foundation: London.	UK	25 participants (10 male 17 female). Age 20s to 70s. Most in their 40s. All white. British (n=23). All had been in contact with mental health services in Somerset. Recruitment included posters, newsletters and through services.	Christian (past or present) (n=22): Roman Catholic (n=7) Anglican (n=5) Methodist (n=5) Baptist (n=3) Quaker (n=2) Spiritual not religious (n=7) Pagan (n=6) Buddhist (n=1)	All used mental health services for at least 6 months, most for over 10 years: Depression (n=13) Schizophrenia (n=6) Manic depression (n=5) Acute affective disorder (n=4) Personality disorder (n=3)	Interviews. Participant/ service user research.	Medium	Service users said they want spirituality to be taken seriously within mental health services and to be treated in a holistic way as a human being rather than an 'illness'. Their spiritual journeys were times of personal discovery with ups and downs, confusion and insight, doubt and opportunities for transformation and healing.

17. **Moller M** (1999). Meeting spiritual needs on an inpatient unit. *Journal of Psychosocial Nursing & Mental Health Services, 37*, 5-10.	US	92 participants: Patients (n=65) Family members (n=27) Equally composed of men and women. Age 19 – 81. Recruited via newsletter and through a community health centre.	Catholic, Protestant, Nondenominational Christian, Jewish, Native American. Eastern religions including Islam and Buddhism.	Patients with psychiatric disabilities who had experienced inpatient hospitalisation.	2 focus groups which became larger discussion groups due to large size.	Low	Four themes emerged in relation to spiritual needs participants identified during hospitalisation: comfort, companionship, conversation and consolidation. Participants wanted reassurance from MHPs and were frustrated when they were labelled or unable to find someone who would listen.
18. **Murphy M** (2000). Coping with the spiritual meaning of psychosis. *Psychiatric Rehabilitation Journal, 24,* 179-183.	US	8 participants (1 male 7 female). Some attended psychosocial rehabilitation centre 'clubhouse'.	Not specified - all saw faith as important to recovery.	All had experienced 1ST psychotic episode between 7 – 35 years. Schizophrenia (n=6) Schizo-affective disorder (n=1) Bipolar disorder (n=1).	Interviews. Thematic analysis.	Low	Spiritual belief systems, attitudes and practices fostered attitudes that promoted health and wellbeing, empowered participants to make positive changes in their lives and provided sources of strength, faith, hope and coping. Some participants said it was their relationship with God/a higher power that allowed them to survive.
19. **Nixon G, Hagen B, Peters T** (2010). Psychosis and transformation: A phenomenological inquiry. *International Journal of Mental Health and Addiction*, *8*, 527-544.	Canada	6 participants (4 male 2 female). Age 25 – 60. Recruited via convenience sample and magazine advert. Only considered if had transformational psychotic experience with higher level of functioning than when pre-psychotic.	All had a spiritual/ mystical aspect to their experience of illness. Most engaged in meditation, yoga, mindfulness and other spiritual practices (e.g. shamanic practices, healing, Buddhism).	All had psychotic experiences in the past with no episodes in last 5 years and not using psychotropic medication.	Narrative interviews. Interpretive phenomenolog-ical approach.	High	All participants stated that finding and embracing a spiritual path was key to coping with their psychosis and integral to their transformation. They worked deliberately and determinedly at these paths and practices to achieve positive results. This highlighted ways in which psychosis can lead to positive changes such as personal growth, transformation, insight, healing and new career paths.

20. **Ouwehand E, Wong K, Boeije H, Braam A** (2014). Revelation, delusion or disillusion: Subjective interpretation of religious and spiritual experiences in bipolar disorder. *Mental Health, Religion & Culture, 17,* 615-628.	The Netherlan-ds	10 participants (4 male 6 female). Mean age 45. All white Dutch and well educated. All outpatients of 'Altrecht' mental health institution. Former clients of one researcher (n=4).	All raised in Christian tradition. Christian (n=5): Protestant (n=4) Roman Catholic (n=1) New Age Spirituality (n=4). 1 no religion but practiced Zen meditation	Bipolar disorder	Semi-structured interviews. Phenomenolog-ical hermeneutic approach.	High	Nearly all participants experienced spirituality, religion and practices as a source of confidence, support and illness-management. Making sense of these experiences and considering their authenticity was important, although the spiritual and existential explanations exceeded the pathology.
21. **Ouwehand E, Muthert H, Zock H, Boeije H, Braam A** (2018). Sweet delight and Endless Night: a qualitative exploration of ordinary and extraordinary religious and spiritual experiences in bipolar disorder. *The International Journal for the Psychology of Religion, 28*, 31-54.	The Netherlan-ds	35 participants (18 male 17 female). Age 23 – 69. Mean age 45.6. Generally highly educated. Recruited via mental health institutions, a peer support project and website/blog.	Most raised as Christian but changed spiritual attitude/beliefs. 'New spirituality' (a contemporary personal expression of spirituality) (n=16) Protestant (n=14) Roman Catholic (n=5) Muslim (n=3) Agnostic/Other (n=2)	Bipolar disorder 1 (n=27) Bipolar disorder 2 (n=5) Bipolar NOS (n=1) Bipolar cycling (n=1) Schizoaffective disorder (n=1)	Semi-structured interviews. Phenomenolog-ical hermeneutic approach.	High	Participants reflected on their experiences in a wide variety of ways especially during manic episodes and in which language used often transcended medical terms. The most frequently reported feature of depressive episodes was absence of or distance from spirituality.
22. **Oxhandler HK, Narendorf SC, Moffatt KM** (2018). Religion and spirituality among young adults with severe mental illness. *Spirituality in Clinical Practice*, *5*, 188-200.	US	34 participants from original study (Narendorf et al. 2017): 46% female. Mean age 21.5. African American 27% White 27% Hispanic 11% Multiracial 11% Recruited through a psychiatric unit.	Original study characteristics: Christian (n=17) Catholic (n=8) Baptist (n=4) Pentecostal (n=1) Nondenominational (n=2) Other (n=6) None or unsure (n=16)	Participants had serious mental illness and had used crisis emergency services. Presenting diagnosis of: bipolar disorder, major depressive disorder or a schizophrenia spectrum disorder.	From a previous mixed-methods study in which the topic of religion and spirituality was talked about unprompted. Semi-structured interviews.	Medium-high	Four themes emerged: positive religious/spiritual coping, negative coping, relationship with God and implications for mental health. Training is described as necessary to appropriately assess and integrate this complex area within health care. Suggestion for mental health providers to respect religious and spiritual diversity and demonstrate competence in this area of practice.

23. **Raffay J, Wood E, Todd A** (2016). Service user views of spiritual and pastoral care (chaplaincy) in NHS mental health services: a co-produced constructivist grounded theory investigation. *BMC Psychiatry, 16*, 200.	UK	22 participants (17 male 5 female). Median age 40 – 59. Recruited from acute, medium and high secure in-patient services at NHS hospital.	Mostly Christian: Roman Catholic (n=8) Church of England (n=5) Pentecostal (n=2) United Reform (n=1) Born-Again (n=1) No denomination (n=1) Multiple (n=1) Atheist (n=1) Did not identify (n=2)	Not specified. Psychiatric inpatients.	Semi-structured interviews. Co-produced research with service users. Grounded theory and Symbolic interactionist approach.	High	A holistic approach and understanding of care which incorporates the spiritual dimension was suggested as important yet missing from conventional care. The importance of spiritual care and chaplaincy was highlighted as providing hope, someone who listens, normalising faith and assisting with recovery.
24. **Rajakumar S, Jillings C, Osborne M, Tognazzini P** (2008). Spirituality and depression: The role of spirituality in the process of recovering from depression. *Spirituality and health international, 9*, 90-101.	Canada	8 participants (2 male 6 female). From Canadian Mental Health and other associations and programmes.	Not specified. All identified that spirituality played a role in their recovery.	Self-identified as having had depression.	Semi-structured in-depth interviews.	Medium-low	Spirituality played a significant role for participants in their recovery. This was primarily experienced as connection and relationship with God, a higher power, self, others and nature, and these provided meaning and purpose.
25. **Rieben I, Mohr S, Borras L, Gillieron C, Brandt P, Perroud N, Huguelet P** (2013). A thematic analysis of delusion with religious contents in schizophrenia: open, closed, and mixed dynamics. *Journal of Nervous & Mental Disease, 201*, 665-673.	Switzerland and Canada	62 participants (77% male 33% female). Mean age 42. White 92%. From public psychiatric facilities in Geneva and Assertive Community treatment programme in Quebec.	Mostly Christian	All met ICD-10 criteria for schizophrenia (82%) or schizoaffective disorder (18%). Mean duration of illness 19 years with 9 hospitalisations.	Semi-structured interviews. Content analysis and Grounded theory.	Medium-high	Spiritual identities are constructed to give meaning to illness or as preferable identities to illness – these can be stable, single, plural, permeable or vulnerable to external influences. Other important themes are finding meaning in the illness, spiritual figures and issues of guilt.

26. **Rosli AN, Saini S, Nasrin N, Bahari R, Sharip S** (2016). 'I can't pray' - The spiritual needs of Malaysian Muslim patients suffering from depression. *International Medical Journal Malaysia, 15.*	Malaysia	10 participants (5 male 5 female). Age 28 – 65 years. Recruited from hospital database at in-patient psychiatric department.	Muslim	Patients who were previously diagnosed with major depressive disorder or persistent depressive disorder using DSM-5 criteria.	In-depth interviews.	Medium	Almost all participants expressed the need for worship. Knowledge and guidance were also important for people in these contexts, as well as existential needs such as calmness, hope, and meaning.
27. **Russinova Z, Cash D** (2007). Personal perspectives about the meaning of religion and spirituality among persons with serious mental illness. *Psychiatric Rehabilitation Journal, 30*, 271–284.	US	40 participants (40% male 60% female). Mean age 47. Caucasian 90%. Recruited from larger study on alternative medicine and recovery.	All experienced healing benefits from at least one and average 5 alternative healing practices e.g. meditation, massage, yoga and prayer. Christian (n=23) Eastern tradition (n=5) Other or none (n=12) All 'very spiritual'. Not or slightly religious (56%).	Self-identified as having serious mental illness: Bipolar disorder (n=17) Schizophrenia spectrum disorder (n=13) Depressive disorder (n=9) Other (n=1)	In-depth semi-structured telephone interviews. Part of larger mixed-methods study.	Medium	Participants had deep yet finely nuanced understandings of concepts of religion and spirituality, which were rich in scope. They had distinct contrasting understandings of religion and spirituality. The study highlighted the multi-dimensionality of the concepts with a diversity of meanings. Religion was often seen as more prescriptive whilst spirituality as more explorative and intrinsic.
28. **Salimena A, Ferrugini R, Melo M, Amorim T** (2016). Understanding spirituality from the perspective of patients with mental disorders: contributions to nursing care. *Revista Gaucha de Enfermagem, 37.*	Brazil	9 participants. Male and female but numbers not specified. Age 35 – 64. From a psychosocial care centre in the city of Minas Gerais in Brazil.	Not specified (though language from quotations suggests predominantly Christian).	Schizophrenia, Bipolar disorder, Panic attacks, Depression, Numbers not specified.	Open-ended interview. Phenomenology	Low	Religion helped the participants cope with their illness and brought encouragement, strength, meaning, and positive change. Attending church was important for people to express their faith.

29. **Smith S, Suto M** (2012). Religious and/or spiritual practices: extending spiritual freedom to people with schizophrenia. *Canadian Journal of Occupational Therapy - Revue Canadienne d Ergotherapie, 79*, 77-85.	Canada	9 participants (5 male 4 female). Age 39 – 59. From community mental health teams in the Vancouver area.	Could clearly articulate their ideas about spirituality. Diverse viewpoints along a continuum (e.g. religious, theistic, mystical, existential).	Diagnosis of schizophrenia confirmed by mental health professional. Not had hospital admission within 6 months.	Interviews. Combination of symbolic interactionism, hermeneutics and phenomenology	High	Engagement in religious and spiritual practices gave participants a way to find meaning, experience empowerment and cope with mental health difficulties. Participants valued agency, freedom and spiritual choice.
30. **Smith S, Suto M** (2014). Spirituality in bedlam: exploring patient conversations on acute psychiatric units. *Canadian Journal of Occupational Therapy - Revue Canadienne d Ergotherapie, 81,* 8-17.	Canada	7 participants (5 male 2 female). Age early 20s – late 60s. Patients recruited from acute psychiatric unit via patient meeting.	Diverse expressions: Christian (n=2) Spiritual but not religious (n=2) Mormon (n=1) Not defined but engage in spiritual practices (n=2).	Not specified. Admitted to acute psychiatric unit at time of study for at least 3 to 4 days, apsychotic and able to reflect.	Focus groups and interviews. Community-based participatory research. Interpretive description.	High	Participants desired authentic spiritual conversations in mental healthcare contexts but were aware of MHPs' caution and propensity to judge or classify their spirituality negatively. They wanted them to 'just ask the question'.
31. **Sreevani R, Reddemma K** (2012). Depression and spirituality - a qualitative approach. *International Journal of Nursing Education, 4,* 90-93.	India	8 participants (2 male 6 female). Age 20s – 40s. Recruited by referral in psychiatric outpatient department.	Hindu (n=6) Muslim (n=1) Christian (n=1)	All diagnosed with mild to moderate depression based on ICD 10 criteria.	Semi-structured interview. Qualitative descriptive approach.	Low	Spiritual practices and activities were important to all participants and helped them control negative thoughts, fear and tension. They had faith God would help them. Symptoms at times impeded their ability to perform rituals.
32. **Starnino V** (2014). Strategies for incorporating spirituality as part of recovery-oriented practice: Highlighting the voices of those with a lived experience. *Families in Society, 95,* 122-130.	US	18 participants (6 male 12 female). Age 20 – 62. Mean age 43. White (n=10) Native American (n=3) African American (n=2) Mixed race (n=3)	Spiritual but not religious (n=8) Christian (n=7) Native American spirituality (n=2). 1 'exploring'.	Psychotic disorder (n=7) Bipolar disorder (n=6) Major depressive disorder (n=4) Dissociative identity disorder (n=1)	Two face-to-face interviews. Hermeneutic phenomenology	High	Participants found it very helpful when MHPs expressed a curiosity and interest in their spirituality and a willingness to discuss ways they use beliefs and practices. Effective listening and a non-confrontational approach were found to be particularly helpful whilst challenging their spiritual experiences was unhelpful.

33. **Starnino V, Canda E** (2014). The spiritual developmental process for people in recovery from severe mental illness. *Journal of Religion & Spirituality in Social Work: Social Thought, 33*, 274-299. (Larger study from which above study was derived).	US	18 participants (6 male 12 female). Age 20 – 62. Mean age 43. White (n=10) Native American (n=3) African American (n=2) Mixed race (n=3). Using services at a Midwestern mental health centre.	Spiritual but not religious (n=8) Christian (n=7) Native American spirituality (n=2). 1 'exploring'.	Psychotic disorder (n=7) Bipolar disorder (n=6) Major depressive disorder (n=4) Dissociative identity disorder (n=1)	Two face-to-face interviews. Hermeneutic phenomenology	High	Participants' experiences differed in relation to levels of spiritual development and the extent to which they were able to integrate their spirituality and recovery. This was described as a non-linear and lengthy process of which spiritual benefits (e.g. meaning-making and improved self-concept) and struggles (e.g. interaction of symptoms) are a natural part.
34. **Starnino V** (2016). Conceptualizing spirituality and religion for mental health practice: Perspectives of consumers with serious mental illness. *Families in Society: The Journal of Contemporary Social Services, 97*, 295-304.	US	18 participants (6 male 12 female) Age 20 – 62 (Details as above – subsection of above study).	Spiritual but not religious (n=8) Christian (n=7) Native American spirituality (n=2). 1 'exploring'.	Psychotic disorder (n=7) Bipolar disorder (n=6) Major depressive disorder (n=4) Dissociative identity disorder (n=1)	Two face-to-face interviews. Hermeneutic phenomenology	Medium-high	There were important nuances, and much variation and overlap in relation to how people with mental health difficulties defined and conceptualised spirituality and religion. Many said they did not want to be constrained by someone else's definition of these concepts.
35. **Sullivan W** (1993). "It helps me to be a whole person": The role of spirituality among the mentally challenged. *Psychosocial Rehabilitation Journal, 16,* 125-134.	US	19 participants. From an original study of 40 participants of the characteristics: 48% male, 52% female. Mean age 39. Former or current consumer of mental health services.	Not specified.	Of original sample of 40: Schizophrenia (75%) Bipolar disorder (20%) Other (5%) Mean number of hospitalisations 5.6	Open-ended interview. Retrospective analysis.	Low	Spirituality was identified from a larger study as the most commonly mentioned factor for success. Spiritual beliefs and practices were important, in particular people's relationship with God or a spiritual presence which could provide comfort, guidance and help with coping.

36. **Wilding C, May E, Muir-Cochrane E** (2005). Experience of spirituality, mental illness and occupation: A life-sustaining phenomenon. *Australian Occupational Therapy Journal, 52*, 2-9.	Australia	6 participants (3 male 3 female). Age 35 – 55. Recruited through two rural Australian community mental health centres.	Not specified.	Diagnostic information not obtained however some self-reported: Depression (n=4) Bipolar disorder (n=1) Psychosis (n=1) Anxiety disorder (n=1)	In-depth interviews. Phenomenology : Heidegger's (1962) hermeneutic circular approach.	High	Spirituality was vitally important for participants and it sustained and enhanced their lives. It did this by providing meaning, sustaining mental and emotional wellbeing and by preventing suicide. Spirituality was a core aspect of participants' identity and sense of self.
37. **Wilding C, Muir-Cochrane E, May E** (2006). Treading lightly: spirituality issues in mental health nursing. *International Journal of Mental Health Nursing, 15,* 144-152. (Same study as above with different findings reported.)	Australia	6 participants (3 male 3 female). Age 35 – 55. Recruited through two rural Australian community mental health centres	Not specified.	Diagnostic information not obtained however some self-reported: Depression (n=4) Bipolar disorder (n=1) Psychosis (n=1) Anxiety disorder (n=1)	In-depth interviews. Phenomenology :Heidegger's (1962) hermeneutic circular approach.	High	Participants defined and experienced spirituality in unique ways and as a life-long journey that changes over time and can be personally transformational. Often mental illness instigated the spiritual journey and was perceived as useful or having meaning because of this. Participants had a strong desire to talk about and share their spiritual experiences but often encountered difficulties in doing so with MHPs.
38. **Yang C, Narayanasamy A, Chang S** (2012). Transcultural spirituality: the spiritual journey of hospitalized patients with schizophrenia in Taiwan. *Journal of Advanced Nursing, 68*, 358-367.	Taiwan, China	22 participants (10 male 12 female) Age 29 – 63 years. Mean age 42 years. From 2 psychiatric hospital long-term rehabilitation units.	Buddhist (n=7) Catholic (n=5) Multi-religion believers (Buddhism and Taoism) (n=4) Atheist (n=6)	All diagnosed with schizophrenia by IDC-10 but not experiencing acute problems at time of study.	Semi-structured interviews. Thematic analysis.	Medium-low	Participants expressed spiritual distress as a result of prolonged hospitalisation (e.g. struggle with self-worth, confusion, loss of hope). They often made sense of what was happening in relation to Chinese philosophy e.g. that illness was predetermined by fate assigned by a higher power, was due to karma and that suffering was a spiritual practice and test.

Studies included a total sample of 594 participants and came from 15 countries: US (n=10), UK (n=7), Canada (n=4), Australia (n=3), two from each of Norway, Sweden and the Netherlands and one from each of Switzerland, Ireland, Saudi Arabia, Jordan, Brazil, India, Taiwan and Malaysia.

There was a broad range of religious and spiritual beliefs and affiliations across all the studies. Most of the main traditional religions were represented in the sample, particularly Christianity and Islam. Many people however did not identify with one specific tradition and used more flexible classification systems.

Participants had experienced a range of mental health problems and severity of symptoms. Mental health service contexts also varied and included inpatient wards, residential units, those in various stages of recovery and those who had not experienced symptoms for some months or years.

Study quality appraisals are shown in the Data extraction table (Table 2.1**)**. Studies were rated against each of ten questions and then allocated to low (0-4), medium-low (5–5.5) medium (6–6.5) medium-high (7-7.5) and high (8 -10) quality. The majority of studies had a rating of 7 and above (23 studies). Although non-standardised, this assessment identified the majority of studies as well designed. The lower rated studies often lacked explicitness or justification of study design, and transparency of researcher positionality. A further limitation in these papers was that they were sometimes more poorly analysed and theoretically developed, reaching conclusions that were not always consistent with the data provided. Higher quality studies had more comprehensive themes and highly developed findings and contributed most to the synthesis (Thomas & Harden, 2008).

2.3.2 Results of Thematic Synthesis

Twelve initial themes were found which were then reviewed against the data set (see Table 2.2). The themes were further condensed, refined and combined to form six overarching themes with nine sub-themes, as described during stages 4 and 5 of Braun & Clarke's (2006) thematic analysis of defining and naming themes. The six overarching analytical themes were: Meaning-making, Identity, Service-provision, Talk about it, Interaction with symptoms and Coping, forming the acronym 'MISTIC'. Analytical themes are appropriate in reviews to inform practice and are created with this and the specific review question in mind (Thomas & Harden, 2008). These are described, along with examples, in Table 2.3 below.

Table 2.2 Initial descriptive themes generated from thematic synthesis

Spirituality in mental health services	Service users wanting to talk about spirituality and their needs	Interaction between spirituality and mental health symptoms
Spirituality as meaning making	Spirituality as vital and part of identity	Fate, destiny and 'God's will' versus autonomy, choice and control
Spirituality as a developmental journey involving change	Spirituality as providing coping and wellbeing	Importance of spiritual practices
Relationship with God/higher power and the spiritual community	Spirituality as preventing suicide and life-sustaining	Spiritual challenges and struggles

Table 2.3 Final analytical themes and sub-themes: Descriptions and illustrative quotes

Theme and Subtheme	Description	Illustrative quotes
1. Meaning making	The ways in which people utilise their spiritual beliefs to try to make sense of their experiences of mental illness.	*'…when you don't know, it's harder to deal with. When you know it's a lot easier to deal with.'* (Heffernan et al. 2016, p. 352)
1.2 Multiple explanations	The often contradictory explanatory frameworks that people grapple with to try to make sense of their mental health difficulties – e.g. spiritual versus medical, which may conflict and lack integration.	*'The most conflicting message I had was the diagnosis of the psychosis like people saying it's ok God's got it in hand, everything's gonna be fine, and then they're saying no you're psychotic you need medication, other people saying no you don't need medication, yes you do, no you don't…. will somebody please just tell me what is going on.'* (Heffernan et al. 2016, p. 352)
1.2 Developmental journey	The ways in which people's perceptions about and relationships with spirituality are dynamic over time, e.g. changes in the ways spirituality is experienced, valued and expressed.	*'I tend to err on the side of it being a transformational process. So that I can work with it. Because if it's a mental illness, it shuts me down.'* (Nixon et al., 2010, p. 538)
1.3 Destiny versus autonomy	The level of choice and control people conceptualise themselves as having in relation to their spiritual belief systems. On one end of this spectrum is the sense that what is happening is divinely intentioned, or as involving a sense of fate or destiny. On the other hand, a sense of choice and control, agency and freedom are important for some.	*'The illness is Allah's will … It is a trial … I pray to Allah every day to make me feel better.'* (Eltaiba and Harries, 2015, p. 732) *'…it should be up to that person to have that choice… if you have belief in yourself and believe what you believe then it's not put into you… it's not forced.'* (Heffernan et al., 2016, p. 350)

2. Identity	The centrality of spirituality for some people's lives and core sense of self. Spirituality as shaping their identities through their experiences of illness, struggle, recovery and meaning-making. Participants draw on their spiritual frameworks to develop and negotiate a spiritual identity.	*'…to invalidate a person's spirituality no matter how distorted that is, is to invalidate that real core sense of self and I think once you do that you risk doing untold damage to somebody.'* (Mental Health Foundation, 2002, p. 22).
3. Service provision	The ways in which people's spiritual needs are addressed or not within mental health care services and how people describe their interactions with services and mental health professionals.	*'I felt very alone and isolated in a strange environment, one which I hadn't experienced before and things were happening to me that I didn't know… I wanted some kind of stability within that and that was why my faith and religion were coming in at that time …'* (Mental Health Foundation, 2002, p. 20)
4. Talk about it	Some people say that talking about their experiences of spirituality and mental health difficulties can be particularly helpful, and yet they may lack opportunities to do so, both within mental health services and more generally. They may experience barriers, such as stigma or fear of judgment, to talking about their experiences.	*'The community psychiatric nurse was terrific. Although he was not a Christian, he asked me very, very pertinent questions about how I could reconcile my faith with what was happening to me and what God meant to me.'* (Mental Health Foundation, 2002, p. 23)
5. Interaction with symptoms	This theme describes how people's symptoms or mental health difficulties interact with their spirituality, sometimes in quite challenging and disruptive ways.	
5.1 Interactive meaning-making	Often experienced as a clash of multiple or different realities which might involve experiencing visions, hearing voices from nonphysical entities or other unusual or anomalous spiritual experiences or beliefs.	*'I don't really believe in a corporeal, non-bodied being [God]. I just don't believe that. On some level I don't believe that, and yet, I've experienced demon possession.'* (Jones et al., 2016, p. 494)

5.2 Spiritual disruption	The ways in which mental health symptoms sometimes intersect with people's spirituality resulting in challenging experiences or impeding their ability to connect with their spirituality and spiritual practices.	*'The obsessions started last year, I started having thoughts about my faith, about the prophet, about God's creation. Then I started having doubts about making mistakes in my prayers or when I read verses of the Qur'an. I started repeating my prayers so many times that I had to miss school on many occasions.'* (Al-Solaim and Loewenthal, 2011, p. 175)
6. Coping	This theme refers to the many and varied ways in which people utilise their spirituality to help them to deal with the challenges of their mental health problems. Coping may be experienced as an active process involving making persistent efforts to engage with spiritual practices and to gain skills and acquire information. This process can be challenging and impeded by symptoms or struggles.	*'To improve things you need different skills. Skills could be acquired and could be lost with illness. I need to work on gaining skills and to change.'* (Eltaiba & Harries, 2015, p. 731)
6.1 Spiritual practices	People engage with a variety of spiritual practices (e.g. prayer, meditation, mindfulness, attending a place of worship or quiet space, or reading religious or spiritual texts) to help them to cope with their mental health difficulties. These can help people to strengthen their connection with their spiritual lives.	*'I feel really sad when bad things happen, but I sit, listen to the Qur'an, and feel better. My family is the same. Religion helps you adapt… the more I pray the more God protects me.'* (Al-Solaim & Loewenthal, 2011, p. 178)
6.2 Spiritual relationship	People's relationship with God or a higher spiritual power is experienced to be central to their faith. It may be described as the most important relationship within some people's lives and therefore has key importance for coping during times of illness. This relationship can provide a sense of comfort, reassurance, protection, guidance, positivity, peace and strength.	*'I really don't look to people. I look to God – because people are not able – they're able to help a certain amount, but the Lord has been my true strength … God has seen me through everything.'* (Sullivan, 1993, p. 130)

6.3 Spiritual struggles	Sometimes people experience spiritual struggles or difficulty finding ways to cope. Common challenges include feelings of guilt or shame, or of stigma from spiritual communities.	*'I have been told by a minister that he does not want the mentally ill in his church.'* (Moller, 1999, p. 8)
6.4 Preventing suicide	Sometimes people's spirituality or relationship with God is described as the very thing that keeps them alive or from hurting themselves during their most difficult struggles with mental health problems.	*'If I had no faith, I don't know how I'd get through it. No faith, no hope, no light at the end of the tunnel. I would end it.'* (Drinnan and Lavender, 2006, p. 324)

2.3.3 Description of themes

Theme 1: Meaning making

The theme of Meaning making refers to the ways in which people made sense or struggled to make sense of their experiences of mental health difficulties and how these interpretations could often change over time. This was one of the most frequently occurring themes and was mentioned throughout nearly all (n = 33) of the studies. This is perhaps unsurprising as meaning is key to most definitions of spirituality. This theme also contained three sub-themes: Multiple explanations, Developmental journey and Destiny versus autonomy.

Many studies highlighted that participants provided explanations of illness that were related to their spiritual or religious beliefs which, in turn, would give meaning to their suffering or to specific symptoms (Lilja et al., 2016; Oxhandler et al., 2018; Rieben et al., 2013). Sometimes this took the form of an 'overflow of meaning' in which participants felt a heightened sense of purpose, 'synchronicity' or 'divine direction' (Ouwehand et al., 2018, p. 46). It also sometimes involved a quest or search for meaning (Macmin & Foskett, 2004). Ouwehand et al. (2014) describe how the quest for meaning for the participants with bipolar disorder in their study sometimes began after a religious experience during manic episodes. They would then attempt to make these experiences comprehensible.

Confusions, doubts and struggles within the meaning making process were common amongst participants across studies, sometimes resulting in a 'crisis of meaning' (Hanevik et al., 2017). This was often because of the conflicting accounts that participants were exposed to regarding their mental health and spiritual experiences, as discussed in the following sub-theme.

Sub-theme 1.1: Multiple explanations

Heffernan et al. (2016) describe how participants questioned the origin of their experiences of psychosis by considering multiple explanations. Because of the conflicting views participants received as a result of the lack of integration of mental health services and religious organisations (Baker, 2010) they often found it very difficult to arrive at an explanatory framework. This framework was considered key because '*when you don't know, it's harder to deal with. When you know it's a lot easier to deal with*' (Heffernan et al., 2016, p. 352). Recovery could be impeded

when participants lacked a structure for understanding their experiences or remained confused between competing models of explanations.

Sometimes people successfully used concepts from different linguistic fields or from medical and spiritual perspectives simultaneously (Ouwehand et al., 2014) developing 'multi-causal models of explanation' which were not experienced as incompatible. For example, Jones et al. (2016) found that participants juxtaposed and blended constructs associated with bio-psychiatry and 'consensus reality' alongside those associated with spiritual, paranormal or magical themes. However, participants were also often acutely aware of ways in which their experiences and interpretations might be judged by others.

Despite these doubts and tensions between different explanatory frameworks, Smith & Suto (2012) found that the participants in their study became quite adept at utilising their spiritual discourse to empower them and meet their unique needs. Perhaps because they had to grapple with such doubts and tensions, they showed a '*tremendous ability to dialogue between different systems of meaning*' (Smith & Suto, 2012, p. 82). The degree to which people were able to do this however often depended on how they made sense of these experiences over time.

Sub-theme 1.2: Developmental journey

Many of the studies reported that participants' perceptions about and relationships with their spirituality were dynamic over time (Lilja et al., 2016), highlighting a change in meanings or a journey of inner development (Baker, 2010). Participants in Buser et al.'s (2014) study described movement from spiritual uncertainty to spiritual commitment and confidence during their recovery, experiencing a decrease in symptoms as they did so. Others reported a change in the ways in which participants experienced, valued and expressed their spirituality (Wilding et al., 2006). For example, Marsden et al. (2007) found that participants in their study experienced a maturation of their religious beliefs or converted to a new faith in a quest to resolve or understand difficulties.

Sometimes people's mental health difficulties would act as a 'call' to participants' spiritual life because it was not until then that spirituality became vitally important to them. As one participant in Wilding et al.'s (2006, p. 147) study stated, *'One of the things that I have actually gained from having a mental illness [is] that I… have*

looked at what this God stuff means.' Another participant in the same study remarked, *'…if I hadn't gone mental I wouldn't have gone spiritual'.*

Many participants viewed their spirituality as a path or journey involving phases of 'dipping in' and 'sitting back', ups and downs, periods of confusion and doubts, as well as insights and opportunities for transformation (Mental Health Foundation, 2002). One participant said she preferred to conceptualise her experience of psychosis as a process of spiritual transformation rather than a psychiatric disability:

> *'I tend to err on the side of it being a transformational process. So that I can work with it. Because if it's a mental illness, it shuts me down'* (Nixon et al., 2010, p. 538).

Participants frequently described how their experiences of illness had changed their lives in positive ways (Corry et al., 2015). They sometimes described their illness as a gift from God because it allowed them to heal from past traumas or personal issues (Rieben et al., 2013) or become better, stronger and more empathetic people as a result (Murphy, 2000).

Sometimes this transformation involved the development of new spiritual beliefs. If participants were left to interpret their experiences in solitude there was a greater chance the belief systems could be interpreted as delusional (Hustoft et al., 2013). However, when they had supportive people with whom to explore the meaning-making process, this provided opportunities for their own spiritual resources to emerge and their 'breakdowns' to become 'breakthroughs' (Macmin & Foskett, 2004).

In a comprehensive analysis of the ways in which participants with severe mental illnesses utilised spirituality as part of their recovery and spiritual development, Starnino & Canda (2014) found that recovery was supported for participants who were able to renew their spirituality and had more helpful and affirming worldviews. However, this could be a complex, lengthy and non-linear process, requiring focus and dedication towards their spiritual development.

Sub-theme 1.3: Destiny versus autonomy

A final subcategory within the over-arching theme of Meaning making concerned the level of choice and control people conceptualised themselves as having in relation

to their spiritual belief systems. On one end of this spectrum was the sense that what was happening was divinely intentioned, often involving a sense of fate, destiny or as being subject to 'God's will'. For example, many of the Muslim participants in Eltaiba & Harries's (2015) study conceptualised what was happening to them as a trial sent by Allah and part of their 'Qadar' or destiny:

> *'The illness is Allah's will … It is a trial … I pray to Allah every day to make me feel better'* (Eltaiba & Harries, 2015, p. 732).

Attributing the cause of illness to an external spiritual force was also significant in some of the other non-western studies. For example, participants in Yang et al.'s (2012) study viewed mental illness in relation to beliefs influenced by Chinese philosophy such as Taoism and Buddhism. Here, mental illness was sometimes understood as an unpredictable difficulty in an individual's 'Ming' or fate:

> *'Ming arranges our lives. If I have to stay in the hospital and suffer from this illness that is my Ming'* (Yang et al., 2012, p. 361).

The idea of 'God's will' was important for some Christian participants, viewing everything that happened in life as an expression of God's will in action (Nixon et al., 2010). Some people conceptualised this sense of destiny more as a letting go of control or of surrender. Being able to rely on a presence greater than oneself and not needing to know all the answers was very reassuring to some people (Corry et al., 2015; Wilding et al., 2005).

On the other end of this spectrum, a sense of choice and control, agency and freedom were important for some participants. This was expressed through the ways they conceptualised and cultivated their own unique spiritual belief systems and identities, sometimes as a strategy to achieve autonomy from society, religious communities and family. Choosing one's own personal spiritual beliefs also provided some participants with a sense of agency, freedom and empowerment (Heffernan et al., 2016; Smith & Suto, 2012):

> *'…it should be up to that person to have that choice… if you have belief in yourself and believe what you believe then it's not put into you… it's not forced'* (Heffernan et al., 2016, p. 350).

Participants who experienced eating disorders in Buser et al.'s (2014) study said that freedom of choice was important when asking for help. They often expressed a great deal of personal responsibility in relation to dealing with their symptoms and were reluctant to ask for divine assistance due to wanting control over their own behaviours or perceiving their symptoms as being too trivial to share with God. Some participants in Starnino & Canda's (2014) study also mentioned self-responsibility and control as important in their lives but they said they relied upon their spirituality in order to achieve this.

Participants made sense of their experiences in a variety of ways, which sometimes involved multiple or contradictory explanatory frameworks, growth, struggle, and themes of destiny or autonomy. The second main theme involves the centrality of spirituality to identity.

Theme 2: Identity

Identity was a prominent theme across the reviewed studies (n = 20) and refers to the centrality of spirituality for many people's lives and sense of self. Spirituality represented for many the core essence of who they are, shaping their identities through their experiences of illness, struggle, recovery and meaning making.

People's identities related to how they understood spirituality. Although people sometimes saw religion and spirituality as intertwined (Salimena et al., 2016), they more often wanted to distinguish between spirituality and religion, especially those who identified as being spiritual but not religious (Corry et al., 2015). Wilding et al. (2006) found that it was important for some participants to define spirituality in their own unique ways and that no participant had exactly the same configuration of religious or spiritual beliefs.

Participants drew on their spiritual frameworks to develop and negotiate an identity as a 'spiritual being' rather than that of a 'patient' as suggested by diagnostic labels (Drinnan & Lavender, 2006; Wilding et al., 2006). Spirituality was seen as vital to life and enabled many participants to develop a healthier more empowered view of themselves, recognising that they were 'good enough' despite their illness (Heffernan et al., 2016; Starnino & Canda, 2014; Wilding et al., 2006).

Sometimes participants' beliefs helped them to feel special (Heffernan et al., 2016) or as if they had special abilities or powers, and these could help them to cope

during times of stress or anxiety (Jones et al., 2016). This might operate through spirituality helping participants to feel better about who they are, fostering creativity, reducing shame and facilitating meaning making in a way which enhanced a sense of personal value and reduced fear (Heffernan et al., 2016; Jones et al., 2016). Mystical experiences could also affect how people saw themselves, such as a sense of unity (Ouwehand et al., 2014) or a sense of transcending the self (Nixon et al., 2010). These kinds of experiences could be pleasant and helpful, or distressing and confusing, for example feeling a disruption from a singular sense of self (Rieben et al., 2013). Although sometimes bizarre or disturbing, they were still considered to be core to how some people understood themselves:

> *'…to invalidate a person's spirituality no matter how distorted that is, is to invalidate that real core sense of self and I think once you do that you risk doing untold damage to somebody'* (Mental Health Foundation, 2002, p. 22).

Participants expressed importance in feeling accepted for who they are, especially in light of experiences of being labelled and rejected due to mental health difficulties (Mental Health Foundation, 2002). Whether this was possible within the context of mental health services is the subject of the next key theme.

Theme 3: Service provision

The theme of Service provision occurred in 23 studies and relates to how participants described their interactions with services and mental health professionals, including provision, or not, of their spiritual needs.

The most commonly reported experience under this theme was that participants felt their spiritual experiences were often dismissed, misunderstood, pathologised and taken as confirmation that they were mentally ill. This often resulted in frustration at the lack of opportunities within services to explore the meaning of their experiences (Drinnan & Lavender, 2006; Jones et al., 2016). Participants also reported a lack of facilities within services (Heffernan et al., 2016), a lack of opportunities to explore their needs (Yang et al., 2012) and a lack of provision for spiritual practices (Salimena et al., 2016) despite wanting their spiritual needs addressed within these contexts (Koslander & Arvidsson, 2007).

One of the reasons it was so important for participants to have their spiritual needs addressed within mental healthcare settings was because of the high levels of distress they were experiencing at the time, which called for a need for safety, familiarity and reassurance.

> *'I felt very alone and isolated in a strange environment, one which I hadn't experienced before and things were happening to me that I didn't know… I wanted some kind of stability within that and that was why my faith and religion were coming in at that time … I wanted to identify with it as soon as possible'* (Mental Health Foundation, 2002, p. 20).

Study participants talked about ways in which mental health professionals and services could provide for their spiritual needs. In a study by Rosli Nabil et al. (2016), Muslim participants suffering from depression in Malaysia identified two distinct sets of spiritual needs, one relating to their religious practices such as worship, religious knowledge and guidance, and the other which was referred to as 'existential', such as the need for calmness, sensitivity and empathy from practitioners. Some participants highlighted the importance of being given access to safe and quiet spaces where they could engage in spiritual practices (Mental Health Foundation, 2002). They spoke of the desire to explore practices such as meditation and yoga or breathing exercises (Sreevani & Reddemma, 2012) and of the usefulness of a menu of options giving examples of spiritual resources on offer (Smith & Suto, 2014).

Participants were aware of the difficulties and demands this kind of care could place upon mental health professionals; that it could be 'unknown territory' or even 'threatening' for some (Mental Health Foundation, 2002, p. 25). Some acknowledged that to be able to offer this kind of care, staff also require opportunities to care for themselves psychologically and spiritually. Alternatively, these needs could be met through spiritual care services including chaplaincy which were seen by some as essential for recovery and providing hope and a listening ear:

> '[spiritual care's] *very, very important for mental health; sometimes it's the only thing that seems, that can maybe get through to someone. It's a different level of understanding that goes beyond words…'* (Raffay et al., 2016, p. 5).

When health care professionals did consider the spiritual needs of the participants this was described as having a positive impact including potentially upon recovery. One of the ways they could do this was by providing opportunities for people to talk about their experiences.

Theme 4: Talk about it

The theme Talk about it refers to the importance participants highlighted, across 13 studies, of being able to talk about their experiences of spirituality and mental health, both within mental health service contexts and more generally.

One of the greatest challenges that participants struggled with during the meaning making process is that that they were often forced to negotiate their experiences in relative social and cultural isolation (Jones et al., 2016). They wanted to talk to gain comfort from their distress and to understand the meaning of their experiences in spiritual terms (Macmin & Foskett, 2004; Mental Health Foundation, 2002). They often looked to healthcare staff to support this process because the experiences could be extremely difficult to interpret alone and doing so could lead to confusion or have adverse effects on recovery (Heffernan et al., 2016; Ouwehand et al., 2014).

Although nearly all participants in Ouwehand et al.'s (2014) study expressed a desire to talk about spirituality during treatment, they had concerns about the difficulties in doing so with mental health professionals. Key themes related to this were worry about whether their beliefs and experiences would be accepted and fear of being labelled mentally unwell (Wilding et al., 2006). Some participants felt huge frustration at their inability to find staff who would listen rather than ignore their spirituality (Macmin & Foskett, 2004; Moller, 1999). When healthcare practitioners challenged the legitimacy of spiritual experiences, this was described by one person as devastating:

> *'Many people don't realise how devastating it is to be told that that's* [spirituality is] *not real, that that's fantasy … Because to the people it is real and it needs to be treated as if it is real instead of just discarded and pushed aside, because it is a very big part of people … It's their core'* (Starnino, 2014, p. 127).

Some participants lacked confidence in practitioners' ability to bring up the subject of spirituality, noticing their avoidance of the issue (Koslander & Arvidsson, 2007;

Murphy, 2000). Others said that they felt reluctant to talk to professionals at all as they had received negative judgments in the past:

> *'I don't tell people because they don't believe ya, you know, so it's not worth it'* (Wilding et al., 2006, p. 148).

Baker (2010, p. 249) found that service users in his study developed skills of non-disclosure and self-control as a form of self-protection within a *'strategy of silence'*. One participant in Wilding et al.'s (2006, p. 148) study said that he felt that spirituality was a *'taboo subject'* but if mental health practitioners were to be holistic, as he felt many claimed to be, they really should discuss spirituality with their clients.

When asked what is helpful within these contexts, participants suggested:

> *'Just ask the question!' (Smith & Suto, 2014, p. 13).*

> *'Listen to what the person has to say … whether it's good or bad, bizarre or whatever'* (Starnino, 2014, p. 126).

> *'Please reassure me that I will get through this'* (Moller, 1999, p. 9).

As well as the importance of asking, listening and reassurance, participants also said it was helpful that practitioners bring up the subject on their own initiative (Koslander & Arvidsson, 2007; Ouwehand et al., 2014).

When participants could speak openly with practitioners they usually found this very helpful and were appreciative of the efforts staff went to in order to sensitively approach the subject and listen to their spiritual experiences (Starnino, 2014). A participant in one study recounted how a nurse had helped by asking him pertinent questions:

> *'The community psychiatric nurse was terrific. Although he was not a Christian, he asked me very, very pertinent questions about how I could reconcile my faith with what was happening to me and what God meant to me'* (Mental Health Foundation, 2002, p. 23).

The final two key themes focus upon particular challenges and coping strategies that were presented by participants' spiritual experiences in relation to their mental health.

Theme 5: Interactions with symptoms

Interaction with symptoms was a theme addressed by 18 studies. It describes how people's symptoms or mental health difficulties interacted with their spirituality, often in quite challenging or disruptive ways. This was the most complex theme and was rarely well defined or developed within the studies, perhaps because it lacks clarity as a topic generally. Two distinctive features could be delineated about it however. Firstly, Interactive meaning making describes the ways in which the interaction between spirituality and mental health symptoms were connected with unusual experiences and the attempts to make meaning from these experiences. Secondly, Spiritual disruption describes how mental health symptoms could disrupt people's ability to engage in spirituality.

Sub-theme 5.1: Interactive meaning making

The first sub-theme concerned anomalous experiences and confusions within meaning making, often involving a clash of multiple realities where people would be left somewhere '*in a state of being betwixt and between that had its own particular features*' (Jones et al., 2016, p. 496). For half of the participants in Starnino & Canda's (2014) study this involved spiritual experiences such as visions or hearing voices from nonphysical entities. Drinnan & Lavender (2006) classified these as 'unusual religious experiences' which included persecutory or grandiose religious beliefs.

Starnino & Canda (2014) suggested that a key factor determining how people experienced these interactions was how effective or convincing their belief systems were at providing explanations for their unusual experiences or whether they provided a sense of hope. The close weaving together of spirituality and symptoms therefore may have functioned as a way of meaning making in a world of changed perception (Hustoft et al., 2013). Hanevik et al. (2017) found that one of the main characteristics of religiousness for their study participants with first-episode psychosis was that it provided a mystical explanation for hallucinatory experiences. By providing meaning to their psychotic experiences, this helped participants to gain a sense of control and coherence in their lives. Other ways participants might

interpret their hallucinatory or mystical experiences included feeling that they were on a 'sacred mission' to save the world (Hanevik et al., 2017), feeling a strong sense of altered awareness as if taken over by another reality (Ouwehand et al., 2018) or that they had supernatural powers or extraordinary spiritual gifts (Hustoft et al., 2013).

Sub-theme 5.2: Spiritual disruption

The second sub-theme of Spiritual disruption refers to the ways in which mental health symptoms could impede people's ability to connect with their spirituality and engage in spiritual practices. For example, performing religious rituals was considered highly important for the Muslim participants in Al-Solaim & Loewenthal's (2011) study, and so the disruption to these practices caused by their symptoms triggered high levels of guilt and anxiety. Some participants reported reductions in their ability to focus, problem-solve and think abstractly when in a state of psychosis, which resulted in difficulties connecting with spiritual practices and rituals (Heffernan et al., 2016; Moller, 1999; Sreevani & Reddemma, 2012). Others struggled to attend church services because they felt too tired, ashamed or that they no longer fitted in. This could result in losses in the ways they could express their faith and fears that their most important relationship in life was broken (Lilja et al., 2016).

Despite these difficulties, some participants stressed that their experiences had spiritual or existential implications that out-weighed the pathology (Ouwehand et al., 2014). They maintained the belief that there was something about their experiences that was more than, beyond and not wholly explained by illness (Starnino & Canda, 2014). The best ways for practitioners to approach these scenarios, participants suggested, was a gentle, non-confrontational approach, which did not assume pathology (Mental Health Foundation, 2002; Starnino, 2014).

Whilst most of the studies reporting on the phenomena focussed on the interplay between spirituality and symptoms, for some participants this distinction was not necessarily clear cut and they questioned the ways in which certain experiences were labelled in the first place:

> *'What I had to sort out was a religious existential problem and to them it was classic schizophrenia'* (Mental Health Foundation, 2002, p. 49*).*

One of the key factors influencing how people dealt with challenging interactions between spirituality and mental health symptoms concerned utilisation of potential coping strategies.

Theme 6: Coping

Coping was a prominent theme highlighted in 34 studies. Because of its breadth and centrality to participants' experiences, it has four sub-themes: Spiritual practices, Spiritual relationship, Spiritual struggles and Preventing suicide.

The theme of Coping refers to the many ways in which people utilised their spirituality to help them to deal with the challenges of their mental health problems. Most often, this was achieved by utilising various spiritual practices or through cultivation of a relationship with their spirituality, faith, God or spiritual communities. The process of coping was not however necessarily easy and could be impeded by symptoms or struggles. For some participants, their spirituality not only helped them to cope but it prevented suicide.

The process of coping was often experienced as an active process involving persistent efforts to engage with spiritual and recovery processes and to gain skills and acquire information. These approaches could lead to a sense of peace and calm, comfort, support, guidance, strength, self-reliance, forgiveness, hope, purpose and positive self-image (Heffernan et al., 2016; Moller, 1999; Salimena et al., 2016; Wilding et al., 2005).

Sub-theme 6.1: Spiritual practices

Sixteen studies highlighted the importance of spiritual practices in helping participants to cope with mental health problems. People engaged with a variety of practices, with prayer reported as having particular significance and being a key source of coping, providing strength and strategies for resilience, maintaining connection with God, promoting gratitude, reducing fear and sustaining a sense of respect and hope (Al-Solaim & Loewenthal, 2011; Corry et al., 2015; Eltaiba & Harries, 2015; Mahintorabi et al., 2017; Murphy, 2000; Oxhandler et al., 2018; Smith & Suto, 2012; Sreevani & Reddemma, 2012; Sullivan, 1993). Prayer was also often seen as a way of communicating with God, for example as a '*direct line to God*' (Mental Health Foundation, 2002, p. 32).

Attending church, temples or places of worship or accessing sacred quiet spaces were also important ways in which people could express their spirituality or gain a sense of peace or comfort (Macmin & Foskett, 2004; Mental Health Foundation, 2002; Salimena et al., 2016). Reading religious and spiritual texts was seen as an important way for participants to cope and seek answers: *'…you could find a solution in the Bible'* (Drinnan & Lavender, 2006, p. 324). Meditation and mindfulness were other practices participants said they found helpful to obtain a sense of connection, peace or guidance or to manage difficult experiences (Corry et al., 2015; Nixon et al., 2010). A range of other practices were mentioned across the studies, including rituals, ceremony, attending confession, singing hymns or spiritual songs, yoga, meeting religious people and attending formal religious services (Hustoft et al., 2013; Mental Health Foundation, 2002; Nixon et al., 2010; Sreevani & Reddemma, 2012; Sullivan, 1993).

One of the benefits of engaging in spiritual practices was that they were sometimes described as strengthening participants' spiritual relationships.

Sub-theme 6.2: Spiritual relationship

Participants' relationship with God, a spiritual figure or a higher spiritual power was very significant for participants, being mentioned in 21 studies. Many people described this relationship as central to their faith or the most important relationship of their lives and for this reason it had crucial importance for coping during times of illness (Hanevik et al., 2017; Lilja et al., 2016). This relationship often provided people with a sense that '*God was still there'* (Lilja et al., 2016, p. 4), cared for them throughout times of illness, and could be called upon whenever needed (Wilding et al., 2006):

> *'I know I matter to God, no matter what, no matter how depressed I am, no matter how much I fail, whatever mistakes I make'* (Russinova & Cash, 2007, p. 278).

This relationship also provided a great sense of comfort, reassurance, protection, guidance and security, sometimes in almost a parental way (Drinnan & Lavender, 2006; Hanevik et al., 2017; Lilja et al., 2016; Rieben et al., 2013). Participants described how this relationship brought them feelings of peace, strength, courage and the ability to be more positive about themselves (Lilja et al., 2016; Murphy,

2000; Salimena et al., 2016; Wilding et al., 2006). God was seen as a salvation or a *'very best friend'* (Wilding et al., 2006, p. 147) who helped some participants to cope with challenges and provided understanding, forgiveness and solutions to problems (Corry et al., 2015; Mental Health Foundation, 2002; Salimena et al., 2016; Sreevani & Reddemma, 2012):

> *'It's God who helps me, I ask him for solutions and slowly he helps me, giving me the answers'* (Salimena et al., 2016, p. 4).

> *'I really don't look to people. I look to God … God has seen me through everything'* (Sullivan, 1993, p. 130).

Sometimes people perceived God or a higher power to act directly as a *'divine intervention'* or *'divine action'* to assist with recovery, coping or reducing symptoms (Buser et al., 2014; Heffernan et al., 2016; Rieben et al., 2013).

Spiritual connection was a key theme in Rajakumar et al.'s (2008) study and was expressed through relationships with not only a spiritual figure but also with self, others and nature. These connections seemed to help participants with depression derive a sense of meaning and purpose from their struggles. Although connecting with faith and spiritual communities was mentioned as important in several studies (Heffernan et al., 2016; Mental Health Foundation, 2002; Sullivan, 1993) perhaps because of some of the difficulties this could also bring through potential rejection and stigma (Baker, 2010; Mental Health Foundation, 2002), greater prominence was given to a direct relationship with a spiritual entity.

A key finding in Heffernan et al.'s (2016) study was that the role of a genuine reciprocal relationship with a deity was so essential that it influenced many other aspects of people's experiences. Losing the opportunity to connect with God or spirituality in hospital settings impeded this relationship and people's opportunities for recovery.

Sometimes such spiritual relationships could also bring struggles when God was experienced to be judging or when people felt ashamed of their failures (Lilja et al., 2016). These struggles are described further in the following sub-theme.

Sub-theme 6.3: Spiritual struggles

The previous themes have identified some of the challenges study participants described in relation to spirituality and mental health experiences. These include issues within service provision, wanting to talk about and make sense of their experiences, and difficult or confusing interactions between spirituality and mental health symptoms. This theme describes spiritual struggles more generally in relation to coping.

One of the most prominent areas of spiritual struggle was feelings of guilt. Often this was because of being unable to maintain rituals or spiritual practices (Heffernan et al., 2016) and sometimes this was a general existential feeling coupled with shame, feelings of unworthiness or of being a sinner (Buser et al., 2014; Drinnan & Lavender, 2006; Lilja et al., 2016; Marsden et al., 2007; Moller, 1999; Rieben et al., 2013). Other problems related to people's relationships with their spiritual communities, sometimes feeling excluded or abandoned by them, or to do with the judgements or stigma they might experience due to their mental health problems (Eltaiba & Harries, 2015; Moller, 1999).

Other spiritual struggles included feeling punished by a higher being, loss of personal agency and hope, isolation, negative emotions, negative religious coping and feeling misunderstood (Hanevik et al., 2017; Hustoft et al., 2013; Mental Health Foundation, 2002; Starnino & Canda, 2014; Yang et al., 2012). Sometimes these struggles led to exacerbation of symptoms (Mahintorabi et al., 2017) or people wanting to give up their faith altogether:

> *'I have actually said to God, why don't you just leave me … It was more comfortable when I didn't know'* (Mental Health Foundation, 2002, p. 16).

Wanting to give up completely however, is the topic of the next sub-theme.

Sub-theme 6.4: Preventing suicide

A phrase one participant used to summarise this theme was: '*Without my faith I wouldn't have survived*' (Mental Health Foundation, 2002, p. 14). Minor variations of this phrase or notion occurred across a number of studies (n=13).

The essence of this theme concerns how people's spirituality, faith or relationship with God was what they said sometimes kept them alive during their most difficult struggles with mental health problems. It did this through the prevention of suicide (Al-Solaim & Loewenthal, 2011; Corry et al., 2015; Drinnan & Lavender, 2006; Hustoft et al., 2013; Lilja et al., 2016; Mental Health Foundation, 2002; Murphy, 2000; Oxhandler et al., 2018; Wilding et al., 2005):

> *'God has saved my life.' 'Probably the biggest impact about my belief in God is when I have been suicidal… my faith has probably been the thing that's most kept me from hurting myself'* (Rajakumar et al., 2008, p. 96).

> *'If I had no faith, I don't know how I'd get through it. No faith, no hope, no light at the end of the tunnel. I would end it'* (Drinnan & Lavender, 2006, p. 324).

Several participants reported experiencing a form of divine intervention at the point they were about to take their lives, seeing this as a 'miracle' or as a sign of God's care and assurance that their lives remained worthy (Corry et al., 2015; Lilja et al., 2016; Mental Health Foundation, 2002; Wilding et al., 2005):

> *'I stood on the edge and ready to jump in and a voice … I felt it was God speaking to me … I suddenly realised what it was and what I was going to do and then I realised I didn't want to do that and I think from that point I started to recover' (Mental Health Foundation, 2002, p. 13).*

Sometimes such harrowing experiences instigated recovery and became turning points in participants' lives.

2.4 Discussion

This qualitative systematic review comprising a thematic synthesis of 38 studies from 15 countries and spanning a range of belief systems is the first of its kind. It identified six key themes characterising important experiences of spirituality among people with mental health difficulties. There was amplificatory force to this review in its overlap with a previous systematic review identifying recovery processes comprising Connectedness, Hope, Identity, Meaning and Empowerment (the CHIME framework), (Leamy et al., 2011). Two CHIME processes map onto two key themes in this review: Meaning making and Identity. This marks relatedness

between the concepts of spirituality and recovery, which are both often defined in relation to finding meaning and purpose in life (Anthony, 1993; Gilbert, 2011b).

Although Meaning included spirituality in the CHIME study, particularly for people of Black and minority ethnic communities, it was largely described in more secular terms. The CHIME theme of connectedness also had similarities to the sub-theme of Spiritual relationship in this review. However, whilst connectedness was described in the CHIME study as relationships with and support from other people, within this MISTIC study, the relationship that seemed particularly important in the context of mental health and spirituality was a reciprocal relationship with a spiritual being. Practice implications could include awareness of the need some people may have for suitable (e.g. safe, calm) spaces to connect with such spiritual relationships.

Meaning making and Coping were prevalent themes in this study. There is a sizeable literature on spiritual coping (e.g. Lomax & Pargament, 2016; Pargament & Raiya, 2007). This includes highlighting the role of spiritual coping and spiritual practices in reducing suicide and mental health symptoms such as depression and anxiety (Koenig, 2009). Desai & Pargament (2015) found that positive spiritual coping and meaning making were the strongest predictors of spiritual struggle resolution. Spiritual struggles, a sub-theme of Coping, is described in the literature to be related to tension and turmoil in relation to a higher power. It can involve interpersonal struggles such as with a spiritual community, or intrapersonal ones, such as inner struggles relating to beliefs. Although some studies suggest that spiritual struggles may lead to growth, the majority of research shows that spiritual struggles can negatively impact mental health and wellbeing (Ano & Pargament, 2013). This highlights the importance of practitioners understanding both potentially positive and negative impacts of spiritual coping on mental health and recovery within clinical contexts.

There has been more limited investigation around meaning making from a psychiatric perspective despite the importance it has for people with mental health difficulties (Huguelet, 2017). Carl Jung was convinced that that meaning, which he referred to as a ‘healing fiction’, had been underestimated in the approach to illness (Jung, 1956). David Tacey (2013a) argues that illuminating the processes of spiritual meaning making may hold important keys to better understanding and assisting recovery of mental health difficulties. The Multiple explanations sub-theme

of Meaning making, and the Interaction with symptoms theme reflect attempts by participants, sometimes very adeptly, to make sense of anomalous or mystical experiences, or co-existing realities. A growing number of researchers acknowledge that some areas of human experience transcend the limits of what can precisely be known. By validating and better understanding what Clarke (2010, p. 114) calls such 'transliminal' experiences, this has the '*potential to reduce stigma and provide a more acceptable sense of self in the world to many who find themselves floundering in the transliminal'*.

Developmental journey, a sub-theme of Meaning making, highlighted the importance of change and ways people might experience different stages of their spirituality and recovery journeys (Starnino & Canda, 2014). Some of the features of these stages are explained by faith development theory (Fowler, 1981) or Culliford's (2014) psychospiritual developmental framework which describes the process of spiritual growth as involving healing, reintegration and a renewed sense of meaning often after encountering and enduring major adversity. Some authors argue that understanding and treating mental health challenges as difficult stages in a natural development process can help facilitate recovery and spiritual development (Crowley, 2006; Grof & Grof, 1989).

Findings from this review add to the increasing evidence of the need for mental health professionals to become familiar with the language of spirituality and the ways it can enable meaning making and support coping amidst challenging life experiences (Sims & Cook, 2009; Swinton, 2001). Some authors argue that the current bio-psycho-social model is insufficient for the holistic care of people who use mental health services and call for a bio-psycho-social-spiritual model (Hefti, 2009). Acknowledging that spirituality can be a causing, mediating or moderating factor on mental health and can affect biological, psychological and social aspects of human life could assist clinical understanding as well as interventions which seek to meet an individual's holistic needs (Culliford & Eagger, 2009).

2.4.1 Implications for practice

This review provides evidence about the importance of spirituality for some people with mental health difficulties and the roles it plays in their lives. These are primarily supportive but can also bring challenges particularly in relation to Spiritual struggles, or as people grapple to make meaning out of their experiences, often in isolation. Spirituality is core to many people's identity, is reported as essential in helping some

people cope with distressing mental health experiences, and may sometimes prevent suicide. It is important therefore that mental health services and professionals are aware of and actively prepared to address and support this dimension, a recommendation which was made in nearly all of the reviewed studies (n=34).

It is hoped that the MISTIC framework can support practitioners and others working in the field of mental health to do so and may be used to inform the development of spiritual assessment and interventions. To assist with the practical use and application of the MISTIC framework within clinical practice, Table 2.4 outlines clinical and practical considerations informed by a simplification and pairing of MISTIC themes in relation to clinical relevance. These include potential types of questions clinicians may consider in relation to these themes. Spiritual assessment and care calls for similar clinical skills to those required for effective clinical practice generally such as sensitivity, openness and empathy. It also requires a thoughtful integration of the spiritual dimension into a person-centred rather than a one-size-fits-all approach (Lomax & Pargament, 2016).

In addition to being published and well cited (Google Scholar, accessed 15/03/23, cited by 58), this systematic review has been discussed at numerous academic and conference presentations and some student teaching and NHS clinical training sessions. The MISTIC framework has also been designed as two user-friendly and evidence-based ‘Toolkit’ resources to enhance accessibility for clinicians and a general public audience (see Figures 2.2 and 2.3). For more information see ‘Thesis-related outputs and knowledge mobilisation’ section in Preface**.**

Table 2.4 Clinical considerations based on MISTIC framework

MISTIC Theme Pair	Clinical relevance	Clinical approaches and potential questions
Meaning making and Identity (MI)	**Understanding the centrality of spirituality** Spirituality is central to some people's identities and how they make sense of mental health difficulties and other experiences. Being open and facilitating exploration of the role spirituality may play in helping someone to make sense of their illness can be a means of supporting recovery.	Being aware that people's spiritual experiences and beliefs may form a core part of their identity and their understanding of mental health difficulties and/or recovery. Asking questions about the importance of spirituality in someone's life. Asking if spirituality or religion help them to make sense of what is happening and if so how. Asking if spirituality or religion are confusing and if so how.
Service provision and Talk about it (ST)	**Practical ways services can meet spiritual needs** How services and practitioners can practically facilitate meeting people's spiritual needs and adopting an open approach towards communication about the topic.	Offering a pro-active yet sensitive approach in addressing the subject if someone would like this. Exploring people's spiritual needs whilst using services. Offering people the opportunity to talk about spirituality. Listening with sensitivity, empathy and open-mindedness. Adopting a person-centred (rather than expert-driven and problem-solving) approach, giving the person space to express themselves, their own experiences and expertise.
Interaction with symptoms and Coping (IC)	**Awareness of challenges and coping strategies** Understanding that spirituality can interact with mental health in complex and sometimes confusing ways and that people may employ a variety of spiritual practices and strategies to cope.	Exploring how people's spirituality and/or practices may be challenging or helpful. Asking about what spiritual or religious practices are used currently or in the past. Asking questions about whether and how these practices are helpful or challenging. Asking questions about whether and how spirituality or religion help with coping. Asking questions about whether and how spirituality or religion can lead to struggles or difficulties.

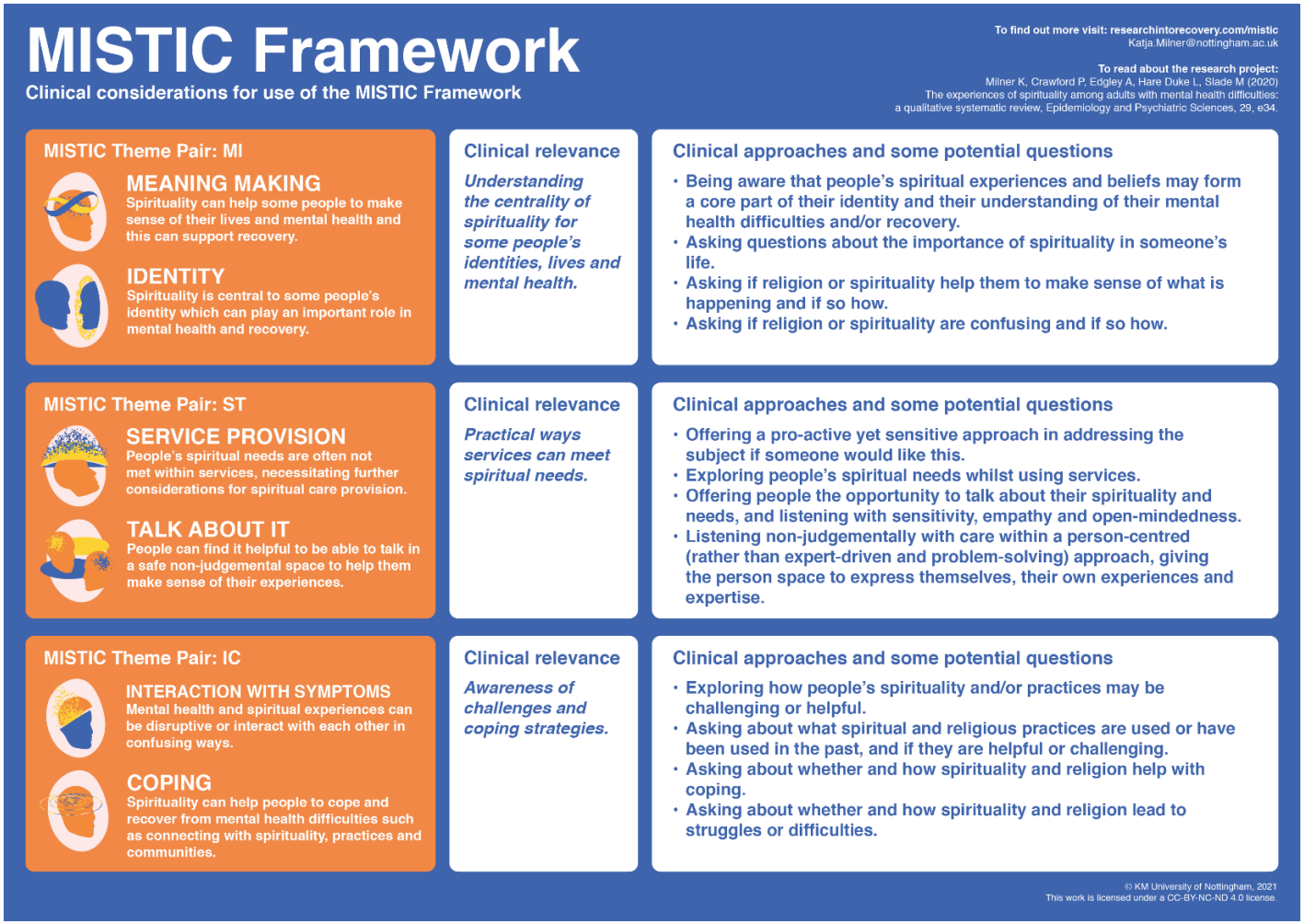


Figure 2.2 Clinical considerations based upon MISTIC framework resource

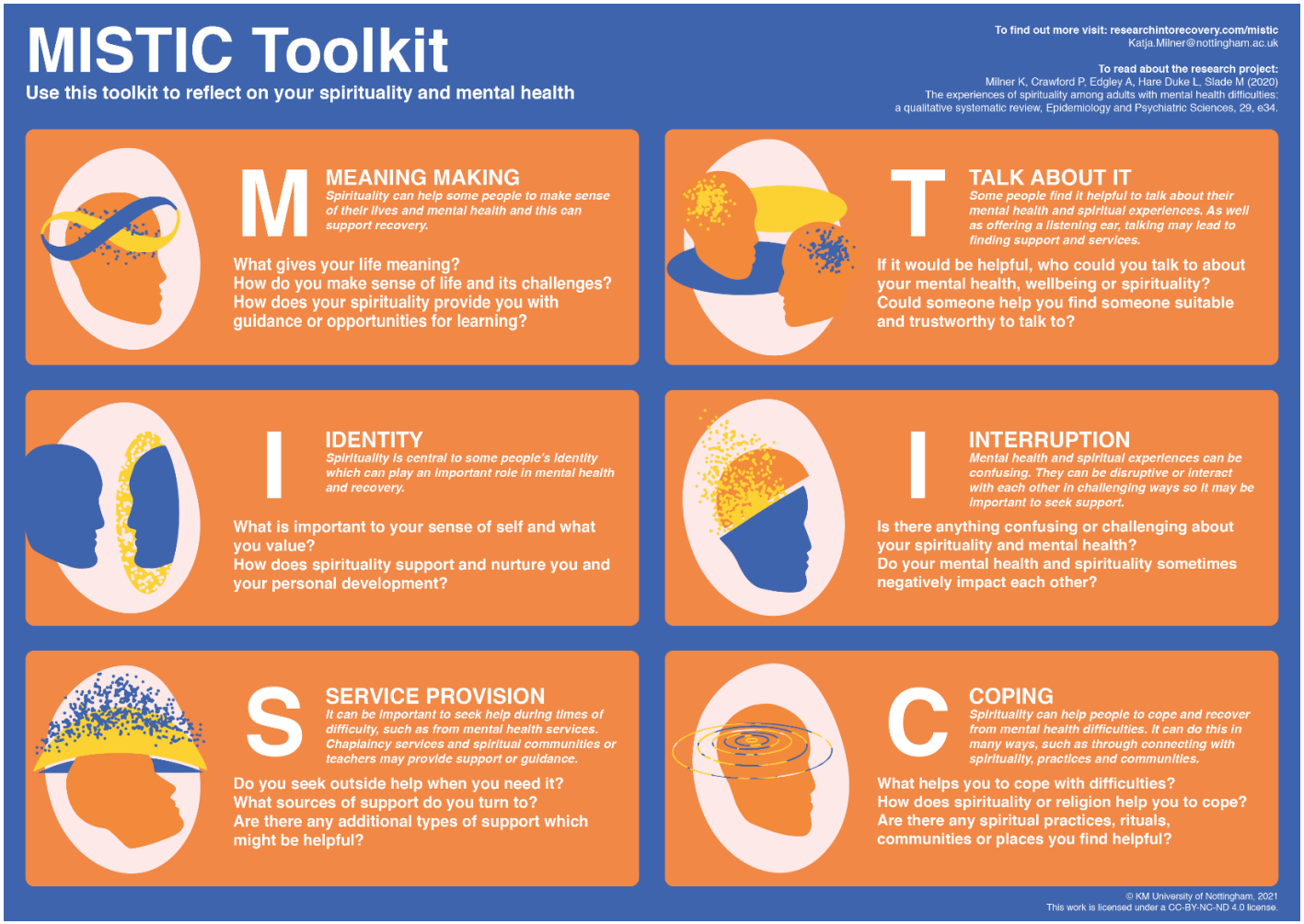


Figure 2.3 MISTIC Toolkit resource for general reflection and wellbeing

2.4.2 Study limitations and strengths

Qualitative systematic reviews are criticised for de-contextualising findings and assuming that concepts found in one setting are applicable to others (Sandelowski et al., 2007; Thomas & Harden, 2008). To address this concern, Thomas & Harden's (2008) suggestions were followed including providing structured summaries of research contexts (see Table 2.1) and checking throughout if emerging findings were transferrable across studies. Although the systematic review aimed to create a simple way of framing complex information, such a strategy risks missing out important components. For example, studies with specific topics that were excluded from the review such as 'specific religious/spiritual phenomena' and 'suicide' may have provided important additional themes and insights relevant to or diverging from the MISTIC themes. These topics could be important areas of investigation in future research.

The development of qualitative systematic reviews is an emerging field with little consensus about methods of synthesis and their optimal use. Explicitness is suggested in reporting methods used for searching, appraisal and synthesis (Vermandere et al., 2011). This was supported utilising the Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) statement, a framework developed to promote comprehensive reporting of the synthesis of qualitative research (Tong et al., 2012). Issues of researcher interpretation were addressed through transparency and reflexivity, systematic research processes, and striving to be as representative as possible of the research participants' accounts.

A key study strength is that this study provides new and important evidence about experiences of mental health and spirituality in a way in which is difficult with individual small-scale qualitative studies. The MISTIC study spans a range of countries, cultures, religious and spiritual beliefs systems, and mental health diagnoses, thus providing a diversity of contexts that contribute to the transferability and rigour of the findings. The accessible language of the themes and framework supports applicability of findings across diverse spirituality and mental health contexts. Finally, the MISTIC framework simplifies what can be a confusing and complex area of understanding for clinicians, and has the potential to impact upon evidence-based training, interventions and policy guidelines.

2.4.3 Conclusions and future developments

This study is the first qualitative systematic review to explore the experiences of spirituality among adults with mental health difficulties and identified six key themes giving the acronym MISTIC. Future research is required to further refine the framework's applicability to clinical and training contexts and to create clear guidelines for this. The study offers a framework for developing holistic, strengths-focussed and person-centred approaches to mental health care, which have the potential to improve the quality of care and the experiences of people using mental health services.

2.5 Rationale for empirical study

In order to provide a refined focus for the empirical study and avoid replicating research included within this review, two themes were chosen derived from the MISTIC framework. These were intended to provide focal points for further in-depth analysis, thereby illuminating more comprehensive understanding in relation to lived experiences of spirituality, mental health and recovery. This decision was made in consultation with the supervisory team and the themes chosen were Meaning making and one of its sub-themes, Developmental journey, although they would be treated as distinct superordinate themes for the purpose of the empirical study.

The first superordinate theme of Meaning making was chosen because of its frequency of reporting across studies, suggesting its importance within participants' experiences, as well as its salience within the wider literature including within definitions and characterisations of spirituality. Despite the centrality of this concept, there remains ambiguity and vagueness in relation to how people make meaning in the context of spirituality, mental health and recovery. Huguelet (2017) points out that the issue of meaning in this context has been sparsely addressed in the literature and most research focusses upon coping with adversities such as grief rather than specifically focussing upon mental health difficulties. At the same time meaning is considered crucial in understanding human experience and central to recovering from stressful and traumatic experiences (Park & George, 2013).

Research tends to distinguish between the constructs of 'meaning in life' and 'meaning making'. Meaning in life is widely recognised as a cornerstone of well-being and broadly denotes purpose, significance and coherence within experience of life (King et al., 2016). In addition, it often involves spiritual dimensions which may

result in better social functioning, psychological and social quality of life and fewer negative mental health symptoms (Huguelet et al., 2016). This is distinguished from the concept of 'meaning making' which is described as an active process involving the search for meaning, appraisal of difficulties and may potentially provide a means for coping during distressing or transformatory experiences (Huguelet, 2017). Although there has been some focus on spiritual meaning making in relation to coping (e.g. Mohr et al., 2006; Park, 2005), the literature lacks clear and in-depth insights about such meaning making processes from the perspectives of lived experience in the context of mental health and recovery. A more comprehensive understanding of meaning making is essential given the central role research suggests it plays in coping and recovery (Park & George, 2013). In addition, developing greater understanding about the role of meaning making in relation to dealing with mental health challenges could inform future interventions (Huguelet, 2017).

The Developmental journey sub-theme of Meaning making was chosen as the second superordinate theme through which to offer a focus for the empirical study. Although it may connect with Meaning making, it is considered within the empirical study as a superordinate theme in its own right to encourage diverse insights derived from personal lived experiences. Further reasons for choosing a developmental theme concern again its centrality to many conceptualisations of spirituality including psychospiritual frameworks of understanding. Additionally, detailed study of potential relationships between spirituality, development and mental health recovery from a lived experience perspective are limited. Starnino & Canda (2014) provided a comprehensive analysis of this topic area, focussed specifically on severe mental illness. They categorised participants' experiences within a staged framework relating to how effectively they were interpreted to integrate their spirituality and recovery. The authors suggest that further research is required to better clarify spirituality in relation to recovery and development. It is of particular interest within this thesis to do so in a way which aligns with personal accounts as far as possible rather than categorising experiences in relation to interpreted stages of spiritual development or recovery.

Because of the psychospiritual approach taken within this thesis, and to support greater clarity and consistency of concepts, the theme 'Developmental journey' is re-framed as 'Psychospiritual development' for the empirical study. Analysis of the *a priori* superordinate themes of Meaning making and Psychospiritual development,

as well as other themes derived inductively are described in Chapter 4., Section 4.7.2.

Chapter 3: Methodology

Chapter 3 sets out the aims and objectives of the thesis as informed by the knowledge gaps identified in the qualitative systematic review (hereon referred to as 'MISTIC study') shown in Chapter 2. The research is located within a critical realist epistemology with an emergent pluralist qualitative design and utilising a narrative methodology. Considerations are also explored regarding rigour and reflexivity.

3.1 Aims and Objectives

This thesis has a broad research question that allows for an open inductive approach towards the research process, data collection and analysis. The research question is: **What is the role of spirituality in mental health and recovery from the perspectives of people who experience mental health difficulties?**

The aim of this thesis is to explore the role of spirituality in the accounts and narratives of people with current or previous experiences of mental health difficulties, focussing specifically on the ways they use spirituality to find meaning in their experiences and how this process may change or develop over time.

To meet this aim, the thesis has two topic-specific objectives and one methodological objective:

1) To systematically analyse and characterise existing empirical qualitative research around the experiences of spirituality in adults with mental health difficulties.

2) To explore the role of spirituality in mental health and recovery within the narratives of people with current or previous mental health difficulties through:

    a) Narrative analysis to ascertain key themes within participants' narratives inductively.

    b) Narrative analysis to investigate superordinate themes of meaning making and psychospiritual development within participants' narratives.

3) To extend and develop narrative-based methodological approaches to highlight lived experience and personal meaning making around psychospiritual themes and the content of sequential features within participants' narratives.

3.2 Philosophical Orientation

The epistemological position for this research is critical realism which assumes that a reality exists independently of our senses and that at the same time the nature of knowledge is contingent and provisional (Edgley et al., 2016). Critical realism provides an alternative to both positivist and constructivist philosophical positions, sitting between and drawing upon elements of each of these positions (Fletcher, 2017; Pawson, 2006). It acknowledges the weakness of positivism in ignoring the interdependency between humans and objects and the tendency in some constructive approaches to over-emphasise these factors (Bhaskar, 1989).

In critical realist ontology, reality is stratified into three interrelated levels. The first is the 'empirical' level. This concerns observable and experienced events which can be measured and are mediated through the filter of human experience and interpretation. The next level is the 'actual' in which events are generated by underlying mechanisms that can be explored and determined through critical realist research. The third is the 'real' level in which causal structures or mechanisms exist and have real consequences within the social world but may not be observable. A mechanism is defined as that which may be capable of making things happen in the world, including within human action, ideas, beliefs and experience even though their effects may not always be triggered or possible to trace (Alvesson & Sköldberg, 2018). Phenomena emerge from an interaction between these three levels and it is a primary goal of critical realism to explain them through reference to the causal mechanisms and the effects they can have throughout this multi-layered model of reality (Fletcher, 2017, p. 3).

Critical realism also emphasises the idea of causal explanation in relation to such mechanisms, by acknowledging that personal and social meanings, ideas and decisions can have causal effects. This differs from a positivist approach to causality that attempts to ascertain exact relations between cause and effect within predictable patterns. For critical realists this is not deemed possible within a social world consisting of open systems which are dynamic, overlapping and ever-changing (Fletcher, 2017). To critical realists, causality is understood as contextual

and emergent, as existing on different levels and generating tendencies rather than inevitable universal and predictable patterns (Alvesson & Sköldberg, 2018).

Critical theorists can gain knowledge through theories which help to identify possible causal mechanisms driving social events, activities or phenomena using rational judgement (Archer, 1998). In this way some knowledge and theory can be seen as closer to reality and more truth-like than others (Fletcher, 2016). At the same time, critical realism is 'fallibilist', accepting that all judgements are open to correction, and that there is no access to the absolute truth (Benton & Craib, 2011; Edgley et al., 2016).

The ability to engage in explanation and causal analysis makes critical realism useful for analysing social problems and highlighting themes related to social change (Fletcher, 2017). Critical realism proposes that an active agent has an important role to play in transforming social structures to a greater degree than interpretive or constructivist theories which can downplay this aspect. Critical realism therefore highlights the important connection between knowledge of self, society and human emancipation (Benton & Craib, 2011; Dobson, 2003). This 'critical' part of critical realism implies that social research can provide justifications for normative (ethical, moral, political) judgements about how things should be to support understanding or provide justifications to preserve or change the state of how things are. For example, social structures can give rise to false beliefs which can in turn give rise to avoidable suffering which, if shown, could justify their transformation (Benton & Craib, 2011).

The importance of social change within critical realism is relevant to this research topic that seeks to contribute towards a way of understanding, theorising and practising mental health care in which the spiritual dimension of health is taken seriously as part of an integrated holistic approach. As outlined in Section 1.6, exploring spirituality in healthcare can be conceptualised as a 'radical enquiry' which involves looking at what has been marginalised and excluded in the past (Cobb et al., 2012). Spirituality can inform novel ways of paying attention to the world and highlight what is missing from care practices, thereby encouraging the development of new thinking around fundamental assumptions and promoting cultural change (Swinton, 2014). Within a critical realist approach where all explanations are treated as fallible (Bhaskar, 1979), service user and lived experience accounts may provide

more accurate explanations in relation to the role of spirituality in mental health and recovery, potentially challenging existing practitioner assumptions or knowledge.

Critical realism may also be a well-placed epistemological approach to explore spirituality since Bhaskar, one of its founding members, took a 'spiritual turn' in the mid-1990s. Bhaskar sought to articulate a spirituality that can appeal to both the secularly minded and the religious (Morgan & Hartwig, 2012). Although this move has subjected Bhaskar to critical scrutiny, it has prompted other writers to focus on *'decisively breaching the last of the big taboos in the Western academy: the taboo now starting to be lifted, on discussions of religious and spiritual beliefs as intellectually respectable topics in the academy'* (Morgan & Hartwig, 2012, p. 14). In coming to terms with this taboo, Bhaskar argued that spirituality is not something outside society but is both within and underpins it, as a spiritual infrastructure without which society could not function, and yet is *'never talked about'* (Bhaskar & Hartwig, 2012, p. 191).

A key criticism of critical realist research is lack of clear methodological development and guidelines (Fletcher, 2017). However, it does emphasise the exploration of ideas that critique underlying assumptions about organisations and institutions such as health care. It supports deep analysis of phenomena, aiming to identify potential underlying causal mechanisms that may produce certain outcomes. Critical realism lends itself well to research which attempts to highlight topics that have historically been marginalised, to give validity to the accounts of those with lived experiences of mental health difficulties, and to produce knowledge with the potential for improving healthcare practice.

3.3 Research design

To address the research question and objectives, a qualitative narrative research design was chosen which seeks to understand the subjective lived experiences of people and the meaning they give to these experiences through the context of their story (Chase, 2011). Although a true critical realist study would involve a range of mixed methods to be able to make any strong claims in relation to causal mechanisms, a qualitative study allows a starting point to explore possible mechanisms that may be at work. This qualitative investigation was informed epistemologically by critical realism whilst adopting a pluralistic approach towards methodology and analysis. It involved an emergent study design to allow for the

development of suitable analytical methods based upon a narrative methodology and a hermeneutic interpretive lens, as described in further detail below.

A qualitative design is well suited to the research aim as it respects the uniqueness of an individual's understanding and experience of spirituality as significant for knowledge and practice (Swinton & Parkes, 2011). In addition, qualitative research is considered the optimal means of bringing comprehensive insight and illumination into complex sensitive and multifaceted concepts such as spirituality (Edwards et al., 2010). Qualitative researchers utilise a diverse range of interpretive methods which seek to develop understanding and transformation in the world, making it visible in new ways and creating spaces for people to have their stories heard (Lincoln, 2011). Although a narrative approach was chosen for this study, other methodologies were initially considered which could also have been appropriate, including grounded theory or a phenomenological approach. Although, similar to narrative methodologies, phenomenological approaches are concerned with the meaning people attach to their experiences, it has a strong philosophical basis and emphasises shared experiences. Narrative approaches however emphasise the individual meaning of lived experience over time which aligned more closely with my research objectives. Grounded theory could have been a relevant approach but it is often used to generate theory about a process or action shaped by the views of a number of participants (Creswell, 2007) which again did not specifically align with the research objectives of this study.

Narrative methodologies are interpretive and interpretation is personal, partial and dynamic (Lieblich et al., 1998). Interpretive approaches in research involve investigating the meanings of human action, behaviour and experience and highlight their fluid and creative construction rather than objective certainties and reductive views of reality (Brown et al., 2003). Interpretive decisions within narrative research require justification and narrative work requires self-awareness and self-discipline as well as the ability to navigate ambiguity in a dynamic way, in an on-going examination of text against interpretation (Lieblich et al., 1998).

Alvesson & Sköldberg (2018) argue that the quality and value of qualitative research are determined by an awareness of various interpretive dimensions and the ability to handle these reflexively. The interpretive work highlights theoretical assumptions and the importance of language and preunderstanding, whilst the reflexive element involves factoring various social and cultural contexts that influence the researcher

position. Rather than follow a ‘recipe-book’ approach towards research and following set procedures, Alvesson & Sköldberg (2018) argue that good qualitative research is not a technical project but an intellectual one, characterised by what they call ‘reflexive interpretation’. Here empirical material is handled in a reflexive way that encourages critical, deep and creative thinking as well as fluidity and integration across different kinds of lenses and approaches. Such pluralist approaches seek to avoid narrow ways of thinking dominated by one particular paradigm, and to encourage the invention of reflexive methodologies and the production of rich, novel and innovative interpretations and results.

This approach aligns with certain thinking within the qualitative research community which critiques ‘methodolatry’ and the ‘McDonaldization’ (Brinkmann, 2012) of research methods with a preoccupation with fixed efficient, predictable and controllable methodological formulae. However, a balance must be struck between the dangers of rigidity and over-emphasis on method at the possible expense of the data on the one hand, and the free speculation or reliance on subjective intuition on the other (Brinkmann, 2012). As Alvesson & Sköldberg (2018) point out, not adhering to fixed procedures does not mean that ‘anything goes’. Rather, they argue, different demands should be made for the production of good research. These are characterised by features such as empirical arguments and credibility, a transparently interpretive dimension to social phenomena, insightful empirical description, reflexivity and novel theory development.

Striking this balance in addressing issues of quality and rigour of the research remained an ongoing effort in the design and process of this thesis including the utilisation of an emergent methodology. The narrative study design and methods were assessed and developed, in consultation with the supervisory team, throughout the research and analytical process, rather than being completely pre-determined at the outset. Such emergent, forming and reforming ‘methods in the making’ are closely tied to the specific research question (Lury & Wakeford, 2012, p. 6). They are well suited to attending to less fixed, easily representable and more ambiguous constructions of everyday life (Jungnickel & Hjorth, 2014) and are increasingly adopted by researchers who suggest they wish to resist the *‘temptation to hold down and dissect these phenomena to study them’* (Büscher et al., 2011, p. 1). This allows for the accounting of the social world *‘without assassinating the life contained within it’* (Back, 2012, p. 21).

An initial exploration of methods such as thematic analyses (e.g. Braun & Clarke, 2006) and some narrative methods highlighted their limitations for deeper investigation of the stories of lived experiences of spirituality, mental health and recovery. For example, some thematic analytical approaches lacked the depth required for this study and tended to fragment themes divorced from their context. Many narrative methods seemed to emphasise analysis of specific features of a story directed by the method, rather than those highlighted by the research objectives. The pluralistic, fluid and integrative reflexive approach suggested by Alvesson & Sköldberg (2018) informed the development of the emergent research design which was rooted within a narrative methodology.

3.4 Narrative research

> *'Hopes, desires, memories, fantasies, intentions, representations of others, and time are all interwoven, through narrative, into a fabric that people experience – and can tell – as a life history. Stories are the linguistic form in which the connectedness of human experience as lived can be expressed' (*Josselson, 2004, p. 2; Ricoeur, 1991*).*

According to narrative theory people are born into a storied world and live their lives through the creation and exchange of narratives. In this sense, stories have ontological status in that they are not just ways of seeing the world, but the world is actively constructed through them (Murray, 2007). Narrative inquiry attempts to understand what people value, how they think through events and how these events are connected and organised into a meaningful whole (Chase, 2011; Riley & Hawe, 2005).

A narrative can be described as an organised interpretation of a sequence of events and can refer to any text or discourse with a specific focus on the stories told by individuals (Murray, 2007; Polkinghorne, 1995). Labov (1972) argues that all narratives are stories about specific past events and that they have common properties and functions. Although the terms 'story' and 'narrative' are often used interchangeably, some authors describe them as analytically different. For Riley & Hawe (2005), and the definition adopted within this thesis, the difference between these concepts relates to where the primary data ends and the analysis of data begins. People tell stories, but narratives come from the analysis of stories (Frank, 2000), therefore the narratives are derived from the researcher's role to interpret the

stories in ways the storytellers may not be able to give voice to themselves (Riley & Hawe, 2005).

The stories people tell are important because they can offer, perhaps more than any other form of discourse, a window into the person's own personal experience, drawing the listener deeply into the teller's point of view (Ochberg, 1988; Riessman, 1990). They are the form through which implicit meanings can be made explicit and through which people can create a narrative identity in which facets of self may be maintained or revised in response to changing interpersonal conditions (Miller, 1994).

3.4.1 Narratives of illness, recovery and spirituality

Narratives provide one of the most powerful forms for expressing suffering and in making sense of illness experiences. The narrative provides meaning, context and perspective about the difficulty and how these are experienced (Greenhalgh & Hurwitz, 1999). Narratives have gained importance in the study of illness as a means of understanding people's attempts to evaluate and deal with their experiences (Hydén, 1997). Illness constitutes a disruption and discontinuance of ongoing life (Bury, 1982) and may force changes in people's identities and relationship with their body, self and the surrounding world. Narratives offer an opportunity to weave together disrupted aspects of life, enabling the construction of new contexts and meaning (Hydén, 1997).

Narrative methods have been increasingly used in health research since the 'narrative turn' in health and social sciences in which scholars began to treat seriously the view that people structure experience through stories (Denzin, 2003). This approach emphasised that an understanding of health requires an understanding of human experience, meaning and personal stories and has been influential within the mental health recovery approach. Narratives of recovery have provided important insights into the lived experiences of those with mental health difficulties, often emphasising themes of empowerment and self-determination (Llewellyn-Beardsley et al., 2019). Spector-Mersel & Knaifel (2018) argue that narrative research is ideally suited for accessing the experiences of mental health recovery because the knowledge that is generated by such studies has played a central role in establishing the recovery paradigm, contributing significantly to recovery-oriented practice and policy. They view narrative research and the recovery approach as 'sister paradigms' which share similar philosophical positions,

both emphasising the importance of meaning, identity, agency and development and aiming to promote social change by giving voice to marginalised groups.

Narrative approaches lend themselves well to the study of both spirituality and recovery since they connect with the idea of a journey, transformation and the story as a means of human sense making (Ricoeur, 1984). For example, writing primarily about chronic physical illnesses, Frank (1995) offers a typology of illness narratives. These are restitution narratives, in which health is restored to well-being, chaos narratives that lack clear movement and hold little hope, and quest narratives in which the teller accepts the illness and sees it as an opportunity to discover and gain something through the experience. In an exploration of the spiritual and religious dimensions of recovery narratives, Fallot (1998) points out that published recovery narratives of mental illness have drawn primarily on the 'quest narrative' as highlighted by Frank (1995). The new meaning found on such a journey often involves the questioning, dismantling and reformation of personal identity. It can also involve the 'reclamation' of an aspect of oneself that may have been invalidated by the consequences of mental distress (Buchanan-Barker & Barker, 2008). However, for some people, recovery may mean the adoption of new stories and aspects of self.

In a systematic review and narrative synthesis of published literature characterising mental health recovery narratives, Llewellyn-Beardsley et al. (2019) challenge and extend Frank's original typology of narratives, arguing that recovery narratives may be distinct from illness narratives. Within their typology, they identify Enlightenment narratives as including a spiritual dimension and themes of empowerment, discovery, redemption or self-actualisation. The authors also point out that recovery narratives are diverse and may be non-linear and multi-dimensional, rejecting a singular or static form of narration.

Spiritual narratives have been described as stories of ultimate meaning because they highlight how people make sense of some of their key concerns, values and questions in life (McAdams, 1993; McTighe, 2018). Spirituality and narrative are both concerned with the processes of interpretation and finding meaning and purpose, and in many cases spirituality is communicated through narrative (Cook, 2016). The stories through which spirituality is conveyed can be powerful and provide a sense of coherence and connection (Mehl-Madrona, 2010). People may

draw upon spirituality in times of crisis in particular to make meaning of their world when established beliefs are threatened (Gockel, 2009; Park, 2005).

When meaning making may be at risk during periods of mental health difficulty, it may become particularly important to weave a self-story encompassing disruption, stabilisation and growth. Recovery narratives can provide an orienting system in which coping techniques and personal values may be highlighted and which place an individual in relationship with their immediate and larger contexts (Fallot, 1998). Because of these potential overarching functions of recovery narratives, Fallott (1998) argues, religious and spiritual themes may be of particular importance for many individuals.

3.4.2 Theoretical approach to narrative analysis

Narrative analysis typically takes the perspective of the teller and gives prominence to human agency, therefore offering a methodology particularly sensitive to subjective meaning making (Emerson & Frosh, 2004). Narrative analysis includes a multiplicity and diversity of approaches, such as focussing on the temporal order, the structure, textual coherence or narrative functions of a story (Mishler, 1995). Generally, however, narrative analysis connects complex contextualised accounts into a meaningful whole and includes both descriptive and interpretive aspects (Murray, 2007).

Narrative analysis is inherently concerned with meaning and the ways in which events are sequenced through time. It is therefore ideally suited to the research objectives, including the MISTIC study-derived superordinate themes of focus for the narrative study, Meaning making and Psychospiritual development. Narratives are analysed by organising them into an ordered sequence, firstly temporally, by laying out events chronologically, and secondly relationally, by looking for connections between different events to understand how they fit together (Crossley, 2000).

The specific approach towards narrative analysis was carefully reflected upon to meet the research objectives as part of the emergent and pluralistic study design. The first consideration concerned the nature of the interpretive lens through which to analyse the data. A hermeneutic approach was chosen which is a disciplined form of interpreting texts. With its roots within biblical exegesis, hermeneutics has evolved into an art, theory, method or sometimes science of interpreting meanings

within texts (Alvesson & Sköldberg, 2018; Josselson, 2004). Within a hermeneutic approach, the meaning of a part of a text is seen to be understood in relation to the whole, and conversely the whole is understood from the parts. Hermeneutic interpretation is also linked to empathy, in which the interpreter attempts to put themselves into the place of the agent or author to understand the meaning or experience more clearly (Alvesson & Sköldberg, 2018).

The hermeneutic interpretive stance can be positioned in different ways. The approach taken for this research is based upon the work of Ricoeur (1981), and expanded upon later by Josselson (2004) called the hermeneutics of restoration or faith. It is characterised by a willingness to listen, to absorb as much as possible of the story in its given form and giving 'voice' to the participant. It contrasts to an alternative positioning called the hermeneutics of demystification or suspicion, which problematizes the participant's narrative and is characterised by a distrust, suspicion and scepticism, seeking explanation beyond the text (Josselson, 2004). Such an approach was not chosen for this narrative study because it requires the researcher to make a claim for authority and re-author the meanings of the person narrating their stories. This does not align with the recovery-oriented and lived-experience validating stance chosen within this thesis.

The hermeneutic interpretive approach taken instead was the hermeneutics of restoration, as it begins with the belief that the story is being told, as best as the story-teller is able, of their subjective experience and meaning making. A researcher attempts to reveal the implicit as well as explicit meanings within the narratives whilst attempting to remain faithful to the various intentions of the narrator, rather than trying to construct them differently. They attempt to understand the person from their own point of view with as little distortion as possible by attempting to presume as little as possible (Josselson, 2004).

Key processes which support effective discernment of multi-layered subjective and intersubjective meanings of participants include a focus upon empathy and a willingness to listen. Importance is also placed upon producing a genuine personal encounter between the interviewer and participant to maximise the potential of meanings being revealed that are important and authentic (Josselson, 2004). Empathy within this context refers to the intuitive understanding 'from within' of the person being researched. Learning to 'listen' deeply and sensitively to the text can be achieved by entering into a 'dialogue' with it and approaching it on an equal

footing rather than passively surrendering to it or approaching it as its master. Listening carefully to the text in this way with a 'keen ear', as well as potentially asking questions of the text can support this process (Alvesson & Sköldberg, 2018).

Narratives of interest from a hermeneutic of restoration align with the thesis objectives and include themes of self-development and representing experiences of marginalised or oppressed groups. Within this approach, there is a care and concern for the story-teller who is presumed to be an expert about their own experience (Josselson, 2004). Such a person-centred and validating perspective of the participant is in keeping with the ethos of the recovery movement. As discussed earlier in Section 1.6, the stance of suspicion, critique or objectifying the narrator through a veil of expertise, is already prevalent within clinical and other institutional contexts, and there has been a great deal of stigma and distrust surrounding experiences of spirituality and mental health. A hermeneutic of restoration approach therefore has the potential to inform a research method which can provide space and validation for participant perspectives, and allow their stories to 'breathe.'

In addition to a hermeneutic of restoration, two methods of narrative analysis were drawn on to inform the overall analytical approach. These were narrative thematic analysis (Riessman, 2008) and Holistic content narrative analysis (Lieblich et al., 1998) which are described in detail in Section 4.7. These analytical methods are suited to a hermeneutic of restoration because they aim to elucidate the standpoint of the narrator (Josselson, 2004) and focus upon the content of what is said by participants (Riessman, 2008).

A challenge arose in attempting to find a narrative method to analyse the sequentiality of narratives from a hermeneutic of restoration perspective. That is, to explore the content of sequences within the narrative rather than the structure or form. This was particularly important for research objective 2.b) which was to investigate the theme of Psychospiritual development. Many methods for exploring narratives, particularly their sequences, were found to be fairly prescriptive in relation to the specific information they attempted to highlight. For example, one of the most well-known approaches for analysing the sequentiality of narrative is Labov's (1972) structural framework. Here, it is argued that most stories follow a chronological sequence that are made from a common set of elements and can be broken down into six potential clauses, each with a function. Although this model can provide a useful starting point for analysing the sequential nature of narrative,

many narratives do not fit well within this framework (Riessman, 1993). Labov's model has been criticised for lacking flexibility because of its dependence on distinct structural elements where many narratives are fractured or interrupted, and it provides little information about the actual story that is being told (Gwyn, 2002).

Other analytical approaches include the life story interview (McAdams, 1993) in which the participant is asked to reflect upon and then talk about their life as though it were a story, describing in detail each section. Crossley (2000) and McAdams (1993) provide methods for analysing such interviews which were considered too prescriptive for this thesis as they emphasise characteristics which were not a key focus within this research. Due to their emphasis on structure and other extraneous features dictated by the method, none was found to be appropriate to meet the research objectives. Therefore, a third objective was created to develop a narrative method to analyse the sequentiality of the content of a story from a participants' perspective. This was informed through the exploration of narrative theory and existing methods outlined above and aligned with an interpretive lens of a hermeneutic of restoration as part of an emergent pluralistic design. This is described in detail in Section 4.7.2.

3.5 Methodological rigour and trustworthiness

Qualitative research is an established approach to investigating phenomena relating to clinical and health care contexts. This is because it enables the investigation of complex and socially-situated health-care interventions, practitioner, patient or client experience, and the development of evidence-based clinical practice. This has led to a heightened focus on how to appropriately assess the quality of qualitative research. One of the key reasons for lack of agreement on this issue concerns the nature of evidence or knowledge produced by the research. Whilst concepts of validity and reliability are readily utilised within quantitative research to assess rigour, the different epistemological status of most qualitative research makes direct transferral of these criteria practically difficult or inappropriate (Walsh & Downe, 2006). Moreover, it contradicts the interpretive nature of narrative research which views knowledge as co-constructed and as understood and analysed in very diverse ways (Lieblich et al., 1998).

The issue of methodological rigour remains important in qualitative research however, and can be defined as the strength of the research design and

appropriateness of the method to answer the research questions (Morse et al., 2002). Lincoln & Guba (1985) frame rigour in qualitative research utilising a model based upon the concept of 'trustworthiness.' Trustworthiness refers to quality and authenticity of findings in qualitative research and the degree of confidence and trust readers can have in them (Cypress, 2017). Trustworthiness is viewed as a goal of the study, and as consisting of criteria from which the research can be judged during and after the study is conducted. These criteria consist of four key aspects, credibility, transferability, dependability and confirmability. Credibility concerns the extent to which the researcher's interpretations could be viewed as credible reflections of participants' views with conclusions that are directly linked to the data. Transferability refers to the degree to which findings are applicable to other contexts and dependability relates to transparency of the research design and the researcher's ability to follow a systematic research process. Confirmability is the extent to which the findings might be confirmed or corroborated by other researchers (Lincoln & Guba, 1985).

Attention to methodological rigour was given throughout all stages of the research process and are highlighted throughout Chapters 3 and 4 in relation to specific methodological phases. For example, strategies for establishing credibility highlighted by Lincoln and Guba (1985) included peer debriefing and consultation and the inclusion of a PPI (Patient and Public Involvement) group as detailed in Section 4.5. Dependability was supported by keeping an audit trail and methodological notes and reflections recording all aspects of planning, thinking, insights, decisions and activities. These detailed all methodological and analytical decisions and procedures as well as their rationale and are further described in Section 4.7.2. Dependability and confirmability were supported through a systematic and transparent development of the emerging research design assisted by regular consultations with the supervisory team. This included considerations of the relationship between the epistemology, methodology, methods and analysis to try to ensure congruence and consistency, which is considered an important feature of good quality research design (Carter & Little, 2007; Tong et al., 2007; Walsh & Downe, 2006). Whilst the aim within qualitative research is not to generalise findings, transferability, that is being able to apply findings from one context to another, can be aided by the researcher providing sufficient descriptive data to make such similarity judgments possible, and these are provided in Chapter 5.

Additional criteria suggested as pertinent to evaluating the quality of narrative research guided the process of developing a rigorous approach to the study. These included ensuring 'comprehensiveness of evidence' which refers to the quality of the interview, observations and interpretation of the analysis (Lieblich et al., 1998). This included observing and reflecting upon outliers and aspects to the stories which were less common, providing numerous quotations within the write-up for the reader's judgment of the evidence and its interpretation, as well as offering thick and detailed descriptions of participants experiences (Lieblich et al., 1998; Lincoln & Guba, 1985). Explicit ethical dimensions, a good quality literature review and researcher reflexivity to ensure authenticity and honesty are also noted as important criteria for evaluating qualitative research (Walsh & Downe, 2006) and are detailed in Sections 3.6 and 4.8.

3.6 Reflexivity

Reflexivity is described as that which draws attention to the complex relationship between processes of knowledge production, their contexts and the involvement of the researcher (Alvesson & Sköldberg, 2018). It requires reflecting critically on the self as researcher and as an instrument within the research process (Guba & Lincoln, 1981). It is the attempt to consciously experience oneself as both inquirer and learner, to deeply consider the research problem and the people who are engaged with, as well as coming to know oneself within the process of the research. A reflexive approach towards research requires an exploration of how aspects of self might be historically, socially or culturally situated and how research efforts might be shaped around them (Lincoln et al., 2018). Alvesson & Sköldberg (2018) frame the reflexive process as a form of liberation from a particular paradigm of thinking which they suggest can be achieved through working with plural frameworks and interpretations, challenging implicit assumptions and working imaginatively to create new ideas and theories.

Reflexivity within research from a position of the hermeneutics of restoration involves the researcher reflecting deeply upon how they are positioned to understand the meanings of participants. The researcher is expected to demonstrate their orientation with respect to the phenomena under study and their capacity to reflect upon their position (Josselson, 2004). For example, my position as a white female often interviewing within the context of a university environment

may have unconsciously influenced the kinds of people who wished to recruit to the study and shaped the kinds of responses and experiences discussed.

My personal interest in spirituality has been a key factor within this research process and will likely have influenced aspects of it. For example, my personal beliefs and ideas may have on some level affected my recruitment strategy, interview process, data analysis and write up to highlight particular kinds of stories or themes. It is important therefore to be transparent about the fact that I am personally deeply interested in the topic of spirituality and have been since a young adult. It is a topic which has been transformational and healing in my own life and within the lives of many friends, spiritual colleagues and service users I have known, witnessed and interacted with. I have been acutely aware of the marginalisation or omission of spirituality from many social and cultural contexts including healthcare and academia, and have sometimes felt frustrated or perplexed by this. My personal way of connecting with spirituality feels very organic to me. I do not identify with any one particular religion or spiritual belief but am respectful of them all and I have explored a large range of spiritual paths, practices, traditions and approaches including healing modalities. I view spirituality as something internal, intrinsic and natural to human nature even though it may be understood, expressed and practiced in a huge diversity of ways.

Another important factor about my positionality as a researcher is the consideration of the potential influence of my role or previous roles, which include my former experience working across multiple mental health contexts and within spiritual care. I found that generally this background experience supported the interview and analytical process. This was partly because in my previous role working within spiritual care in mental health, I had learned to work in an open-minded, recovery-focussed and person-centred way as far as possible, putting my own spiritual beliefs very much in the background and foregrounding the service users' personal beliefs. This provided what I think was important training for research in this field as I had the opportunity to listen to a large range of experiences within this topic and attempted to adopt a non-judgmental and curious stance towards differences in beliefs. My curiosity about this topic made me want to learn more about those experiences and beliefs that were different to my own, wanting to understand better how they made sense to the individual and their personal context. I found this learning and experience helpful within the interview and analytical process. I believe that it, along with my personal interest in spirituality, may also have helped me gain

rapport with participants as many seemed happy to open up and divulge sometimes very personal experiences.

Despite the potential benefit of this experience in relation to the research topic, it was important to remain reflexively vigilant, perhaps all the more so with topics I personally felt professionally and personally comfortable with or passionate about. It was therefore important throughout the research process to reflexively consider how my previous experiences, beliefs and pre-conceived ideas might be brought to the research including during the interview process, data analysis and write up. Such reflexive engagement was supported through documentation of my thoughts, feelings and initial reflections at each stage of the research process. For example, after each interview, I completed a document which included a section where I described my initial personal thoughts, feelings and impressions, attempting to be as honest as possible including any judgments or challenges I experienced within the interview. This process helped me to improve my interview technique, as I became more aware of what might be more or less helpful in facilitating conversation, such as the manner in which I asked a particular question.

Noting down these impressions reflexively made me more aware of my personal responses or reactions to the interviews. For example, some stories seemed easier to connect and interact with and listen to than others. One story, for example, did not have any ‘resolution’ and ended with the person expressing how lost they felt. I found this a difficult way to end the conversation and I observed myself searching to find something positive to say but this then felt quite superficial. I noticed at this point a clash between my previous role in spiritual care and the boundary of my researcher position limiting the degree of wellbeing support I was able to offer. Although the story provoked some discomfort within me, it operated as an important outlier in relation to other stories within the analysis and contributed towards some themes highlighting challenges in relation to spirituality, mental health and recovery.

I was also aware that, due to what I believe is my quite empathic and sensitive nature, this could be a double-edged sword in both helping me to deeply connect with participants’ meaning and perspectives, as well as potentially encountering the problem of over-identification with their stories. This is particularly pertinent within the hermeneutic of restoration in which the researcher must be scrupulous that the meanings discovered within participant accounts haven’t simply been substituted by their own (Josselson, 2004). I found that through becoming increasingly aware of

my reactions to the narrated stories, this supported my ability to be present with myself in relation to my feelings and responses, noting them and attempting to keep a watchful eye.

Reflexivity throughout the research process was underpinned through a reflexive diary as recommended by Lincoln & Guba (1985). The reflexive diary recorded my general personal reflections, thoughts, feelings, experiences, perspectives, understandings, poems, doodles, diagrams, and meaning making processes and struggles throughout the research journey. Within this form of documentation, I allowed myself to depart from the more usual modes of rational thinking to enable me to feel into what was happening for me as the 'human instrument' (Lincoln & Guba, 1985). I found this was particularly important considering the in-depth, sensitive, emotional and existential themes which the study was highlighting. This was amplified by the challenging context I sometimes found myself working within, including the Covid-19 pandemic and lock-downs. Sometimes this use of a reflexive diary provided an opportunity for catharsis (Lincoln & Guba, 1985), as did peer debriefing in which I could openly discuss both the academic component of conducting the research as well as associated emotional and personal experiences with research colleagues. This process aided reflexivity through being able to talk openly about my research experiences and receiving honest feedback and helpful reflections from those I shared with.

A term which felt pertinent to describe one way in which I felt impacted through the research journey, particularly within the Covid-19 pandemic and the interview and analysis stages, was 'epistemologically challenging.' This concerned themes of confusion, uncertainty and crisis of meaning which I sometimes experienced personally during the pandemic, and also observed within the stories I was analysing. For example, the theme of Meaning making in the context of spirituality and mental health sometimes felt difficult to interpret and analyse because of the abstract, nebulous, mystical and existential nature of this topic area. Multi-dimensional, liminal or anomalous experiences were highlighted within participant stories, which could be difficult to conceptualise or analyse. Both participants expressed and I experienced myself grappling with uncertainty and meaning making within this context, and within the analysis I was attempting to bring all of this into clarity in some kind of rational sense-making way. The spiritual dimension within these meaning-making experiences could render the topic challenging to talk about with others in a way which furthered understanding or resolution. At one point of

such grappling, the phrase came to mind: ‘It’s like trying to look at ghosts under the microscope.’ Although it did not solve the analytical problem, the metaphorical nature of this phrase spoke to the nebulousness of what I was attempting to analyse and struggling to grasp in logical coherent ways. It felt illuminating and validating to be able to articulate this feeling.

Although reflexivity is often documented in the research literature as something the researcher does by connecting with their subjective ideas and judgments, feelings and thoughts, I personally found that a combination of personal reflection and talking through with others was helpful. Peer debriefing, supervision and PPI input helped me to continue engaging with other perspectives and make transparent my own personal process and reflections. This is because I think, similar to a therapeutic process, talking with another can help to reveal assumptions, clarify understanding and personal psychospiritual and emotional processes, which may be difficult to illuminate only through personal reflection. In these different ways the reflexive processes throughout the research journey was often illuminating and taught me a great deal about myself as a person. The idea resonated with me strongly that reflexivity in research is seen not only as a process of discovery of the subject, but also a process of becoming and discovery of the self (Richardson, 2000).

Chapter 4: Methods and Procedure

Chapter 4 outlines the methods, procedures and narrative thematic analysis approach utilised to collect and analyse participants' narratives of their experiences of spirituality, mental health and recovery. Considerations regarding ethics, reflexivity and rigour during this stage of the research project are also highlighted.

4.1 Sampling

A purposive sampling method was used to recruit participants which aims to select people based upon particular characteristics of interest, such as attributes and knowledge relevant to the topic being investigated (Denscombe, 2010). The characteristics for this study were adults with past or present experiences of both spirituality and mental health difficulties. Both concepts were self-defined, that is, based upon an individual determining whether they related to such experiences. It was clarified that spiritual experiences could include religious, non-religious spirituality or combinations of these.

A total of 30 participants were recruited for the study, a number deemed congruent in research studies achieving substantive narrative-based information. As such, determining adequate sample size in qualitative research is ultimately a matter of judgment related to the research question, methods and intended research product (Sandelowski, 1995). The decision to recruit 30 participants, was based on expectations for substantial data collection and pragmatic considerations in terms of the feasibility of meeting the research objectives as agreed with the supervisory team. Although generalisable findings are not an aim of this study, the substantial sample size supports the critical realist-informed research objective to highlight important themes and patterns across a number of diverse stories and to produce transferable knowledge which might impact upon clinical practice and mental health contexts.

4.2 Eligibility Criteria

Adult participants were recruited who were 18 years of age or older. Full inclusion and exclusion criteria are shown in Table 4.1 below. Eligibility criteria included participants being willing and capable of talking about their own experiences of mental health difficulties and spirituality, however these concepts made sense to

them or were self-defined. Participants were excluded if there was any uncertainty about whether sharing their story may detrimentally impact their wellbeing. This was determined by providing clear information about the research, clarifying any risks of participating in the study and ascertaining whether this was a suitable time for the person to share their story. My own experience working in mental health helped to contribute towards this process and making an ethical judgement about eligibility.

Table 4.1 Study eligibility criteria

Study Eligibility Criteria
Inclusion criteria • Aged 18 or over at the time of recruitment with no upper age limit. • Current or previous experience of mental health difficulties, as defined by the participant (which may or may not include a mental health diagnosis). • Current or previous personal experiences of religion or spirituality, as defined by the individual. • Capable of giving informed consent. • Willing to attend an audio-recorded interview and share their story and experiences. • Able to understand and speak English.
Exclusion criteria • Currently experiencing a significant period of feeling unwell or mental health difficulty. • Currently having an in-patient admission or under the care of crisis services.

4.3 Recruitment

Participants were recruited from the general public and community settings rather than from the NHS. This was primarily for ethical reasons due to the potential sensitivity and personal nature of the topics in question of both mental health difficulty and spirituality. Additionally, because a key eligibility criteria was that

people should feel stable and well enough to share their story without detrimental effects to their wellbeing. The study was advertised through mental health, spirituality and general community networks and settings. Initial communications had been made with various groups, networks and organisations and links/gatekeepers who had agreed to assist with recruitment where possible. The sources of participant recruitment included religious and spiritual buildings, centres, groups and communities including the university chaplaincy service, and local holistic wellbeing centres. Additionally, local mental health groups, steering groups and organisations, community centres and local Black and Minority Ethnic (BME) groups and organisations. Targeted promotion was used with printed or electronic posters (see Appendix 4) or short articles/adverts in two local universities, local PPI groups, local newsletters and in general local areas including community centres, cafes, libraries, leisure centres and book shops. Participants were also recruited through some talks and presentations I gave about the research at several local events or groups. Snowball sampling was also used by asking participants if they would consent to take a research poster and inform other relevant people about the research.

4.4 Data Collection: Narrative Interview

This study used open style narrative interviews which are commonly used in narrative research. Narrative interviews obtain detailed and in-depth data of people's personal experiences, beliefs, ideas and stories which are meaningful and important to them. This requires the researcher to follow participants' personal streams of expression, encouraging them to speak in their own ways and construct answers that make sense to them (Riessman, 2008). In alignment with a hermeneutic of restoration approach, narrative interviews are sometimes described as empowering methods of data collection, allowing participants to direct the data to express their feelings and choose what is important (Pinnegar & Daynes, 2006).

Within the interviews, a narrative-based interview schedule was created (see Appendix 5) with open-ended questions used to guide, and provide structure and focus around the research objectives, and to clarify and uncover personal meanings around key concepts. These asked about what spirituality means to the participant, how they use spirituality to make sense of their lives and their experiences of mental health difficulties, and how this might have changed over time. The concluding question invited participants to add anything else they wished to say and to reflect

upon the process of sharing their story. Additional prompt questions were included to draw out further rich and meaningful data. Participants were told the interview would last approximately an hour to an hour and a half depending on how much time they wished to speak for.

During the course of the interview, care was taken to be emotionally attentive and engaged in the conversation, minimising interruptions to facilitate extended talk from the participant (Donovan & Sanders, 2005; Riessman, 2008). This was to create an atmosphere of trust and openness and help prevent overly directing or influencing the types of responses given. Interview skills were utilised such as deep listening, use of open and attentive body-language, gestures and verbalisations to support and encourage the participant where appropriate (Mason, 2002). Additionally, adopting a respectful, patient and sensitive approach seemed to support participants in exploring memories and deeper understandings of their experiences (Polkinghorne, 2007).

The interview method is heavily dependent on people's ability to verbalise, interact, conceptualise and remember, and the knowledge that is gained is situational, that is subject to the social and contextual factors present during the specific interview scenario (Mason, 2002). Polkinghorne (2007) points out however that the researcher's primary aim is not to ascertain if the participant's accounts are accurate reflections of actual events but to understand the meaning they attach to them. However it is important within narrative research to remain mindful that words are not always sufficient to communicate meaning, that narrators are selective in the stories they express, and that the context and audience shape which ones are narrated.

4.5 Patient and Public Involvement

Patient and Public Involvement (PPI) has been increasingly emphasised within clinical research and generally refers to the active and direct participation of patients, service users and other groups with relevant expertise or personal experience within the design, undertaking or evaluation in research. Utilising PPI is particularly pertinent to interpretive approaches towards health research, which value the exploration of personal experience to inform service development (Morrow et al., 2012). PPI is viewed as beneficial to research because if the perspectives, ideas and needs of people involved can be reflected within the

research it may be more likely to produce results which could improve clinical practice (Department of Health, 2000).

There are however potential challenges of PPI such as the need to exercise caution around the potential to view ideas from one person or a few people as representative of a whole group. Additionally, there is the possibility of people within PPI groups feeling disempowered or being utilised in a tokenistic way (Stickley, 2006; Trivedi, 2001). Attempts were made to address these issues by exploring literature and training around effective PPI within research, and obtaining guidance from PPI leads and representatives within the university.

One of the issues I faced in setting up a PPI group was not being able to pay PPI members. Although a lack of funding for these purposes is not unusual for PhD research projects, I agree with authors and researchers such as Trivedi & Wykes (2002) that ideally PPI members should be paid for their time. This issue was addressed though a pragmatic approach of keeping the group small, involvement and time minimal, and inviting people to volunteer within circles I had connection with including former colleagues and existing PPI members within the University. Although this could potentially limit the diversity of perspectives, it did create the advantage of people generally feeling comfortable in the group and membership being less demanding of time.

The PPI group was set up to provide insights from people who currently have or in the past had lived experience of mental health difficulties and different spiritual and/or religious beliefs. In addition, some PPI members were selected to represent expertise from clinical or healthcare settings to offer insights about potential applications to practice (Barrett & Oborn, 2018). Clear information and guidelines were created for PPI group members (see Appendix 6), highlighting the voluntary nature of the involvement. I also clarified that the level of involvement was not as a participant or collaborator as within some research projects. I outlined that the type of involvement required was at the level of consultation (Morrow et al., 2012) and that all views and ideas would be respected although I could not say if or how they would influence the research.

In order to optimise effectiveness of the PPI process and avoid tokenism, I attempted to fully engage with all comments and feedback from all members, making notes of and reflecting upon all ideas, especially if they differed or clashed

with my own. In addition, PPI meetings were set up (prior to the Covid-19 pandemic) to encourage ideas and reflections that emerged from discussion amongst PPI members. An ethos of respect for different views was set up within a group agreement to encourage open and honest discussion. The PPI group met in-person four times prior to the Covid-19 pandemic. The meeting place was a relaxed public café space on the university premises. There were some additional communications of feedback via email, and one-to-one meetings for interview piloting. From the Covid-19 pandemic onwards, all communication with PPI members was made over the phone or via email.

PPI input was helpful as it enabled discussions about the research in addition to the supervisory team from a range of experiential and practitioner perspectives. They provided useful feedback and suggestions on specific aspects of the research process such as recruitment and clarifying wording for the research posters, participant information sheet and interview protocol. Some members also offered support with piloting two interviews so I could practice interview skills and gauge feedback about my skills as an interviewer. PPI members also provided feedback on both MISTIC study findings and outputs, including the toolkit resource, as well as narrative study findings, themes and coding frameworks. Although there were few questioning or critical comments in relation to the findings of the research, feedback informed latter stages of the analytical process, finalisation of coding frameworks, researcher reflexivity and reflections within the Discussion in Chapter 9, including applications to practice.

During the period of the Covid-19 pandemic, formal PPI meetings were discontinued because few members wished to meet online and there was less need for PPI input during this time of transcribing and initial analysis. As I started engagement with the analytical process, I organised ongoing phone meetings with one member who was a mental health clinician and also had knowledge and interest in spirituality. We had on-going discussions throughout the rest of the research project, which provided support and helped to clarify my thinking, as well as bringing a clinical perspective to the emerging findings. I documented the feedback and reflections which arose from these discussions as part of the reflexive research process.

4.6 Procedures

A poster or advert (see Appendix 4) was emailed to or displayed at the organisations, groups, and other relevant target locations outlined in Section 4.3, or sent to identified gatekeepers for use when inviting people to take part in the study. People who expressed an interest were given a copy of the participant information sheet (PIS) (see Appendix 7) either by email or in person, depending on how they were recruited. They were asked to take time to read this and consider it carefully before agreeing to take part in the study. The PIS provided clear information about the research, including details about eligibility criteria and any risks of taking part, for example that sharing personal stories can be distressing may and bring up emotions and difficulties. This was to encourage careful consideration about whether to take part and to ensure people felt well enough and happy to share stories containing potentially personal and sensitive information. Potentially interested participants were encouraged to ask questions about the research.

After reading the PIS, if someone made contact and expressed an interest in taking part in the research, eligibility was checked and key points of the PIS were highlighted, such as making sure potential participants were aware they could withdraw from the research at any time. Eligible participants were then invited to an interview at a time, date and venue that was convenient and comfortable for them. In line with considerations of safety, confidentiality and risk, interviews were conducted in public, quiet and private locations and not in participant homes. Most participants were happy to meet at private university interview room spaces. A minority of interviews took place at a local community centre, church or health centre. In these instances someone else was also present at the space, such as the gatekeeper or a receptionist, who knew the interview was taking place. No payment was provided for the interview, but a reimbursement of travel expenses was offered.

Prior to the interview, the room was set up to attempt to create a comfortable space for the participant. At the start of the meeting the key points of the PIS were clarified once again to ensure understanding and check wellbeing at that time. Participants were encouraged to ask questions, and were asked if they had any particular needs or timing requests in relation to the interview process. Participants were then given a consent form (see Appendix 8) to read and sign before commencing the interview and the key points on the form were explained. Participants were also asked to fill in a demographic information form (see Appendix 9) but it was explained that it was

entirely voluntary what information they chose to provide. Information requested on this form was kept minimal and only most relevant, such as age, ethnicity and gender. It also asked people to describe mental health difficulties and their religious or spiritual beliefs or affiliations in their own words. The narrative interview was then conducted, using the interview schedule (Appendix 5).

Reflections and observations were documented immediately after the interview, including immediate impressions, reflections about the interview process, and initial ideas about key themes and observations about the story that had been shared. The audio recording was immediately transferred onto the university computer and deleted from the audio-recorder. Data was kept secure, anonymous and stored in accordance with the Data Protection Act (1998; 2018).

4.7 Analysis

Data analysis in qualitative research involves the process of systematically searching, arranging and bringing order and meaning to the collected data to increase understanding of the phenomenon or topic being researched (Wong, 2008). This process predominantly involves coding or categorising the data, pursuing the relationship between categories and themes, identifying significant patterns and drawing meaning from the data (Patton, 2002).

Narrative analysis emphasises content and its meanings, which are sometimes revealed in structural forms (Josselson, 2011). Participants co-construct and negotiate the meaning of their stories with the researcher, both learning and changing from the encounter (Pinnegar & Daynes, 2006). Therefore the resulting story is not mimetic, that is, it is not understood to be an exact representation of what happened, but one particular construction of events, created for a particular setting, audience and purpose at a particular point in time (Mishler, 2004). Narrative analysis does not regard a person as fixed in any representation of their words and because there is no single self-representation, narrative analysis cannot claim any finality as to what a story means (Bakhtin, 1986; Josselson, 2011).

The emergent and pluralistic analytical approach developed for this research was based on narrative thematic analysis (Riessman, 2008). This is because the primary focus of narrative thematic analysis is on the events, experiences, content and themes within participant stories and what is said by the narrators of the story,

rather than how it is said, to whom or for what purpose. Narrative thematic analysis is suited to many kinds of data and may include identifying common thematic elements and theorising across research participants whilst preserving the narrative features of their stories. Whilst sharing similarities with other analytical approaches such as grounded theory, narrative thematic analysis differs in relation to the place of prior concepts or theories which may guide narrative enquiry whilst allowing novel theoretical insights from the data (Riessman, 2008). Narrative thematic analysis endeavours to preserve the sequence of a story and attempts to understand the themes in relation to one another as a dynamic whole, rather than fragmenting it into disparate units (Josselson, 2011). In addition, thematic approaches are well suited to providing a broad overview or cross-case analysis of the data set (Shukla et al., 2014). Therefore this method was deemed to suit the study objectives, which sought both rich in-depth data situated within the specific context of an individual's story, as well as potential patterns of themes which might be illuminated across the data set.

Narrative analysis generally focuses on patterned relationships within the flow and sequence of narrated events and experiences. The process of analysis involves piecing together data, deciding what is significant and salient within the data, and connecting facets of experience together (Josselson, 2011). In this way, it lends itself to the depth of analysis aimed at within a critical realist approach of exploring potential underlying patterns which may have important effects on experience. Texts are read multiple times, and within the interpretive context of a hermeneutic of restoration and the hermeneutic circle, considers how the whole story illuminates the parts, and how the parts in turn offer a fuller more complex picture of the whole. After each participant's story is understood as well as possible, including noting of contradictions and ambiguities, cross-case analysis can be performed to illuminate patterns across individual stories including potential differences between experiences (Josselson, 2011).

Narrative analysis is a creative process of organising data so that an analytic scheme will emerge, and there is no dogma or orthodoxy about how to conduct it. This creativity and openness of approach was a key factor in choosing this methodology within an emergent design. However, the lack of clearly described narrative methods which related to the research objectives resulted in the need to develop a suitable emergent method. This challenge was addressed by carefully developing an emergent and staged approach towards the narrative analysis based

on narrative theory, narrative thematic analysis and the interpretive lens of a hermeneutic of restoration. This approach was also informed by the Holistic-content narrative method of Lieblich et al. (1998). These authors attempt to address the criticism of narrative methodology as defying clear order and systematization, by highlighting strategies and the development of techniques that could be employed in relevant studies. They suggest that such clear exposition of processes and providing a coherent rationale for choice of methods can add to the rigour, credibility and trustworthiness of the research.

The Holistic-content narrative method (Lieblich et al., 1998) was also chosen to inform the initial stages of the emergent method of narrative analysis because it focusses on the content of the story as a whole rather than other aspects, such as the story's form or development into categories. The Holistic-content method also aims to highlight the standpoint of the participant and therefore aligns well with a hermeneutic of restoration (Josselson, 2004). Further details of the Holistic-content method and how it was integrated into the emergent method of narrative analysis which comprised of three principle stages, are detailed in Section 4.7.2 and Table 4.3 below. Initial preparatory stages of analysis are first outlined below.

4.7.1 Preparatory stages of analysis

The analytical process begins during the phase of conducting, reflecting upon and transcribing interviews. Therefore the stages described within this section are considered as preparatory, before conducting the formal analytical method. In addition, a short pilot analysis was undertaken at this stage to explore potential analytical methods and assess the suitability of NVivo (Version 12), a computer-assisted qualitative data-analysis software programme, for the data analysis.

Throughout the analytical process, attention was paid to methodological rigour, credibility, transparency, trustworthiness as well as endeavouring to adopt a reflexive and ethical approach within each stage. Specific examples of these are described below.

4.7.1.1 Post-interview initial observations and reflections

Making notes immediately following an interview is a recommendation made across qualitative research literature, including within narrative analysis which encourages deep reflective interpretive work to engage with and uncover rich data. The on-going

documentation of field notes, memos and reflections is also recommended by Lincoln & Guba (1985) to contribute towards rigor of the research and supports researcher transparency about their positionality and influence in the analysis of the data. Notes about the interview were part of both the analytical and reflexive process of observing myself as an interviewer and how I experienced and evaluated the interview. To this end, I completed a document termed 'Post-Interview report and reflections' straight after every interview was conducted. The report included personal reflections, any pertinent information about the participant's body language or gestures and initial impressions about themes observed at the time.

Although these reports provided a general first impression rather than formal analysis, they were useful in starting to cultivate ideas, an overall sense of the story, and developing skills in reflexivity by attempting to be honest about my personal impressions and judgments about the interview. As I gained further interview experience, I developed better understanding of their co-constructive nature and learned to more quickly and appropriately respond to any challenging moments. The interview reports and reflections were also useful to refer to during later analytical stages, for example to check for consistency with later analytical findings.

4.7.1.2 Transcribing

In its basic form, transcription is a rendering of oral to written mode of discourse. It is an interpretive and an initial analytical process underpinned by decisions and judgments based on theoretical and methodological goals (Brinkmann & Kvale, 1999; Davidson et al., 2009). Transcription involves a transparently selective process which renders the transcript more useful as extraneous information can be difficult to read and may obscure the research purpose (Davidson et al., 2009). Because the process of transcription often proceeds in tandem with the progression of the analytical process (Mondada, 2007), it is subject to a continual process of revision (Coates & Thornborrow, 1999; Davidson et al., 2009). Specific decisions about transcribing did change slightly within the study but these were documented so that any developments would be included as a part of a transparent process that adheres to a reflexive and rigorous approach towards interview transcribing.

In the first stage of the transcribing process, six of the thirty interviews were transcribed by myself, verbatim, and by including a greater level of detail than was required during later stages. Researchers who transcribe their own interviews can

learn about their own interviewing style and begin immersion within the data analysis (Brinkmann & Kvale, 1999), which I experienced during this process.

The practice of adding emotional content notations to transcripts is common practice amongst transcriptionists (Gregory et al., 1997). Although they can assist in understanding better the content of interviews, MacLean et al. (2004) argue that these notations should be used cautiously to avoid providing an additional level of interpretation to the content. Notating some salient emotional content was used in the transcripts to assist the research aims of exploring personal meaning.

The remaining twenty-four of the thirty interviews were transcribed by a professional transcribing service endorsed by the university. The transcribing service omitted some of the details I had previously included such as vocalisations, response tokens (e.g. 'Hm', 'Erm', 'Mm'), and what were interpreted to be significant emotion, tone and pauses. The issue of some discrepancy of transcribing style was addressed through my checking in detail each transcript whilst listening carefully to the audio recordings and adding in some of these additional features. However, as the transcribing process progressed, some of these details were deemed to be less necessary than previously considered. Checking the transcripts was also a good way to ascertain the quality and trustworthiness of the transcribing service as suggested by Poland (1995). Additional ways of adding to the rigour within transcribing was to keep a detailed audit trail of both process notes and methodological steps including reflections and reasons for the decisions made (Lincoln & Guba, 1985).

In relation to ethical, confidentiality and anonymity considerations, steps were taken to ensure the data were transferred and stored by the transcriber in a secure way. Any names of people, places and other identifying information which might compromise someone's anonymity were changed in the finalised transcript. Pseudonyms, description titles or generic descriptions replaced names and places.

4.7.1.3 Piloting analytical methods using NVivo

An assessed module assignment undertaken during my PhD, 'Advanced Qualitative Data Analysis (using NVivo)', was utilised to pilot and assess suitability of the analysis of two research transcripts using NVivo, a computer-assisted qualitative data-analysis software programme. NVivo can support qualitative analysis by helping to manage data and ideas, and it has been found to improve the efficiency

and transparency of research (Hoover & Koerber, 2011). However, some authors highlight issues about using programmes such as NVivo uncritically and concerns have been prompted that these tools can influence qualitative research in undesirable ways, for example by imposing methodological restrictions around research activities (Maher et al., 2018; Woods et al., 2016).

A pilot analysis was conducted on two transcripts using both manual methods and NVivo software so that they could be compared. This approach of combining manual and NVivo methods was informed by studies by Welsh (2002) and Maher et al. (2018). They suggest manual methods may include materials such as coloured pens, sticky notes and display boards which allow the researcher to engage with the material on a variety of levels, visualising larger scale maps of relations and gaining micro- and macro- views of the data over a period of time.

Coding was conducted initially using a manual colour-coding system. The transcripts were then imported into NVivo and nodes were creating based on the manual coding. The use of NVivo supported the systematic categorisation of segments of texts into nodes and node trees. However, similarly to the findings of Maher et al. (2018), it was found that NVivo did not fully scaffold the analytical process. This is because data interaction was limited by the software design and dependency of viewing data through a screen which constrained the learning and interpretive process. This issue could have been related to the narrative methodological approach used, since NVivo may be better suited towards certain research designs and methods. These include grounded theory, phenomenology, and thematic analysis which focus on segmenting sections into separate themes (Zamawe, 2015). It may be less well suited to narrative analysis which attempts to understand the themes in relation to another as a dynamic whole (Josselson, 2011).

The manual methods utilised however, such as using colour-coding and mind maps were found to be supportive of reflective thinking and analytical processes. It was decided to therefore continue utilising them within the main research study. They seemed to support the relational, visual and kinaesthetic forms of learning that would be pertinent for in-depth analysis, contextualisation and reflection upon rich multi-layered stories (Maher et al., 2018).

4.7.2 Conducting narrative analysis: Narrative thematic and sequential analysis

The narrative analysis, termed ‘Narrative thematic and sequential analysis’ that was developed for the specific research objectives consisted of three main stages. Firstly, a preliminary overview of the data to gauge initial impressions and observations; secondly a systematic and detailed analysis engaging with the data on an individual and predominantly descriptive basis, and thirdly a more interpretive and integrated stage of creating coding frameworks and exploring patterns across stories. These stages are summarised in Table 4.2.

Table 4.2 Narrative thematic and sequential analysis stages

Analysis stage
Stage 1: Preliminary 1.1 Initial post-transcribing observations and reflections 1.2 Narrative thematic analysis stage 1 1.3 Sequential analysis stage 1
Stage 2: Descriptive 2.1 Creation of Story map 2.2 Narrative thematic analysis stage 2 2.3 Sequential analysis stage 2 2.4 Ensuring rigour during stage 2
Stage 3: Integrative 3.1 Creation and analysis of narrative summaries 3.2 Creation of Analytical mind map 3.3 Sequential analysis stage 3 3.4 Narrative thematic analysis stage 3: Development of initial coding frameworks and coding across stories

3.5 Theme development and write-up

3.6 Ensuring rigor during stage 3

Whilst the Narrative thematic and sequential analysis was constructed specifically for the narrative study objectives, based broadly upon narrative thematic analysis, it was guided by a protocol suggested by Lieblich et al. (1998). Table 4.3 below provides a summary of their analytical stages and how these corresponded to the first two stages (Preliminary and Descriptive) of the Narrative thematic and sequential analysis. Stage 3 (Integrative) departed from The Holistic-content analysis model through the development of methods that highlighted the integration of themes across stories.

Table 4.3 Stages of Narrative Holistic-content analysis (Adapted from Lieblich et al., 1998, p. 62–63)

Holistic-content analysis stage and description	Corresponds to Narrative thematic and sequential analysis stage
1. Read material several times until patterns emerge. Read or listen carefully, empathically, and with an open mind. Believe in your ability to detect the meaning of the text, and it will "speak" to you. There are no clear directions for this stage. Notice the parts of the story to which you might want to pay special attention, depending on the whole story and its context, and how you might evaluate the story.	Stage 1
2. Put your initial and global impression of the story into writing. Note exceptions to the general impression as well as unusual features e.g. contradictions. Note also disturbing or disharmonious features of the story.	Stage 1
3. Decide on special foci of content or themes that you are choosing to follow in the story as it evolves from beginning to end. A special focus is frequently distinguished by the space devoted to the theme in the text, it's repetitive nature, and the number of details the teller provides about it. However, omissions or brief references to a subject can also sometimes be indicative of focal significance.	Stage 1 & 2
4. Using coloured markers, mark the various themes in the story, reading separately and repeatedly for each one.	Stage 2
5. Keep track of your results in several ways: Follow each theme throughout the story and note your conclusions. Be aware of any transitions between themes, the context for each one and their relative salience in the text. Pay special attention to episodes that seem to contradict the theme in terms of content, mood or evaluation by the teller.	Stage 2

Stage 1: Preliminary analysis

After transcription had been completed, all transcripts were thoroughly checked for accuracy. This was accomplished by listening through each audio recording slowly and carefully whilst reading through each transcript and amending any errors or omissions. The first stage of analysis was then completed using a structured document called 'Initial post-transcribing analysis' which was divided into sub-headings to guide and systematise this process for each transcript. This was used to document the following steps; initial general observations and reflections, narrative thematic analysis stage 1 and sequential analysis stage 1 which are described below.

1.1 Initial post-transcribing observations and reflections

The first stage of the narrative analysis was informed by and corresponds to stages 1- 2 of Lieblich et al.'s (1998, p. 62) Holistic-content analysis as described in Table 4.3 above. Their suggestions were followed which included reading the transcripts carefully and repeatedly until patterns emerge. An empathic and open-minded approach was adopted in relation to engaging with the data, which aligned with the hermeneutic of restoration research focus. Initial and global impressions of the story were included under a sub-heading 'General observations and reflections'. This also included exceptions, unusual features and contradictions as well as other general reflections about the story.

1.2 Narrative thematic analysis stage 1

A narrative theme is described as a recurrent pattern of human interaction which describes the level of story concerned with what the characters in the narrative want and how they pursue their objectives over time (McAdams, 1993). Within stage 3 of their Holistic-content analysis (see Table 4.3) Lieblich et al. (1998) suggest looking at specific foci or themes that the researcher chooses to follow as the story evolves from beginning to end. Themes may be distinguished by their repetitive nature, the space devoted to them in the text and details provided about them. However omissions of such information or brief references can indicate significance of a topic. Using this approach, initial impressions were noted down of any broad, general or striking themes. This process was conducted inductively, attempting to hold lightly prior knowledge of the MISTIC framework and other theories related to this topic so that they were not unduly influencing the analytical process.

1.3 Sequential analysis stage 1

As outlined in Section 3.4.2, as part of the emergent design, a method was developed which aimed to elucidate the narrated sequentiality of the story, and potential psychospiritual development experiences in relation to mental health and recovery. This was termed ‘Sequential analysis’ which focusses upon narrated content of stories within a hermeneutic of restoration approach. Some aspects of this method were informed by ‘Narrative thematic analysis stage 1’ and the stages described by Lieblich et al. (1998). It was distinctive in the way in which the data was organised which supported the analysis of progression of themes, story and development over time. The first stage of the sequential analysis involved dividing the story into segments using narrated time duration, turning points and developmental stages as indications. Psychospiritual and emotional turning points and stages were included within this process as well as age change and distinct temporal shifts in the story, such as discussing a later ‘chapter’ in life. Meeting particular people or changes in spiritual beliefs were examples of potential turning points. The ‘Sequential analysis stage 1’ was an initial rough map of numbered stages to give an idea of the key stages of the story and how the story progressed.

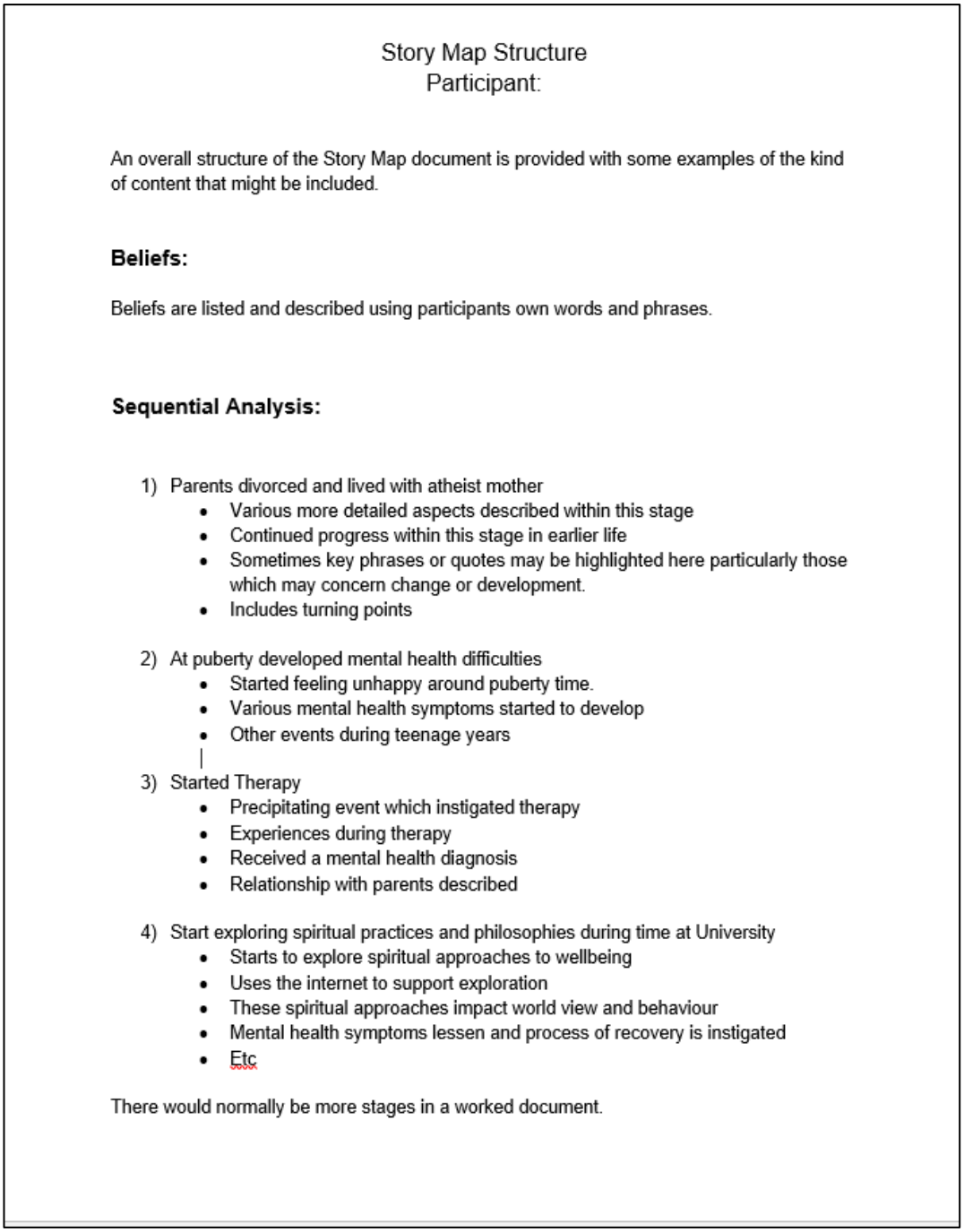
Stage 2: Descriptive

Whilst the first stage of analysis was a general initial impression and reflection of each story, its sequence and key themes, the second stage of the Narrative thematic and sequential analysis was descriptive, in-depth and systematic. It aimed to gain a thorough picture of the story, its sequence and salient themes. This involved paying close attention to the detail of what was being said including the specific wording the person used within their own forms of expression. The distinct aspects developed within this stage of analysis was the creation of a ‘Story map’ document to organise and structure the analysis for each story, and the development of the sequential analysis, as described below.

2.1 Creation of Story map

The Story maps were consistently structured to organise and systematise the analysis and to provide useful summaries of findings for each participant. They provided comprehensive central reference points for this and subsequent stages of analysis and included transcript page numbers to cross-reference themes and quotes if further detail was required. The Story map was informed by the Stage 1

document ‘Initial post-transcribing analysis’ but went into greater depth and detail in relation to documenting the 2nd stage Narrative thematic and sequential analysis findings as described below. The Story map documents also included information about participants’ beliefs as narrated within their stories, and a summarising section of key themes or quotes. An example of a Story map structure with some examples of content is shown in Figure 4.1 below. Because Story maps contained rich detailed information about participants an actual example was not included to protect participant confidentiality.



Story Map Structure
Participant:

An overall structure of the Story Map document is provided with some examples of the kind of content that might be included.

Beliefs:

Beliefs are listed and described using participants own words and phrases.

Sequential Analysis:

1) Parents divorced and lived with atheist mother
   - Various more detailed aspects described within this stage
   - Continued progress within this stage in earlier life
   - Sometimes key phrases or quotes may be highlighted here particularly those which may concern change or development.
   - Includes turning points

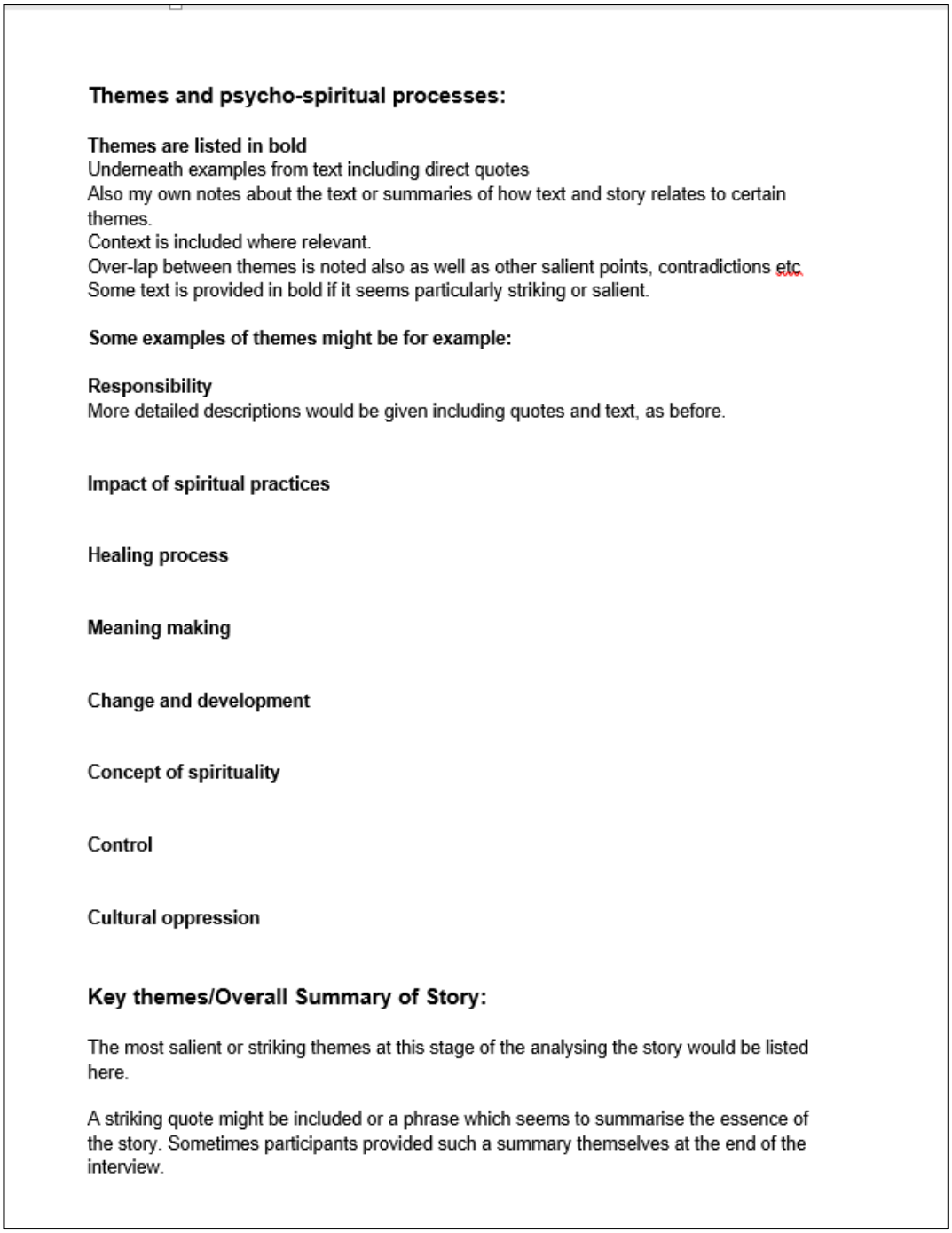
2) At puberty developed mental health difficulties
   - Started feeling unhappy around puberty time.
   - Various mental health symptoms started to develop
   - Other events during teenage years

3) Started Therapy
   - Precipitating event which instigated therapy
   - Experiences during therapy
   - Received a mental health diagnosis
   - Relationship with parents described

4) Start exploring spiritual practices and philosophies during time at University
   - Starts to explore spiritual approaches to wellbeing
   - Uses the internet to support exploration
   - These spiritual approaches impact world view and behaviour
   - Mental health symptoms lessen and process of recovery is instigated
   - Etc

There would normally be more stages in a worked document.

Figure 4.1 Story Map structure and some examples of content page 1



Themes and psycho-spiritual processes:

Themes are listed in bold
Underneath examples from text including direct quotes
Also my own notes about the text or summaries of how text and story relates to certain themes.
Context is included where relevant.
Over-lap between themes is noted also as well as other salient points, contradictions etc
Some text is provided in bold if it seems particularly striking or salient.

Some examples of themes might be for example:

Responsibility
More detailed descriptions would be given including quotes and text, as before.

Impact of spiritual practices

Healing process

Meaning making

Change and development

Concept of spirituality

Control

Cultural oppression

Key themes/Overall Summary of Story:

The most salient or striking themes at this stage of the analysing the story would be listed here.

A striking quote might be included or a phrase which seems to summarise the essence of the story. Sometimes participants provided such a summary themselves at the end of the interview.

Figure 4.1 Story Map structure and some examples of content page 2

2.2 Narrative thematic analysis stage 2

This stage of the narrative thematic analysis was characterised by immersion in the data and informed by stages 3 – 5 of Lieblich et al.'s (1998) Holistic-content analysis (see Table 4.3). Here decisions were made about themes and foci of the story,

using coloured markers to highlight various themes, reading separately and repeatedly for each one and by noting down conclusions about them. Working iteratively across each story transcript, attention was paid to the wider context and nuances of each theme, its relative salience and repetition within the text, as well as episodes which seemed to contradict the themes. As outlined in Section 4.7.1.3 the analysis was conducted manually by interacting with the data in paper form, making notes in the margins and using the coloured pens as suggested in stage 4 of Lieblich et al.'s (1998) Holistic-content analysis. Ideas and reflections were noted in the margins and a colour-coding scheme was used for each story to identify different codes and potential themes and to underline segments of text relating to those.

Within the Story map document, themes were also listed alongside what was termed 'Psycho-spiritual processes'. This term refers to potential dynamic or causal processes which related to people's narrated psychospiritual experiences. These might have a dynamic or temporal nature and were of particular interest, both in relation to the psychospiritual lens of this research, as well as the critical realist interest in potential underlying processes and mechanisms within people's narrated experiences.

2.3 Sequential analysis stage 2

Utilising the Initial post-transcribing analysis document which marked out initial overall impressions of story sequence, the transcripts were worked through to analyse the sequences more systematically and in greater detail. Attention was paid to turning points, described changes in the person's experience, emotions, psychology and spirituality, as well as external events and characters who entered and left the story. Text within the transcript was marked and numbered to corresponded with a potential narrated chronological stage. Although the stories were not all told clearly chronologically, for most stories there were quite clear demarcations of stages. For the few stories which were more chaotic or where the chronology was not completely clear, an overall sense of the story and the way it was told was used to interpret the chronological sequence.

Distinct stages of the story were then numbered and documented within the Story Map. Each stage was given a descriptive name which corresponded to occurrences within that particular phase of the story. This allowed for a chronological narrative

overview of the progression of the story including potential story trajectory and developmental themes. Each stage was then amplified using bullet points to describe further details of events or experiences within that particular stage of the story, as shown in Figure 4.1. As far as possible participants' wording, phrasing and imagery were used to name the stages and chronological steps within them, noting any particularly striking uses of language. Aspects within the story were also highlighted which denoted change or progression within that stage and included details about described feelings and the tone of the experience.

2.4 Ensuring rigor during stage 2

To support the rigour and trustworthiness of the research, documents were created to detail a clear and regularly updated audit trail, research and methodology notes and personal reflections about the analytical process. Dated entries were made detailing specific methodological actions taken, decisions made and their rationale.

Within this descriptive stage of analysis it was an important consideration in relation to rigour and trustworthiness to utilise participants' wording and descriptions as closely as possible within the Story map document. Within the documentation of the analysis I distinguished between what was in the participants' own words and what might be my own interpretation or re-phrasing. This process was supported by careful and slow reading of the text and re-reading any more complex or confusingly articulated segments, as well as consideration of the whole story and contextual factors to support a rigorous interpretive process.

Stage 3: Integrative

The third stage of the Narrative thematic and sequential analysis utilised all the documents created in previous analytical stages, though focussed primarily on the participant Story maps. Whilst earlier stages of analysis were more descriptive, paying close attention to the details of how participants described their experiences, the third stage of narrative analysis was more interpretive and integrative, synthesising ideas and themes across documents for each participant, as well as exploring salient patterns across stories.

Decisions were required at this stage about what to highlight and what to leave out within the finalisation of coding frameworks. This was informed by the hermeneutic of restoration approach to remain close to the data and the participants' own

experiences. It also involved the hermeneutic analytical process of moving back and forth between the whole data set and an individual story or part of the story. In addition, the psychospiritual and critical realist focus highlighted interest in psychospiritual processes, which might indicate potential underlying causal mechanisms. The critical realist focus also highlights interest in real-world applications of findings to potentially influence change and benefit. This informed questions asked within this stage of data analysis in relation to clinical and mental health practice contexts. These included 'What would be helpful to better understand about this topic area within clinical/mental health contexts?' and 'What aspects are less well understood and require more detailed illumination and nuance within clinically applicable research?' (see Figure 4.2).

3.1 Creation and analysis of narrative summaries

The third stage of analysis began with the creation of narrative summaries. Murray (2003) proposes that such summaries of the overall stories can identify key features in which the research is interested. By then reading across the summaries it is possible to get an idea of the main themes and to develop a coding framework which could be applied across the group of narratives, capturing both their overall meaning and the specific issues raised in each. These narrative summaries were also created to identify key focal points, striking phrases or imagery which framed the story. They also provided a form of evaluation or coda to highlight the 'so what' aspect of the story and summarise its importance (Labov, 1972). These story essences were reflected in short titles assigned to each story. Although the narrative summaries were not finally included as part of the study write up, two examples are provided in Table 4.4 below, along with the short summative titles given for each (Table 4.5).

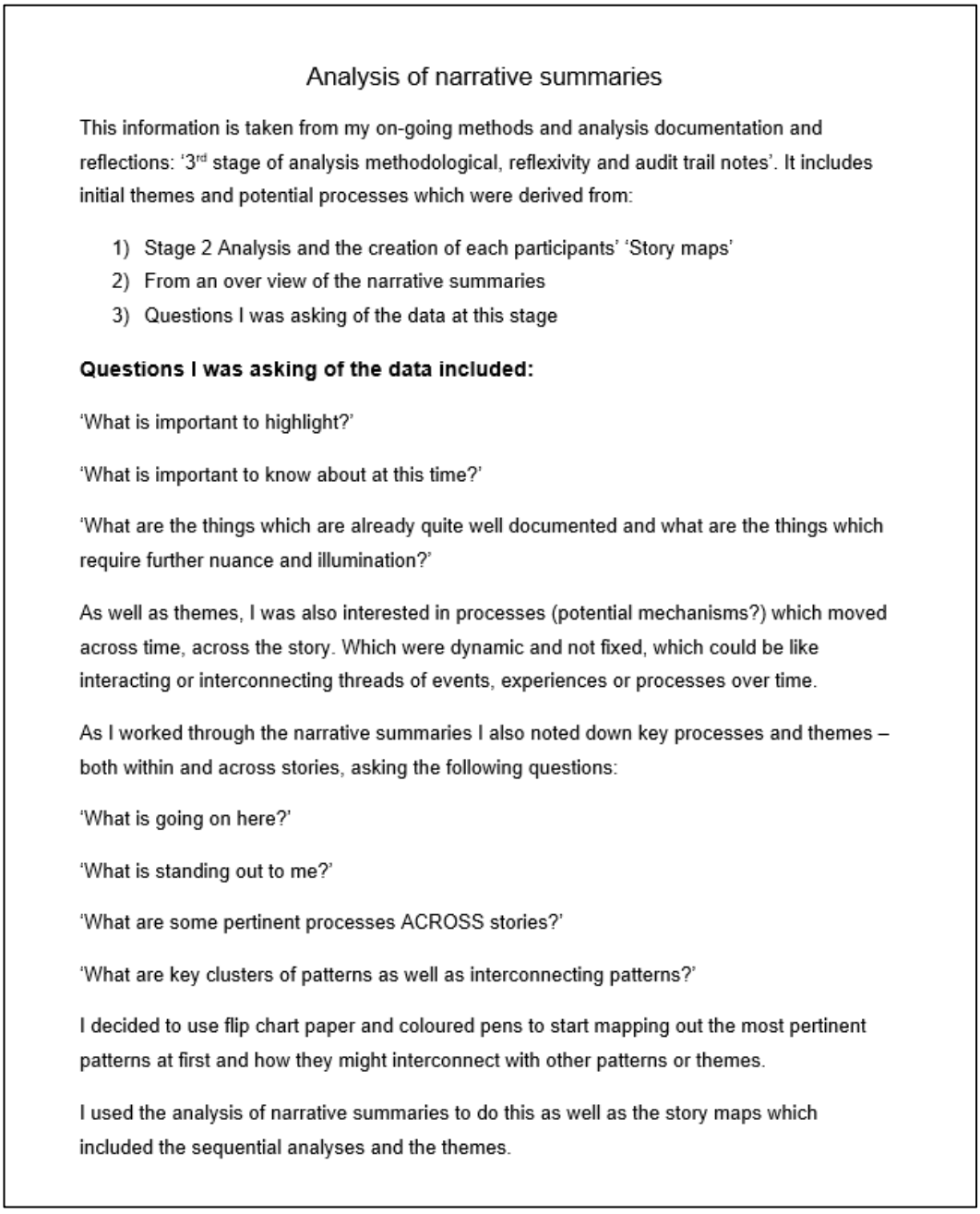
Table 4.4 Two examples of participant narrative summaries

Two examples of participant narrative summaries
Narrative summary 1 **Emily: A story of loving God** Emily is a Christian woman grappling with mental health issues and her relationship with God. She expresses a potential interaction between these aspects, exemplified by her statement, *"I think if I hadn't experienced mental health problems I might not have realised my need for God"*. Emily describes struggling with challenges of perfectionism and low self-esteem which rooted into her mental health issues. Her journey oscillates between a deepening of her relationship with God, and with doubt, questioning and disconnect from her faith. Ultimately she depicts these phases as providing the opportunity for reconciliation, personal reflection and realisation, and they seem to play an important part in her spiritual development and recovery process. Emily narrates a loving and meaningful relationship with God throughout her story, exemplified by the phrase *"God shows love for me in an incredible way. He has a plan for me"*. She describes integration of learning from her journey and reflects that it has resulted in both strengthening and softening her as a person: "*So it's using the freak outs and the struggles for good and for growth and to make me into a stronger and more other-centred person."*
Narrative summary 2 **Rashid: A story of religious and cultural identity struggle** Rashid is a Muslim man raised in an Indian family in Britain who is grappling with his Muslim identity in a Western country. A word that seems to coin his journey is one that he says was used inappropriately by his psychiatrist to describe his drinking of alcoholic beverages in relation to his religious tradition; "incompatible". Rashid expresses struggle with what he frames as a controlling family and cultural context which he says stigmatises mental health issues or fails to recognise them altogether. It is when he becomes mentally unwell that he starts to question these aspects about his upbringing: *"And I think when I became unwell that's when I started questioning things for myself, and also realised how much stigma there was."* He indicates that his mental health issues may have led to him becoming less religious. He also acknowledges the difficulty of being a Muslim person within the wider political context and Islamophobia. However, despite these challenges, he talks about working hard within his recovery to try to become a better person. This has been supported by pro-actively exploring and engaging in a range of wellbeing practices including mindfulness and going swimming. He says that these as well as utilising mental health services have all supported his recovery and helped him to attain a greater acceptance of himself.

Table 4.5 Summative titles of participant narratives

Summative titles of participant narratives
Emily: A story of loving God
Adita: A story of overcoming fear
Elizabeth: Gaining control over life through "Blissapline" ("bliss and discipline")
Morgen: "Dancing to the beat of your own drum"
David: Crystal companionship
Simon: From conformity to authenticity
Michael: A story about being saved and born again
Noam: Following the light of healing - from oppression and abuse towards spirituality
Rashid: A story of religious and cultural identity struggle
Carl: Seeking "emotion archaeology"
James: Fighting the monster
Cynthia: A story of spiritual loss and disconnect
Angela: The journey of the "Prayer warrior"
Thomas: Seeking the right framework
Silvia: Spiritual support and spiritual disruption
Helen: "Did I look at the blackness, or did I look at the stars?"
Mingyu: Another me
Andrei: Spirituality as an interconnected "tapestry"
Lajla: Utilising religion and spiritual practices for coping and wellbeing
Stephen: Taking responsibility and control
Katie: Exploring and travelling to "be with life"
Anna: Finding "Quanglican"
Keyshia: Making an ally of other-dimensional spirit beings
Gregory: "Saved" by spiritual and extra-terrestrial intelligence
Isla: "Spirituality's gave me the boost to carry on working on myself"
Charlotte: Love in the brokenness
Alaia: Surviving enduring abuse and oppression
Alexandra: Following the "golden thread"
Rachel: Moving through a spiritual crisis and awakening
Peter: Healing from religious abuse

The process of creating the narrative summaries facilitated the third stage of narrative analysis by providing an initial broad 'birds eye view' over the stories. This helped to illuminate initial impressions of patterns across the stories including repetitions in themes, sequencing and trajectories. After completing the narrative summaries and re-reading them whilst asking certain questions of the data, some key patterns, over-arching themes and processes were noted. These questions, initial themes and further details about the analysis of the narrative summaries are shown in Figure 4.2 below.



Analysis of narrative summaries

This information is taken from my on-going methods and analysis documentation and reflections: '3rd stage of analysis methodological, reflexivity and audit trail notes'. It includes initial themes and potential processes which were derived from:

1) Stage 2 Analysis and the creation of each participants' 'Story maps'
2) From an over view of the narrative summaries
3) Questions I was asking of the data at this stage

Questions I was asking of the data included:

'What is important to highlight?'

'What is important to know about at this time?'

'What are the things which are already quite well documented and what are the things which require further nuance and illumination?'

As well as themes, I was also interested in processes (potential mechanisms?) which moved across time, across the story. Which were dynamic and not fixed, which could be like interacting or interconnecting threads of events, experiences or processes over time.

As I worked through the narrative summaries I also noted down key processes and themes – both within and across stories, asking the following questions:

'What is going on here?'

'What is standing out to me?'

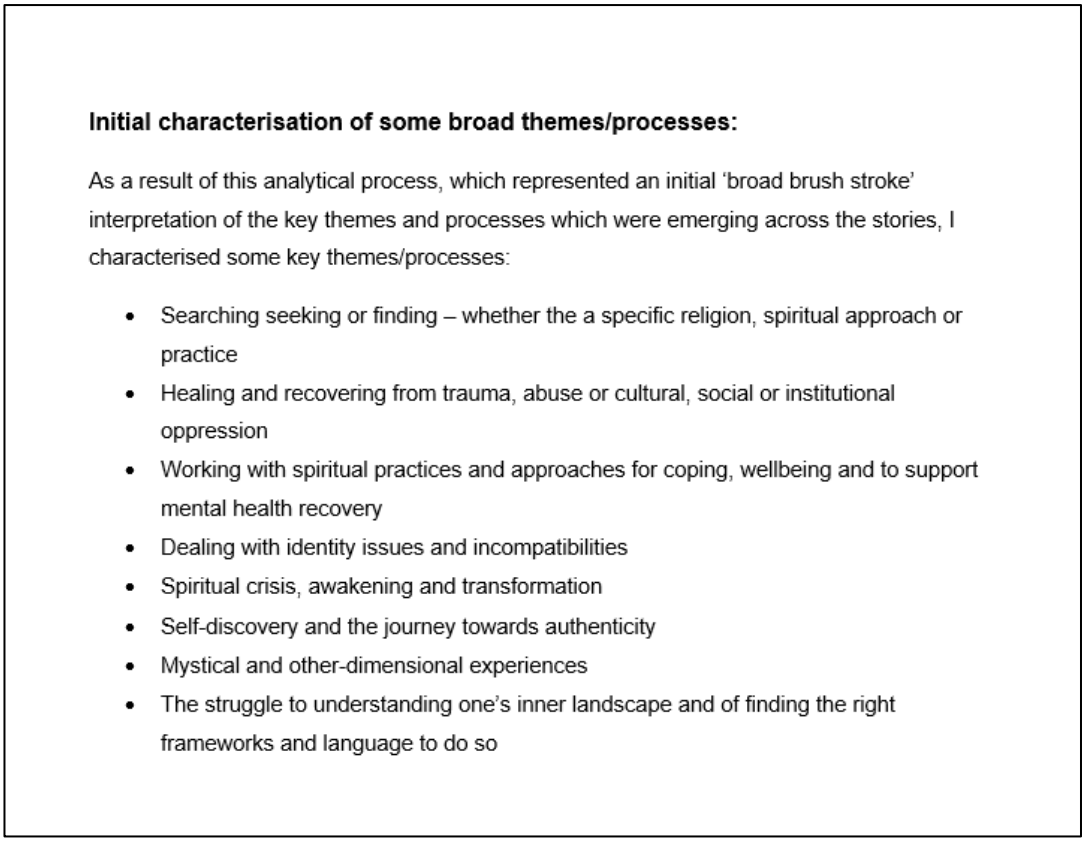
'What are some pertinent processes ACROSS stories?'

'What are key clusters of patterns as well as interconnecting patterns?'

I decided to use flip chart paper and coloured pens to start mapping out the most pertinent patterns at first and how they might interconnect with other patterns or themes.

I used the analysis of narrative summaries to do this as well as the story maps which included the sequential analyses and the themes.

Figure 4.2 Analysis of narrative summaries page 1



Initial characterisation of some broad themes/processes:

As a result of this analytical process, which represented an initial 'broad brush stroke' interpretation of the key themes and processes which were emerging across the stories, I characterised some key themes/processes:

- Searching seeking or finding – whether the a specific religion, spiritual approach or practice
- Healing and recovering from trauma, abuse or cultural, social or institutional oppression
- Working with spiritual practices and approaches for coping, wellbeing and to support mental health recovery
- Dealing with identity issues and incompatibilities
- Spiritual crisis, awakening and transformation
- Self-discovery and the journey towards authenticity
- Mystical and other-dimensional experiences
- The struggle to understanding one's inner landscape and of finding the right frameworks and language to do so

Figure 4.2 Analysis of narrative summaries page 2

3.2 Creating an Analytical mind map

The analysis of narrative summaries and the second stage thematic and sequential analysis documented on the Story maps informed the creation of a large document using flip chart paper called an 'Analytical mind map' (see Figure 4.3 below). This document aimed to integrate and synthesise the key findings across the stories so far. It was laid out to broadly depict patterns of the dynamic movement and overall trajectory of the stories. These were listed under headings: 'Type of process' which related to the overall type of story trajectory, 'Characteristics' headings which denoted other features, themes and processes which occurred across the stories, and 'Outcome' which listed some key narrated outcomes of the stories related to spirituality, mental health and recovery. Writing this out in a 'mind map' form using coloured pens supported my kinaesthetic and visual learning and thinking which included gaining a sense of a temporal dimension and dynamic patterning of themes and interacting processes.

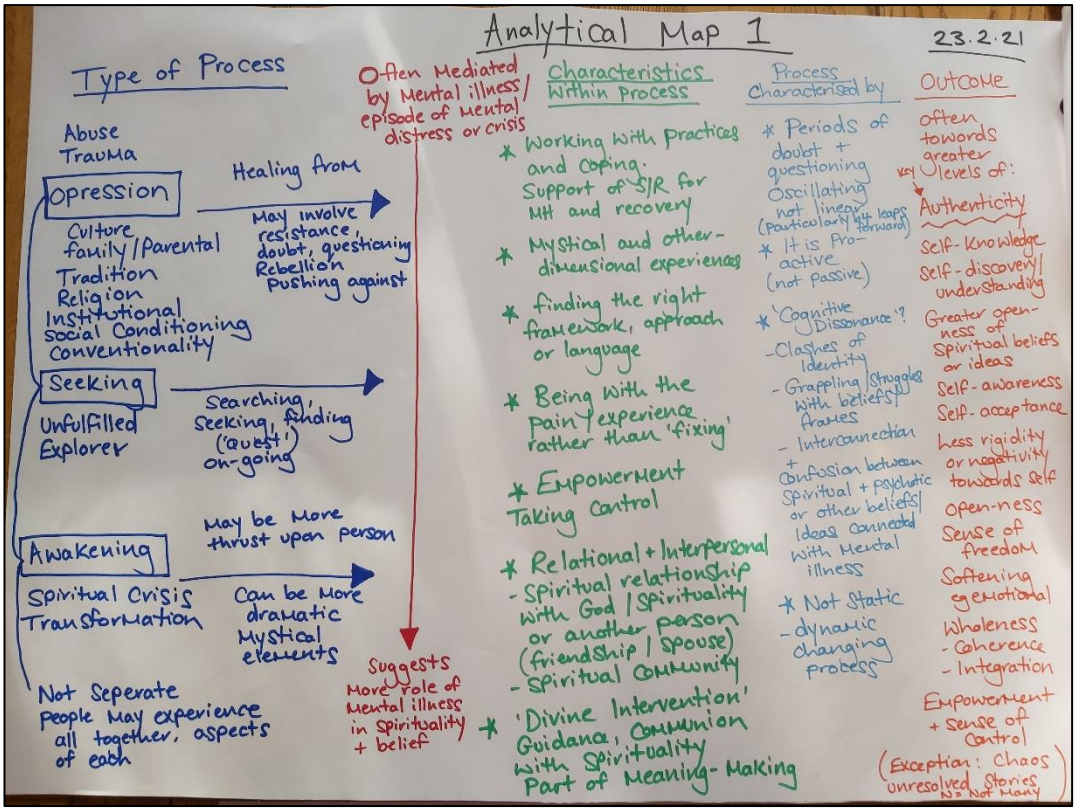


Figure 4.3 Analytical Mind Map 1

3.3 Sequential analysis stage 3

The sequential analysis stage 3 was conducted in conjunction with the Analytical mind map, being informed by it and contributing to its further development. Characteristic of hermeneutic analysis, I moved from the broader overall patterns depicted across the stories within the Analytical mind map, back to detailing these patterns more specifically within the individual stories. I used the Story map documents to do this, examining in particular the sequential analysis sections within them, including the headings of the stages of their journey, and the more detailed notes of events within each stage.

Using the same sub-headings and colour-coding as the Analytical mind map, I created a new document for each individual participant called a 'Process map.' Here I documented patterns which related to the development of story trajectory, other aspects concerning the progression and dynamic nature of the story, and the main narrated outcomes of the story, particularly in relation to spirituality, mental health and recovery. The Process maps also included additional details about key turning

points, reported changes in spirituality and belief, whether the trajectory overall was positive or negative and any observations about how mental health, recovery and spirituality were potentially narrated to intersect throughout the story. An example of a Process map and how it related to the sequential analysis is provided in the worked example below (see Table 4.6 and Figure 4.5).

A worked example of a sequential analysis with participant Carl: To clarify the process of a sequential analysis and information provided in a Process map, a worked example is provided with participant Carl. A narrative summary gives an indication of the story as a whole, followed by an adapted and shortened, to protect confidentiality, sequential analysis. Finally the Process map created for Carl is shown with the colour coded sub-headings.

Table 4.6 Narrative summary for Carl

Narrative summary and condensed sequential analysis for participant Carl
Narrative summary **Carl: Seeking "emotion archaeology"** Carl's story is one of spiritual searching, seeking and "dabbling". After living what he describes as a very conventional life and upbringing, Carl is left with a poignant sense of feeling unfulfilled and like there was "something missing" from his life. After rejecting his religious upbringing, Carl describes becoming interested in new age spirituality including enjoying a connection with nature and Paganism. He says that he is a seeker and that he has explored a large variety spiritual workshops, courses and healing practices. However, nothing ever quite "hit the spot". In addition, Carl noticed some challenging aspects about spiritual communities, particularly in relation to people's vulnerabilities. He found that engaging in rational and critical thinking which arose from studying for a degree helped to balance his perspective. Over time he describes integrating an understanding of the wisdom he had gained from all his experiences and cultivating a comprehensive toolkit of good mental health practice. He reports that this aided his recovery, helped him to positively re-frame his story and cultivate the "*necessary emotion archaeology to be done to understand why I was.*" Carl describes this as involving a kind of excavating of his internal experiences to find out why he was the way he was and to develop his sense of self-knowledge.

Condensed sequential analysis from Carl's 'Story map'

1) "Blind acceptance" of Christianity as a child
    - Grew up in what he says was a very typical white middle class Church of England way and went to Sunday school.

2) Questions and actively resists Christianity
    - At around 12 years of age, having heard a lot of Bible stories, he started to think: "I don't believe a word of this" and "This is rubbish".
    - He stopped going to church.
    - He became interested in other ideas at this time and also felt a sense of teenage rebellion.

3) Absence of religion or spirituality and 'Going through the motions of life'
    - He describes this time as "going through the motions of life in a very conventional way". He was very embroiled in his career and family.

4) Sought help for stress and mental health
    - He experienced stresses in life impacting on his mental health.
    - He was prescribed medication by his GP which he found had no impact.

5) Sense of something missing and introduction to spirituality and new age practices and paths
    - He had a sense of something missing from his life. He felt he had done all the things he was "supposed to do" yet he was unfulfilled.
    - He started exploring spiritual practices and spiritual paths.
    - This connected him with a different social circle.

6) Connection with nature, Paganism and new community
    - He felt a deep connection with nature and found that this became the "best medicine" for him and "kept him sane" at the time.
    - He started to meet other like-minded people and became aware of nature-based spirituality and Paganism which called to him.
    - He got involved with a Pagan community. He found a connection with nature and a sense of community that he had never experienced before.

7) Seeking, exploring, dabbling, needing something more
    - He was still struggling with his mental health and experienced what he called a kind of "mid-life crisis" which impacted his life in various ways.
    - Retrospectively he sees this point as one in which "I had lost it."
    - He had an on-going sense of needing excitement, seeking and "dabbling" with spirituality approaches but found that "nothing really hit the spot still."
    - He also experienced issues within the spiritual community including that others were in a similar position in crisis and seeking something – which had detrimental impacts.

8) Developed more rational explanations and critical thinking
    - He took a degree, really enjoyed it and it taught him to understand and perceive in a more rational way.
    - He gained a greater understanding about what he was looking for and a period of counselling helped him to better understand himself.

9) Turning point: Catharsis through Tantra - delving deep into his childhood conditioning
    - This spiritual healing practice helped him "turn the corner eventually."
    - It included cathartic work looking back at his roots which the counselling work alone had not supported him to do.
    - He had important realisations from this cathartic work.

10) Integration of all aspects has led to feeling better than ever in life
    - He has experienced being better equipped in more recent life to deal with mental health difficulties and has better coping skills.
    - His gaining of self-knowledge and understanding has supported his mental health: "…*knowing why I am like I am, and why I feel the way I am has led me to feeling more sorted now that I've felt ever in my life… generally my mental wellbeing is as good as I could possibly want.*"

Figure 4.4 Condensed sequential analysis for Carl

Carl's story seemed to fit a 'Seeking' type of process or trajectory and this seemed to motivate much of his spiritual exploration. Other key themes characterised within his story included the importance of community and of integrating both rational as well as spiritual approaches towards understanding and self-knowledge. These are

explored in detail within the Findings Chapters. Information from the sequential analysis and Story map inform the summarising Process map as shown in Figure 4.5 below.

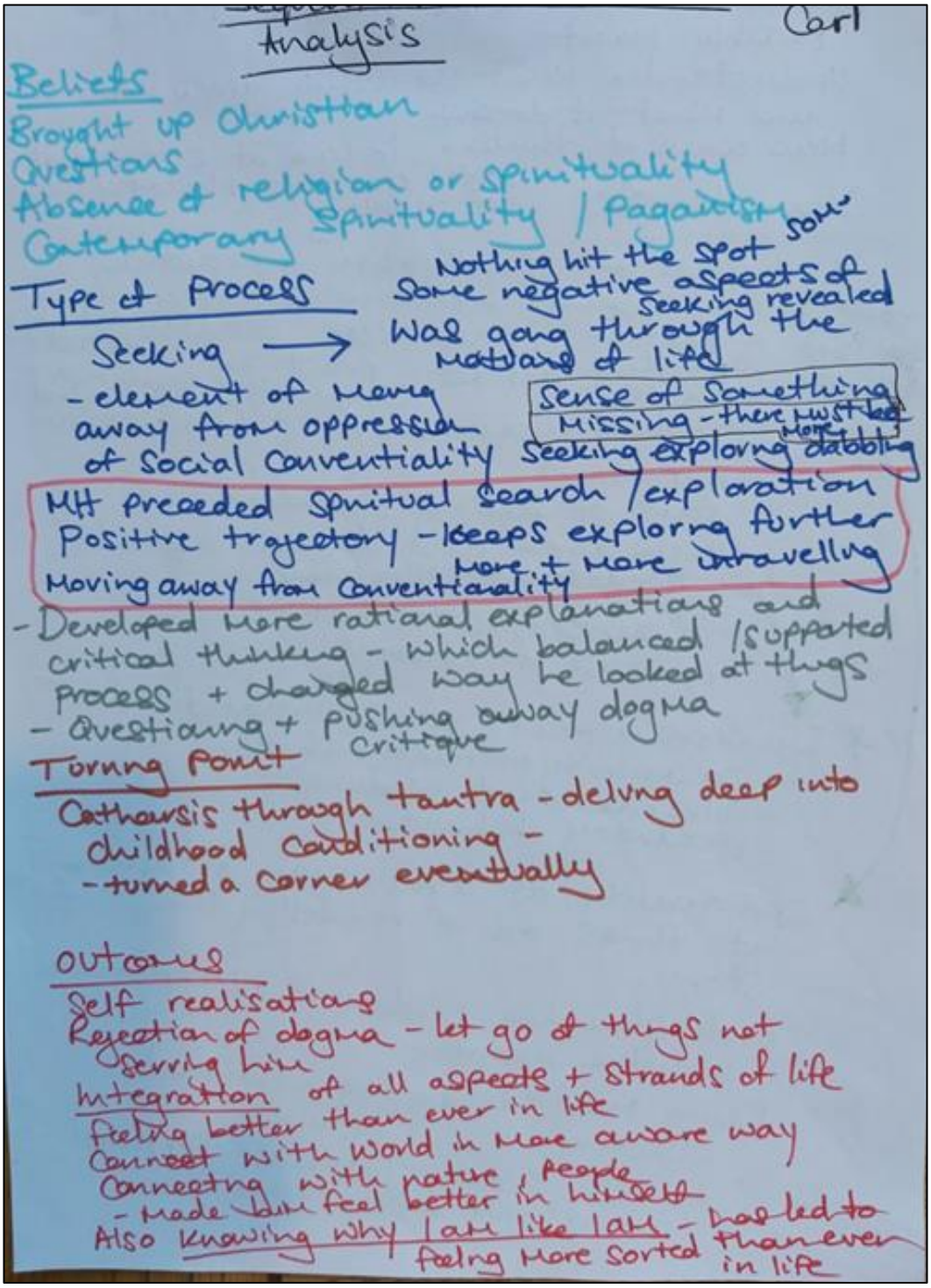


Figure 4.5 Process map for Carl page 1

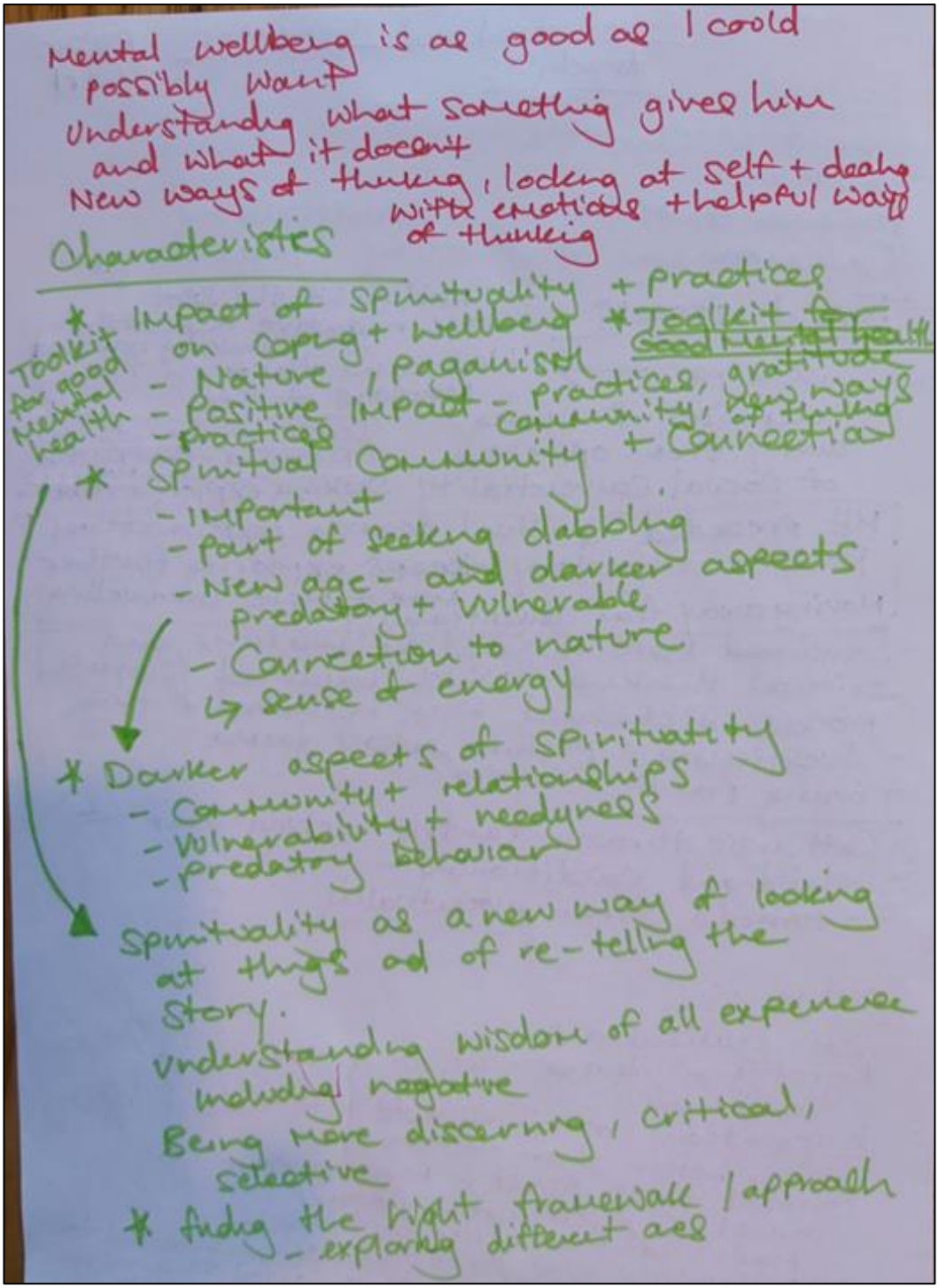


Figure 4.5 Process map for Carl page 2

The completed Process maps then informed additions and developments to the Analytical mind map which became more complex and rich in information, as shown in Figure 4.6 below. A clear typed-up version of this Analytical mind map can be found in Appendix 10. The kinaesthetic aspect of mind-mapping, sketching out

ideas and using colour coding was helpful to illuminate potential themes and support moving back and forth between the details of individual stories and patterns across the stories as a whole.

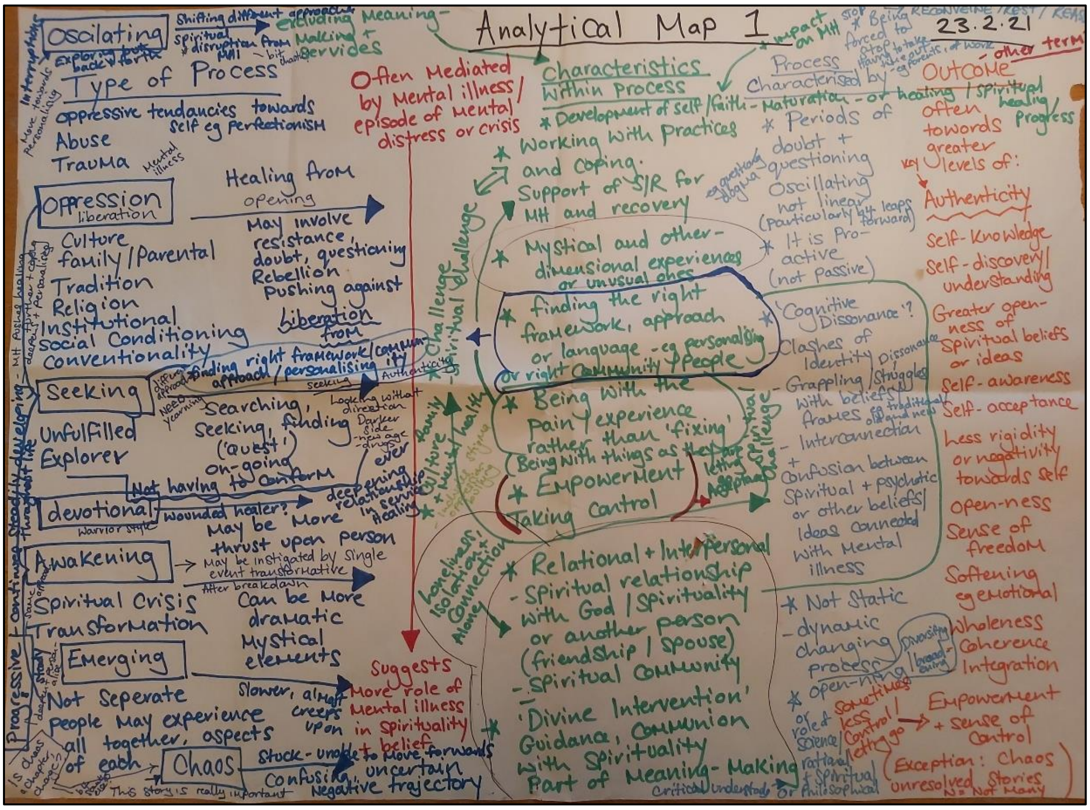


Figure 4.6 Analytical Mind Map 2

3.4 Narrative thematic analysis stage 3: Development of coding frameworks and coding across stories

After completing previous stages of analysis, four superordinate themes were ascertained. Two had been determined *a priori,* as outlined in Section 2.5; ‘Meaning making’, and ‘Psychospiritual development’. Two further superordinate themes were found inductively from the data, based on the ways in which themes clustered into overall topic areas, as well as their frequency within and across stories and their potential saliency in relation to mental health and recovery. These were ‘Spiritual connection’ and ‘Spiritual practices and coping’.

An initial coding framework was then created for each superordinate theme using a sticker based colour-coding system. Images of these coding frameworks for each

superordinate theme can be found in Appendix 11. Analytical notes and reflections supported theme development and making decisions about which ones to highlight and how to structure the initial coding framework.

The four superordinate theme coding frameworks were then used to systematically code for each participant using the Story map documents. Sticker-based colour coding documents were created for each participant for each of the four superordinate themes. Additional notes were made about the specific nature of the themes and sub-themes within that participant's story to preserve the context and specific nuance of meaning. Themes which presented contrary pictures to the more generalised patterns were also noted. Initial superordinate theme coding frameworks were then checked to ascertain accuracy, representativeness and structural organisation of the themes and sub-themes. At the end of this coding process, based on the analytical observations which had been noted in memos, some changes were made to develop more clearly organised and succinct coding frameworks. This included re-arranging some themes and omitting others and developing clearer theme titles. A simplified version of this process was also undertaken to explore participants' characterisations of spirituality which was included as an additional *a priori* superordinate theme to gain an initial understanding of participants' spiritual beliefs.

3.5 Theme development and write up

The colour-coding frameworks for each of the superordinate themes and the Process maps for each participant were used as easy-to-access reference points as I started drafting the write up of the findings. Because the findings emerging from this process were very rich and detailed, after consultation with my supervisory team, I decided to exclude the superordinate theme of 'Spiritual practices and coping'. This was because this particular theme is already well documented within spirituality and mental health research (see also Section 2.4). Although its inclusion could have been a useful addition to the literature, a pragmatic decision was made to focus instead on a deeper, richer analysis of other less well documented themes with a chapter dedicated to each. This meant that, including the 'Descriptions and characterisations of spirituality' superordinate theme, three *a priori* and one inductive superordinate theme were the focus of the analysis.

I worked sequentially and systematically using the coding sheets to search for comprehensive examples for each theme and sub-theme and then referred to the Story maps or transcripts for further details and potential examples of quotes. I looked for examples which gave clear and in-depth representations of the themes and which could assist the reader with further understanding. I also attempted to maintain the nuanced and context-dependent nature of themes as they related to individuals' stories and actively sought out instances which might contrast or contradict with a general consensus or pattern across the stories.

Throughout the process of writing up the research findings, I endeavoured to privilege the voice of the participant in concordance with the hermeneutic of restoration stance adopted within the analysis. I did this by carefully reading and re-reading excerpts of transcripts and potential quotes to illustrate themes and reflect upon various potential interpretations and meanings, attempting to empathise as far as possible with the participant. However, as Riessman (1993) points out, interpretation cannot be avoided as individuals' narratives are situated in particular interactions within social, cultural and institutional contexts and that written reports are limited portraits with ambiguous and fluid meaning. Furthermore, every text is plurivocal and open to a variety of interpretations and constructions. Awareness of these forms of representation however allows researchers to be more conscious, reflective and cautious about the claims they make about the data.

After gaining feedback from the preliminary report of findings and coding frameworks as described in Stage 3.6 below, I made some changes including re-structuring and re-naming of some themes so that they were clearer and more informative.

3.6 Ensuring rigor during stage 3

Lincoln & Guba (1985) use the term credibility to refer to the extent to which the researcher's interpretations are credible reflections of participants' views. In order to provide opportunities to ascertain the quality and credibility of the preliminary findings and my interpretations, feedback was sought from various sources (Van Manen, 1990):

1. *Consultation of the supervisory team* - The supervisory team were consulted throughout the analysis and their feedback was sought for the emergent and developing methods, analysis and findings. Maintaining transparency about

these aspects including research design supports research dependability which refers to following a systematic research process (Patton, 2002). In addition, supervisory consultation supported research confirmability and trustworthiness through gaining external checking on aspects such as audit trail and documentation of methods (Lincoln & Guba, 1985).

2. *PPI and peer feedback from a preliminary report of findings* - A preliminary report was created with the coding frameworks for each superordinate theme and an example of more detailed findings which included further descriptions and example quotes. This preliminary report was sent to the PPI group and to a spirituality symposium for peer debriefing, feedback and critical reflection. Peer debriefing is a technique which is useful in establishing research credibility and aims to explore aspects of the inquiry which might otherwise remain only implicit within the researcher's perspective. This approach aims to maintain honesty within the researcher by asking searching questions, exploring meanings and probing for clarification of interpretations (Lincoln & Guba, 1985). The spirituality symposium provided useful insights from people with expertise in the field of spirituality including researchers, practitioners and people with lived experiences.
3. *Consultation with an experienced qualitative researcher* – I also periodically consulted an experienced qualitative researcher based at the University who was external to my supervisory team. This was useful in shedding light upon my own interpretive and analytical process, and also sometimes provided an opportunity for debriefing, gaining emotional support and offloading feelings of stress and challenge. This sometimes had a cathartic effect which Lincoln & Guba (1985) suggest can support clarity of judgment, emotional support and reflexivity within the research process.

Member checking was not used within this study. Although this approach, in which findings and interpretations are tested for confirmation with participants, is viewed by some to increase the credibility of qualitative research (Lincoln & Guba, 1985), others argue that in relation to contextually-embedded narratives, it cannot validate the data (Silverman, 2013). In addition, Riessman (1993) questions the extent to which a researcher's interpretations can be affirmed by member checks, pointing out that stories are not static and that the meaning of experiences changes over time. However, Lincoln & Guba (1985) do suggest that member checking is possible with members of a similar stake-holding group who could check that interpretations

and conclusions are recognisable as adequate representations of their own experience, and in this way a form of member checking was carried out with the PPI group in relation to initial findings and coding frameworks as described above.

4.8 Ethical Considerations

This research project was conducted in accordance with the ethical principles which originate from the Declaration of Helsinki (World Medical Association, 1996) and received ethical approval from the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee (Ethics Reference No: 98- 1809.)

It is a fundamental feature of ethical research that it protects the dignity and interests of the participants, ensures participation is voluntary and based on informed consent, avoids deception, operates with scientific integrity and complies with the laws of the land (Denscombe, 2010). In addition, there are specific ethical issues to narrative research and, following Josselson (2007), an 'ethical attitude' was adopted. This involves thinking through ethical issues on an on-going basis and making decisions about how best to honour and protect the interests of participants whilst maintaining standards of good scholarship. Within narrative and emergent study designs, McLeod (1994) argues that ethics should be more reflexive than procedural and interpreted under local conditions rather than fixed rules, requiring a commitment to ethical values rather than *a priori* behaviours (Josselson, 2007). Reflexivity and transparency were utilised to understand and manage any ethical tensions which emerged throughout the research, discussing any queries or uncertainties with both the supervisory team and other members of the School of Health Sciences who had expertise in research ethics.

Although the sharing of long and personal in-depth stories can be of benefit to some participants (Overcash, 2004) it also carries an increased risk that they may feel vulnerable or exposed, or that the more detailed sharing could trigger distress (Chase, 2011). Adopting an ethical attitude within research involves remaining aware of the uncertainty of how others will respond within an interview process or to the interpretations or findings of the research (Adams, 2008). There were a number of ways that this risk was addressed within the study. For example, thoroughly explaining the narrative research to participants from the recruitment stage though to interview completion (Josselson, 2007). The ethical principle of informed consent includes a clear understanding of the purpose of the research, how the information

will be used and people's rights to privacy, safety and confidentiality (Abrahams, 2007). Clear information was provided to all research participants informing them about the research project and its aims, what their role would be and how the information would be collected, stored and analysed. Participants were also informed about the approximate duration of the meeting and that interviews would be audio-recorded (Josselson, 2007).

Opportunity was provided for potential participants to ask questions about the research and if people agreed to take part they were asked to read and sign a consent form. It was made clear to participants, both verbally and on the form, that they were free to withdraw their participation at any time without question or needing to give reason. They were also informed that all information and data collected would be treated confidentially and their details kept anonymous, both in storage and dissemination of information. This meant that everything possible was done to disguise and safeguard material, including changing all names and places in the texts. A pseudonym was used to identify participants and the information linking participant details to the pseudonym was stored separately from the transcripts on a password protected computer. Any hard copies of interview transcripts and handwritten researcher observations and reflections about the interview were stored in a locked unit. It was made clear that only the researcher and supervisors would have access to the anonymised data and that anonymised quotations may be used in the final analysis and journal publications.

Care was taken throughout the recruitment, interview, analysis and write up process to safeguard the wellbeing and interests of participants at all times. The duty of care towards participants necessitates awareness and sensitivity before, during and after the interviews due to the possibility that sensitive issues can arise during an interview. As people were asked to talk about their spirituality and mental health, which can both be personal and sensitive topics (Canda & Furman, 2010), I was mindful that it could be emotive or create distress for some people. I took care to inform participants about this possibility prior to taking part in the research and again on the day of the interview. I also suggested they consider sources of support should they become distressed, and listed some suggestions and contact details on the participant information sheet should this be needed after the interview took place. During the interview I took care not to coerce or pressurise participants to talk about any issues or reveal information about themselves which they did not feel comfortable sharing and clarified this prior to the interview. I also encouraged

participants to stop, pause or take a break any time should they need to and to prioritise their wellbeing.

Participants sometimes take the opportunity to reveal the most sensitive areas of their lives during narrative interviews. The narrative interviewer may therefore have to deal with complex and painful emotions, to be able to contain what is said and listen empathetically but nonjudgmentally (Josselson, 2007). During the interviews, my skills and experiences working in a broad range of mental health contexts were utilised. These included working in spiritual care, as a Cognitive Behavioural and Multi-systemic therapist, a Samaritans volunteer and those gained from a spiritual counselling course and post-graduate certificate in psychological therapies. I endeavoured to create a safe, supportive and welcoming space for participants as far as possible. I also tried to adopt a centred, clear and empathic stance throughout the interview, remaining sensitive to the participants' words, body language and feelings to help gauge how best to facilitate the interview.

I asked all participants about their wellbeing and how they felt at the end of the interview. Most said they were fine, and many said they enjoyed the process of telling their stories. A few participants became emotional or distressed at certain points during the interview. At these points I provided the opportunity to stop, take a break or conclude the interview if wanted. Only one participant became very distressed because she said she had never shared her story before. We discussed the situation and agreed that it would be best for her to take a break and return to the interview on another day if she chose to, which she did.

Conducting qualitative research can also impact upon the researcher's own wellbeing, particularly when researching sensitive or potentially distressing topics. Support was sought from student peers, family and friends, as well as personal spiritual and wellbeing practices. The reflexive approach I took towards the research process facilitated reflection on the personal and inter-personal process of conducting interviews, aiding the recognition and interpretation of emotions and reactions. This helped to maintain the ethical attitude through supporting the development of the self-knowledge and self-reflection necessary to clarify with honesty any personal challenges and positioning that might have influenced the interaction with participants and the interpretation of data (Josselson, 2007).

Due to challenging personal circumstances I experienced during the course of my PhD, as well as the on-going Covid-19 pandemic and lock-down, it became necessary to consider my wellbeing more deeply than I had planned for. After conducting over 10 interviews I hit a point where I felt it was important to debrief from the emotional impact of these in-depth, personal and often distressing accounts. I remember a poignant moment during one interview which particularly impacted me. I bumped into a colleague afterwards who asked how I was doing and we debriefed about the experience. I wrote about this in my Post-interview reflections document:

> *"I was asked an interesting question today by an interviewee. She had just shared an incredibly powerful and quite harrowing story. At the end, when the recorder was switched off, she asked me what I am going to do with this. I started to talk about how this was part of my PhD and she said 'No, I mean what are you going to do with this, this story I have shared with you, I saw your eyes well up at times.' I replied that this was a very good question.*
>
> *I am aware that reflexivity and transparency is talked about a huge amount in the qualitative research field and yet I am wondering, how are we to do this well primarily on our own? We can of course write field notes and talk with supervisors but I think only relying on our own more usual ways of thinking about things may miss the processing and insights that can happen when there is deeper sharing and facilitation with another. This may be parallel to a therapeutic process where a therapist would have clinical supervision and even on-going therapy themselves. We are not doing therapy as researchers and yet we are potentially gaining contact with those layers of the human psyche that people may not often reveal to anyone else, or even themselves normally. I wonder how we are meant to navigate these realms effectively as researchers without more in-depth opportunities for guided companionship and sharing about such aspects."*

Speaking with other PhD colleagues who were also conducting research into difficult or sensitive topics I realised I wasn't alone in these thoughts. I also became aware later that spirituality research could potentially add another dimension of challenge. This was difficult to talk about and explain however, particularly as I was not directly situated within a community of spirituality researchers. It became particularly apparent when analysing stories and themes which were what I called

‘epistemologically challenging’, relating to crisis or uncertainty within meaning, as well as anomalous or mystical experiences. Eventually, I met with an expert in the field of spirituality research and discussed this difficulty. She works with spirituality researchers and reflected to me that my experience was common within this field. She said it is very difficult to conduct spirituality research without being affected or changed by it and this is recognised. She said it was like working in a ‘radioactive field’ which has a powerful impact simply by residing within it. Because of this, all the researchers working where she is based have a mentor to support their personal process. Hearing her share this felt incredibly validating and a huge relief to know I was not alone in these feelings. I came to the decision after this to engage in some coaching sessions to support my personal process.

Learning the importance of researcher wellbeing was a key realisation for me during the PhD. I gained a deeper understanding into the challenges of researching topics like spirituality and mental health, for example because of the ways they can be triggering, as well as illuminate themes of personal meaning making, identity, transformation and healing within one’s own life. In this way, the cultivation of self-understanding and self-care within the ethical process, as well as attempting to work with respect, care and sensitivity for others with integrity and transparency, were some particularly important aspects of learning within the PhD journey.

Chapter 5: Findings preface and participant characterisations of spirituality

5.1 Introduction

This chapter describes participant characteristics provided by the demographic information form completed during participant interviews. It provides a brief summary overview of the overall coding framework outlining the four superordinate themes explored during the analysis. It goes on to show the results of the first narrative thematic analysis, that is participant descriptions and characterisations of spirituality. Spirituality is used as an umbrella term to include both religious and non-religious or mixed expressions, however specific understanding and characterisation of religion is included when this term provides further nuance within particular instances. Information about how participants said they understood spirituality was an important starting point from which to illuminate further themes and their relationship with spirituality, mental health and recovery. It also supported the hermeneutic of restoration approach that sought to understand how participants made sense of and described spirituality from their own perspectives.

5.2 Participant Characteristics

Recruitment routes included poster placement at university (n=9), community location (n=5) or online (n=2), contact with researcher (n=7) and recommendation from others (n=7). Interviews were conducted in private rooms at University (n=24), places of work (n=3), community centres (n=2) or churches (n=1).

Demographic information was collected at the beginning of each interview. Participants were informed that the provision of this information was entirely optional and could be declined if wished. One participant chose not to provide all demographic information. A summary of participant characteristics is provided in Table 5.1 below.

Table 5.1 Participant characteristics

Participant Characteristics	N=30 (Participants choosing not to provide all demographic information N=1)
Age	43 Years (Mean) Range = 20 – 79 years
Gender	
Female	17
Male	12
Non-binary	1
Ethnicity	
White British	17
White non-British	6
Asian	4
Black	1
Mixed Ethnicity	1
Participants identifying a mental health diagnosis (N=17)	
Depression	5
Anxiety	4
Bipolar disorder	3
Psychosis	2
Obsessive Compulsive Disorder	1
Eating disorder	1
Neurological symptoms	1
Symptoms reported by participants not identifying a diagnosis (N=9)	
Depression	3
Anxiety	3
Anxiety and depression	1
Obsessive Compulsive Disorder	1
Post-Traumatic Stress Disorder	1

Use of mental health services	
Yes currently	11
In the past but not currently	12
No	7
Spiritual/religious affiliation	
Christian	7
Christian mixed with other approaches	6
Muslim	1
Hindu	1
Buddhist	1
Bahá'í	1
Pagan/Animism/Shamanism	2
Spiritual (no specific tradition)	8
Agnostic	2
Other	1

Although educational level was not included within the Demographic information form, in the attempt to minimise the amount of additional information collected from participants, it was noted from participant accounts that 21 (70%) of the participants described attending education at or above undergraduate university level.

5.3 Findings Overview

After conducting the Narrative thematic and sequential analysis, four coding frameworks were devised and revised as described in the Methodology chapter. These comprised of three *a priori* superordinate themes and one superordinate theme which was derived inductively. All subsequent themes and sub-themes emerged from an inductive narrative thematic analysis. An overall summary of the superordinate themes and their main themes (not sub-themes) is shown in Table 5.2 below.

Table 5.2 Overview of analysis coding framework

Theme	Theme description
1. Descriptions and characterisations of spirituality	Participant descriptions and narrated understandings of spirituality.
1.1 Spirituality as functional	Descriptions of spirituality in relation to its narrated function or impact.
1.2 Spirituality as changing	Described changes in spiritual beliefs over the course of participant spiritual journeys, nearly always moving in the direction of becoming more personalised. Five specific trajectories of change are described.
1.3 Spirituality as self-discovery	Descriptions of spirituality pertaining to gaining a sense of on-going understanding and discovery about the self.
2. Meaning making	The ways in which participants described making sense of their experiences in relation to spirituality, mental health and recovery.
2.1 Reframing	Ways in which participants framed or constructed meaning making in relation to their spiritual beliefs and perspectives and how this functioned in relation to mental health and recovery.
2.2. Navigating mythos and logos	The interplay, integration and juxtaposition of spiritual 'mythos' frameworks with rational 'logos' frameworks of meaning making and their potential effects upon mental health and recovery.

2.3 Discerning spiritual guidance	The role of various forms of spiritual guidance (e.g. intuition, synchronicity, coincidence, signs and visions) and ways these are discerned in relation to functional meaning making, mental health and recovery.
3. Psychospiritual development	Participant descriptions of their personal growth in relation to psychological and spiritual factors and experiences. These include the unfolding of their spiritual journey over time, as well as experiences of mental health and recovery.
3.1 Developmental trajectories	The characterisation of sequences of narrated experiences and events and their unfolding over the story arc in relation to psychospiritual development.
3.2 Developmental interactions	Forms of interactions between spirituality, mental health, recovery and development and their described effects.
3.3 Developmental qualities	Cultivation of nine developmental qualities which characterise psychospiritual development within participant stories. Sometimes these are contributed to or mediated by spiritual practices.
3.4 Authenticity	The described experience of a progressive understanding of self or deepening sense of spiritual self-knowledge. The experience of development and personal-growth in relation to becoming increasingly more ‘true’ to oneself.
4. Spiritual connection	The ways in which participants described various kinds of relationships or inter-personal themes which related to their experience of spirituality, with potential implications for their mental health and recovery.

4.1 Spiritual person	Relationship with a person described as spiritual or having spiritual significance and potentially impacting mental health and recovery.
4.2 Spiritual being	Relationship with a spiritual being or entity described to have spiritual significance and potentially impacting mental health and recovery.
4.2 Spiritual practice	Spiritual practices to mediate or cultivate spiritual connection and potentially impact mental health and recovery.
4.3 Spiritual community	Relationship and experiences with religious or spiritual groups, communities or networks and their potential impact on spirituality, mental health and recovery.

5.4 Superordinate theme 1: Descriptions and characterisations of spirituality

To address the research aim of acquiring understanding of the role of spirituality in the lives and recovery journeys of people who experience mental health difficulties, it was important to first gain a sense of how participants described and characterised their understanding of spirituality. After conducting a narrative thematic analysis on participant descriptions and characterisations of spirituality, three major themes were found: Spirituality as functional, Spirituality as changing, and Spirituality as self-discovery (Section 1. of Table 5.3), as described below.

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Theme 1.1: Spirituality as functional

Many participants discussed and characterised spirituality in relation to its impact and functionality within their lives, including in relation to their mental health and recovery. This included facilitating understanding and meaning, supporting change and development, enabling connection, encouraging peace and compassion and providing comfort and guidance. Isla, for example, lists several features she experiences spirituality to offer, including happiness and a sense of purpose.

> *"I think it's* [spirituality is] *about having faith, and, yeah, it's something to believe in… It's just what makes me happy, and what works for me to like live my best life, and, I think having, my spirituality has given me a boost in life, and more like a purpose, I can make sense of things now in my life."* Isla

Alaia's understanding of spirituality includes the impact and function of practicing religious doctrine, which she says teaches her to be kind, respectful and "a good Hindu person".

> *"It's like you've got to be kind, you respect people, that's what the religion teaches. I do prayer, I do meditation, that's what a good Hindu person should be practising… donate to the… needy people…. this is what I strongly believe and I pass it on to my children as well..."* Alaia

A significant number of participants discussed spirituality functioning to support their ability to understand, explain and make meaning in life. This is succinctly epitomised in Andrei's encapsulation of his definition of spirituality.

> *"So spirituality for me really means investigating and understanding or advancing in your understanding of reality…"* Andrei

For Helen the contribution of spirituality to her meaning making is described, utilising colourful metaphorical imagery, as a "definitive interpretation" which provides a greater framework of understanding.

> *"I've got this image… of spirituality being this sort of… glass container… with all sorts of purply, greeny, silvery colours to it… it's the biggest picture of who I am, certainly beyond the physical. And if I can get to that outside*

bit of that container then I can forget me and I can look outside at the real big picture… the spiritual perspective is the definitive interpretation of my existence…The spiritual is the big picture isn't it?" Helen

Stephen describes how spirituality brought meaning to his life and how this in turn may have functioned to change his perception and wellbeing in supportive ways.

"I think spirituality is… like the way you view the world and what meaning you derive from the things that happen around you… I changed from thinking that everything is completely meaningless to even the slightest potential that there could be meaning in everything definitely changed how I view the world… it gives you much more reason to act and try to find out what that meaning is than there being no chance and just sort of wallowing in self-pity." Stephen

Somewhat distinctive to accounts aligning spirituality with providing understanding, Thomas suggests that for him spirituality provided a liberating and emotionally supportive function by emphasising uncertainty and enabling an "acceptance of the mystery".

"…I think a lot of my own unhappiness and a lot of people's unhappiness in general is created by feeling that they know all of the options for themselves, for what life is like, for what their experiences are and they become, I became kind of trapped in that. And spirituality for me now kind of means an acceptance of mystery or uncertainty about the world." Thomas

A significant number of participants, particularly those who connected with a traditional religion, described spirituality as a relationship, for example with God, their faith or a spiritual community, and implied that spirituality functioned through that connection. For example, Charlotte states that to her, spirituality is a relationship with Jesus in which she can pray and feel heard.

"I would say my spirituality is that I have a relationship with Jesus and that I can pray to him and he hears me." Charlotte

For Peter, spirituality is a connection with God and implies that without this, there can be a detrimental impact.

"What spirituality means to me is… it's ultimately a relationship with God, through whatever sort of format or framework that people have it. I think that we have a spiritual part of our psyche, of our being, and I think that people's lives can be very detrimentally affected if there's a void there." Peter

Other descriptions of the relational function of spirituality, such as Cynthia's and Silvia's, referred to the importance of spiritual communities and belonging to a church

"Christianity meant to me that I had a worldwide family in a church." Cynthia

"…the other thing about spirituality is about belonging to a church, I'm not someone who just goes on my own with my spirituality, I like to be part of a church." Silvia

Spiritual community is described by Andrei as having an important global function within the Bahá'í faith.

"… in the Bahá'í faith, a key spiritual concept is the oneness of humankind… you have teachings about how to build a global community… and to that sense the purpose of the Bahá'í community is generally to create, to show that a global community on a smaller scale can function based on principles of religion and scientific reason." Andrei

The specific ways in which participants described spirituality to function within their stories in relation to mental health and recovery, is explored in detail in Chapters 6 to 8.

Theme 1.2: Changes within spiritual beliefs

Nearly all participants described changes over time in relation to their spiritual or religious beliefs. There was only one story in which a change was not clearly discernible. Five distinct types of types of change were found, shown in Table 5.4 below.

Table 5.3 Narrated changes within spiritual beliefs

Type of spiritual belief change	Number of participants	Description	Example quotes
From religion to spirituality	10	A religious upbringing, followed by a period of questioning or disconnect from spiritual belief, or of atheism, followed by a later renewed interest in spirituality not rooted within a religious tradition. Sometimes this included a rejection of the religious upbringing because it did not resonate with the participant's developing values or sense of self. Future interests in spirituality may be distinct from experiences of religious upbringing and focus on spirituality as a personal exploration. Mental health experiences might sometimes mediate this process.	*"I have a lot of problems with religion, or at least I should specify organised religion… this whole idea of acting upon a certain way just because you are scared of God didn't really make a lot of sense to me…So throughout my teenage years I think I identified much more with atheism… since then I've integrated tarot like a self-care spiritual practice… for me it was much more like sitting with myself and sitting with my, yes, people say my own divinity that you have in yourself." Morgen* *"…in the past I would have said I was religious… I was Christened a Catholic… I was like 'Oh Dad I don't want to go back to Church, they're not the people that I thought they were!'… so now I would say I'm more spiritual." Elizabeth*
Personalisation of religious faith	8	Participants practiced the same religious faith throughout their stories, however over the course of their development they described changes in the ways they related to, practiced or understood their faith. These changes involved their belief system becoming more aligned with their developing sense of self. They included changes in their specific religious denomination, or perceptions of their faith becoming more authentic.	*"So my faith has been something that has been completely personal and completely something that I've sought after and something that I've created for myself almost. And in a way that's quite empowering and special and it's something that's completely mine…I finally settled on a small C of E church… where I've been going since…I have still taken part in the… Quakers stuff... And I think being part of both of them that has finally come to a place where I can be both a Christian and a Quaker, so now I define as a 'Quanglican', so a Quaker Anglican." Anna*

From atheism to spirituality	6	Participants describing themselves as being atheist, or not spiritual or religious earlier on in their lives and then going through a process of seeking and exploring spirituality.	*"I was spiritually dead… believed in nothing, worshipped nothing, prayed to nothing, I thought that was all a waste of time… And then I started thinking about non-physical matters. About spirituality… and spirituality actually saved me, or, it started a journey." Gregory*
Deepening of religious faith	3	Participants describing no change in their choice of religion throughout their story but did articulate a deepening within their relationship with their faith. This deepening might involve an increasing commitment to their place of worship or spiritual community.	*"He* [God] *brought me home and I knew that something had changed… I learned to understand that it was possible to make this journey with God… And I felt that release and I knew something had changed and I knew that I could never go back to where I was. I became a committed member of the congregation." Angela*
Finding a new religion	2	Participants descriptions of not connecting with the religion they were brought up within. This was followed by a period of disconnection with spirituality and then later discovering a different religious tradition or denomination.	*"The school that I went to was a Church school so, I didn't really sort of connect with Christian faith at that time even though we were fed the Christian faith… at the age of* [later in life] *I became a Born again Christian" Michael*
No clearly described change	1	One participant's account did not describe a clearly discernible change in their spirituality or faith.	

Overall, the changes narrated by participants seemed to align with changes within their developing lives, identities and understanding of themselves. In that sense, most participants described a personalisation of their spirituality, that is, an overall process of developing increasingly authentic connections with their chosen spirituality, tradition, framework or approach. Whether it was a deepening or evolving relationship within one religious tradition, changes of spiritual approaches, or periods of spiritual disconnect or atheism, these seemed to resonate with personal developments within the participants' life, identity, beliefs or values. The ways in which such changes may have influenced or been influenced by mental health difficulties and recovery are explored in Chapter 7.

Theme 1.3: Spirituality as self-discovery

A number of participants described spirituality as relating to gaining a sense of on-going understanding about who they are as a person. This understanding was often depicted as resulting from a process of deep reflection and life experience, including periods of doubt, confusion, challenge and mental health difficulties. Therefore such participant descriptions of spirituality tended to orientate around the idea that it was self-defined and related to concepts such as inner-authority, personal autonomy, authenticity or the process of self-discovery. For example, Noam describes spirituality as a process of becoming closer to an ongoing sense of being "true to yourself."

> *"Now a big part of spirituality for me is also being true to yourself if you like. And that has been an ongoing part of, an important part of that process. I see my life from… in one aspect as becoming or coming ever nearer to who I really am and that's in terms of what I do with my life now and, engage with the world and so on."* Noam

In a similar vein, Rachel describes understanding spirituality as part of a journey which involves learning to trust a sense of personal inner authority.

> *"So I think that's also really important in my understanding of spirituality is the idea of each person being their own authority. That authority doesn't lie outside of us. It lies inside of us and being able to tap into that deep intelligence, again which is often quite different to what our heads might be saying. To really start to trust that, I think is a big part of the journey."* Rachel

Katie and Mingyu depict their understanding of spirituality to be centred around a sense of self and Katie highlights a potential challenge in being able to perceive this.

> *"It's* [spirituality is] *the essential nature of how you are, who you are, your being-ness. And in that way really it's easy not to see it. But it's in the not seeing it that the troubles start to kick in."* Katie

Mingyu expresses her experience of spirituality as strong self-belief, which seems to allow her to independently cultivate coping strategies that support her wellbeing.

> *"I just believe myself… because I think whenever I have problems I just, I may cry… and I believe I can solve this problem by myself… I need to take all of the sorrow, all of the sad emotions by myself. It's a way of my own growth. I need to depend on myself. That's why I believe myself."* Mingyu

For some participants, exploring and learning about different spiritual practices, ideas and traditions was an important part of their self-discovery and how they characterised spirituality. This was sometimes reported as being facilitated by the internet, or through creativity or travel. For example, Keyshia says that she used the internet to support her exploration of spirituality. She articulates that she was specifically drawn to the way in which this allowed her to discover her own form of spirituality in an adventurous way without the rules and hierarchy she experienced in her former belief system.

> *"… I was like 'I don't want hierarchy in my life!'* [laughs] *Because I did not want to feel anybody has power over me or anybody has like any measure of manipulation or whatever over me because of going through psychosis. So I started now looking into like other different types of spirituality and I found New Age and I liked New Age actually because it's one like you describe your own spirituality. They don't tend to have - well, only the YouTube, I mean the Google pages I could find - I couldn't find one that has like rules and things, it felt like it's like your own little adventure. Yeah, so I liked that."* Keyshia

Keyshia goes on to highlight a syncretic nature of her exploration, of combining different religions or spiritual approaches and "picking and choosing" which ones

best suited her. She says the lack of rules allows her to relate to and define spirituality in her own way and creatively utilise her imagination within this process.

> *"It's* [spirituality is] *very adventure-like and it's one that I'm defining for myself as well. So I'm looking into like Christianity, Buddhism and the New Age and all that, and just trying to find what suits me best and kind of creating my own* [chuckles] *spirituality so to say… So I'm kind of like picking and choosing which ones I like. And also just exploring with my own imagination, I mean, it's a relationship that doesn't have any rules so to say so you can create your own rules or just interact with the spiritual in an imaginative way and creative way."* Keyshia

Katie expresses that her main mode of spiritual exploration involved global travel and seeking to experience spiritual practices and understanding across different cultures and indigenous traditions.

> *"I've come to spirituality through, I spent a few years, several years travelling around the world, and in doing so coming in to encounter different traditions and religions, different people, different attitudes and different practices, and in and amongst all of that I think I've got a greater sense from all these different angles of what the unchangeable thing was at the centre of it that I was connecting with."* Katie

Spirituality was characterised as a form of self-discovery in a variety of ways, leading to greater levels of understanding or sense of authenticity in personal belief and perspective. The ways in which this was potentially mediated by mental health and recovery is explored in Chapters 6 and 7.

5.4 Conclusion

After providing a summary of participant characteristics and an overview of the analysis, key features of the ways in which participants characterised their understanding of spirituality were presented. A principal way in which participants depicted spirituality was in relation to how it functioned in their lives. This included ways in which it impacted upon their mental health and recovery and supported understanding, meaning and spiritual connection. Nearly all participants expressed spirituality to be a changing aspect throughout their lives within their stories, often in

relation to their developing identity and values. For a number of participants spirituality was characterised as self-discovery and therefore was defined in relation to an evolving understanding of the self.

Chapter 6: Meaning making

6.1 Introduction

Chapter 6 describes the second *a priori* superordinate theme of Meaning making that was explored through narrative analysis.

6.2 Superordinate theme 2: Meaning making

The superordinate theme of Meaning making is defined broadly as the ways in which participants described making sense of their experiences in relation to spirituality, mental health and recovery. After conducting the narrative analysis, three main themes were found: 2.1. Reframing, 2.2. Navigating mythos and logos, and 2.3. Discerning spiritual guidance (Table 6.1). Theme 2.1. Reframing, has three sub-themes; Bigger picture, Evolving and Validation. Themes 2.1. and 2.2 concern frameworks of meaning which denotes particular ways in which participants may have constructed meaning, for example to highlight a particular perspective. Theme 2.2 Navigating mythos and logos, captures participant attempts to articulate, navigate and make sense of spiritual, mythical, non-rational, or symbolic frameworks of meaning making, termed ‘mythos’. Often this occurred in relation to, integrated with or juxtaposed to rational, logical or scientific frameworks of meaning making, termed ‘logos’. Theme 2.3 Discerning spiritual guidance, highlights a potential function of spirituality in relation to providing guidance within meaning making in the context of spirituality, mental health and recovery.

Table 6.1 Meaning making coding framework

Theme	Theme description
2. Meaning making	The ways in which participants described making sense of their experiences in relation to spirituality, mental health and recovery.
2.1 Reframing	Ways in which participants framed or constructed meaning making in relation to their spiritual beliefs and perspectives and how this functioned in relation to mental health and recovery.
2.1.1 Bigger picture	A form of reframing in which spirituality enabled a more effective broader perspective.
2.1.2 Evolving	The ways in which the process of reframing meaning was described to be fluid and evolving.
2.1.3 Validation	A function of reframing meaning in the context of spirituality and mental health as being validating.
2.2 Navigating mythos and logos	The interplay, integration and juxtaposition of spiritual 'mythos' frameworks with rational 'logos' frameworks of meaning making and their potential effects upon mental health and recovery.
2.3 Discerning spiritual guidance	The role of various forms of spiritual guidance (e.g. intuition, synchronicity, coincidence, signs and visions) and ways these are discerned in relation to functional meaning making, mental health and recovery.

The specific frameworks and contexts of meaning making described by participants varied according to their personal experiences and belief systems. For example, James says he arrived at a framework which guided and supported his own meaning and decision making through a process of searching, exploration and researching of spiritual information.

> *"I started reading a lot more outside of the educational system, started reading books about astronomy and astrology, all different things. I was just looking for as much information as possible, answers about my place in the world… I came to the conclusion that there must be a God… There must be some sort of creating force else why would I exist… He's revealed things about my own path that gives me a great deal of meaning and direction… I wanted to make sense of life and my place in the world… I just wanted to make the right decisions."* James

Whilst James's description of sense making seems quite cognitive or cerebral, arriving at an understanding from a process of research and almost logically deriving the existence of God, Helen talks about spiritually informed meaning making quite differently. She articulates it as something which doesn't "help" her to understand, but, more directly and viscerally "makes sense." She describes it as a form of knowing within her body and a way in which the experience of truth could be a kinaesthetic sense or feeling.

> *"Help me make sense? I would just remove 'helped' out of that sentence. It's* [spirituality has] *made sense. It makes sense - I mean making sense - making – sense - is just, is feeling isn't it? Sense is actually feeling the truth about things, it's making sense isn't it, feeling,* [inhales] *finding your truth and sensing it on all levels. Yeah. But my body makes sense of things as well you know."* Helen

The process of meaning making was not always described as straightforward and some participants seemed to find it easier to articulate than others. In addition, meaning making could be confusing. Most participants' stories were characterised by periods of questioning of beliefs, doubt and uncertainty. However these were mostly articulated as particular periods within the story, sometimes as turning points which led to realisations, renewal of meaning or personal growth. An example of the struggle to find a suitable and functional meaning making framework was provided

by Cynthia. She describes a previous blind faith in God which disintegrated into confusion and loss of meaning which detrimentally impacted her mental health and perception about her ability to recover. The difficulty for Cynthia seemed to be connected with what she describes as a contradiction in her faith.

> *"I find it difficult because I might have a contradiction to my faith. I think we're meant to be joyful and live life to the full and all this but I feel paralysed in a way, unable to do that… And so I'm living all these contradictions… and I'm stuck and can't move on in my life. And I don't know how it can get better… I find living life at the moment with spirituality as a theme, it's hard, very hard, to live your life when you feel as if you're contradicting everything you believe in just because of fear and not knowing what you really ought to be doing or scared to live a life on your own."* Cynthia

Although Cynthia's struggles in meaning making seemed to have negative implications for her mental health, most participants described the process of constructing meaning making frameworks in the context of spirituality to be supportive of their mental health, particularly when viewed within a temporal context over a developmental trajectory within their story. Although the ways in which they did this varied, characteristic patterns or frameworks could be discerned across participant stories which are described below.

Theme 2.1: Reframing

The first theme highlights the ways in which many participants described ways in which their spiritual perspectives enabled them to reframe their experiences, understanding and ways of making meaning. This was depicted as providing various functions which supported mental health and recovery. For example, within his Bahá'í faith, Andrei describes the reframing of challenging experiences as a test with the potential towards positive transformation.

> *"Because all I could do was… think 'Why is this happening to me' and try to make sense of the universe… And this is the key principle for theodicy in the Bahá'í faith. So something bad happened to you because this is taking you somewhere good if you're willing to go with the process and have the right attitude. And it's also a test…"* Andrei

For Andrei, a religious outlook seems to provide balance and a sense of fluid perspective which allows him to reframe particular issues such as suffering in a meaningful way that supports his mental health.

> *"For me the religious outlook gives you a particular balance… I've learned of a way of thinking that makes sense and I'm using it, and it gives me perspective for many things… I mean that's what religion is. It gives a perspective about the world in which you have to, you frame certain key issues. Like for example you frame suffering… So if you frame these things in a meaningful way that is not rigid and static and limited, that's very helpful… when you talk about coping with mental health and health issues and issues of any kind, this sort of perspective really really helps…*
>
> *And I think any health issue would focus you, what's most important in your life and what is life to you? After you go through this kind of terrible thing you start to see connections... you start to see the tapestry of life."* Andrei

The process of reframing was characterised in a few specific ways in relation to its described functioning: as providing a 'Bigger picture', as 'Fluidly evolving' and as sometimes providing a 'Validating' function which are summarised in the following sub-themes below.

Sub-theme 2.1.1: Bigger picture

Sometimes spiritually-informed reframing was described by participants to involve figuratively stepping back and attempting to gain a 'bigger picture' perspective upon their lives, mental health or internal psychospiritual landscape. Lajla describes this bigger picture as including her religion and relationship with God which, she says, offered comfort and a way of better understanding her mental health difficulties and recovery.

> *"I think it* [belief in God] *helps with somebody who has anxiety to like have a constant reminder that there is something that is always there for you… So for example, some things that used to be problematic for me and caused me my mental health issues, now I don't see them in the same light anymore because I managed to sort of like understand them in a better way… I think religion in particular helped me understand… that the problem that you're facing at the moment… It can be overcome if you just like take a*

step back and look at the big picture. In that sense, my anxieties disappear and so I would say in terms of recovery, it plays a great role." Lajla

Helen describes her spiritual framework of meaning, rooted in Shamanism, to function by providing what she calls a "geography" with "tools" which help her to chart and navigate different internal landscapes. She says this helps her to understand and overcome obstacles and to gain a bigger picture perspective of her life which can provide a helpful rationale for making sense of difficulties.

"Shamanism has been amazing really in terms of giving me a geography… tools to understand all the different landscapes that exist and how to chart one's way through there, how to unlock things when you get stuck… It's just like it makes sense on the biggest level possible, on the biggest scale of things... And I now on a good day have the perspective that everything that's ever happened to me has happened for a reason, including the things that one would traditionally see as being rather bad." Helen

Rachel echoes Helen's landscape idea in her own account, which includes archetypal markers which to her seem to move beyond subjective experience towards something which can be mapped.

"And obviously all our experiences are unique, but I do think there is a - you can have an understanding of the lie of the land… I think there is an archetypal mystical journey that has particular points to it… So it is possible to have a map and to know - to have an understanding…" Rachel

Some participants described the bigger picture perspective using vivid metaphors and imagery which seemed to facilitate understanding including of mental health and recovery. For example, Carl utilises the term "emotional archaeology" to describe the process of exploring and excavating his internal psychospiritual landscape to reveal self-knowledge.

"So there was a necessary, emotion archaeology to be done to understand… Going back into your own past and, you know, in the same way as you would excavate a site, looking at the features and saying, interpreting them and saying 'Well what did that do?'… So actually only by looking at it, and then you go… 'I'm not going mad, there's a reason for it!'

It's reassuring in a way. It's a bit frightening to look at it, but once you have that self-knowledge you can then do something with it." Carl

Carl explains that this kind of perspective and understanding was made possible through his spiritual practices, courses, and psychospiritual work. These supported management of his mental health issues by providing access to metaphors and helpful ways of thinking which allowed him to functionally reframe his story.

"… what it [spirituality] *has done is given me access to ways of thinking and environments where I can both look at and deal with mental health issues… it was the fact that I went to this workshop and had this new tool, this new way of looking at things that actually helped. And yes whatever it was, the ritual or the thinking behind it was there, but actually that was a metaphor for something else that, it was a way of telling the story if you like that helped me to retell the story, reframe the story in a different way that sits more comfortably in my head today."* Carl

Although, the archaeological work of excavating meaning utilising spiritual insights and tools was described to have positive outcomes for Carl, he presents a warning, using the imagery of 'light' and 'dark', about this work being potentially inherently challenging.

"So we're not encouraged to go and explore the very fringes of thought, and therefore we're not encouraged to go to the dark places, and shine a light into those dark places that helps us to accept them. But it does need to be done in a safe way… that's the issue with spirituality… you have to take more responsibility for yourself in spirituality I think, which is difficult if you're in mental health crisis." Carl

The metaphor of light and dark is also used in Helen's story, who describes it in relation to the challenge of meaning making in response to a traumatic experience in her early childhood. She utilises the imagery of her potentially dissociative experience of floating in space to reflect upon her later experiences of depression. There is a sense in her account in which her recovery has allowed her to reframe the "alien" blackness by understanding it as part of the landscape that is needed to see the light of the stars.

"…if I left my body and I went out into outer space… into the blackness of space… there was no warmth, there was just nothing. Did I look at the blackness or did I look at the stars? Which way do you face when you have nothing? Do you look at the nothing or do you look at the lights that are always there? Because there's always light within the dark… that's been my journey… for years I was depressed…. I was looking at the blackness. I was looking at what wasn't there. And now I've made a conscious decision to look at what is there. Acknowledge the blackness, but not see it as - alien… it's just part of the stuff of what actually is. You can't have the stars if you don't have the space to have the stars." Helen

The last sentence in Helen's comment relating to having the "space" from which to see the stars may epitomise the importance of reframing in the context of spirituality and mental health. Reframing seems to provide an important way in which participants describe constructing meaning which offers a helpful change in perspective. Such perspectives, which could also offer a 'bigger picture' frame of understanding, seemed to be supportive of mental health and recovery.

Sub-theme 2.1.2: Evolving

For some participants the process of reframing meaning was described as being fluid, progressive or evolving. For example, Helen describes a process of learning, within her spiritual tradition, about what she calls "pain tapes" which she says is concerned with limiting beliefs rooted in past painful experiences. Through becoming increasingly aware of these limited beliefs, Helen describes a process of transformation in how she reframes and consequently can relieve pain.

"Pain tapes, so limited beliefs about myself or the world that were false and painful, because it's all a question of perspective… And if you accept the experience then the pain element of it starts to dissolve… if I really leapt into that pain experience and fully immersed myself into it then it changed and improved and altered. I could actually relieve the pain… You face it… And once it's seen then it changes." Helen

Rachel describes a functioning of meaning making in relation to allowing new meanings to be found and experienced rather than there be one definitive 'answer.' She describes the importance of the ability to "be" in the meaning without having to

definitively conclude what it must be about. This implies a function in the fluid and evolving process of meaning making.

> *"I've had a couple of experiences where - things come up that clearly aren't from my life… So we could speculate about past lives or collective unconscious or whatever it is… without needing to say 'Yeah but this isn't real because it didn't happen,' or just being willing to be in it… without needing to then go 'Oh well I had this experience so I 100 percent believe in past lives'… it then doesn't need to become a thing. So what I see frequently in both myself and others is that there's a richness of the understanding-making that a deeper meaning then comes out of."* Rachel

Rachel goes on to suggest that the ability to openly hold newly evolving or expanding meanings without having to definitively conclude about them may be supportive of a psychospiritual developmental process.

> *"It's like a lot of the beliefs I had have actually completely unravelled. So meaning that was in existence has become sort of unmeaning… there's always an openness to the meaning then becoming something else… something else could come along and go 'Oh right OK. Well here's another layer.'*
>
> *So there's not a kind of holding on to 'Well now I know that this means this and so I have to kind of keep that and hold it and solidify it.' It feels like it's a more organic kind of meaning making that essentially doesn't really have an end in a way…. there's always an openness to a different angle on it or a different kind of insight… it means that we can hold meaning with much more ease… because it is evolving and fluid. … I don't need my beliefs to be 'me' in the same way that I did."* Rachel

Rachel's description of meaning making as evolving and fluid suggests a way in which the reframing of meaning making may function in general developmentally, and to potentially support mental health and recovery.

Sub-theme: 2.1.3 Validation

Some participants described how their spiritually-informed meaning frameworks offered a reframing which helped to validate their mental health and spiritual

experiences, including those which were difficult to otherwise conceptualise or explain. This experience of validation was sometimes described as having an effect upon mental health. For example, Thomas highlights the role of spirituality, in his case Zen Buddhism, on his challenging thought processes by acknowledging and validating these experiences and providing a vocabulary for them.

> *"A lot of the Zen literature is about - thinking and how we think and difficulties in thinking... Because that was my problem, I would get involved in this like train of direct thoughts that took me downhill quite quickly but that didn't ever seem to be invalid. I didn't want them to go away. I wanted them not to be a problem. And Zen seemed to be saying 'Yeah, all of those things are completely true and thinking is a tremendously difficult thing and we have been working on how you can,* [chuckling] *you know, do it better… They've got a big vocabulary for describing states of mind…"* Thomas

Thomas goes on to describe how Buddhism provides a framework which seems to speak to his understanding of his internal thinking processes. He contrasts this with his experience of a clinical approach towards segregating illness experiences, or the "bad stuff" from the "good stuff". This latter approach had not seemed helpful to Thomas, and instead he reports that the non-pathologising change in focus provided by the Buddhist framework supported his understanding and mental health recovery.

> *"If you're thinking about thinking about thinking… that's an illness and we can cure that. And it felt like the Zen approach was much more 'Oh that can happen'… And I was like 'Yeah, this is somebody who's not trying to divide the world into the good stuff and bad stuff'… Because my experience has been that you can't ever do that… And that with a change in focus… some of them just stopped being problems and they kind of dissolved because I understood them… the way my head works isn't a problem I'm trying to get rid of… And that's kind of what Buddhism feels like to me."* Thomas

Rachel echoes the validating effect of not viewing mental health symptoms through a pathologising lens. She suggests, rather, to conceptualise them in relation to what she calls their "essential intelligence" and potential wisdom which for her is contextualised within a spiritual framework of meaning. She describes experiencing

this in herself as well as clients she works with holistically and how this deeper perspective of understanding seems to support the recovery process.

> *"I think the deeper we go the more we're able to hold the symptoms and look at them really deeply, the more they reveal their intelligence to us… And it was hugely validating. And I see this with clients all the time. That we think like 'Oh my God, there's something really wrong with me. I'm wrong, I'm fucked up.' And actually to see that all of these mechanisms started out, are rooted in the system's own attempt to find what it needs or to heal itself in some way… And when we peel it back to that place, then recovery takes on a different tone. I think then it becomes not stopping the symptoms but being willing to be curious about the symptoms and willing to explore them."* Rachel

Noam describes how the process of validation from his counsellor in relation to the importance of spirituality within his own meaning making process had been very supportive. This was particularly the case in light of the indifference or negative responses he says he might otherwise receive.

> *"I've told the counsellor that I work with my spiritual teachers and he had to get his head around that… when I was talking about spirituality and he just said 'Yes this makes sense to me', and that was wonderful… it was helpful, it was also very gratifying and it made me very happy in that it was validation. Because again in this society, unless you go to particular places you don't get validation for spirituality; you might get the opposite, or you might get nothing, indifference. So it was very helpful that the counsellor helped yes… and rather than push it away, integrate it or allow it to be integrated."* Noam

Participants narrated the meaning making processes to sometimes be supported by the ways in which their spiritual beliefs or mental health experiences offered new more helpful or informative perspectives. Such reframing seemed to function by including bigger picture understanding, approaching meaning making as a fluid evolving process or by offering validation of personal experience.

Theme 2.2: Navigating mythos and logos

The second main Meaning making theme concerns how participants described and navigated two distinct and potentially contrasting overall frameworks of meaning making in relation to their experiences of spirituality, mental health and recovery. These are characterised as either non-rational, spiritual, mystical or symbolic ways of understanding, termed 'mythos', or, on the other hand, rational, logical or scientific frameworks of meaning, termed 'logos'. These categories are not precise descriptions since, for example, spirituality could potentially be conceptualised as rational or constituting rational, scientific or logical components. For the sake of simplicity, the terms 'logos' and 'mythos' were utilised to provide a general and broad conceptualisation in relation to ways participants described processes of sense making. Participants depicted the integration, juxtaposition or, at times, rejection, of these forms of understanding as supporting the functionality of their meaning making process as well as their mental health and recovery.

For Andrei, these contrasting frameworks are described as "objective" and "subjective" and, he says, support his understanding of the world and his health through finding balance between them.

> *"…for me it's an issue of epistemology, it's how you see reality and how much you learn from it. And some part of it is more objective, some part of it is more subjective and you try to correlate the two and make sure your subjective interpretation is not out of balance, it's not unbalanced… for me it works, and for my health it works and my doctor… actually he said this to me, that I am such a positive example in how I cope with it medically."*
> Andrei

Carl's story demonstrates the role of an increasing emphasis upon the rational logos framework of meaning making as an important step within his recovery and psychospiritual development. This seemed to provide a balance to the previous emphasis on spiritual mythos frameworks of meaning informed by a tendency to engage in a variety of spiritual practices, groups and courses. The turning point seemed to be instigated by a focus upon study, learning about psychology and the "rational exploration" this then inspired. Carl's experience of greater objectivity is described to support his psychospiritual understanding including identifying unhealthy attachments.

"…that whole sort of very rational psychological thinking started to change the way that I looked at things. And I think that rational exploration of things started to knock down some of these things that I'd been clinging to as a crutch, and make me look at them in a more objective way, and - start to really drill into some of the things I realise now." Carl

The process of integration of logos and mythos meaning making frameworks seems to continue to develop over the course of Carl's story. He describes a progression that was not possible from the rational focus provided by his counselling sessions and was instigated by a spiritual practice of embodied cathartic healing.

"What helped me turn the corner eventually was… I was looking at Tantra… was some really cathartic work… I think I'd done the counselling very rationally, but I'd not let myself go. Whereas the opportunity to, in a safe space with a teacher who I had a great deal of respect for, to do this cathartic, and actually get back to where the real triggers were… And I think for the first time in my life I realised that, as it always does, it goes back to your childhood and your parents… But I think all of that came out in this very cathartic work that I did." Carl

Carl's psychospiritual development and recovery therefore seems to have been facilitated by an oscillation between and integration of logos and mythos approaches to meaning making. He suggests that his rational focus may have provided him with a more objective perspective and heightened ability to discern what was helpful or less helpful within his spiritual and therapeutic explorations. It also led him to rejecting more dogmatic approaches to spirituality and potentially developing increasingly functional ways of making meaning supportive of his mental health and recovery.

"And so the combination of that and the more rational thinking I was doing in a sort of academic way, I started to… let go of some of the things that… I'd been dabbling in… I've looked at them objectively. I've realised what they were giving me and what they weren't giving me… the whole religious dogma… I now reject. But what I have held onto is this sense of, you know that you can connect with the world in a more aware way, and you may or may not call that an energy… And that in itself has made me feel better in myself. That coupled with knowing why I'm like I am, and why I feel the way

I am has led me to feeling more sorted now [chuckling] *than I've felt ever in my life."* Carl

A significant number of participants highlighted the importance of mythos ways of understanding and the effects of this framework of meaning making upon their experiences including their mental health and recovery. Some of these descriptions highlighted the distinction between mythos and logos frameworks of meaning. Mythos approaches were sometimes viewed as supporting functional meaning making, particularly in relation to certain external, conditioned or cultural narratives which might over-emphasise logos frameworks. For example, Morgen, having grown up within a culture and education system which strongly emphasised atheism and rationality, describes how contact with spirituality in her early adulthood provided her with greater levels of understanding about herself.

"My spirituality has helped me to make sense of it in the sense that I am recognising much more that I am not just a rational human being… I was really struggling with a lot of these things… being really rational, like science and all sorts, so I feel like spirituality has helped me to come to terms that it's not all so clear-cut and it's not all so straightforward and people are not one thing or the other, but we are all wobbling a bit about in certain spectrums or in certain spaces and there is lots of change." Morgen

Morgen explains that the spiritual shift in emphasis within the development of her framework of understanding supported her mental health and recovery because she felt unwelcome and unaccepted within those scientific spaces which she says denied the reality of spirituality. Morgen implies that spirituality provided a kind of counter-narrative which created an acceptance for her identity.

"I think it had [impacted on her mental health and wellbeing] *like me discovering this more funky way of spirituality I think it definitely had a positive impact for sure. Because I feel like a lot of… atheist practice or atheist, let's say, discourse is incredibly, incredibly racist, sexist, misogynist and homophobic…. science being held up as this pinnacle of objectivity… this movement has very little to offer to me except old white men yelling at clouds…*

… these are spaces that I'm not welcome in and I know that when I was interacting with these spaces that my identity and who I am weren't really acknowledged… they don't even look at it and put it in the bin, because it might have a spiritual influence or it comes from a softer place. To come into the space and be like, no… we need tables and numbers and nothing else counts, is quite an intense thing to do considering we're just organic blobs moving about." Morgen

Katie explains how making sense of her mental health and recovery involved a process of surrendering the temptation to be logical and rational, because, she suggests, these frameworks may not always be relevant or helpful. Although, something she calls "objective observation" may be beneficial, she reflects that the process of trusting and "being with" the experience may sometimes be more useful than the attempt to understand and be logical.

"But also in the mental health side of things, there's an aspect of it that involves the trust and the letting go, the surrendering, because it might not be able to be understood. It might not be something that's happened in my life that I can understand… that carries with it a certain traumatic response that I can't understand to fix. So there has to be an element of not needing to rationally understand to overcome things as well. The objective observation helps, but the being with is the most important, because I think it's very easy to try and get logical about it all." Katie

Participants used various concepts and language to describe more specifically the ways in which mythos forms of sense making supported them and their mental health. For example, Morgen uses an array of concepts including "dream" and "magical", as well as "imagination" to describe the "soft" and imprecise mythos realm which she suggests people may connect with. Despite being difficult to precisely explain, Morgen implies that it may have a creative potential within its spiritual function.

"…this idea of that you can't access all of these things inside yourself and you're… this organic blob… when you dream about stuff, I feel like there is something very magical in there… maybe I don't have the super precise language to explain this, but I feel like there are so many things even inside

yourself that people can't a hundred percent understand or a hundred percent explain...

I feel one part of consciousness is in itself quite spiritual with like dreaming and memorising… these are such like soft, out there kind of things we are able to do right? Like… I could dream about, or you can imagine something, imagination also… I think that's incredible... I think there is something in there that's quite magical or quite spiritual in a sense…" Morgen

Mingyu explains the way in which her imagination may have played a role in cultivating a personalised form of functional spiritual meaning making. She says that this supports her during times of stress for emotional regulation and to guide her in making decisions.

"I think it's spiritual because… there is another me in my heart telling me what's the wrong thing, what's the right thing…. Sometimes in my imagination when I was three I just created some stories.... From my childhood I just imaged I'm an actress in my heart. In my heart another me is an actress, a hero. When I grow older… when I prepare my exams I will feel very pressured. Then another hero in my heart will experience some very relaxing things, unlike my reality. So I use these ways to comfort myself… and transformed those sorrow things into happy things to image how these things can be a happy thing… it's just like meditation. Through this process maybe I can find the solution…. It's just helped me to make better decisions…" Mingyu

A few participants described what may be construed as "mystical" experiences which are broadly defined as experiences which may have an anomalous, numinous or transcendent spiritual quality. Participants sometimes found these experiences difficult to tangibly describe or understand but despite this they were often depicted as having a profound or life-changing impact. For example, Rachel described mystical experiences following what she called a "spiritual awakening" and a crisis period of mental health breakdown. She says that the mystical experience impacted her awareness of her sense of self, so that her perception shifted to what she describes as a form of unity consciousness. She noticed that from this view, her usual sense of critical self-judgment disappeared. This may have

impacted her mental health and recovery over time as she explains that this form of negative thinking, over the years, had disappeared.

> *"So this was probably one of the most profound, what I would now call like awakening or mystical experiences… a whole sort of series of insights that just came… There was this huge kind of undoing of the whole kind of position of self as it were…. the words that are often used are things like, 'unitary consciousness' or 'oneness'… I wasn't seeing it through any sort of conceptual filters anymore. It was like that whole layer had gone… the normal run of judgments wasn't happening… I used to have a really strong inner critic… And it just - over the years it's just really not there… there isn't any of that old self-talk. That's completely gone."* Rachel

David also describes mystical experiences which relate to his connection with and use of crystals. He describes the kinaesthetic, transcendental and other felt and sensed experiences when he holds crystals and interprets these positively as invigorating. Although David acknowledges he would prefer scientific explanation for such experiences, they seem to positively impact his mental health by helping him to feel connected and less lonely.

> *"I feel things from them* [crystals]*, I get energy, and I see things and I hear things. I don't hear voices or anything like that, it's rawer than that it's like energy. I can hear tones, I can hear, I can see, like if the lights are dim I can see sort of sparkly kind of things, sort of shapes and I can feel energy. I feel tingly in my body, I feel sort of electrical impulse… And it feels good, you know, it makes me feel invigorated.*
>
> *… get to the mental health difficulties…, I just felt a lot of loneliness, isolation… And connecting with the crystals gave me something that sort of transcended a lot of that… it could be just a figment of my imagination what I'm experiencing, but it's a comforting illusion. It makes me feel like I'm not alone for whatever reason, it connects me to something transcendent… I guess I want proof scientifically and there is no scientific proof of what I'm experiencing… it's a non-verbal experience… It's a different type of consciousness."* David

The lack of tangibility or clear explanation seemed to be characteristic of mythos experiences yet they nonetheless often provided important components of participants' meaning making processes. They were also often a feature of a form of meaning making in which participants' said they experienced a sense of spiritual guidance which is explored in the following theme.

Theme 2.3: Discerning spiritual guidance

A number of participants talked about various forms of what might be broadly conceptualised as the experience of spiritual guidance. The frameworks of meaning in which this guidance was experienced were more often mythos than logos due to their spiritual and sometimes mystical or symbolic nature. However sometimes participants described utilising logos approaches to rationally discern the mythos spiritual experiences and guidance. Understanding and navigating the meaning within these experiences could sometimes be challenging or confusing, particularly in relation to mental health difficulties. On the other hand, when participants described discernment processes which seemed to functionally support meaning making, this was often reported as having positive effects, including upon mental health and recovery.

Noam describes intuition as an important form of spiritual guidance in his own life. Because of the oppressive cultural context Noam depicts growing up within, his intuition may not only have functioned as a form of spiritual guidance, but by also helping to keep his personal integrity and authenticity intact.

> *"…the vast majority of my life in fact was controlled from the outside. So there was a lot of stuff on which… it was too risky to make decisions that really involved how I really felt, or what I really wanted to do, or what I really had to say... But I had good intuition and there was also scope for … knowing what to accept of the things that I was brought up on and taught and brainwashed into… and what to reject… So this intuition, which I consider part of the spirituality that I experienced, was there as well and very very helpful."* Noam

Later in Noam's story, he describes intuition as guiding a process of healing and recovery from his past trauma. Utilising this intuitive and spiritual connection, he articulates engaging in what he calls 'self-therapy', to find ways to solve problems and find answers within himself.

> *"I began to do something which could be defined as self-therapy. But again it's all come from intuition, this is nothing to do with intellectual reading… studying and reaching conclusions and applying them… it all came from within from this part of me that was connected with that light, with that spark, intuitive. Now what the intuitive ability I suppose or element in me gave me was an awareness that the source of my problems was within me and therefore they were transformable or solvable from within me. And it became a matter of… thinking in a particular way, in an, obviously an intuitive kind of way… and then the answer comes. And answers did come, you know, insights, and I did make progress."* Noam

A commonly reported form of spiritual guidance within participant stories related to the experience of receiving and interpreting spiritual signs or messages. Participants most often described these phenomena as synchronicity and coincidence, and sometimes also as signs, messages, dreams and visions. They operated in different ways within people's lives, sometimes as internal or mystical experiences, or sometimes through events, conversations or interactions with other people, and were articulated across different spiritual belief systems.

Most of the participants who spoke about this phenomena, described related positive experiences such as feeling spiritually guided, connected and supported. For example, Charlotte shares an experience of being prayed for by others and of then receiving information from them which feels personally and spiritually significant. She interprets this as a "crazy coincidence" which she believes God is somehow involved with.

> *"And sometimes when other people are praying for you… they kind of know things that they shouldn't know or can say things that they don't understand but have a real significance to you… and like what would be a crazy coincidence if you didn't believe that God was involved. So I've had people give me pictures or words or just be able to comfort me in ways that they shouldn't be able to because they don't know things – that, I believe, is God.."* Charlotte

Like Charlotte, Cynthia alludes to a sense of God or a spiritual presence guiding through life situations or people. Cynthia offers a rationale for how this presence

functions in her life – to offer help, provide her with strength and to help her to cope, particularly when she is struggling to manage on her own.

> *"I've believed that spiritually… the people that I met on the way were there, to help me in different situations that I couldn't have managed by myself… helping me to cope in these situations… And I believe that God seemed to put people there that could help me… And I thought well, that's a bit of a coincidence… somehow God's spirit was there in things that were happening… I felt a strength that to me at the time was a help - I was being helped by some kind of spirit…"* Cynthia

The ways in which Charlotte and Cynthia talk about spiritual guidance via coincidence as embedded within their religious belief contrasts with Elizabeth's more pragmatic description of this phenomenon. She highlights the importance of a sense of control, choice and creativity within her life and reflects that the idea of coincidence, although helpful in this endeavour, may well be nonsense. She reasons however that, although this idea may be a thought or belief, it can hold power, and therein lies its functionality, which for her is a sense of increased positivity and empowerment.

> *"I feel like I've got control now, of my life… I just… feel like I've got somebody guiding me more now. All these just little things, little coincidences that happen. I don't think they are coincidences any more... Somebody was guiding me to do it… even if it is a load of baloney, I mean why not? Why not have these thoughts because – the more you believe in something the more power it has and the more it works. And life is just so much more positive now for me, you know? And magical and wonderful and I really do now believe the sky's the limit."* Elizabeth

Lajla emphasises the importance of a sense of rationality when understanding spiritual guidance, which she conceptualises with the term 'signs'. She describes this as something that was important to her in her earlier life and provided a sense of comfort until she researched this from a psychological perspective. This led to her disputing her earlier experiences with the spiritual meaning they provided her, and reframing them according to a psychological understanding as 'confirmation bias'. Although this allowed her to view her experiences within a more rational framework,

she seems uncertain whether this had an entirely positive result, as she says it "broke all my dreams."

> *"I think there is something out there that we can't really define and that gives me comfort… I sort of like believe in energy and like signs and stuff like that… it was a big thing for me maybe like years ago. I was reading a lot about that, trying to understand, you know, from the psychological perspective and also I kept on like seeing things that could like give me signs and I would like follow them. But then I didn't know whether that was… good or bad…. And then I heard something that really like broke all my dreams… I read this book… called 'Confirmation Bias'… It's the sort of bias that we create in our head."* Lajla

Lajla describes a kind of cognitive dissonance between the competing narratives of her former more spiritually-informed framework of meaning and later developed rational and psychological one which seemed to suit her identity as an academic and her need to understand in a scientific way. However, she acknowledges that this shift in perspective has felt like she is working against and harming herself in some way, perhaps because it fails to provide the comfort of her former frameworks of meaning making.

> *"I really like to understand everything on a very scientific way. I'm an academic. I want to break things down to what they mean. So sometimes I'll be working against myself in a way because the more I, you know, destroy these illusions that I have, I feel like it's harming me. Like I feel less supported. Whereas, if I was just living in my ignorance, I'd be fine* [laughs] *maybe seeing signs and stuff… I do strongly believe that it all depends where your focus is and what you want to do and achieve. If you are looking for a comfort, for example, you would then focus on signs and focus on these things that give you comfort."* Lajla

Other participants' accounts of coincidence, synchronicity and spiritual messages described potential challenges and confusions within interpretation, particularly in relation to mental health difficulties. For example, Silvia describes how she seeks guidance from God when she feels uncertain about what to do. She says that coincidences are a way in which God speaks to her and answers her prayers. Although Silvia perceives these coincidences as guidance from God, she also

highlights an awareness of the need not to be “silly” with such interpretations and to “weigh and test” the information and messages using her “brain”. This connects with the earlier theme of integrating logos frameworks of understanding to potentially support the functionality of the mythos meaning making process.

> Silvia: *“I’ll ask for guidance as well, if I don’t know what to do in a certain situation or… the direction of my life, I pray for guidance and then I feel that God speaks to me. Perhaps it’s a coincidence that happens and I feel that that coincidence means that God has spoken to me about it and so as part of my prayer life I have to trust God that he will guide me if I ask for guidance…”*
>
> Interviewer: *“Can you say a bit more about that coincidence… and the way that you receive guidance?”*
>
> Silvia: *“It may be that I have a conversation with somebody and they’re talking about exactly the same issue that I’ve just been praying about, that sort of thing.”*
>
> Interviewer: *“Do you see that as a sign of guidance from God?”*
>
> Silvia: *“Yes. Possibly, because I have to use my brain as well, I don’t feel that I should be silly and just imagine things. I feel that I have to weigh and test information and messages that come to me and I have to use my brain, not do something stupid.”*

Silvia goes on to highlight experiences of receiving messages from God that are unhelpful and which she connects with her mental illness because she feels they could lead her into “potentially dangerous situations”. Attempting to illuminate what distinguishes the experience of functional versus non-functional messages of spiritual guidance, Silvia articulates that the two are quite similar but the ones connected with her illness feel stronger with a greater force of conviction. In these cases, she might engage in repetitive behaviours which may have an obsessive nature. On the other hand, during times when she experiences the helpful guidance, Silvia says she would be more likely to weigh up the information received and therefore integrate a more rational aspect to the process of meaning making.

Silvia: *"I used to read things in the newspaper or listen to things on a CD and it used to feel that it was especially for me, a message for me as if from God. A special message for me, which of course it wasn't, it was all just part of my illness…"*

Interviewer: *"And how do you experience those experiences…?"*

Silvia: *"They're just like normal thoughts, it's just like normal thoughts and they feel absolutely true and absolutely right and it feels like the penny dropping kind of experience, 'Ah that's this, that's that.' And of course it leads me off on a tangent into potentially dangerous situations…"*

Interviewer: *"And how do those experiences compare with what you told me before that was a helpful guidance… from God, like the coincidences?"*

Silvia: *"It feels a bit like what I feel when I'm well and I feel that there's a coincidence. It feels a bit similar to that, but it feels stronger than that, it feels more forceful. Yes… it feels overwhelmingly true; whereas when I'm experiencing a coincidence I'm sort of thinking now is that - could that be God speaking to me? And weigh it up and think 'Yes I think it is' or weigh it up and think 'No, it probably isn't', so it's slightly different."*

Interviewer: *"Are there any other differences in those two experiences?"*

Silvia: *"…Say like it's a CD that I felt the words meant something to me I might play that CD over and over and over again when I'm not very well. But I wouldn't do that when I'm well."*

Alexandra gives an account of potential developmental stages of meaning making throughout her story, which include the experiences of what could be interpreted as both functional and dysfunctional meaning making processes that impact her mental health and recovery. She describes a challenge in learning to navigate this effectively which she says was rooted to some degree with her experiences of attending church and an over-emphasis given here on interpreting religious meaning and signs. She says that the lack of control she experienced within this context may have led her to later feeling wary of such interpretations and a consequent lack of trust in herself.

"So the church I was involved in in my teens you'd be… seeing signs around about what you should be doing… so maybe giving too much significance to those things. And so, then if I did start to realise I was getting more in touch with my instincts and seeing those connections more, feeling a bit wary of it, because of having experienced it in a kind of churchy way… so it takes the control away from you… if your mental health is breaking down then that can be a sign of that anyway, like finding over-significance to connections… and you're thinking that something's happening when it - isn't… But mainly I think it was around feeling like you can't trust yourself." Alexandra

As her story unfolds, Alexandra highlights the functional contribution of developing discernment within the process of meaning making, which may have impacted upon her recovery by allowing her to more effectively make sense of her perceptions and experiences. Not dissimilarly to Silvia's earlier account, she also explains how holding the information lightly, rather than with the conviction she experiences during a psychotic episode, is helpful, as it allows her to apply a form of critical rationality to the process. The element of doubt and taking time to decide how best to respond also seem to add to the functionality of her meaning making process.

"It's not only having a better idea about how things are, but sort of learning that kind of discernment to sort of sifting through and the being unsure, holding things lightly as part of it. You know whereas in psychosis that's completely not what it is, it's being you're so sure that you can't [chuckling] *think about it. Whereas actually being able to hold something lightly and not be sure is maybe part of working out if it's the right thing or not… I had to have that element of doubt because of that, that actually I'm getting more comfortable with it, to sort of see it quicker… not to just charge ahead with it straightaway..."* Alexandra

Alexandra goes on to describe how discernment and learning to trust her instincts rather than be frightened of them, has helped her to be with and navigate her experiences with potentially more awareness rather than reacting to them through "grabbing hold" of them as she may previously have done.

"…the pondering and wondering that can build a discernment, so that kind of not grabbing hold of it, but, kind of staying with it and seeing… if there

are coincidences… It might not mean that there's anything to them but to the fact that - they've all got meaning to me… that actually I do sometimes have decent instincts, but sort of how to work with that… And I'm not going to be right all the time, but yeah, it's that I'm learning to trust - my own judgement a bit more, but also my own instincts." Alexandra

James' story also highlights meaning making in relation to discerning spiritual guidance and how these relate to mental health experiences. James discusses spiritual guidance in relation to what he perceives as dreams, visions and synchronicities. He describes a challenging dissonance between the frameworks of understanding utilised in his experience of mental health services in relation to his own contrasting spiritual narratives of meaning.

"I would get dreams, visions and synchronicities… since being in, like really in the thick of it of the mental health system, I've come to understand… the significance of how my faith has helped me through those experiences in the mental health system. Without my faith I would have completely gone under…

I believe strongly that these visions and dreams and things do give me direction, they do help my faith and spirituality… I've come to realise over my time in mental health services that I'm not going to allow them to replace the narrative of my life." James

For James, there is a sense of needing to hold on to his spiritual framework of meaning making to protect him from the challenges of his experiences of the mental health system which he believes want to replace his own with incompatible forms of understanding. Although he emphasises the central importance of the spiritual framework of meaning and that it has supported him through his mental health difficulties, his perception of the lack of congruence of his understanding with others' seems to present a challenge within his experience of meaning making.

"For me it's central, it's a central theme in my life… The dreams and the visions… Trying to make sense of it and it's not easy… People don't seem to understand my point of view… But it's my faith, the dreams and visions that God gave me, the sense of direction that God gave me… And I find

that really helpful… That's how my spirituality has helped me through 'mental illness' in inverted commas." James

The dissonance between medical and spiritual narratives of mental illness is alluded to in Keyshia's story, although she approaches this potential dichotomy by adopting and successfully integrating medical language within her spiritual frameworks of meaning making. Keyshia uses the medical terminology of 'delusion' to describe her experience of mental illness, but she discusses a specific way in which she related to and was guided by this concept which seemed to support her recovery. She describes how by "embracing the delusion" she was able to make meaning out of her mental health difficulties and gain a greater understanding of the psychospiritual dimensions of her experiences.

"… the thing that I've come to understand is to actually embrace my delusion because it's me and it was telling, it's my subconscious telling me about things about myself. And so that's why I like, if I meet someone with a delusional story, I don't want them not to believe in that delusion.

I want them to embrace it because it's such an intimate side of you. It's like somebody just unfolded you and just told you how things are inside… actually take the delusion and follow it and create a bigger story. Just follow on the delusion, create something about it because it's such a special thing for a person." Keyshia

By accepting and being able to embrace and give meaning to her delusion, Keyshia says that this allowed her to actively create her own ending and new beginning to her story.

"I embraced my delusion as a story about me… and created the ending: how would I like the ending to be… And finished the delusion. Because when you don't have a completion of the delusion, you always ask yourself what if, what if? I felt like I took that special part of me and I gave it a special meaning and it has an end because I came out of hospital and I've continued on with life... And I feel like that part of my life closed and now I'm the next stage of my life. And I'm creating a new story." Keyshia

Spiritual guidance was articulated by participants to emphasise mythos frameworks of meaning which may not be easy to articulate or understand. Participants however

depicted phenomena such as signs, synchronicity, coincidence, dreams and visions to be important components of meaning making and at times mental health recovery. Sometimes participants actively utilised logo frameworks to support discernment within this process and a few participants acknowledged the potential for such experiences to be delusionary, but this did not necessarily detract from their importance or function.

6.3 Conclusion

Findings from the narrative analysis suggest that participant descriptions of meaning making in the context of spirituality, mental health and recovery highlighted three main themes, Reframing, Navigating mythos and logos, and Discerning spiritual guidance. Participants often demonstrated wisdom, insight and effectiveness in their ability to navigate often confusing spiritual and mental health experiences. Participant accounts highlighted that the process of meaning making and constructing functional frameworks informed by spirituality and mental health experiences was not necessarily easy and could be an on-going developmental process over the course of their lives or recovery process. They occasionally suggested that an over-emphasis of logos or mythos frameworks without a balance of both could be detrimental to their mental health. Nonetheless, spiritual perspectives often seemed supportive within the construction of functional meaning making frameworks by providing helpful new outlooks, validation, understanding and guidance and thereby often positively impacting mental health and recovery.

Chapter 7: Psychospiritual development

7.1 Introduction

This chapter describes the second superordinate theme of Psychospiritual development that was explored through narrative analysis.

7.2 Superordinate theme 3: Psychospiritual development

The concept of psychospiritual development is defined broadly as narrated descriptions of personal growth in relation to psychological and spiritual factors and experiences. This may include the unfolding of the spiritual path or journey over time, as well as experiences of healing, mental health difficulties and recovery. Participants did not always distinguish between the processes of growth, development, healing or recovery, and these concepts often seemed to be inter-connected within the context of narrated psychospiritual dimensions of experience.

After conducting the narrative analysis, four main themes were found. The first theme Developmental trajectories describes the overall developmental trajectories of the stories and could be categorised into a typology. The second theme Developmental interactions captures the main patterns of interaction between spirituality and mental health challenges and how these relate to psychospiritual development and recovery. The third theme highlights the cultivation of what was termed Developmental qualities which were potential components and outcomes of psychospiritual growth. The fourth main theme Authenticity is described as an overall key driver or orienting factor within psychospiritual development. Authenticity is defined in this context as a reported sense of deepening self-knowledge and discovery, of progressive understanding of self or identity, including in relation to personal values, or a sense of increasing spiritual self-understanding.

These themes and their sub-themes are described in Table 7.1 below.

Table 7.1 Psychospiritual development coding framework

Theme	Theme description
3. Psychospiritual development	Participant descriptions of their personal growth in relation to psychological and spiritual factors and experiences. These include the unfolding of their spiritual journey over time, as well as experiences of mental health and recovery.
3.1 Developmental trajectories	The characterisation of sequences of narrated experiences and events and their unfolding over the story arc in relation to psychospiritual development.
3.1.1 Emergence from oppression	Trajectory of development originating in oppressive, restrictive or damaging experiences, beliefs or social conditioning and moving towards healing, recovery or authenticity.
3.1.2 Seeking	Trajectory of development characterised by an on-going tendency to explore different belief systems, spiritual approaches, traditions or practices.
3.1.3 Awakening	Often a dramatic transformatory experience which may follow a personal breakdown, crisis or severe life event. Often viewed as a form of spiritual awakening with related insights, change and sometimes mystical experiences.
3.2 Developmental interactions	Forms of interactions between spirituality, mental health, recovery and development and their described effects.
3.2.1 Transformation	Descriptions which focus upon transformational developmental effects.

3.2.2 Support	Descriptions which focus on supportive developmental effects.
3.2.3 Disruption	Descriptions which focus on disruptive or harmful developmental effects.
3.2.4 Dissonance	Descriptions which focus upon experiences of dissonance, questioning and doubt.
3.3 Developmental qualities	Cultivation of nine developmental qualities which characterise psychospiritual development within participant stories. Sometimes these are contributed to or mediated by spiritual practices.
3.4 Authenticity	The described experience of a progressive understanding of self or deepening sense of spiritual self-knowledge. The experience of development and personal-growth in relation to becoming increasingly more 'true' to oneself.

Theme 3.1: Developmental trajectories

Six types of story trajectory were found after conducting the Sequential analysis. The story trajectory refers to the sequences of narrated experiences and events and how these unfolded over the story arc in relation to psychospiritual development. These are shown below in Table 7.2 below.

Table 7.2 Developmental trajectory typology

Trajectory type	Number of Participants (N= 30)	Description of trajectory type
3.1.1 Emergence from oppression	12	Trajectory of development originating in oppressive, restrictive or damaging experiences, beliefs or social conditioning and moving towards healing, recovery and authenticity.
3.1.2 Seeking	8	Trajectory of development characterised by an on-going tendency to explore different belief systems, spiritual approaches, traditions or practices.
3.1.3 Awakening	4	Often a dramatic transformatory experience which may follow a personal breakdown, crisis or severe life event. Often viewed as a form of spiritual awakening with related insights, change and sometimes mystical experiences.
3.1.4 Progressive	3	A steady progression of psychospiritual development. Mental health experiences may be disruptive or challenging but ultimately deepen and personalise spiritual connection, cultivating coping and recovery.
3.1.5 Oscillating	2	Moving back and forth between spirituality and spiritual disconnect which may be caused by mental health difficulties. There may be a progressive element but this can be interrupted by mental health challenges.
3.1.6 Chaos	1	Confusing and chaotic story with a negative or uncertain trajectory. A sense of being stuck or unable to progress which may be instigated by mental health problems.

Due to the large amount of information for the Psychospiritual development superordinate theme, a pragmatic decision was made to focus upon the three most frequent and distinctive trajectories Emergence from oppression, Seeking and Awakening which are described below. It is important to note however, that although these major trajectories had a progressive characteristic, suggesting a form of psychospiritual development and/or recovery over time, there were some exceptions to this, most notably the 'Chaos' trajectory. Here the trajectory was articulated as negative and at a place of being stuck and lost rather than in recovery.

Although frequency is not often a key component of narrative analysis, categorising trajectories into a frequency-oriented typology was deemed useful in gauging a clearer picture of their presence across the sample group. Using frequency in this instance was not incompatible with a critical realist, pluralistic and emergent research design. It allowed for the stories to be categorised in relation to the most frequently occurring, salient and often most clearly articulated trajectory types which is relevant to narrative analysis. Some stories contained more than one type of trajectory.

Sub-theme 3.1.1: Emergence from oppression

Emergence from oppression story trajectories were characterised by a transition over time from oppressive past experiences in earlier life which may have impacted beliefs and identity, towards healing, recovery or greater authenticity. Sometimes this occurred after periods of major questioning, rebellion or resistance. Experiences were often described as liberating or featuring new realisations which allowed for personal change. The oppressive experiences were described as being limiting, restrictive, abusive or damaging, mostly within the participants' earlier life. Oppressive sources included family, parental upbringing, culture, sub-culture, institutions, social conditioning, tradition, religion, abuse, trauma and oppressive tendencies within mental illness.

Mental health issues experienced within this form of developmental trajectory often served to illuminate the oppressive aspects within participants' lives and provided an impetus for transformation. Participants' spirituality mostly served to support the process of transformation but this could sometimes involve the transformation of the spiritual belief system itself if it included oppressive aspects. In that sense,

participants' spirituality would tend to become more personalised and authentic so that it was aligned with their developing values and personal growth.

Although a few of the Emergence from oppression stories focussed on individually-oriented oppressive tendencies such as highly restrictive, debilitating and negative thinking or self-beliefs, most sources of the oppression were described as arising from broader contexts, such as institutions, culture, family and religion. For example, James's story highlights the impact of institutional oppression in the form of mental health services. Rashid, Noam and Mingyu describe forms of cultural oppression which could be amplified through family and religion. Noam, Helen, Alaia and Peter describe various types of extreme or long-term abuse from parents, family and religious organisations which had oppressive traumatic impacts upon their lives. For example, Noam outlines what he describes as the psychological and spiritual effects of abusive behaviour from his mother.

> *"Well, the abuse was from my mother. She was the abuser and I realised that what she did was… spoon out the real me, or the authentic personality that was who I am and replaced it with her own. I'm sure that can be understood in psychological terms, but I call it energetically, because we all have this energetic essence… the spiritual are subtle energies… She worked on that level. That's why it's been so difficult… to get over. And it requires healing on that level."* Noam

Noam explains how this abusive behaviour influenced his development by spooning out his authentic sense of self. He depicts the impact of this as including a spiritual dimension which required spiritual healing to address this issue. He goes on to suggest that such ingrained levels of conditioning and patterns of abuse from his childhood required a subsequent deep level of spiritual work and understanding to support healing and recovery.

> *"That's what childhood is about, whether you call it socialisation or whatever, we are brainwashed, we are programmed. And if there has been abuse, if the programming has not been loving, then the programming has to be changed. Now how can you change programming that's so deep and so ingrained… without doing some very serious work… That's how spirituality enabled me to being able to make sense of it. Spirituality is all complete change in the way you perceive everything..."* Noam

Keyshia's story provides an example of emerging from an experience of religious oppression. She says she started questioning and rejecting the Christian belief system she had been brought up within, because she experienced it as disempowering and creating a sense of victimhood. Keyshia describes a turning point after experiencing mental illness in which she perceived a hierarchical relationship within spirituality as being problematic and potentially exacerbating her mental health problems.

> *"So that's why I totally just gave it* [Christianity] *all up … the whole concept of there's somebody in charge of you who knows better. And you're a victim… you have no power… So after my illness I said I don't want any hierarchy anymore; I want like an equal relationship… Because I noticed that with my illness, I suffered more because I felt a victim of a superior being that I can't see."* Keyshia

Keyshia reflects upon the positive impact upon her wellbeing of her decision to actively recreate the relationship with her spirituality as one that was supportive, exploratory and empowering rather than based on a sense of oppression and fear.

> *"I felt like instead of running away from my experience, why not label it as a good thing. Because during my illness the spirit realm was very against me… demons and the devil and evil…. So I decided instead of doing that, why not think of it like they are nice, they're just not familiar, so if I make them familiar but I trust that they are good people, and then I build the relationship from there. That empowered me actually to be able to keep well."* Keyshia

Keyshia explains how after starting the recovery process she began questioning everything in her life including her former Christian beliefs. This marked a phase in which she says the exploration of new forms of spirituality helped her to break down ideas and beliefs which may have been limiting her psychospiritual development. Although Keyshia describes the process of realising the hold of her former beliefs as taking some time, she says that taking ownership over her relationship with her spirituality was empowering and helped her to feel in charge of her own life.

> *"… after getting better… I questioned everything about my life completely and I… found out about the New Age and how they interpret spirituality and*

I kind of just broke all the little walls that I had in my brain and my experiences… And that's how it's kind of like opened it all out… it also has helped me to actually take charge of my own self, take charge of my life, be a leader of myself… absolutely empowering, but it took me quite a while because it took me to deal with a lot of doctrines and belief systems I didn't realise I was holding very strongly to." Keyshia

Participant descriptions of Emergence from oppression story trajectories highlight how their spirituality and mental health issues often interacted to illuminate beliefs and conditioning which had once been a limitation to development. They articulated how these could be transformed through newly arising awareness often instigated by their spirituality and sometimes mental health difficulties, and potentially supporting psychospiritual development and mental health recovery.

Sub-theme 3.1.2: Seeking

The second major developmental story trajectory was termed Seeking. Some participants narrated seeking various forms of spirituality, practices, and frameworks of understanding which would resonate with their developing personal needs, values or interests. Sometimes this process seemed to be instigated by a desire for quest, exploration, greater authenticity or changes in identity. The seeking process might also involve a period of engaging with travel, different cultural world views or spiritual traditions, or the use of recreational or psychedelic drugs or medicine plants. The underlying motive for seeking was often described as being unfulfilled or dissatisfied with the status quo, a sense of something missing, or a questioning or rebellion against an existing culture, sub-culture, tradition or sense of conformity. For example, Carl's seeking story trajectory was instigated by a sense of there being "something missing" after living what he describes as a very conventional life.

"…looking back now I can see that I very much had a sense of something missing in my life. Because I'd had this very conventional upbringing, I'd done all the things I was supposed to do, I'd got the family, I'd got a pretty good career, and yet I was unfulfilled. It's a cliché but I was thinking to myself there must be more." Carl

Overall, there was a positive trajectory within the seeking stories, that over time the seeking gradually led to spiritual approaches and practices which were more closely aligned to the person's needs and values. Participants depicted finding out

something new about themselves, their spiritual nature and a sense of deepening authenticity. This process of self-discovery often helped them gain acceptance of their mental health difficulties and supported their recovery process.

Katie's story provides an example of seeking through travel and engaging in a variety of spiritual practices across different cultural traditions. She suggests a connection between her on-going curiosity and exploration, and the cultivation of a deepening spiritual sense of self.

> *"I've come to spirituality through, I spent several years travelling around the world, and in doing so coming in to encounter different traditions and religions, different people, different attitudes and different practices, and in and amongst all of that I think I've got a greater sense from all these different angles of what the unchangeable thing was at the centre of it that I was connecting with… so, different practices and traditions that I've really resonated with… brought me into my first visceral experience of… 'Who am I?'… I've always been very curious and this curiosity in itself is… driving me everywhere."* Katie

Katie describes the effects of this on-going spiritual exploration as impacting her evolving relationship with life. She suggests some of the potential psychospiritual processes within this development as involving a greater awareness of self-limiting beliefs and perspectives.

> *"…the more that over the years of going to different places and living in different communities and living in different traditions… brought about a continual evolving of my relationship to life… there's a whole shift in how you relate to your being in that change of perspective that has been transformational in psychological problems, limiting beliefs, behaviours and certain things that come up in living a human life that are more gracefully traversed by having a bigger perspective…"* Katie

Although seeking seemed to serve a useful function in relation to participants' psychospiritual development as well as their mental health and recovery, there were aspects that people described as challenging. For example, after rejecting his conventional upbringing, Carl describes engaging in a period of spiritual seeking, in which he explores a large range of spiritual beliefs and practices. He says that the

seeking, which he describes as “dabbling”, was driven by a sense of curiosity as well as a grasping need for something in which nothing quite “hit the spot”.

> *“So I dabbled a lot. It was a need to do a lot of different things to try them. And part of that was out of curiosity, and part of it I think was because nothing really hit the spot still. So I was still looking… I think a lot of it was about looking for a sense of community as well… that sense of absence becomes pervasive and niggles at you. And that in turn then starts to seek something else. Not just seek but grasp for something else. Every little new thing could be the thing that you’re looking for… And then it’s, it’s not quite it…”* Carl

Thomas describes his seeking behaviour as being instigated by and potentially exacerbating his mental health difficulties which he says had an obsessive nature and were always seeking a solution. He describes how the initial directionless nature of his seeking led him to what he describes as a terrifying drug experience.

> *“My mental health problems are always looking for a solution. I guess that’s the obsessive character. Is that they’re always looking for a solution…*
>
> *I grew up… with a lot of pain and a lot of unhappiness… they obsessed me… And so I became kind of a seeker.*
>
> *So I was looking for bigger pictures. But I didn’t really have any direction. There was nobody in my life who was a seeker. I didn’t have any religious people in my life. And so the form this took was drugs, which was the wrong form for it to take… It was just the most terrifying experience of my life… it had just really ripped the lid off of all the dark stuff.”* Thomas

Although the trajectory of seeking seemed to characterise a good proportion of the participants’ stories and often seemed to support mental health and recovery, at times the nature of seeking was not depicted as entirely healthy or functional and in those cases may have triggered or exacerbated mental health issues.

Sub-theme 3.1.3: Awakening

The third developmental story trajectory was termed Awakening. This concept is also articulated in spirituality literature and is sometimes referred to as a ‘spiritual

awakening' or 'spiritual crisis'. The Awakening story trajectory was often narrated to occur in quite a dramatic way and was triggered by a powerful event or turning point that seemed to be thrust upon someone's life. The awakening processes described resulted in powerful healing, personal and spiritual transformation and psychospiritual development. This also involved a personal breakdown of identity, beliefs or values, or changes in everyday life situations such as work and relationships. These changes and developments were also reported to impact mental health and recovery.

Michael's and Gregory's awakening processes were both instigated by near-death experiences which subsequently led to experiences of healing, recovery and spiritual awakening. For Michael the experience was triggered by the attempt to take his own life following a prolonged period of depression, by deliberately crashing his car. He describes how an interaction with a religious person he did not know very well whilst he was hospitalised after the incident, led to a huge emotional release. This become a turning point in his religious life with the decision to become a born-again Christian. Michael also comments on the rapid helpful impact this had upon his mental health recovery.

> *"I was intent on killing myself… I drove as fast as I could down the hill… Miraculously I did not suffer any significant injuries at all… I was admitted to a ward. I was numb and I was incapable of expressing any emotion… A couple of days later I was visited by someone… I explained what had happened and then a remarkable thing happened. He put his arms around me and spoke to me… explaining that I wasn't worthless and that God loved me. As he held me I sobbed and sobbed… He encouraged me to turn to God and become a Christian. In those moments all my emotion came out and I felt quite different….Just over a month later I was back in my flat and continuing to recover well… I went to several churches… The Vicar really helped me and guided me... So for me Christian faith has played a very important part in my recovery which… was really very quick…."* Michael

Gregory's awakening process was triggered after nearly dying from a second medical emergency in one year. He describes how this instigated existential questioning about his survival as well as experiences of shock and mental health difficulties.

"They rushed me… straight into theatre, emergency operation… They saved my life… I realised that I should have been dead… I was alive. But why? That kept coming up in my thoughts… why aren't I dead? Sometimes it can take a shock, a big shock to wake somebody up. Well I had two in one year, and I was really waking up fast. I started to question everything that I'd taken for granted previously that I'd believed in… I was an emotional wreck, I was a mental wreck, couldn't see any way forward." Gregory

Gregory goes on to depict a progression from this challenging experience to discovering spirituality and a particular form of healing which he says had a powerful transformatory effect. As well as providing physical healing, Gregory describes additional effects including impacting his emotions, beliefs, mental health recovery and the development of what he describes as healing and metaphysical abilities.

"…you change overnight. Your thought patterns change… metaphysical abilities… start to appear… I was spiritually dead anyway before I went… and from that… woke me up, completely… And I found that I could heal people…. So many things have happened. Unbelievable things… No more negative thoughts. No more doubting myself… the transformation is absolutely unbelievable… And it's getting better every day, because I've changed my belief systems. I believe in myself… and spirituality actually saved me… So I have changed. In every way possible: mentally, physically, spiritually, everything." Gregory

Rachel describes her awakening process as initiated by what she calls a "dark night of the soul" and "crash". Rachel depicts a painful personal breakdown in which she experienced old trauma and a stripping away of her former identity to reveal a more authentic sense of spiritual self.

"And then I went into the long period that… I came to call 'the dark night of the soul'… I called it 'the crash'… the words I described were 'crashing and hitting the wall at 100 miles an hour.' So it really felt like I just can't keep it all together anymore. And there was a deep falling apart. Now that was both incredibly painful and on some level deeply relieving… there was old, old trauma… on such a deep existential level. I guess you could say a soul level… I think it's a fundamental stripping away of the persona to leave

what's essentially us. And at first that's excruciating because I didn't know that I wasn't the thing that I thought I was…" Rachel

Like Gregory, Rachel also depicts mystical experiences occurring after the onset of her awakening process. For Rachel, she says these occurred spontaneously and provided her with insights and a sense of connectedness with the world around her.

"But within that I started to have… quite profound mystical experiences… often they would happen completely unexpectedly… what I would now call like awakening or mystical experiences… there was a whole sort of series of insights that just came over one after the other… There was this huge kind of undoing of the whole kind of position of self as it were… the words that are often used are things like 'unitary consciousness' or 'oneness'" Rachel

An overall impact of this awakening process according to Rachel was to facilitate her recovery by transforming her relationship to her mental health difficulties. She describes the transformation as a shift in focus from a pathological and individualised orientation in which she viewed herself as flawed and requiring fixing, towards a more inter-connected understanding of herself.

"I think some of the process moves from the idea which I absolutely held for a long time and I think many people do, that fundamentally there was something deeply flawed in me that was showing up as, you know, symptoms. And what I had to do was get in there, understand what it was and fix it… I think it then moved from being about me as this person who was – and I think a lot of us feel this, you know uniquely damaged… it moved from being this very personal very individualised model if you like to… seeing myself now much more as… a member of the species… as somebody in wider humanity... and the idea like I say of there being something to fix has really changed." Rachel

Although the awakening trajectory was described as very disruptive and challenging, for participants in this narrative study it appeared to lead to powerfully transformational psychospiritual development, as well as healing and support for mental health recovery.

Theme 3.2: Developmental interactions

As participants' stories unfolded, interactions between spirituality, mental health, recovery and psychospiritual development were often suggested. Although these interactions were sometimes complex, some overall characteristics and described effects within the participants' stories could be delineated. These could be broadly categorised as Transformation, Support, Disruptive and Dissonance and are described below.

Sub-theme 3.2.1: Transformation

A number of participants described spirituality as being inherently developmental or transformative. According to Gregory, spirituality may change everything within a person, if they allow it to.

> *"Spirituality is a concept that lives within you. If you accept it… over time, you change. Your thought patterns change, and who you are changes. Your behaviour changes.*
>
> *That's what spirituality will do to you. It will change you if you let it... it changes everything."* Gregory

This point is echoed by Katie, who specifically highlights the changes in her engagement and interactions with life.

> *"Fundamentally* [spirituality] *completely changed my interaction with life, my interaction with every moment, my action in every moment, my relationship to everything, everyone, most importantly myself and… to others…"* Katie

Morgen emphasises an interactive and interpersonal aspect which may relate to the transformatory power of spirituality. She suggests that this comes about through personal responsibility and a sense of creative choice about practically carrying out desired changes.

> *"I think spirituality is also something where I feel like it enables people to change or to believe that they are able to change… and you can take this responsibility for yourself and you can try to carve out your own little path there and I think that's very empowering… and you can change yourself…*

You're this malleable being that can change or that can also go forward and influence other people or other people can influence you." Morgen

A few participants drew upon specific models of spiritual development when describing the transformatory nature of spirituality. For example, Andrei uses a framework of understanding the developmental stages of the soul within the Bahá'í faith.

"… it continues on a journey of development… And the key thing in this world is to understand what you need to develop as part of your soul… This means that the entire journey of life here is a development… you're developing the soul and you're moving closer to God, or a religious or divine identity… these are stages of the soul in a way…" Andrei

Noam compares the holistic transformation within spiritual development to the process of therapy, which requires both proactive work, and a form of guidance.

"Spirituality is all complete change in the way you perceive everything, the world and so on… All I had to do was to allow it, you know, to do so, to cooperate, to do the work that's required. Because progressing in spirituality there is no difference from progressing in therapy. You need a guide who knows what they're doing and you need to do work…" Noam

Mental health difficulties were highlighted within some stories as instigating change, including within participants' spirituality and development. For example, Simon describes how his homosexuality created dissonance with his faith which in turn seemed to exacerbate his mental health difficulties. This led to a period of what he describes as deconstruction of his faith, the questioning of his spirituality to the point at which he was able to transform some of the beliefs which did not resonate with his own authenticity. He reflects that this process led to improvements in his mental health.

"… did I get this all wrong, did I hear God wrong all those years ago, have I completely missed the mark? So I think that was perhaps fuelling a lot of my low mood at the time… And years of hoping and trusting that God would do the work in me that I thought he had to do to make me whole, i.e. you know, straight [laughs] *was not happening… But has also started like this process of me really deconstructing my faith and my spirituality… I'm very different*

now in terms of how I define my spirituality, how I define my relationship with God…. I think my mental health has improved… it's almost like my experiences have started to teach me a lot more about my faith… I'm starting to really understand my spiritual self in a very different way than I ever have." Simon

Rashid also reports that his experience of mental illness changed his relationship with religion by encouraging instead a focus upon his wellbeing, and supporting a sense of self-acceptance. As a result he says that he experienced personal growth as well as an improvement in his mental health.

"Because of being depressed I think about religion a lot less. And I think about focusing on positive things, and focusing on what helps me get better.

And I've replaced like going to the mosque with mindfulness or going swimming…because I had the lived experience it changed things massively… it's definitely affected my religion.

So I don't go to the mosque and stuff like that, but I'm still a Muslim. I'm more sort of open about who I am as a person... I think it's helped me in lots of different ways, the depression or the mental health thing has helped me become a better person. I've grown as an individual but, it's helped me accept myself in terms of my identity… it's taught me a lot about myself." Rashid

Emily echoes that her mental health difficulties have had a transformational impact upon her faith. She says that they have taught her to break down a sense of independent pride and to become more open to the love and support within her relationship with God.

"I think if I hadn't experienced mental health problems I might not have realised my need for God. So it's always a kind of breaking my pride and self-reliance which is very very painful but it's getting to… re-realise the love and support and relationship that God offers. So yeah they've definitely been instrumental in developing… my faith and also my ability to just take care of myself as well." Emily

These participants frame spirituality and sometimes mental health difficulties as potentially powerful transformatory agents within their psychospiritual development.

Sub-theme 3.2.2: Support

The most prevalent interactions between spirituality and mental health were described as ones which supported mental health recovery and psychospiritual development. Because of the prevalence and pervasiveness of this theme it is described in further detail in Chapters 6 and 8. in relation to Meaning making and Spiritual connection. It is also highlighted across other Psychospiritual development themes within this chapter.

A summary of some of the ways in which participants generally described the supportive relationship between spirituality and mental health and their consequent potential impact upon recovery and psychospiritual development are outlined below. These include providing access to helpful ways of thinking, a sense of purpose and hope, and the feeling of being nourished and loved.

> *"… what it* [spirituality] *has done is given me access to ways of thinking and environments where I can both look at and deal with mental health issues."* Carl

> *"And I just feel that God, or Christianity… gave me a purpose in life and I felt that if God loved me, or God loves me, so I must be here for something. And without this belief I feel hopeless and lost…"* Cynthia

> *"In terms of my recovery I feel that I'm managing my anxiety and depression a lot better… feeling kind of supported, like that feeling that I feel completely loved, that definitely comes from my faith… the actual kind of shine to my life, or the feeling supported and nourished for who I am, that comes from my faith. And I just don't know where I'd be without it."* Anna

Some participants said they experienced spirituality to "save" them during some of their most challenging experiences of mental health difficulties, including when they had thoughts of suicide.

> *"… spirituality, in fact… it saved me… Yes I can say it saved me…. Spirituality brought me back from the brink…. So I have changed… And it*

saved my life. Cause if I'd have continued on that road. I'd top myself. I'd put an end to it there and then." Gregory

"… I do feel since I've found faith or been a spiritual person I haven't really felt severely suicidal, even though I've had some really low times… but I've never felt really suicidal, since I've been spiritual. And I wonder if that sense of meaning and having a purpose here gives me a reason to stay even when I've felt really low. So obviously that's really special and important." Anna

Other participants described spirituality as providing a way to carry on when experiencing severe challenges. For Noam, it was a progression of getting closer to a spiritual spark of light in a dark place, which he suggests, may have prevented him from being admitted to a psychiatric hospital.

"In the moment then, which was very negative… my life would be about getting ever nearer to that spark… making the progress. And ultimately I would reach the light and then I would be in a far better place.

So I can say that it kept me going in fact… Two of the people I've worked with… said to me that it's quite amazing that I managed to keep my sanity… and avoid mental hospital or possibly even worse. And I attribute that completely to that spark, to the fact that the spirituality was… there." Noam

James suggests that his spirituality not only prevented him from "going under" but to survive the challenges he experienced within the mental health system.

"Without my faith I would have completely gone under… I think spirituality, not only in my case but in a lot of people's cases can really help people through… not only the mental difficulties that they have but all the added difficulties placed upon them by the mental health system." James

In these ways spirituality was often described as providing a supportive and sometimes life-saving influence upon participants' mental health and recovery as their developmental journey unfolded.

Sub-theme 3.2.3: Disruption

Although the majority of references to the interactions between spirituality and mental health over the course of participants' stories were described to have positive effects in relation to their psychospiritual development and recovery, some disruptive or harmful aspects were highlighted. For example, Silvia says that she lost interest in her faith when she became mentally ill, and as a consequence her relationship with her spirituality "disintegrated."

> *"Well I think it* [spirituality] *disintegrated a bit really. Because I wasn't going to church regularly, I was off on a tangent somewhere… So I wasn't really engaged properly with my faith, that all sort of disintegrated… When I'm well and stable then I think my faith gets into operation, it gets into gear again alright. But when I'm ill it all falls by the wayside."* Silvia

Cynthia describes the challenge of becoming obsessed with her religion and taking her religious perceptions and practices to the extreme. She acknowledges that this was probably connected with her mental health issues and led to her getting worn out.

> *"… a little bit of everything is good for you, but not if you just get obsessed with the one thing. I learnt that at one point in my life I was very ill and I became obsessed with Christianity and I began to see God even in adverts on television or when I was walking down the road, I'd be praying for every single person and getting totally worn out by seeing God in everything… with my type of mental health problem you can always take things too much to the extreme."* Cynthia

For Peter, having been brought up in what he describes as an abusive religious community impacted traumatically on the rest of his life. He says that one way of coping with this was to completely distance himself from spirituality for a while as he distrusted religious groups and traditions as a consequence. Although Peter suggests that the very damaging impact of this issue including upon his mental health is on-going, he does indicate a gradual path of recovery.

> *"I had a gap in my life where there was really very little spirituality at all. I… was just disillusioned with the framework that had been sort of forced upon me… And because of that I developed a negative attitude towards all types*

of religion… I think I felt angry with God, I just felt like I'd got no time for him…

With it being so, so, so damaging the time that I spent then, I think it will be really really difficult to put that completely behind me. I've always got sort of alarm bells ringing. And that's part of my mental health issues as well that I can be quite paranoid about situations… But I do it less and less and I've become more and more tolerant." Peter

A few participants made the point that the relationship between spirituality and mental health can be potentially challenging to navigate and therefore requires a good degree of care and responsibility. Carl suggests this might especially be the case when experiencing a mental health crisis.

"…that's the issue with spirituality. By its very nature it's not regulated… you have to take more responsibility for yourself in spirituality I think, which is difficult if you're in mental health crisis." Carl

For Noam, the oceanic nature of spiritually in the context of mental health may be difficult for the intellect to grasp and therefore feel like there is a lack of "safe ground".

"Mental health, from my perspective and the way I've gone through it is that spirituality is the ocean that you must leap into and start swimming. And when you do that you are not this kind of safe ground, of… my intellect can put everything in the right boxes and see what's what." Noam

Other challenges articulated by participants were not described as being necessarily disruptive, but as key features within their psychospiritual development, and are described below.

Sub-theme 3.2.4: Dissonance

Experiencing periods of dissonance was commonly reported within participants' psychospiritual development. Dissonance is described broadly as a clash or contradiction within personal experience including cognitions, emotions, spirituality, and beliefs, meaning making frameworks or identity. For many, it included periods

of doubt and questioning and often seemed to perform an important function within the developmental process to motivate or instigate functional change or recovery.

Participants often reported periods of dissonance to be intertwined with mental health difficulties, such as the onset or intensification of symptoms. For example Emily describes it as involving disillusionment with her faith because of the challenges of her mental health symptoms and feeling punished by God.

> *"So it* [mental health] *all kinda started to slip and I… in the end just felt quite disillusioned with God and felt like he was… almost sort of punishing me or turning away from me because I wasn't good enough. I thought he'd set this standard and because I hadn't met it my mental health was slipping. So I got angry with him and just wanted to turn away and say 'No I don't want to have anything to do with you anymore'. And, that sort of was when things just got darker and darker and I was in a really bad period of depression… I was feeling very hopeless about the future, didn't want to live any longer…"* Emily

This period of questioning and dissonance was followed by a reconnection with her faith, potentially in a renewed way which Emily suggests supported her psychospiritual development as well as her self-care and mental health recovery.

> *"I felt like God was sort of calling back… slowly sort of regained my faith and my love for God again. Realising… There are things that I'd been doing that weren't very helpful. I was putting too much pressure on myself, I was trying to ignore God… eventually I felt like it was a time of personal growth realising, partly that I just needed to look after myself a bit better, and partly that my faith is, vital to my life… when I've struggled with mental health he's* [God has] *almost sort of redeemed the experience and made it into a time of personal growth… "* Emily

The role of dissonance within psychospiritual development was particularly revealed within Emergence from oppression stories to highlight outdated and restrictive beliefs and ideas about self, life and identity. This sometimes involved phases of rebellion, in which the previous sets of beliefs or values were actively riled against. For example, Keyshia reflects upon the act of rebellion within her story as an

important developmental phase involving questioning her previous religious beliefs which she perceived to limit her spiritual exploration.

> *"It was very hard to start with because I remember going to the Buddhist centre and because of the whole concept of idol worship is very condemned in the Bible… I did it out of rebellion to start with actually because I was like 'I don't care because you* [God] *didn't help me out* [laughing] *when I was in hospital… so I'm going to do exactly the opposite of the things that you told us to do.' So it was a rebellious stage… and I kind of like just broke all the little walls that I had in my brain and my experiences."* Keyshia

Periods of dissonance and confusion seemed to feature strongly in those stories featuring overcoming oppressive social conditioning and consequent transformation of identity. For example, Rashid and Noam said they experienced dissonance between their cultural upbringing and their developing spirituality and identities. For Noam, this involved a period of study, learning, and cultivating the ability to reject unsuitable aspects of his cultural conditioning.

> *"I didn't fit in in Israeli society because of my spiritual beliefs and also my nature. I was a very untypical Israeli. So it had to be kept out of sight in terms of the society… that… certainly had no qualms about oppressing the individuality for the sake of the community… But I did spend a lot of time and energy on thinking and reading… just trying to get my head around it and figure it out... you have to go through this phase of saying no, this is all wrong…"* Noam

Rashid suggests that the nature of the dissonance for him concerned a conflict between his religious identity inherited from his culture and his developing Western values and lifestyle. He says that the issues of incompatibility between these contributed towards an identity crisis and exacerbated his mental health symptoms.

> *"…there's often a lot of conflict because of the religion, because of the culture. So my mum says it's because you don't pray, or you're not a good Muslim… and it's been really problematic… and it's as a result of my religion and culture… you know question about compatibility all the time where 'Oh does it fit in with my religion, does it fit in with my identity?'… And*

it can be quite challenging… I was struggling with my identity, I was having a bit of a crisis, and I didn't really know where I fitted in." Rashid

Another important area of dissonance and identity crisis highlighted by participants concerned sexuality in relation to LGBTQ+ (Lesbian, gay, bisexual, transgender, queer and more) themes. Three participants talked about such experiences and how they seemed to contribute towards their mental health and identity struggles as well as instigate questioning of existing religious beliefs. For example, Morgen describes feeling rejected and undermined due to her sexual identity in relation to her Christian upbringing which she says contributed to her mental health difficulties.

"And I was very miserable throughout my teenage years and trying to find identity. I think identity is something really important for me also for spirituality… you get faced with this kind of contempt, 'oh why are you rattling the cage, why are you not conforming?'… and then to come in and be like 'Yeah actually the Bible says… being gay is not OK'…

It's scary… because what you think your holy scripture is telling you is completely undermining my human rights. That I'm sinning just by existing the way I am… I felt like that this whole identity thing is something that's much more strongly connected to my mental distress too…" Morgen

The dissonance often seemed to ultimately propel participants' psychospiritual development forwards, in a search to find spiritual approaches which resonated more authentically with an emerging sense of self. For example, when Simon realised that years of denial in relation to his homosexuality exacerbated his mental distress, he started to question his relationship with God and his religious beliefs.

"Because I think I still doubted whether God really accepted my same sex attraction… I felt like I needed someone in my life to correct that and maybe having a wife would correct that… there was these recurrent depressive episodes that would seem to come out of nowhere… and I think I really started questioning who God was, why is he sort of leading me down this path… and that was really grating with my understanding of 'Am I living, did I get this all wrong, did I hear God wrong all those years ago, have I completely missed the mark?'" Simon

Simon describes his former identity as developing at the expense of his own sanity. Over the course of questioning the guises he created to attempt to fit in with the role he thought he was required to play, he depicts the emergence of a newly and potentially more authentic sense of self and relationship with his spirituality.

> *"…there's very much this sort of formulaic drive of what it means to commit to a church… But I felt it was beginning to be at the expense of my own sanity* [chuckles]*. It was almost like I was losing my sense of identity… I was doing all the stuff in this guise of not really accepting the real me, who I really am… I found myself in situations where I was challenging all of that… is God still pleased with me now* [chuckling] *if I'm just sat here just, in a sort of spirit of contemplation?"* Simon

Dissonance, although often challenging and confusing, was mostly described as being an important phase within participants' psychospiritual development. It often involved questioning, doubt and periods of rebellion or of figuring out newly emerging identities which aligned with a greater sense of authenticity.

Theme 3.3: Developmental qualities

Most participants described what were collectively termed Developmental qualities which refer to a group of specific personal qualities that were depicted as being cultivated during participants' psychospiritual development. The emergent aspect of these qualities related to their described development over a course of time, or as a result of participants' experiences of the interactions between their spirituality and mental health.

The salient Developmental qualities narrated by participants were termed: Awareness, Personalisation, Empowerment, Healing, Integration, Self-acceptance, Self-care, Compassion and Presence. For pragmatic reasons, these are presented along with descriptions and examples in Table 7.3 below.

Table 7.3 Developmental qualities

Developmental quality	Description	Example quotes
Awareness	The experience of developing self-awareness within the context of the spiritual journey to support understanding and self-knowledge. This may progress gradually or as sudden illuminating 'leaps' of awareness within mystical or inspirational spiritual experiences.	*"I have described an increasing awareness and development of consciousness in myself that impacts on all aspects of life… But it will still be development of consciousness, and from a Bahá'í point of view will be equal to spiritual development…."* Andrei *"…there was a whole sort of series of insights that just came over one after the other… There was this huge kind of undoing of the whole kind of position of self as it were… the words that are often used are things like 'unitary consciousness' or 'oneness'…"* Rachel
Personalisation	Personalisation of spirituality is the process of constructing spiritual belief systems which increasingly align with personal developing values, identity and experiences. The directionality of change is mostly towards open-ness and authenticity and of a deepening self-knowledge.	*"I've opened myself up to this idea that God or that my spirituality has shifted with those changes… it's made me a lot more open about you know how do we make sense of our experiences as humans?... But has also started like this process of me really deconstructing my faith and my spirituality… I'm very different now in terms of how I define my spirituality."* Simon *"…I do love Jesus and that's why I'm following him. It's not just because it was something that my parents had a faith so I kind of just followed along. It's like it's my personal faith, not something I've just inherited."* Charlotte

Empowerment	The cultivation of personal empowerment and responsibility. A sense of gaining control and feeling enabled to consciously create within life. A sense of increasing self-responsibility, internal leadership, self-mastery or inner-authority. Often progressing from a time of feeling disempowered or an over-emphasis on external factors having excessive or oppressive authority and control.	*"It* [spirituality] *also has helped me to actually take charge of my own self, take charge of my life, be a leader of myself… it has made me see myself as an individual through it all… And what I want to do, my ideas are valid. Because before, I thought only God's ideas are valid, I'm not important… I no longer feel like somebody else has authority over me… And also just taking the trust that I have the knowledge in me to know what's good for me."* Keyshia *"So I think that's also really important in my understanding of spirituality is the idea of each person being their own authority. That authority doesn't lie outside of us. It lies inside of us and being able to tap into that deep intelligence… To really start to trust that, I think is a big part of the journey."* Rachel *"…it just became a lot more about responsibility for your own actions … and I realised that I can't just blame other people for things I do, it sort of changed how I think about everything..."* Stephen
Healing	Descriptions of personal healing and at times the development of skills to practice healing on others. Narrated as being connected with spirituality but also as holistic and effecting other aspects of being including mental health recovery.	*"And they have healing chambers, which I was going in every day… When I arrived there I was hobbling like a little old man of 90. And after 10 days I walked out with a straight back like a man of 50… I went from being nothing, with no belief system whatsoever, I became a Reiki Master… Learning to heal people, and heal yourself… when you heal the physical body, you also heal the other three: the mental, the emotional and the spiritual. You heal them at the same time because they all run in unison… it's a team that work together… So, my spiritual journey was first healing me… in all four bodies…"* Gregory *"I think the deeper we go the more we're able to hold the symptoms and look at them really deeply, the more they reveal their intelligence to us… And actually to see that all of these mechanisms started out, are rooted in the system's own attempt to find what it needs or to heal itself in some way…*

		But the original intelligence that's trying to do that is really, it's kind of on the right track…. And when we peel it back to that place, then recovery takes on a different tone." Rachel
Integration	The experience of the integration of disparate or fragmented aspects within oneself or one's life coming together in more harmonious ways. A sense of becoming whole, often following the development of understanding or healing.	*"I felt like I became whole because before I felt split into the spiritual side and the physical me and now I feel like everything has merged into one… I feel like I integrated myself together and I'm now one person."* Keyshia *"…everything started to come together in terms of just sort of being able to see how these threads of my life worked together… I suppose I felt like a fresh chance to work out who I really - the bits of myself that I couldn't see before."* Alexandra *"After you go through this kind of terrible thing… I started to see how different things connect… you start to see the tapestry of life and how what looked like separate events worked together…"* Andrei
Self-acceptance	The development of self-acceptance and valuing of the self, often through addressing negative thinking patterns and low self-esteem.	*"…when I became unwell I started to accept myself for who I was."* Rashid *"No more negative thoughts. No more doubting myself. And then I realised I had completely changed….And it's getting better every day, as we go along now, because I've changed my belief systems. I believe in myself. That's the greatest change that I've made. I believe in myself."* Gregory
Self-care	Cultivating self-care, kindness and compassion towards oneself, often after these lacking previously in life. Often accompanied by a sense of nurturing gentleness and emotional softening within oneself.	*"… being completely broken and having everything I'd relied on taken away, that really, softened me and… kinda took away that – sharpness to an extent, and I felt like God was kind of guiding me through that helping me to be more open with other people to be… kinder, more gentle - and also to be kinder, more gentle to myself."* Emily

		"And if I can sort of think about that and have compassion for myself and other people that really changes my outlook on things… It's made me realise that I'm human, that I make mistakes, but I guess I can still have compassion for myself. You know, that I did the best I could under the circumstances, and so not to beat myself up too much about it." David *"It taught me compassion and primarily compassion about for myself. Because I don't think I ever had that in my life and I think I don't know when it came to existing… it was primarily through Buddhism and just that notion that… it's your responsibility to take care of yourself… when I'm really struggling with something and really feeling really anxious, I just say to myself 'It's OK to feel like that.' Because before I'd be like very harsh on myself… all these like negative things that people say to themselves. …But now I just like changed the link in my brain and now I just immediately go into the habit of thinking 'It's OK'."* Lajla
Compassion	The development of compassion and empathy towards others, often after cultivating these first towards oneself. May be accompanied by becoming more socially aware, respectful, tolerant and caring. Becoming motivated to help, support or be of service to others.	*"…you develop these virtues to the point that you give up this constant focus with bettering yourself and your condition… And you focus on giving to others and to things, other causes… an important milestone in your spiritual life and in your life is to reach this level where actually most of what you do impacts and supports other people or other social structures in a concrete way."* Andrei *"I've become more and more tolerant. And I think I respect more that they're just humans just like me just trying to do their best; whereas my expectations I think have been unrealistic in the past. So I find that over time I'm softening and perhaps becoming more approachable… being part of the foodbank and helping all the different organisations… it's spiritually rewarding. It lifts your spirits. It makes you feel like you've made a difference to people's lives…"* Peter

		"…spirituality helps you to see the good in people… spirituality, the kind that I know, helps you to feel compassion and love for others… I think a spirit in this life can help me to encourage people when they're struggling… I feel I can boost their confidence because the spirituality in my life helps me to do that." Cynthia
Presence	The cultivation of presence in which personal experience is approached in an accepting, non-judgmental and non-pathologising way. A particular quality of observation and awareness is cultivated which creates a space to 'be with' challenging experiences such as mental health difficulties rather than reacting to or attempting to fix them. Presence may have an accepting and trusting quality and a transformational effect upon the nature of experience which can illuminate understanding or facilitate healing and recovery.	*"…it's all a question of perspective…if you accept the experience then the pain element of it starts to dissolve. So that's something I've found that with pain, you know, when I… fully immersed myself into it then it changed and improved and altered. I could actually relieve the pain."* Helen *"And this is something I saw many many times over the years. That when I was able to connect with pain and really feel it, not just talk about it but really be in it, the anxiety would reduce… when I was in that place of really being able to be with myself and be with whatever it was as it came up… to be really present to myself… without censoring myself. And in that there would be sometimes insights that would arise… a sense of - of deep love and presence there…* *…I mean any strategy, any trying to change it or fix it made it so much worse that eventually I learnt to just stop doing that… I think the whole thing about being present is really key… I think there is something about a deep being with ourselves that… allows an opening to happen… whatever's here becomes OK. Even when it's not OK. So it's like there's much more space in which things can be."* Rachel

Developmental qualities were often cultivated by and contributed to by spiritual practices. In this sense spiritual practices often mediated the contribution of developmental qualities to mental health and recovery. For example, Helen describes how her spiritual practices, which she calls “tools”, changed her life by empowering her to gain a sense of self-respect and control over her negative self-talk. Helen suggests that her life and mental health improved as a consequence.

> *“…that little ceremony or tool or process was a life changer… I realised I had a position of power… I just couldn’t believe how much negative self-talk I’d been giving myself… that was, yeah a real awakening… I respect myself a lot more… I’ve got lots and lots of tools now for keeping on track and my pattern in life is just gradually improving so that I don’t collapse into that - abyss…”* Helen

Morgen also emphasises the Developmental qualities of Empowerment and Self-care as a result of engaging in spiritual practices which in turn supported her mental health recovery.

> *“I bought myself a* [Tarot] *deck and ever since then I’ve integrated Tarot like a self-care spiritual practice… so I think went from someone who was very, very, in quite a miserable, overly overtly rational space, to someone who is much more calm and softer… throughout my mental distress… I think spirituality has helped me to kind of connect these things and maybe ritualise some of these practices in a way that I wouldn’t normally do where I’m like ‘OK I’m taking care of myself’”* Morgen

Lajla highlights the contribution of prayer and meditation towards Developmental qualities of Self-care and Compassion and their supportive effects upon her mental health recovery.

> *“…when I'm praying or meditating or you know, I think the focus is just on me and it's OK. I feel like it’s OK… It taught me compassion and primarily compassion about for myself… And that's when you can take care of other people… I feel calmer, so it really really helps my anxiety. And I just feel like my quality of life increased a lot…”* Lajla

Often the overall directionality of Developmental qualities seemed to progress towards an increasing sense self-knowledge or authenticity, which is described in the next theme.

Theme 3.4: Authenticity

The theme of authenticity as an important factor within psychospiritual development was either directly discussed or indirectly implied in relation to other themes across many participant stories. Authenticity is defined in this context as a reported sense of deepening self-knowledge and discovery. It is a progressive understanding of self or identity which is experienced as increasingly true, congruent or aligned, including in relation to personal values or a sense of increasing spiritual self-knowledge. Authenticity is often implied as a kind of developmental driver and on-going change-agent, rather than a final destination, and may be consciously sought after, or experienced as a result of the interplay between participants' spirituality and mental health experiences.

Authenticity was implied within some participants' descriptions of spirituality and characterised in relation to the theme of Self-discovery (Section 5.4, Theme 1.3). It also seemed to underlie the directionality of many developmental trajectories (Theme 3.1) as well as personalisation of Changes in spiritual belief (Section 5.4, Theme 1.2) and the Personalisation Developmental quality (Theme 3.3) to increasingly align with participants' developing values and identities. This pattern was similar for Developmental interactions (Theme 3.2) between spirituality and mental health which often moved in the direction of a greater sense of authenticity. Finally, the Developmental qualities (Theme 3.3) were often narrated to be cultivated in alignment with an increasing sense of self-understanding, sometimes enabling the participant to experience connecting more deeply with their true nature.

Specific examples of how participants described their experiences of authenticity and how this related to psychospiritual development and mental health and recovery are provided below. For example, Rashid describes how, after becoming unwell, he started to develop a greater sense of self-acceptance which led to the realisation of the importance of authenticity, of being himself, which he frames as having a beneficial effect upon his life.

"…when I became unwell I started to accept myself for who I was… often people say to you be yourself, be yourself, and that's when it sort of hit me that actually I needed to be myself instead of trying to be someone else.

So I think I'm more myself now than I was before, so yeah that's definitely been a positive…" Rashid

Morgen describes authenticity in relation to the supportive effects of spiritual practices helping her to cultivate a sense of being present in a way which can be otherwise difficult in the context of mental distress.

"I think spirituality also has helped me to be more present in myself that I think in moments of prayer, in the moments of maybe pulling a card or in moments of meditation that it allows myself to be myself in myself, if that makes sense, in a way that's not always possible I think throughout my mental distress, because a lot of it is quite mind heavy…" Morgen

For Noam the process of becoming more authentic is expressed as an intrinsically spiritual and on-going developmental process and relates to the integration of different facets of himself, as well as how he engages with the world.

"So the spiritual process for me, again spirituality has been the progress towards being ever more authentic and integrating, you know, the inner child and the authentic self and letting go… you can actually engage with the world in authentic ways and in feeling OK… It's an ongoing process..." Noam

Simon also describes authenticity as part of his spiritual journey and connected with Developmental qualities of Personalisation of his spiritual beliefs. Although he narrates the experience of the loss of his former identity as painful, he frames the overall developmental process in a positive light and as offering a sense of hope.

"I'm living more authentically and more whole which I think is giving me a sense of my spirituality as something broader than I'd ever expected it to be. But also that my mental health and my physical health and how all of that is positively affected through that as well… it's like I'm losing a sense of who I am, but in that I'm kind of finding a different sense of who I am and

that's… kind of a good thing, change in that respect for me is painful, but a necessary thing. So yeah it's sort of hopeful for me." Simon

For Keyshia the importance of authenticity is expressed as a special re-connection with an original sense of herself, a "real" and "original me", and doing so seems to be powerfully transformational.

"I have that special connection back again. I feel like the real self that is the pre- being born here, I kinda like feel I'm in touch with that me, the original me… And once I connected that I'm one individual who has all these experiences, that changed everything." Keyshia

Both Helen and Rachel discuss the idea of truth and suggest its importance within their spiritual journeys. For Helen, truth is described as something she has had to face, find and discern the meaning of.

"I mean for me it's [spirituality has] *been about facing my truth, facing the truth, finding out the truth. Finding out my truth, the truth of what happened, the truth of what it really means."* Helen

Rachel depicts truth within her spiritual journey as something which is real and that she genuinely longed and yearned for. She describes this as something which has depth and requires commitment and willingness to get to.

"I think the other aspect of this is a real longing. A real longing, a deep yearning for what I call… the real. Like there's something in us that really wants to be with truth. And I don't mean the truth with a capital T. I mean what is real and true right now… I think there is a really deep yearning in us for something deeper, bigger, more real, more truthful. And I think when we have that, coupled with a real willingness to go there, and I've seen it myself and I've seen it with many many people I've worked with, we get to the point where a deep commitment happens." Rachel

Rachel goes on to discuss authenticity more directly in relation to spirituality and mental health recovery. She describes her anxiety as arising due to a fear of being disconnected with an authentic sense of self, which she also relates to the concept of a soul. She depicts recovery as a reconnection with this deeper authentic and

spiritual sense of self which, she says, has helped her to feel more “normal” and more “sane”.

> *“So I think in terms of people’s recovery - for me at least, the spiritual aspect has been profound… I think there’s a deep anxiety about not really being ourselves actually… there was some sense of having lost connection with myself in a really deep way.*
>
> *Just through, you know, life stuff and having to become a certain person in a certain way that gave rise to a lot of the deeper existential anxiety. And feeling very cut off from I guess what you could call my soul. And as that reconnection has happened, I’ve become more and more grounded and more and more sane… deepening more and more into spirituality has actually made me much much more normal… more grounded… more sane.”* Rachel

Although authenticity is described in slightly different ways by different participants, it seems to play an important role for many, in their psychospiritual development and mental health recovery.

7.3 Conclusion

Psychospiritual development was central to how many participants said they experienced and understood spirituality, as something which changed over time, and in so doing, was transformative in and of itself. The interplay between participants’ spirituality and mental health difficulties over the course of their described stories often seemed to be supportive of psychospiritual development and recovery as well as at times challenging or hindering. The periods of dissonance within this process however were described as key components of change and sometimes marked periods of transition between newly forming stages of identity or psychospiritual growth. In at least one ‘chaos’ story however there was no indication of the person currently experiencing themselves to be in recovery. This is an important indication that psychospiritual development may not always have a positive trajectory, and recovery may not always be experienced in the context of spirituality and mental health.

The overall narrated trajectories of development could be characterised within a typology in which the majority of stories could be conceptualised as Emergence from oppression, Seeking or Awakening. These depicted phases of challenge and uncertainty, as well as experiences which seemed to propel the participants' story forwards into newly emerging realisations about self, spirituality and mental health. Within such story trajectories, nine personal developmental characteristics could be delineated which seemed to be cultivated as a result of developmental progression. These were termed Developmental qualities and seem to relate positively to both psychospiritual development and mental health recovery and were sometimes described to be supported by the use of spiritual practices. The final theme of Authenticity was present across all Psychospiritual development themes. It suggests that for many participants, the overall directionality of development that was influenced by spirituality, mental health and recovery experiences was often towards a deepening awareness and understanding of self.

Chapter 8: Spiritual connection

8.1 Introduction

This chapter describes the superordinate theme of Spiritual connection which was identified inductively from the narrative thematic analysis.

8.2 Superordinate theme 4: Spiritual connection

Spiritual connection is defined as pertaining to relationships and interpersonal themes which relate to and potentially influence and mediate the experience of spirituality. Spiritual connection is explored in relation to its potential effects upon or interactions with mental health and recovery.

Four main themes for Spiritual connection were identified: Spiritual person, Spiritual being, Spiritual practice and Spiritual community, with ten sub-themes, which are described in Table 8.1 below.

Table 8.1 Spiritual connection coding framework

Theme	Theme description
4. Spiritual connection	The ways in which participants described various kinds of relationships or inter-personal themes which related to their experience of spirituality, with potential implications for their mental health and recovery.
4.1 Spiritual person	Relationship with a person described as spiritual or having spiritual significance and potentially impacting mental health and recovery.
4.2 Spiritual being	Relationship with a spiritual being or entity described to have spiritual significance and potentially impacting mental health and recovery.
4.2.1 Loving presence	Descriptions of relationship with spiritual beings as loving presence.
4.2.2 Guiding friends	Descriptions of relationship with spiritual beings as guiding friends.
4.3 Spiritual practice	Spiritual practices to mediate or cultivate spiritual connection and potentially impact mental health and recovery.
4.3.1 Tools for mental health	Descriptions of spiritual practices as having mental health benefits.
4.3.2 Connecting “beyond myself”	Descriptions of spiritual practices enabling a form of transcendent spiritual connection.
4.3 Spiritual community	Relationship and experiences with religious or spiritual groups, communities or networks and their impact on spirituality, mental health and potential recovery.
4.3.1 Safe and healing spaces	Descriptions of spiritual communities as providing safe spaces which potentially support mental health and recovery.
4.3.1.1 Sharing and support	Descriptions of spiritual communities as providing spaces for sharing and support.
4.3.1.2 Belonging	Descriptions of spiritual communities as providing a sense of belonging or home.

4.3.2 Challenges	Descriptions of spiritual communities as being challenging with potential detrimental impact upon mental health and recovery.
4.3.2.1 Loss	Descriptions of loss of spiritual community.
4.3.2.2 Harm	Descriptions of spiritual communities as being harmful.

Theme 4.1: Spiritual person

The theme of Spiritual person concerns participant descriptions of one-to-one relationships with a person who held a spiritual significance within their story. Participants talked about relationships with spouses, partners or friends as being spiritually important and as influencing their spiritual journey, as well as their mental health and recovery. Sometimes the person appeared to instigate important turning points and transformation within participants' stories.

A few participants reported their partners as playing a clear role in their spiritual journeys. For example, Michael said that meeting a spiritual partner provided a powerful turning point of finding support and happiness after a period of isolation and struggle with his mental health.

> *"…meeting my future wife - I wanted to meet another Christian so that I could explore the Christian faith and, for me you know that is a really wonderful thing… so having really studied the Bible with my wife which is a joy, being able to share your life with someone who is a committed Christian, I mean that's obviously different to if you were on your own… I'm very thankful and blessed that I have."* Michael

Peter also shared that meeting a spiritual partner was a significant turning point in his life. He said it helped him to turn around a propensity towards anger and criminality which he indicated had developed as a result of his past experiences of abuse growing up within a religious community.

> *"…I got involved in more serious crimes and spent probably five years identifying as a criminal. You know, that was my lifestyle, until I met my partner who I'm with now. That was a turning point for me… it just takes one*

person to have that sort of confidence and belief in you that makes you change your way of behaviour… Vanessa's quite a spiritual person. She's a person with a lot of faith… I was just the opposite to her with the criminal activities… It was violence which came from a sort of anger… those [religious] *teachings are very hard to remove from your emotions, from your reactions and that. But yeah meeting Vanessa was a turning point…"* Peter

Peter goes on to describe how Vanessa's gentle and supportive approach, in leaving "the door ajar", helped him to slowly rebuild trust in spirituality and in himself, thereby potentially facilitating his recovery process.

"But she never forced it… she would always leave the door ajar. When she went to church she would always say 'Do you want to come? If you don't want to come it's not a problem.'… And I think over time I just became more and more curious and thought… there's no hypocrisy with her. And that's really what led me to become sort of part of her church… Vanessa was pivotal in me changing my outlook and being more open… we had some frank conversations about prayer and, the subject of faith. I think Vanessa could see that there was… some point in me… at a time when I couldn't see that there was really any point in me… and it helped me to sort of open my heart to the thought of a God as a creator and things like that." Peter

Other important spiritual relationships with people included friendships and key people who might turn up within participants' stories to act as a spiritual signpost or guide within their life. Sometimes they helped the participant to explore new or pertinent ideas in relation to spirituality which might be beneficial for their recovery. They might also inspire development towards more authentic spiritual meaning making and understanding about themselves. For example, through exploring a relationship with a bisexual spiritual director, Simon was able to develop a more open understanding of God and Christianity.

"And talking to people who were very much more liberal in terms of beliefs around sexuality, I started seeing a spiritual director in the Church who himself is bisexual and he was opening my eyes to seeing God in a whole different way of like, you don't have to strive, you don't have to earn his approval or earn his love or -. And I think for me that started altering how I view this term Christian, what it means to be a Christian." Simon

Other participants described friendships which acted as both signposts and support at pertinent stages in their story. Isla, for example, describes a particularly low point in her life in relation to her mental health, when a friend encouraged her to see a psychic for the first time. She says it had a powerful impact on her and formed a major turning point in her recovery because it ignited a belief in spirituality and gave her hope of a positive vision for the future.

> *"…when I got ill, my friend… she used to see a psychic for years, and I was in a really bad place so she was all 'Oh why don't you come with me?' …So I went with her, and, this woman knew everything about me… it made me realise well there is something more… it gave me like faith because before I went I was in such a low place I thought my life would never get better… it just gave me that boost that I needed… and that like faith to think well maybe things can get better…"* Isla

Alexandra describes her friend as providing a potential turning point in her mental health recovery through asking her a pertinent question about her spirituality. This led to Alexandra questioning potentially limiting or unhealthy thinking patterns about her relationship with God which led to an important transformative realisation about her mental illness.

> *"I had made this friend… their spirituality again was very much something that made sense for me, so I think that kind of kept that going… She just said to me one time - because I felt that God really didn't love me… And she said to me 'If you think God loves everybody else, which I know that you do, what makes you so* [chuckling] *different?'*
>
> *And it just, that clicked… and made me realise actually that I guess in psychosis the beliefs that you have feel more profound and convincing than any belief you've ever had before is… And so just that little chink of doubt of 'Just because I believe something's true doesn't mean it is'. That was what started to change that."* Alexandra

Mingyu's story highlights a form of spiritual relationship which was not discussed by other participants. She describes her spiritual connection to be with herself, which seemed to arise from a need and desire to be independent and, she says, supports her emotionally and mentally.

> *"I'm a very independent girl… I just get used to deal with problems by myself… normally I spend time with myself alone… whenever I think about myself, maybe I just talk to someone in my heart… I just communicate with someone in my heart… just like chat with myself… share my own happy things or sad things with myself… I use these ways to comfort myself…"* Mingyu

Although participants described relationships with spiritually significant people as providing guidance and potentially powerful turning points which in turn often supported their mental health and recovery, more commonly narrated spiritual relationships concerned non-physical beings, as described in the following theme.

Theme 4.2: Spiritual being

Participants commonly described the importance and strength of their spiritual connection to be expressed through a relationship with a spiritual being such as God or another form of spiritual guide or entity. Participants often described relationships with spiritual beings as a form of Loving presence or as Guiding friends, which both seemed to offer supportive functions in relation to mental health and recovery.

Sub-theme 4.2.1: Loving presence

Many participants described their relationship with a spiritual being as a supportive and loving presence. Such a relationship was often narrated to occur in the context of a religious God. For example, Emily reflects upon the cultivation of her relationship with God and how it is expressed as a presence and "still small voice" within her which provides meaning, guidance and reassurance in her life, including during mental health struggles.

> *"…in that first period of struggle when I was sort of first realising the reality of God… I really felt like there was a presence with me… it was God saying 'I'm here, I'm right here with you. I know you're struggling, but I'm, I'm right here.' … most of the time my sense of God is just sort of a – sureness… Some people describe it as 'a still small voice'…that kinda says like* [gentle soft tone] *'Trust me it's gonna be ok'. When I'm really tempted to just freak out about everything it's, it's there* [gentle soft tone] *'It's gonna be ok'"* Emily

Emily's relationship with God seems to take on a positive paternalistic nature at times in her story, contributing towards a sense of guidance, compassion and love as well as challenging negative thinking which, she explains, played a key factor in her mental health recovery and personal growth.

> *"… learning that there's no, there's no judgment there's no harshness it's a kind of fatherly 'I want the best for you, and that means guiding you in the right way but that doesn't mean sort of hitting you with a stick every time you do something bad.'… realising, he's good I can turn to him when I need help… if I'm struggling I can pray or write in my journal and say 'I'm struggling with this I need help'... that was a really important part of recovering and, also sort of challenging all the negative thoughts in my head when I was depressed; I very often thought 'Oh I'm just, I'm rubbish… I've failed' – but to be able to look at the Bible and say 'No… God shows love for me in an incredible way. He has a plan for me.' In the past when I've struggled with mental health he's almost sort of redeemed the experience and made it into a time of personal growth…"* Emily

Simon similarly describes the reassuring effect of his relationship with God in relation to coping with mental health difficulties. Like Emily, he mentions the use of journaling to support the expression of his feelings and communion with God. In this way Simon's perception of his relationship with God is described to have an almost therapeutic nature, as an "ever present presence" he can "offload" to and reflect with, in a way he could not with anyone else.

> *"…God understood. Like he understood what it was to feel the way I was feeling and he was a kind of, an ever present presence if you like that I could call out to when I was panicking…*
>
> *God was there, he understood… what it was like to suffer with depression and anxiety and he could help… I almost felt like I could offload that to God. Like he was a support for me, like he allowed me to express these fears and anxieties to him that I couldn't to anyone else. So I got a lot of comfort from that really through journaling, writing things down in a journal as if to God, to help me reflect on all of these experiences."* Simon

Similarly to Emily and Simon, Anna describes her relationship with God as a loving parental figure who is always there for her and who she can communicate with honestly anytime.

> *"I love the idea that kind of God's with me all the time… and you can be completely honest with him. So that's what I really love is that sometimes you feel like is there anyone who could love me completely as I am and I feel that God does... being a child of God, feeling like you have this ultimate almost parental figure who loves you as you are, who knows your heart completely and that you can talk to at any time."* Anna

Charlotte talks about how the unconditional nature of love within her relationship with God seems to help her gain a greater level of self-acceptance which provides reassurance and motivation, particularly in relation to her mental health struggles and feeling broken.

> *"And knowing that he's* [God is] *always loving… and never gives up on me just because I've done something wrong or I've failed to do something that I was supposed to do, I think understanding that more this year has also been like a thing that's made me really love him more… There's the way that God loves us is completely unconditional… So that's a nice reassurance to have… My motivation is that God loves me a ridiculous amount even though I am broken…"* Charlotte

Gregory also depicts an unconditionally loving relationship, although for him it is with a spiritual guide rather than God, who he connects with during a meditation practice. He describes this experience in relation to a feeling of family and going home.

> *"…another time in meditation, I decided I wanted to go home again. Home, back up there, right, to the second dimension. And I called* [name of spirit guide]*… Because the family connection is so strong. That's what gets me… And the love that I felt… was coming from him… because I have exactly the same feeling today, when he turns up… I can start crying, just [*clicks fingers] *just like that. I can't cry to order, but he makes me cry and it's just unconditional love. Bang! And it just overwhelms you immediately."* Gregory

A number of participants described the loving and often unconditional or supportive parental nature of their relationships with a spiritual being. Sometimes they narrated experiencing an ability to commune together in a way they could not with another person. They talked about sharing some of their deepest and honest thoughts and feelings which could provide a form of therapeutic support within their mental health struggles.

Sub-theme 4.2.2: Guiding friends

When discussing spiritual beings, some participants emphasised the importance of their guiding function within the context of a developing relationship with a supportive friend or ally. Such relationships seemed to be particularly prominent within the accounts of participants who connected with spiritual beings outside of the context of a religious God.

For example, Gregory specifically names the spiritual beings he connects with as "spirit guides" and highlights this guiding function in his life, in his case through synchronicity, which he says makes him feel like he is not alone.

> *"And, once you start on that path, you're guided. You're not on your own… once your spirit guides know how you're leaning, which way, which path you're taking, they will step in… Synchronicity: they will make certain things happen, that you meet certain people, they will make certain things happen… you mustn't forget that you are not alone."* Gregory

David describes his relationship with crystals as always having "friends" who he can relate to and have, he believes, a kind of consciousness of their own.

> *"…connecting with the crystals it's sort of like I've always got friends in a sense, I mean it's inanimate, but I sort of feel like there's something there and I can sort of relate to and that I can experience… It's a different type of consciousness. And if there is consciousness in the crystals, if there is some sort of consciousness or beings or entities, they have a different consciousness than we do…"* David

Keyshia describes a reconceptualisation of her relationship with what she calls the "spiritual realm" and associated spiritual beings. She explains that she was able to

question the framing of such beings as characterised by fear during her mental illness, to ones she could interact with more positively, like “anybody else”.

> *“…during my illness the spirit realm was very against me or I felt like what Christianity would say: demons and the devil and evil coming to you… Then I told myself actually you don’t need that; I just, create your own self and interact with these beings….So why not just interact with them as I would interact with anybody else? Like say ‘Hi how are you?’… And that’s how it's kind of like opened it all out now…”* Keyshia

Keyshia illuminates how she was able to transform her perception and subsequent relationship with spiritual beings from those who may have been detrimental to her mental health, to ones which she came to view as friends. The key to this was the realisation that she had choice in how she wanted to perceive and relate to these beings. She says that choosing to relate to them as friends rather than as unfamiliar, fearful and evil changed her outlook and empowered her to keep well.

> *“… the experience of the spiritual beings I thought I was experiencing were not familiar to me and that’s why I thought they were evil. So I decided instead of doing that, why not think of it like they are nice, they're just not familiar, so if I make them familiar but I trust that they are good people, and then I build the relationship from there. That empowered me actually to be able to keep well. Because even if I have like a delusion where I feel like I have all these like beings speaking to me or whatever, it's no longer scary or ‘My goodness, I'm demon possessed’, it's sort of like ‘Oh yeah so what do you have to say’… And that’s how I turned it around. I said ‘OK fair do’s, I’ll make you my friend…’”* Keyshia

Keyshia is able to apply this form of transformative relationality towards what she describes as a delusional being that she experienced to be controlling her life during a psychotic episode. After hospitalisation, she experienced a breakthrough in this relationship, in which she said she “embraced my delusion” and worked together with this being rather than rejecting them and viewing them as the enemy. This became a powerful step in her self-acceptance, empowerment and recovery, including being able to create her own ending for the delusion.

"… for me to reject that side of me that created that [delusional being] *made things worse, so I was fighting against* [chuckling] *my own self. I had created an enemy to fight against, but actually that was me…. So when I accepted those things about myself, I embraced my delusion as a story about me… and created the ending: how would I like the ending to be."* Keyshia

Keyshia describes how her on-going communications with spiritual beings, which she comes to perceive as friends and spiritual guides, provide guidance and support to her spiritual development.

"I started listening to what they're [spiritual beings] *saying… I had made them my friends instead of my enemies… They are my friends now, yeah. Because I've read as well a lot about like spirit guides… the spirit guides are there to guide you in a particular like mission you have… the spirit beings allow you to develop naturally. It's sort of like you're evolving as a soul."* Keyshia

Some participants described the importance of guidance and developing closeness within their relationship with God. For example, Emily describes how, after a period of feeling doubtful and struggling with her mental health, the guidance she received from God helped to reconnect their relationship and supported her mental health.

"I remember reaching a point where I was like 'God I'm not 100% sure if you're there but I know I need you, I'm completely at the end of my own ability to cope… I'm a mess and I don't know what to do'.

And actually, I felt like God was sort of telling me at that point 'I'm here, I'm with you, I love you, I have a plan for you'… that was a really special time of growing closer to God… And also most importantly I found that I needed God in my life, I needed, sort of his input and his guidance… and a big part of being well is having a relationship with God…'" Emily

Angela reveals her relationship with God as developing a level of intimacy which included both honesty and friendship. This relationship is depicted to be cultivated through utilising a spiritual practice Angela calls "divine dictation" in which she writes down what she experiences God to dictate to her. Angela describes God as being there for her when sometimes she had no one else to turn to.

"… sometimes the only person I could go to was God, because I didn't know where else to take it. I couldn't take it anywhere else… I realised that each step I went along, God was there in that mix, you know. He was not going to bale on me…

…the prayer journals by now, it's what I call divine dictation. For example God will speak in my head and I will write it down word for word. But what has changed over the time has been the level of intimacy. A couple of years ago God said to me 'I want complete and absolute honesty, I want you to talk to me as you talk to your friends. I expect you to tell me the truth'."
Angela

Participants sometimes described their relationships with spiritual beings as guides or as providing guidance, or as a form of developing friendship which often seemed to be supportive of their mental health and recovery.

Theme 4.3: Spiritual practice

Spiritual practices are described as specific activities which are carried out for the purpose of creating spiritual experiences or cultivating spiritual development. It may be a discipline or regular activity which may deepen or nourish a person's relationship with their spirituality. Participants depicted spiritual practices as enabling spiritual connection including relationships with a spiritual being. Spiritual practices were often described as practical means of providing specific mental health benefits, as well as cultivating connection with something spiritually greater or transcendent "beyond" themselves.

Sub-theme 4.3.1: Tools for mental health

Spiritual practices were commonly described as supporting participants' mental health and recovery through enabling spiritual connection. For example, Silvia shares her experience of the cultivation of her relationship with God through prayer as a way of asking for help. She explains how this supports her mental health and recovery through lifting her mood and providing a sense of peace and calm.

"I just used to have depression and I used to find that prayer often helped a lot with that. If I prayed about things that were troubling me that it was as if the mood would lift from me and I would feel better. I suppose I believe that

if I ask God for guidance he will give me guidance, if I ask him for help he will, if I ask him for strength he will, if I ask him for peace when I'm anxious he will help me in that way and for light when things are dark and depressed...

So I believe that it's useful for me to pray… And I do feel that it helps with how I feel and gives me a bit more confidence…And then that calms me down because I feel God is going to help me… So I attribute that to God listening to my prayer and the fact that I have prayed just calms me down."
Silvia

Prayer is also described by Charlotte as key to her relationship with Jesus and God. She says that prayer helps her to feel like she can rely on Jesus and God to hear and support her during challenging times in the form of what she experiences as "divine intervention."

"I would say my spirituality is that I have a relationship with Jesus and that I can pray to him and he hears me… I think coming to university was obviously a very big step and I was very worried about a lot of things… I was able to pray about it and feel a lot more like I could rely on God… I thought right, I need some divine intervention here because I can't do it. And I think that's kind of been the theme of a lot of my life… where I'm like I can't do this on my own that I try and involve God in whatever I'm doing."
Charlotte

Anna describes spiritual practices as supporting her mental health and wellbeing by cultivating a sense of presence and mindfulness. She suggests that the act of a spiritual form of journaling or diary provides the experience of connecting with God which she describes as having almost therapeutic value.

"I'm part of a home group I go to twice a month where we do kind of look at the Bible and I have my own practice where I do something spiritual every day. So I've previously done journaling… then I talk about what's on my mind, almost like a diary to God. And I've found that really helpful, similar to what I got from CBT [Cognitive Behavioural Therapy] *but more, even deeper… And because of my kind of relationship with God… It makes me more present… and helping me be more mindful, and that's having a really*

good impact on my mental health. If I'm having a really hard time I'm able to pray and that's really helpful… And that is a very amazing thing to feel when you're feeling absolute rubbish in your own mental health." Anna

Helen describes the spiritual practices she connects with as "tools" and explains how cultivating and applying these to her life has provided her with the means to choose between remaining spiritually disconnected or not. She implies that the choice to spiritually connect has led to a powerful transformation including in relation to her mental health and recovery.

Helen: *"… it's not just a sort of mental health tool it's an everything health, body, emotions, mind, spiritual, because I can, you know, I can spiritually torment myself or I can do the opposite. I can be spiritually disconnected and alone in that vast space in the cosmos. In the black hole, away and cold and lonely and isolated or I can be looking at the stars and connected to the light and have everything I need… every moment of every day..."*

Interviewer: *"So would you say this path has been quite important to your mental health and recovery?"*

Helen: *"It's transformed it. Yeah, I would say Shamanism, the study of Shamanism. The experiential, the experiences, not just learning bits in books and theories but actually going through the rituals and the ceremonies has, yeah, has changed me beyond belief."*

Another common way in which participants described spiritual practices as being supportive of mental health was by providing a sense of spiritual connection with something "bigger" or "beyond" as described in the following sub-theme.

Sub-theme 4.3.2: Connecting "beyond yourself"

Several participants highlighted the effectiveness of spiritual practices, including in relation to their mental health, as concerning their ability to connect them with something they experienced as spiritually transcendent or "beyond" their sense of self. For example, Anna explains that a variety of spiritual practices including attending church, singing, sermons and connecting with a higher being, seem to be supportive of her mental health by enabling her to think about something "beyond yourself" which provides a helpful focus during periods of anxiety.

"… for me church, so it's also really nurturing for my mental health… for example I find singing… brings me a lot of joy. Especially singing with other people, again that being with others is really helpful. So singing and just feeling connected to kind of higher being or something beyond yourself takes you away from whatever the little things are going on in your life, even if they feel really, really bad, that's really helpful. The sermons, giving you something to think about beyond yourself; because it can be very easy to get stuck in… that particular anxious week. So it's useful to have something to go and learn from and feel like you're… again connecting with that higher being…" Anna

A few participants described their relationship with nature as a form of spiritual connection providing a sense of escape or a bigger picture which seemed to be supportive of their mental health. For example, Carl depicts his deep connection with nature as the "best medicine", as well as an important aspect of his spirituality and mental health.

"I felt a very deep connection with nature, and being out in nature and I think that was the best medicine for me at the time… being out in nature was the one thing that kept me sane at that time, and was an escape from the rest of the life I had. And then when I started to meet other people, and exchanging experiences, I guess Paganism and the various aspects of it, the nature based spirituality I became aware of, and that really called to me." Carl

Peter describes how being in nature provides a sense of relief because it reminds him of being overseen by a more powerful creative force.

"I think if you really immerse yourself in nature and in the beauty of the world, you've got to admit that there must have been an architect… and at times when if I'm feeling low, then often I'll return to that sort of material… I love my garden.

So, that's a place where I can go and feel close to nature. But I think nature is the core of my spiritual belief… And the thought that we are being overseen by something much more powerful, much more omnipotent, I

think that's a cause for us to feel relief… Certainly being out in nature is just a positive experience alone isn't it…" Peter

David describes his relationship with the use of crystals as a form of spiritual connection and practice. He says that after a period of depression instigated by isolation and loneliness, his relationship with crystals helped him to feel less lonely and provided the experience of connecting with something transcendent.

"I just felt a lot of loneliness, isolation, probably some depression because of the loneliness and isolation. And connecting with the crystals gave me something that sort of transcended a lot of that… It makes me feel like I'm not alone for whatever reason, it connects me to something transcendent..." David

David describes the way in which crystals helped to shift his perception from one focussed on separation towards feeling he could meet with other people and connect with something greater outside of himself.

"I mean it [spirituality] *got me out meeting people, like-minded people and sharing my experiences. They would share their experiences… But then also it's sort of like the idea of separation, isolation, where we're sort of separate creatures, we're separate from other people… So these experiences with the crystals made me realise that I could experience something outside of myself directly in a different way… it gave me some connection with something outside of myself, something bigger…"* David

David's relationship with crystals seem to help him to feel less lonely and to enable him to meet like-minded people which implies a supportive effect upon his mental health and recovery. A wide variety of spiritual practices across different belief systems were depicted by participants to significantly facilitate their sense of spiritual connection and often, as a result, support their mental health and recovery.

Theme 4.4: Spiritual Community

Spiritual community was a commonly discussed theme concerning Spiritual connection. Spiritual community is defined as a group of people who connect, meet or engage in activities together which relate to their spirituality which they share in common. Spiritual communities were described by participants as taking different

forms including more traditional church or faith communities, spiritual groups, networks of like-minded spiritual people, or spiritual friendship groups. The large majority of participants who spoke about spiritual communities described them in positive ways and as benefitting their lives and mental health. The specific ways communities provided this support took a variety of forms, though participants often highlighted the importance of safe spaces which sometimes provided opportunities for sharing and support or helped them to feel a sense of belonging. Participants occasionally described challenging experiences of spiritual communities, such as instances of losing connection with such groups, or when they could be harmful to their mental health.

Sub-theme 4.4.1: Safe and healing spaces

Spiritual communities were often described beneficially as providing safe spaces to share with others with whom they felt a commonality and a sense of acceptance, to be vulnerable within, and to receive or give different forms of support.

Sub-theme 4.4.1.1: Sharing and support

Many participants highlighted that spiritual communities could be supportive by providing spaces to talk openly and share with one another. For example, Angela reflects that after encountering a new church community, she was able to share in a way she had not experienced in a long time, and in doing so realised its importance.

> *"For the first time in a long time I was able to share things with them* [church community]*, their journey and my journey. I hadn't had that before and that led me to think how important it is to be able to talk about things, to share things and grow them along. Consequently I started going to church there…"* Angela

Emily describes her church community as offering different forms of support, such as "hugs or meals" depending on what was needed at the time. Emily suggests a level of deep emotional support provided by this group as facilitating a form of open authentic sharing that was beneficial to her mental health.

> *"…say I'm having a bad week and struggling with this. And there's people to give us hugs or meals or support or whatever it is that we need… Also having the amazing support of a Church who believe the same things that I*

do… So having people to help, both practically and just sort of emotionally and spiritually is really really vital and – yeah a big part of staying well is making sure that I've got people who can ask 'How are you doing? No, but how are you really?' And actually have that sort of honesty and knowing that they're not gonna judge me for being honest with them because we're all part of the same community and we're all there to sort of love and look after each other." Emily

Charlotte describes a similar kind of relationship with her Christian community and, like Emily, reflects upon the importance of a group of people who share a common belief or value system. She suggests this may allow for a level of openness, vulnerability and shared unity she would not experience within other communities.

"I have found that the sort of community that you get within Christian groups… there's like a level of vulnerability that you get from being in a group of Christian people. I don't know whether it's just because you have a very strong, common thing… you all believe that one thing is the most important thing... So I think there's a sort of unity that means that you can be a lot more vulnerable with people. And I've always found that I could actually be vulnerable within Christian groups a lot more than I could in any other groups… I think having people that want to support you and want to pray for you and they're also willing to share their own vulnerabilities and issues that they're having makes you feel a bit less ridiculous." Charlotte

Charlotte goes on to explain how her mental health issues have helped her to form deeper connections within her spiritual community, helping her to empathise with other people's struggles and find shared experiences in common.

"I think with having some sort of mental health issues, it helps you to connect with other people who have similar things that they struggle with… You have something in common… being able to share my experience of anxiety with people and how God is helping me through it… It gives me a human thing that people can relate to and see that I don't have my life together at all." Charlotte

Anna speaks about the beneficial impact of her church community on her mental health by connecting through communal worship and having the opportunity to

converse with others who might empathise or understand her at a deeper and spiritual level. Like other participants, Anna emphasises the uniqueness of this kind of community.

> *"You're not sitting on your own feeling depressed or anxious, you're with others… So I think in terms of my depression and anxiety and my experiences with meeting for worship it's just very peaceful, I feel connected to other people and I feel I have to sit and be OK with whatever's going on in my life and the world doesn't end and then afterwards you can go and have a nice cup of tea with some nice people… you're just part of this community that is very unlike anything else that I'm part of. But you've always got people to talk to… other people that are going through maybe similar things to you… And because they kind of understand your spiritual side you feel like you can go quite deep with them."* Anna

Morgen talks about a form a mutual support within the spiritual communities and spaces she has connected with as a "radical form of self-care". This involves what she describes as "holding space" for one another, in which the group might employ certain techniques or practices to support personal reflection, inter-personal support and the exploration of ideas.

> *"… people are quite fond of doing a more, let's say radical form of self-care or like, there is a lot of techniques that are being taken also from humanistic side, like journaling or holding space for each other… and influence other people or other people can influence you…. and you can overcome things with people or you can figure out new ways with people…"* Morgen

Rachel describes a similar kind of egalitarian and mutually supportive spiritual group space that she facilitates. She also refers to the idea of "holding the space" in relation to her role within it, as well as the effects of allowing a rich quality of sharing, listening, connection and compassion as a consequence of what she describes as a "deep sort of human communion".

> *"And then we can look to communion between people in an equal way. So for example I do a monthly online gathering where people who are in the dark night or some sort of spiritual crisis come. But I'm holding the space but I'm not doing anything more than that. So there's the real sense of the*

equality of all of our experiences. There's no teacher or leader in that… there's a deep sort of human communion in that which feels really rich…

Because there's a sharing and a listening at a really deep level. And I think when we're sharing and listening from the place of no judgment, no advice given, no analysing, you know simply present to somebody else's experience, they're sharing from that place, there's just a very natural compassion that happens…" Rachel

The importance of safe spaces which offered the opportunity to openly share, be vulnerable and mutually support one another was commonly discussed by participants and seemed to positively contribute towards mental health and recovery experiences.

Sub-theme 4.4.1.2: Belonging

A further sub-theme which relates to the safe and healing spaces participants said were provided by spiritual communities, concerns a sense of belonging or coming home. This is described vividly by Angela who shares her experience of finding the church she felt she could call home. She depicts this as a transformational moment in her life in which her woundedness could be recognised, welcomed and accepted.

"…for the first time I walked through those doors…. the church was ablaze with light. And I just came in, and I knew I'd come home. Over the door… there's an inscription, which reads 'God has taken in this piece of ground and made a garden there for those who want herbs for their wounds.' And I thought 'That is me, I am wounded, I'm hurt, I need whatever is here.' So I came in, and all I could say for the first six weeks… was 'Thank you. Thank you to God.' He brought me home and I knew that something had changed." Angela

Sometimes the sense of belonging and coming home was depicted to occur after experiencing seeking for a resonant spiritual community, as was the case for Thomas.

"So then I kind of went seeking a little bit amongst different Buddhist groups and I didn't really find anywhere that I was entirely happy with. But then I moved… and they had a little Zen group there and it really was like an

arrival home… it just felt like well here's the answer, this is something I can work with… These people are kind of so off-putting in a way [laughing] *that I sort of trust them! And, when I talked to them afterwards they were just very very sensible people… very caring, warm people… And so I just started sitting with them and the more I did it, just the* [sighs] *just the more it felt like the right thing to do."* Thomas

Morgen describes how discovering a suitable spiritual community felt empowering in relation to her previous struggles with identity, by providing a "refuge" in which she felt she could fit in, and find herself again.

"…I could find myself again. I was like 'Ah now a lot of things fall into place and a lot of things make sense', that some of these things that I was feeling… they weren't just individual struggles… other people are feeling too. And I feel like that gave me a bit of refuge to think about it that I fit somewhere into this awkward collective. So that was very empowering." Morgen

Silvia describes her connection to her church as providing a sense of belonging and that this, along with participating in church activities, contributes towards her mental health as well as fulfilling a need to be connected with a community.

"But the other thing about spirituality is about belonging to a church, I'm not someone who just goes on my own with my spirituality, I like to be part of a church… I feel happy in a group of people and I will do, say for example I do coffee shop… And we have people come from the local care homes… I definitely need, I definitely don't do very well if I find myself isolated. I need to be mixing with people and to be getting into groups with people." Silvia

Cynthia depicts the cohesiveness she experiences within a spiritual community as akin to being part of a football team or worldwide family. She describes such a community as providing support for her life, survival and mental health, without which she says she is lost.

"Christianity meant to me that I had a worldwide family in a church… And if I meet with other Christians, especially, I feel like if you're a member of a football team you play a lot better when there's a team than when there's just you on your own. And I suppose it's a bit like that in life… and I believe

that's the only way I've got through life apart from the fact that lots of Christian people have helped me so much - loads and loads and loads - to survive really and help me and encourage me in bringing up children and trying to be the best person I can be… I feel a bit lost really without the structure and support of Christian people." Cynthia

Participants described a number of positive and supportive effects of being part of a spiritual community. These centred around the sense of spiritual communities providing uniquely safe and healing spaces in which participants said they could share openly, engage in mutual support and feel a sense of belonging. For these reasons spiritual communities were described as being supportive of mental health and recovery.

Sub-theme 4.4.2: Challenges

A small number of participants described challenging experiences in relation to spiritual communities. These are separated into sub-themes of loss and harm.

Sub-theme 4.4.2.1: Loss

A few participants talked about loss in relation to no longer feeling connected to a supportive spiritual community and the resulting detrimental impact. For example, Cynthia highlights the challenge to her mental health of feeling disconnected from her spiritual community. She conveys the resulting spiritual loss and feeling of being left on her own through the metaphor of a smouldering coal that has fallen off the fire.

"…my spirituality is shaken when I'm on my own… It's kind of like, you know coals on the fire and when you fall off the fire, you kind of smoulder and then you can burn out. And my spirituality is very much tested when alone…

And to feel the loss of spirituality in your life, which is usually when I'm alone… makes me deeply sad…

I think a lot of this [mental health difficulties] *has developed because I've had too much time on my own and I've needed other people in my life to keep me going in a way… when I'm on my own, I just think well… as if I*

don't matter to anybody… I feel trapped by evil thoughts that you can't talk about… When I'm alone things are much harder to face and there's no let-up…" Cynthia

Keyshia talks about loss of spiritual community in relation to her cultural identity. She describes her upbringing within her Christian community in Africa as providing a sense of spiritual connection through a rich and vibrant support network.

"So Christianity became very important… So I grew up like that… that became like my home and that became like my base and my safety net. And because of the way the church is, there was lots of opportunities to like present yourself and sing and do drama and help. And so your leadership skills, your confidence and everything was literally the church… it was like the base of life. So that's how I grew up… So for me Christianity was my life. Church was the place to be." Keyshia

Keyshia says that when she moved to Britain she experienced a significant loss as she could not find a similar kind of supportive Christian community to the one she had grown up within due to cultural differences.

"And so when I came here [to Britain]*, it's very different. Here, the church is like not that prominent* [laughs]*, so I was like a little bit shaken… trying to find friends outside church became a little bit hard because the church was very different. It's not as vibrant and exciting like it was in* [Africa] *and I found it a bit boring… very formal and quiet... So I started dropping off because I just didn't like it. And I think when I fell ill, I didn't have the base of a church to lean to, and I didn't have a community to lean to either… I didn't have anybody… I fell ill twice."* Keyshia

Keyshia seems to attribute her developing mental illness to the loss of her former spiritual community within the context of her culture of origin with its support and friendship network centred around a church.

Sub-theme 4.4.2.2: Harm

A number of participants described various detrimental or harmful experiences in relation to spiritual communities. For example, as explored in Theme 3.2 (Chapter 7), some participants highlighted Dissonance in relation to attitudes towards their

sexual identity within their religious communities. They also articulated experiencing detrimental effects from role expectations placed upon them by such communities. In the attempt to conform and embrace these roles, Simon and Anna said they experienced a form of burden and challenge to their mental health. Simon reflects that the pressure of conformity challenged his mental health and sense of identity.

> *"I still had fears and at times bouts of depression… I guess through being involved more in the church… there's this, a sense of pressure for me to conform… this was the sort of expectation that I felt I had placed on me. And I suffered a lot with anxiety in that time… there's very much this sort of formulaic drive of what it means to commit to a church… But I felt it was beginning to be at the expense of my own sanity* [chuckles]*. It was almost like I was losing my sense of identity…"* Simon

Anna also talks about the burden of the responsibilities she took on within her spiritual community as becoming detrimental to her mental health.

> *"So at one point I think I had ten different hats on and it was too many… and I just cracked. That was really, really bad. I just felt really overburdened and nowhere to go... there's so many different things I was doing at once and that was exhausting, so I think that had a negative impact… I didn't feel like there was anyone I could go to. So I kind of just crashed with the burden of all of the work…"* Anna

Although spiritual community was an important aspect of Carl's spiritual journey, he reflects that there might have sometimes been problematic elements within the motives of people joining those groups.

> *"So I dabbled a lot… And part of that was out of curiosity, and part of it I think was because nothing really hit the spot still… But I think looking back, there was a lot of other people in the same position as I was, and that was the attraction. So the sense of connection was a lot about other people being in crisis* [laughing] *as much as anything… and yes realised that yes it was a sense of community, but actually the community I'm in is not good for me."* Carl

Carl explains that due to the vulnerability, neediness and mental health difficulties of some people joining these communities, in his experience this can attract predatory

behaviour and highlight “dark” and “dangerous” elements within their interpersonal dynamics.

> *“And indeed some of it’s quite dark and dangerous, and there are aspects of spirituality that you know, can be quite predatory I think. Because I think a lot of people are very vulnerable who are seeking, particularly on the fringes… There’s some very dodgy people lurk in those regions… I think because people in mental health crisis are willing to cling to anything that they think will help them or rescue them, are far more vulnerable to being pulled into unhelpful or even dangerous relationships… So yeah, there’s definitely that vulnerability and that neediness I think that comes out of being in crisis…”* Carl

Carl goes on to highlight the danger of hierarchy and power which may reside within a spiritual community, particularly in relation to spiritual leaders and potential abuse.

> *“I think anything that has a hierarchy in it… where there are teachers, priests or whatever they like to call themselves, they become the object of adoration as well, and respect. And I think that gives them a power, and with that power comes a responsibility that not everybody I’ve experienced lives up to.”* Carl

Peter’s early experiences of spiritual community are articulated as abusive and harmful because of the degree of control this community exerted over him and then later excommunicating him, leaving him completely alone from the age of 15.

> *“…my own experiences of spirituality as far as religion’s concerned have been quite challenging and sometimes quite detrimental… they don’t allow you to associate with people that aren’t fellow believers. So it’s very much, very controlling… I was forever being reproached for asking questions…*
>
> *…life was thoroughly thoroughly miserable and full of restrictions… when I was 15 I was excommunicated, which meant that my parents would no longer have any contact with me, and it also meant that all of the people that I knew… would blatantly have nothing to do with me… I lost my faith in people as much as in anything spiritual.”* Peter

Peter says that being brought up within a spiritual community he experienced as abusive had detrimental effects on his mental health, including in later life.

> *"With it being so, so, so damaging the time that I spent then, I think it will be really really difficult to put that completely behind me. I've always got sort of alarm bells ringing. And that's part of my mental health issues as well that I can be quite paranoid about situations… I think certainly to start with those first religious experiences were detrimental to my mental health."* Peter

A few participants described cultural factors to be influential in relation to challenging experiences of spiritual communities. For example, Rashid identifies tensions and struggles between his Muslim culture of origin with its particular norms and values, and his growing identity as a Westerner in Britain. Rashid describes how his experiences of pressure to fit in and be compatible in relation to the religious cultural values of his community, led to identity struggles and contributed towards his mental health breakdown.

> *"But there are challenges, like you know me trying to live my life how I want to… you know question about compatibility all the time where 'Oh you know, does it fit in with my religion, does it fit in with my identity?' And I suppose an element of guilt… when I'm out with my Muslim friends I can't talk to them about my night out for example. I can only talk to them about certain subjects because of religion… that's how I became depressed. I was struggling with my identity, I was having a bit of a crisis, and I didn't really know where I fitted in."* Rashid

Another challenge articulated by Rashid in relation to experiences of cultural clashes is of mental health stigma. He describes a denial and discrimination within his experience of some communities around mental illness.

> *"Because I come from a Muslim family that has massive implications for my mental health. So when I tell my mum for example that I see the psychiatrist or the care coordinator, she often says to me 'Why do you go there, why do you use those services?'... And there's this denial or refusal to accept this mental illness… There's a lot of stigma, there's a lot of discrimination."* Rashid

Although spiritual communities were most often reported by participants as positive and supporting mental health, some participants highlighted challenging or harmful effects which were detrimental to their mental health.

8.3 Conclusion

Participants described various forms of spiritual connection. Four main themes for Spiritual connection were identified: Spiritual person, Spiritual being, Spiritual practice and Spiritual community, with ten sub-themes. These forms of spiritual connection were mostly described to have beneficial effects upon mental health and recovery. These effects were described in a variety of ways depending on the form of spiritual connection, but often involved experiences of guidance, understanding, unity, care, sharing and safety, and sometimes a sense that spiritual connection offered a unique form of support that was beneficial to mental health. Challenging impacts of spiritual communities were also sometimes described where careless or harmful actions of the group might have detrimental effects upon a participants' mental health.

Chapter 9: Discussion

9.1 Introduction

This chapter discusses the main narrative study findings of superordinate themes Meaning making, Psychospiritual development and Spiritual connection in relation to the empirical and theoretical literature. It explores how the findings of this study relate to previous research, and the MISTIC study, considering points of departure and originality. Findings of both the narrative and MISTIC studies are then integrated and summarised and a simplified guidance framework is suggested which could be utilised within clinical practice. Further implications for practice and future research directions are then explored, along with reflections of the study's limitations, strengths and key knowledge contributions.

9.2 Superordinate theme: Meaning making

Narrative study participants described meaning making in relation to how it functioned in the context of their spiritual and mental health experiences. They sometimes depicted an active psychological process of constructing meaning making frameworks that allowed participants to reframe their experiences in ways which were often supportive to their mental health and recovery. Such frameworks could also be described in relation to rational ('logos') ways of meaning making, or in relation to spiritual ('mythos') ways of understanding. The main focus of the discussion relates to the final theme of Discerning spiritual guidance due to its saliency within participant accounts yet lack of attention within empirical research.

9.2.1 Constructing frameworks of meaning

> *'But meaning is something mental or spiritual. Call it fiction if you like. Nevertheless this fiction enables us to influence the course of the disease far more effectively than we could with chemical preparations'* (Jung, 1932, p. 494).

Meaning is considered crucial in understanding human experience, especially in the context of distress (Burke & Neimeyer, 2012; Park & George, 2013). According to Frankl (1992, p. 139) '*Once an individual's search for meaning is successful, it… gives him the capability to cope with suffering.*' Similarly, narrative theory highlights

the human motivation to preserve a meaningful self-story which maintains consistency in life especially when it has been disrupted through stressful events such as illness (Burke & Neimeyer, 2012). Bruner (1990) argues that a crucial feature of narrative is that it specialises in creating links between the exceptional and the ordinary and that stories achieve their meanings by explicating deviations from the ordinary in a comprehensible way.

Spirituality and religion can provide reliable meaning systems and have been explored broadly in relation to 'Meaning making framework' theory (Park & George, 2013). Here, spirituality and religion are considered part of a 'global meaning' system which include beliefs, goals and a subjective sense of meaningfulness, and translate into specific every day or 'situational meaning' which can be threatened and changed during stressful encounters (Huguelet et al., 2016). The meaning making process is described as the effort to achieve congruence between global meaning and situational meaning (Park, 2010). Discrepancies between these, such as violations of global meaning, can result in distress, which in turn can initiate cognitive or meaning making processes in an attempt to reduce this discrepancy. This allows for integration of the stressor within a person's global meaning system which in turn can lead to better adjustment (Park, 2010). Meaning making processes seem to include deliberate coping efforts to understand the situation in a different way, such as making positive reinterpretations and reattributions of finding helpful ways to perceive and accept the situation (Folkman & Moskowitz, 2007).

Findings from the narrative study support such 'meaning making coping' theories, (Folkman, 1997; Park, 2010) in relation to participant accounts of utilising spirituality for positive reappraisal of their experiences and distress. The narrative study extends and refines such understandings by highlighting specific cognitive processes implicated in such meaning making processes, most notably, Reframing of perspective. This includes ways in which spirituality may have contributed towards a bigger picture perspective, the validation of experiences, or the ability to fluidly change perspectives. These may have contributed to the construction of meaning making frameworks which supported coping with mental health challenges and recovery.

9.2.2 Navigating the mythos and logos

A commonly reported theme in relation to Meaning making was experiencing and navigating between mythos and logos frameworks of meaning. Mythos and logos

are described as two dichotomous yet complementary dimensions of expressing human experience. Mythos is characterised as involving personal experience, meaning, symbolism, intuition, insight, imagination and subjective perspectives, whilst logos involves logic, reasoning, order and a sense of objectivity. They are both thought to be essential for human development and information processing (Zagórska, 2018). Narrative study participants seemed to demonstrate this as they depicted successfully juxtaposing mythos and logos ways of meaning making as a way of obtaining a more balanced understanding that seemed supportive of their mental health and recovery. This was also indicated within the MISTIC study, in which some studies reported participants were able to effectively integrate medical (logos) language with spiritual or paranormal (mythos) themes and successfully develop 'multicausal models of explanation' (Ouwehand et al., 2014).

The importance of mythos and logos frameworks of meaning making is explored in greater depth in relation to the theme of Discerning spiritual guidance below. Here, experiences were reported to be particularly of a mythos type, with attempts to sometimes make sense of them more rationally through logos approaches.

9.2.3 Spiritual meaning making as an internal guidance system

The narrative study provides novel empirical evidence by highlighting intrapsychic or internal spiritual guidance as a potentially important component of meaning making in the context of spirituality and mental health. Although there is a lack of empirical research exploring this theme, some authors provide potential theoretical insights, particularly in relation to mythos forms of meaning making. For example, Tacey (2013a) argues that whilst mythos forms of thinking can promote reconnection with spirituality and intuition, this is something beyond the capability of logos. Tacey goes on to suggest that the utilisation of the holistic understanding which mythos may provide could be vital to health and that this may involve the integration of a spiritual dimension:

> *'Mythos looks at the whole rather than the part, and the whole is animated by forces which the part can experience but rarely comprehend…. and our civilisation will not recover health and balance until it rediscovers a transcendental basis to its outlook' (Tacey, 2013a, pp. 16–17).*

Within the theme Discerning spiritual guidance, participants described phenomena such as synchronicities, signs, messages, visions, dreams, symbols, intuition and

imagination. These have been theorised to operate to support meaning making in the context of mental health by providing a focus upon the internal realms of the psyche and thereby promoting recovery, healing and psychospiritual growth (Tacey, 2013a). It is beyond the scope of this thesis to explore these phenomena individually, though there have been theoretical and empirical efforts to investigate them. Notably, Jung (1921) viewed the imagination as a key component to meaning making which could support both physical and mental illness. Jung (1955) also found that synchronicity was a frequently reported phenomenon in his patients despite their fear of ridicule in speaking out about such experiences. He defines synchronicity as a psychic factor denoting a meaningful coincidence in time. Later authors criticised Jung's focus upon such phenomena as irrelevant (e.g. Kime, 2019), whilst others highlight synchronicity as a function of human meaning making which can be understood in relation to mythos ways of understanding the world (Colman, 2011). From the perspectives of participants, what seemed most important in relation to meaning making was not the ontological nature of their experiences, but the ways in which they functioned within their lives, often providing forms of spiritual guidance.

Some authors have pointed to a rationale that may explain why mythos and intrapsychic spiritual guidance experiences may be poorly understood or researched. For example, psychiatrist Iain McGilchrist's extensive review of neurological literature brings him to the conclusion that the two hemispheres of the brain provide different ways of paying attention to the world. The left hemisphere maps onto logos thinking whilst the right hemisphere (mythos) adopts a more holistic relational understanding:

> *'The hidden story of western culture… is about how the abstract, instrumental, articulate and assured left hemisphere has gradually usurped the more contextual, humane, systemic, holistic but relatively tentative and inarticulate right hemisphere…The nature of the attention we choose to pay alters the nature of the world we experience, and governs what it is we will find… Before long we are locked into a certain vision of the world…'*
> (McGilchrist & Rowson, 2013, pp. 12 & 4 & 14).

According to this theory, the left hemisphere's way of making sense of the world has come to dominate post-Enlightenment Western cultures. This is to the detriment of religion and spirituality, and mythos forms of meaning making that, due to the

relative under-activity of the right brain, may no longer make sense to many Westerners. As a result, Western culture can tend to undermine the importance of spirituality because it literally requires the brain to be used in a different way (Swinton, 2014).

In a similar vein, Jung (1954) reflected on why Western traditions have not valued the interior subjective realm of the psyche which he viewed as a repository of the sacred. He argued that there was a tendency to discount the psyche within both Western secular scientific and religious cultures in which subjective spiritual experience had been denigrated in favour of externalised ideas or institutions.

> *'…very little attention is paid to the essence of man, which is his psyche…Man's greatest instrument, his psyche, is little thought of, and it is often directly mistrusted and despised. "It's only psychological" too often means: It is nothing'* (Jung, 1964, p. 102).

Although for Jung the study of the psyche indicated answers to many so far unanswered questions, Tacey (2013) argues that its undervaluation was due to a fear of interiority and the seemingly dark, unknown, sinful or chaotic nature of the inner world. In addition, ordinary people were not to view themselves as capable of intimacy with the divine, as they would then be judged as deluding themselves and expressing hubris.

Such theories highlight the multiple layers of taboo relating to understanding meaning making in the context of spirituality and mental health. As well as a dismissal of mythos forms of understanding, the idea that guidance and functional meaning making could be derived from within, especially if they are informed by spirituality, could be viewed in relation to a historical and cultural distrust of the internal subjective realm of experience. In the context of mental health challenges, the risk of pathologising such experiences can be greater still. Despite this, narrative study findings highlight ways in which such internal spiritual experiences can become important and function in the context of mental health and recovery, including instigating or illuminating the process of meaning making. Some authors also point to the importance of mythos forms of meaning making operating as helpful metaphors in navigating and making sense of psychotic experiences. They suggest this may function to support understanding of such symbolic meanings by introducing individuals to themes, conflicts and resolutions that can reveal the

deepest workings of the psyche and instigate transformation (Hartley, 2010; Lukoff & Everest, 1985).

Attempting to discern spiritual guidance was sometimes reported to be challenging, particularly when there seemed to be a confusing interaction with mental health symptoms. Some theories suggest this might be partially explained by the emphasis placed upon rationality and logos forms of meaning making within Western culture which offer limited maps for understanding subjective mythos experiences. Participants were highlighting, however, from their lived experience perspectives, the importance of internal mythos forms of meaning in supporting functionality via spiritual guidance. Therefore, such participants may have been demonstrating a form of internal guidance system operating mostly in mythos mode within a cultural context which operates predominantly in logos mode.

9.3 Psychospiritual development

> *'…the "awakening of the self"…. no matter what the stage or grade of life… a rite of moment, of spiritual passage, which, when complete, amounts to a dying and a birth. The familiar life horizon has been outgrown; the old concepts, ideals and emotional patterns no longer fit; the time for the passing of a threshold is at hand '* (Campbell, 1949, p. 51).

Narrative study participants talked about spirituality in the context of mental health and recovery in relation to change and transformation, giving credence to the idea that psychospiritual development is often a central feature within such experiences. The changes included the nature of their spiritual beliefs, their mental health and recovery experiences, and the ways in which these interacted in either supportive or disruptive ways. Specific characteristics of change could be delineated across narrated stories as trajectories, the most commonly highlighted being Emergence from oppression and then Seeking and Awakening. Seeking and Awakening are discussed to some degree within the literature. A novelty of the narrative study however is highlighting the relative prominence of the Emergence from oppression theme across participant accounts as this seems less well explored within the literature. Presenting a range of trajectories as ways in which spirituality and mental health stories may unfold is also a distinct finding that could be informative for those seeking to increase their understanding of such experiences. These trajectories are explored in relation to psychospiritual developmental theories and empirical

literature. It is important to note that not all experiences relating to spirituality and mental health will inevitably depict positive trajectories, psychospiritual development or recovery, as highlighted by the one 'chaos' story which had a confusing and unresolved ending.

There was also a cluster of personal Developmental qualities (e.g. Empowerment, Self-acceptance, Self-care, Compassion etc.) which were often mentioned by participants as key components within their spirituality and recovery journeys. This is a unique contribution of this study and although such characteristics are individually well discussed within the literature, they have not been framed collectively as potentially important components of psychospiritual development. That is, they have not been discussed as a group of key Developmental qualities within the context of spirituality and mental health from lived experience perspectives. Some examples of psychospiritual developmental theories and empirical studies which allude to a specific Developmental quality are outlined below. Although the Developmental qualities included within the research findings are not meant to be exhaustive, they could provide an important exploratory platform for further research or wellbeing interventions.

A key finding in relation to psychospiritual development was the tendency for participants to highlight transformation as having a potential orientation point towards greater levels of Authenticity. Such deepening levels of understanding towards an inner sense of self, or of a seeking or progression towards this, seemed to be instigated or perpetuated by participants' experiences of spirituality, mental health and recovery. This theme of Authenticity may contradict some of the taboos (e.g. delusional, subjective, irrational) which can surround spirituality and mental health experiences, as discussed in Chapter 1 and in the earlier Section 9.2. This is further discussed in Section 9.3.2 in relation to the research literature, after first exploring some key psychospiritual developmental theories and how these illuminate some of the Developmental trajectories, Developmental interactions and Developmental qualities highlighted by participants as salient features of their psychospiritual journeys.

9.3.1 Psychospiritual development theories and features of the journey

Numerous models for psychospiritual and spiritual development theories (from now on referred to as psychospiritual development) exist which broadly share the idea that human beings have a propensity for engaging in spiritual growth. Although this potential may not be fulfilled by everyone, it may involve a lifelong progression towards a sense of wholeness and self-discovery (Starnino & Sullivan, 2016). Psychospiritual development can be viewed as intrapersonal changes residing within the individual, as interpersonal in that it relates to social relationships, and as transpersonal, in that it can point to something beyond the individual such as their connection with the sacred. In some models, psychospiritual development may be understood as sudden and unexpected, whilst in others it is viewed as gradual or as consisting of a number of continuous stages. It is sometimes theorised to be unidirectionally progressive towards a kind of goal, or as consisting of both ascents and descents which intermix across the journey (Friedman et al., 2010).

One of the most influential psychospiritual development theories which has attracted much attention and inspired empirical research internationally, is James Fowler's (1981) theory of faith development. Fowler outlined a course towards moral maturity in his theory of six stages of faith that he describes as a fundamental feature of human nature. Faith development therefore influences psychology including emotions, behaviour, cognitions and moral outlook, depending on the stage of development attained (Culliford, 2011b). Fowler's stages include three stages in childhood and adolescence which are characterised by conformity and relatively unexamined beliefs, and three potential subsequent stages which involve critical reflection, flexibility and integration in relation to beliefs and values (Canda & Furman, 2010).

Such theories can throw light upon some participants' experiences of change and transformation within their stories. For example, Fowler (1981) describes that in order to reach the fourth 'individuative-reflective' stage of faith, a phase of critical questioning must occur of the implicit assumptions surrounding beliefs and values which have formed from life experiences. These are then made explicit so that they become consciously chosen and may lead to gaining clarity of understanding about spirituality. This stage also involves reflecting upon the nature of identity beyond externally defined roles that may cultivate qualities of empowerment, responsibility

and autonomy. Many narrative study participants highlighted the importance of questioning and doubt within their psychospiritual development in the Dissonance sub-theme. Although confusing and challenging at times, such periods seemed to operate to bring greater clarity to the beliefs and values of some participants. The developmental trajectory Emergence from oppression may also connect with Fowler's individuative-reflective stage of development in which participants often described the challenging processes of claiming a more empowered and authentic sense of self after outgrowing limiting, oppressive and imposed forms of identity. The emerging sense of autonomy that may arise from this stage also points to the Developmental qualities of Personalisation and Empowerment as well as the theme of Authenticity.

Fowler's stages of faith model offers useful insights about how some people may transform their spiritual worldview in conjunction with their psychospiritual development. Fowler warns however against viewing the stages as an achievement scale or as representing educational or therapeutic goals. His theory has been criticised for failing to account for empirical evidence indicating that many religious experiences do not have stage-like qualities, or to accommodate more ordinary religious experiences (Boyatzis, 2001).

Periods of doubt and questioning were key features within of most participants' Developmental trajectories. Erikson (1980) refers to such experiences as developmental crises and argues that they can create uncertainty and questions, which in turn motivates heightened curiosity and may drive further development and learning. Development according to this theory is viewed as a lifelong process towards higher levels of Integration (one of the Developmental qualities) and wholeness. This occurs across both stable and unstable periods, the latter of which can become a crisis when a person may be temporarily unable to cope or whilst undergoing significant transformations within their life. When such crises have been associated with religious or spiritual abuse or trauma, they have been found to lead to resilience and identity changes (Ellis et al., 2022). These include taking personal ownership of one's faith, a strengthening relationship with God and increased empathy, open-mindedness and vulnerability with others (Crocker, 2021). For others it may involve experiences of healing, spiritual transformation and adopting a new spiritual identity as a source of strength (Swindle, 2017).

Most of the cases in Taylor's (2013) study reported a 'spiritual awakening' triggered by intense periods of psychological distress or crisis associated with events such as illness, bereavement, psychosis and depression. For nearly half of those participants, the experience was sudden and dramatic and occurred in conjunction with general developmental progressions. Taylor (2013) describes this form of deep and holistic personal transformation as potentially experiencing being re-born or gaining a new sense of identity, as was the case with some narrative study participants. Awakening trajectories were described by narrative study participants as initially highly disruptive and in two cases occurring after a near-death experience. However, the recovery process brought positive outcomes for all such participants, including healing and positive changes in their general lives.

Spiritual awakening has been gaining increasing attention within the literature. It is described as *'temporary expansion and intensification of awareness'* which brings about transformation, self-discovery, healing, and involves physical, emotional, psychological and spiritual growth (Lucas, 2011; Taylor & Egeto-Szabo, 2017, p. 45). Similar terms used to characterise such experiences include 'spiritual emergence' to describe a gradual unfolding of spiritual potential, and 'spiritual emergency' to represent those experiences that occur more suddenly and dramatically (Grof & Grof, 1989). A spiritual emergency can involve a temporary crisis when growth and change becomes chaotic and overwhelming with a sudden disruption in psychological and social functioning (Lukoff et al., 1998). Whilst spiritual emergencies can be highly distressing, research indicates they can have a unique psychospiritual development enhancing potential if adequately supported and resolved (Canda & Furman, 2010). Spiritual emergencies and awakening have been shown to lead to improvements in health and well-being, positive affective states, increased altruism and enhanced relationships (Lukoff, 2005; Taylor, 2013).

Questions remain however about the specific kinds of presentations that are indicative of a spiritual awakening or emergency. It may be informative however to focus upon learning about the transformative aspects of all experiences, however they may be defined (Brett, 2010). Concepts such as spiritual awakening or emergency can be potentially useful explanatory models which may assist the recovery process because they are normalising rather than stigmatising (Crowley, 2006).

9.3.2 Authenticity as a psychospiritual developmental orientation

Authenticity was a theme highlighted by a number of participants as salient within their developmental process, and was alluded to across other themes including Developmental qualities and Developmental trajectories. It was also suggested within participants' characterisations of spirituality, within the themes Spirituality as changing and Spirituality as self-discovery. These themes denoted changing belief systems in relation to participants' evolving identities, self-understanding and psychospiritual development.

Authenticity is described as a life-long process of self-discovery in a comprehensive concept analysis by Starr (2008). It includes the realisation and expression of personal potential and responsibility, including through suffering, culminating in a congruency in ideals, values and actions. Self-discovery has also been found to be a major theme within post-traumatic growth in mental health recovery and is described as '*a fuller and deeper understanding of oneself'* which involves *'the ability to access, accept and be mindful of difficult feelings'* (Slade et al., 2019, p. 5).

The narrative study findings give weight to theories that connect authenticity with spirituality and psychospiritual development. For example, Tacey (2012) argues that although it may involve turmoil and angst, spirituality is the attempt to find something genuine within the psyche and is the discovery of an authentic self. Authenticity is described by Maslow (1998) as the most salient feature of self-actualised people. Self-actualisation is described by Maslow (1971) as the pinnacle of development within his hierarchy of needs model. At this level deep spiritual fulfilment occurs and is attainable once lower level and survival needs are fulfilled. Maslow (1971, p. 314) proposed that the developmental process is incomplete without spirituality which he suggests is '*part of the Real Self, of one's identity, of one's inner core...*'

The positive trajectory related to the cultivation of authenticity within psychospiritual development is viewed as indicative of spiritual maturity and psychological health (Robinson et al., 2013). It is associated with identity development and a congruence between actions, beliefs and a personal sense of self (Love & Talbot, 2000). Carl Jung described such a lifelong continuous process of psychospiritual maturation and self-discovery as individuation. It involves the individual understanding better their internal realities and the emergence of the authentic sense of self (Cranton & Carusetta, 2004). Carl Rogers (1980) also suggested that authenticity was an

intrinsic aspect of spiritual maturation which he describes as a tendency of personal growth towards the development of awareness, wholeness, integration and a sense of unification.

Authenticity has also been highlighted within empirical research exploring spirituality and recovery narratives. Fallott (1998) describes seven key themes which emerge from people's recovery stories. He conceptualises one of the key themes as: 'Recovery is a journey towards genuineness and authenticity' that describes the journey in which people discover or rediscover their 'true self'. This journey may be framed by some as a return to the person they were before, whilst others perceive it as a progression, discovery or creation of an emerging sense of self. Fallot argues that there may be a fundamental motive to consolidate a consistent sense of self, despite the challenges in doing so, and that the development of a greater authenticity can be inherently and implicitly a spiritual concern.

The process of developing authenticity is described to sometimes include Emergence from oppression in which self-transformation may include a reduction in unhealthy rigid psychological patterns which can create barriers for the individual (Kass, 2007). It also relates in the literature to various Developmental qualities. These include Compassion, (Kass, 2015); Awareness, Integration, Presence and Self-acceptance (McGee, 2014). Such attempts towards a *'radical acceptance'* of the self, rather than condemning or oppressing, is suggested as *'a secret paradox for change'* in that it can facilitate the internal transformation inherent to cultivating authenticity (McGee, 2014, p. 727).

9.4 Spiritual connection

Narrative study participants talked about Spiritual connection as principally occurring in four specific ways: through a relationship with another person, through a relationship with a spiritual being, through spiritual practices or by connecting with a spiritual community. The findings provide empirical evidence for these four types of spiritual connection as important within the context of mental health and recovery. Because of their prevalence within participant accounts, the main focus within this discussion will be upon the themes Spiritual being and Spiritual community.

In the literature spiritual connection is often a defining feature of the concept of spirituality. For example, spirituality is described as the ability to experience a

special connection with something which transcends everyday experience (Hyland et al., 2010) or as a sense of connectedness to self, others or to the universe (Sharts-Hopko, 2003). Spiritual connection is also discussed as 'relational spirituality.' This is described broadly as 'ways of relating to the sacred' however the individual may define this. Embedded in a network of relationships, individuality, identity and sense of value is viewed as being largely determined by and arising out of relational experiences. Therefore relatedness is seen as a primary and fundamental characteristic of being human, and is considered essential in order to develop as full and authentic human beings (Verhagen & Schreurs, 2018).

9.4.1 Relationships with spiritual beings

Participants in the narrative study spoke mostly positively about their relationship with God and other spiritual beings; as a Loving presence or Guiding friend. At times such relationships were narrated to take on a parental nature and occasionally were fraught with challenge or doubt. These relationships were also often described to change over the course of the story, nearly always in the direction of greater depth, intimacy, love or trust in a similar way to the potential development of a healthy human relationship. This is consistent with study findings of de Castella & Simmonds (2013) that a significant component of participants' spiritual growth was the deepening of their relationship with God. Narrative study participants described such a personalised and changing relationship with God or a spiritual being to include the development of love, which is also highlighted within the literature (e.g. Schreurs, 2006).

A theoretical perspective which has guided research on many kinds of relationships including spiritual ones is attachment theory. Bowlby (1988) identifies attachment as a distinct internal motivation which serves to protect an individual from harm, cultivates feelings of security and safety, and results in a person attaining proximity to an identified individual perceived better able to cope with the world. The quality of attachment relationships developed within childhood are thought to effect subsequent relationships in later life which include spiritual relationships (Kimball et al., 2013). Research indicates parallels between attachment to parents and attachment to God although relations can be complex. For example, there can be a lack of parallelism when a secure relationship with God is sought to compensate for an insecure one with parents. In that case such spiritual relationships may foster

hope and provide a stepping-stone to more secure attachments with others (Granqvist & Kirkpatrick, 2013).

Exploring attachment to God in emerging adults' spiritual relationship with God, Kimball et al. (2013) found that participant narratives demonstrated very personalised and intimate experiences with God. They spoke about reaching out to God in challenging times as well as receiving God's help and encouragement, including through prayer. These experiences allowed participants including those with insecure parental relationships to cultivate self-worth and develop positive perspectives about their ability to form healthy relationships. This parallels narrative study participant accounts of intimate communion with God, including during times of distress, which often provided support for their mental health and recovery. This was sometimes supported by engaging in spiritual practices such as prayer. Attachment theory and the means by which people may be able to form experiences of secure, safe, intimate and loving relationship with a spiritual being could illuminate one of the functions of spiritual connection, including within the context of mental health and recovery.

Although the analogies, highlighted within attachment theory, between human and spiritual relationships can be helpful, the potentially unique character of a spiritual connection can also be significantly different from a human relationship (Schreurs, 2006). Some participants in this study did suggest that this was the case, highlighting for example being able to communicate with or feel understood or accepted by God or a spiritual being in ways they would not with a person.

Both MISTIC and narrative studies highlighted the importance of a relationship with a spiritual being in providing reassurance, guidance and a safe or loving presence. Whilst the narrative study emphasised a guiding and loving aspect to this relationship, the MISTIC study highlighted the importance of such a relationship for coping with the challenges of mental health difficulties. For example, through providing a powerful and reciprocal relationship which supported the cultivation of qualities such as peace, strength, courage, positivity and understanding (e.g. Heffernan et al., 2016).

Although narrative study participants tended to highlight positive experiences within their relationships with a spiritual being, other research including the MISTIC study (within the sub-theme of Spiritual struggles) suggest such relationships can also

sometimes be challenging in relation to mental health. These include experiences of feeling judged or punished by God and feelings of guilt or unworthiness (e.g. Lilja et al., 2016). Allen (2013) highlights that challenging and traumatic experiences may become spiritual struggles and in turn undermine connection with a spiritual being or spiritual communities. Pargament (2007) identifies different types of struggle which may affect spiritual connection. These include interpersonal struggles with people and spiritual communities, and what he calls 'divine struggles' which stem from conflict within a person's relationship with God. Pargament suggests that such experiences can be pivotal in leading either to positive spiritual coping and transformation or to spiritual disengagement that can lead to adverse consequences for physical and mental health.

9.4.2 Spiritual community

A prominent theme expressed by participants about Spiritual connection was the beneficial impact of belonging to spiritual communities, including in relation to mental health and recovery. These included providing safe and sometimes healing spaces in which participants could receive support and understanding, often in ways they struggled to find elsewhere. This allowed some participants to share openly about their mental health experiences which they described as mostly being met in supportive ways within these contexts and therefore being helpful for their recovery.

Hodges (2002) describes spiritual community and the shared values and support which often accompany it as a key dimension of spiritual health and wellbeing. This could be viewed in relation to an innate desire humans as social beings tend to have for community, as well as for relationships with others, nature and a higher power (Koch, 1998). Spiritual communities can provide a means of support in transitioning through periods of illness and difficulty and contribute towards personal growth and development through and beyond this time (Hodges, 2002). Through spiritual practices such as singing, prayer, chanting or meditating with others, an empowering sense of unity can be experienced within such contexts (Maton, 1989). Religious service attendance, for example, has been found to be a powerful indicator for a number of health outcomes, including lower rates of mortality and depression, and lower likelihood of suicide (VanderWeele, 2017). Participants in both the narrative and MISTIC studies found spiritual practices to be supportive of their mental health and recovery, and as a means of spiritual connection individually and collectively.

Narrative study participants highlighted, within the sub-theme Belonging, the importance of being part of a spiritual community with shared values, sometimes with the sense of coming home, acceptance and support for their recovery and coping with mental health difficulties. Belonging was found to be important for mental health recovery in a study by Doroud et al. (2018, p. 118). They describe belonging as a form of *'connectedness, mutual support, social interactions, a sense of affirmation and contributing to the community'* and that personal recovery is connected with taking an active role to do with and for others.

Spiritual communities can serve as a powerful social role in the life of people experiencing mental health difficulties as they can offer supportive relationships, a sense of safety and spiritual support at a challenging time of transformation (Balboni et al., 2017). Narrative study participants talked about the importance of receiving spiritual support and guidance from others within their spiritual communities, as well as ways in which Safe and healing spaces potentially supported their mental health and recovery. A study by de Castella & Simmonds (2013) similarly found social connection through church attendance to provide a sense of safety and support for participants in their research. They also found that religious learning and coping was facilitated through the guidance of others and supportive interpersonal relationships.

Experiences of spiritual communities within the MISTIC study were more mixed than the narrative study, highlighting to a greater degree some of the struggles and challenges that may arise in that context. These include potential stigma, rejection or being unable to attend spiritual communities due to the challenges of mental health symptoms. Although there were relatively fewer reports of challenges posed by spiritual communities in the narrative study, those that were mentioned sometimes indicated serious abuse and life-long trauma which remained a consistent focus within participants' recovery journeys. Ellis et al. (2022) found that religious communities can contribute towards abuse and trauma by misusing power or inducing control or fear in others. In addition, they found that rates of abuse could be higher within certain vulnerable populations such as LGBTQ+ communities, highlighting the importance of intersectionality and cultural factors within this context. Narrative study findings similarly indicated that sexuality and cultural factors may have contributed to challenging experiences within spiritual communities.

9.5 Findings integration and conclusions

The narrative study produced rich and in-depth findings with complex interweaving and interconnecting themes and story threads. These were sometimes difficult to isolate and determine in the refined concise ways necessary for thematic analytical work and reporting. Nonetheless, salient themes were derived after undergoing a number of thorough analytical stages and revisions.

A potential issue with thematic analysis is that it can depict data such as people's experiences as though they are discrete units which function in their own right, when the whole picture is often far more complex and integrated. Critical realist research however attempts to access such complexity, including the difficulties of understanding and representing subjective experiences. It attempts to present it in such a way that may be useful across a variety of contexts and potentially create beneficial change. This has been my attempt throughout the research process, even when dealing with multiple, subjective and sometimes difficult to articulate phenomena as spirituality, mental health and recovery. In this vein, I brought together and attempted to integrate and simplify findings from both MISTIC and narrative studies with a view to balance both accessibility and comprehensiveness. (Figure 9.1). Within this context, a new emergent centralising concept is introduced of 'Spiritual functionality' which is explained below.

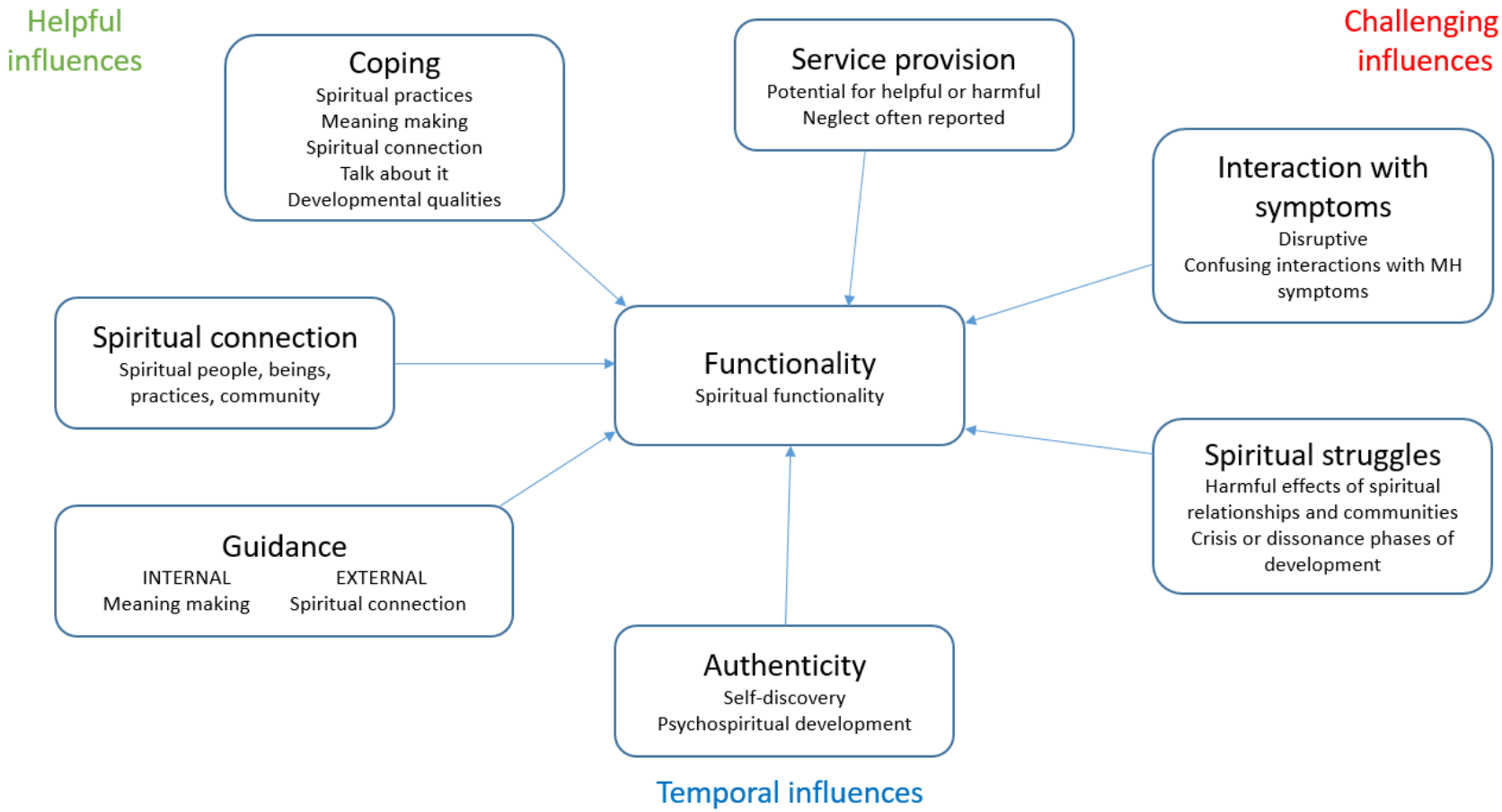

Figure 9.1 Integration and summary of findings of narrative and MISTIC studies

A central concept theorised as supportive in responding to the question about the role of spirituality in mental health and recovery from the perspectives of people who experience mental health difficulties, is ‘Spiritual functionality’. This concept emerges also in light of the relevant literature relating to the themes covered in the MISTIC and narrative studies. Spiritual functionality is defined as various ways in which spirituality may operate to impact on a person’s health, wellbeing, recovery and general functioning. It is mentioned briefly within the literature although not explored conceptually. It is used for example to discuss research trends exploring variables which may mediate the relationship between spirituality and wellbeing (Wnuk & Marcinkowski, 2014).

Spiritual functionality is suggested as a useful concept, particularly from a psychospiritual perspective, and which may be informative within clinical contexts. This is because it can potentially address a gap between information provided by subjective experiences of spirituality, mental health and recovery and the pragmatism or objectivity often demanded within clinical contexts. It does so by emphasising the impact of such experiences rather than their ontological nature. The term also addresses the issue of attempting to define or delineate between recovery, healing, spirituality or psychospiritual development in relation to an individual’s lived experience. This is because the breadth and integral nature of the concept can include them all whilst highlighting the ways in which spirituality may interact with and operate in relation to them. Indeed, participant accounts of recovery rarely made such conceptual distinctions and instead often focussed upon a whole range of experiences of mental health, wellbeing, recovery, spirituality, healing, self-discovery and psychospiritual development.

When viewed in relation to functionality, ontological concerns about whether an experience is real or shared by others become less important than the way spirituality may operate within and impact that person’s life and mental health. This includes issues surrounding subjectivity and how specific beliefs may be interpreted by another person. Understanding spirituality in relation to how it functions within someone’s life is also potentially less stigmatising and pathologising. It has the potential to open up and support exploration during conversations on this topic area.

The simplified summary of MISTIC and the narrative study themes in Figure 9.1 are depicted to influence spiritual functionality generally in either helpful (located towards the left) or challenging (located towards the right) ways, acknowledging that

phenomena are rarely completely polarised in their effects. Service provision is located right of centre because it tends to be reported as having detrimental effects, though there is a potential for both helpful and challenging influences. Authenticity which was narrated to be a key overall aspect of psychospiritual development, is located as being concerned with temporality, as something which potentially can evolve over time. Understanding the importance of temporality within a person's spiritual, mental health and recovery experiences may allow practitioners to better understand that someone may be currently undergoing a period of doubt or crisis that may lead to different later periods of psychospiritual development. These may include cultivation of Developmental qualities as well as helpful change of spiritual beliefs, self-discovery and deepening levels of authenticity.

The terms Authenticity and Guidance are also highlighted in the figure due to their greater nuance and tangibility than Psychospiritual development and Meaning making. Guidance is shown to be an important part of Meaning making from an intrapsychic perspective. That is, participants often narrated meaning making to support their ability to attain guidance 'from within', through the cultivation of meaning making frameworks, or as a predominantly spiritual mythos experience of guidance attained from some kind of spiritual source. Spiritual connection in all forms, through relationships with other people, spiritual beings, practices and community was also narrated to provide spiritual guidance. This could be viewed as external guidance because it generally came through a relationship with another.

The theme Coping was significant within the MISTIC study and could be considered to connect with a number of themes and sub-themes within both the MISTIC and narrative studies. The MISTIC Coping sub-theme Spiritual struggles is utilised as a way of highlighting some of the challenging experiences study participants narrated such as harmful effects of spiritual communities and crisis periods within a developmental trajectory. MISTIC themes Interaction with symptoms and Service provision provide other key areas in which participants tended to report challenging experiences of spirituality, mental health and recovery. These may sometimes exacerbate mental health problems or impede recovery.

9.6 Implications for practice and future research

9.6.1 MISTIC Framework

Implications for practice and clinical applications in relation to the MISTIC framework have been discussed in Chapter 2. Since the publication of the MISTIC Framework (Milner et al., 2020), I have also created a user-friendly evidence-based toolkit based on this framework which is freely accessible online. Additionally, the MISTIC Framework findings have been disseminated at various national and international conferences. I have also created and delivered University Undergraduate and Masterclass teachings sessions as well as clinical training sessions for mental health practitioners within the NHS based upon the MISTIC Framework. The MISTIC Framework has received interest internationally in Australia where it has been presented and discussed within a mental health organisation. These are discussed in further detail in Section 2.4.1.

9.6.2 Spiritual functionality guidance framework

The integration of MISTIC and narrative study findings (Figure 9.1) provides a comprehensive and in-depth picture of the role of spirituality in mental health and recovery. Although this could be utilised or adapted for people who require a comprehensive understanding of spirituality within their work, it may be too complex for general mental health clinicians. Therefore a simplified framework was created utilising concepts which may offer a slightly more concrete understanding, particularly within healthcare contexts in which time and resources are likely to be restricted (shown in Figure 9.2).

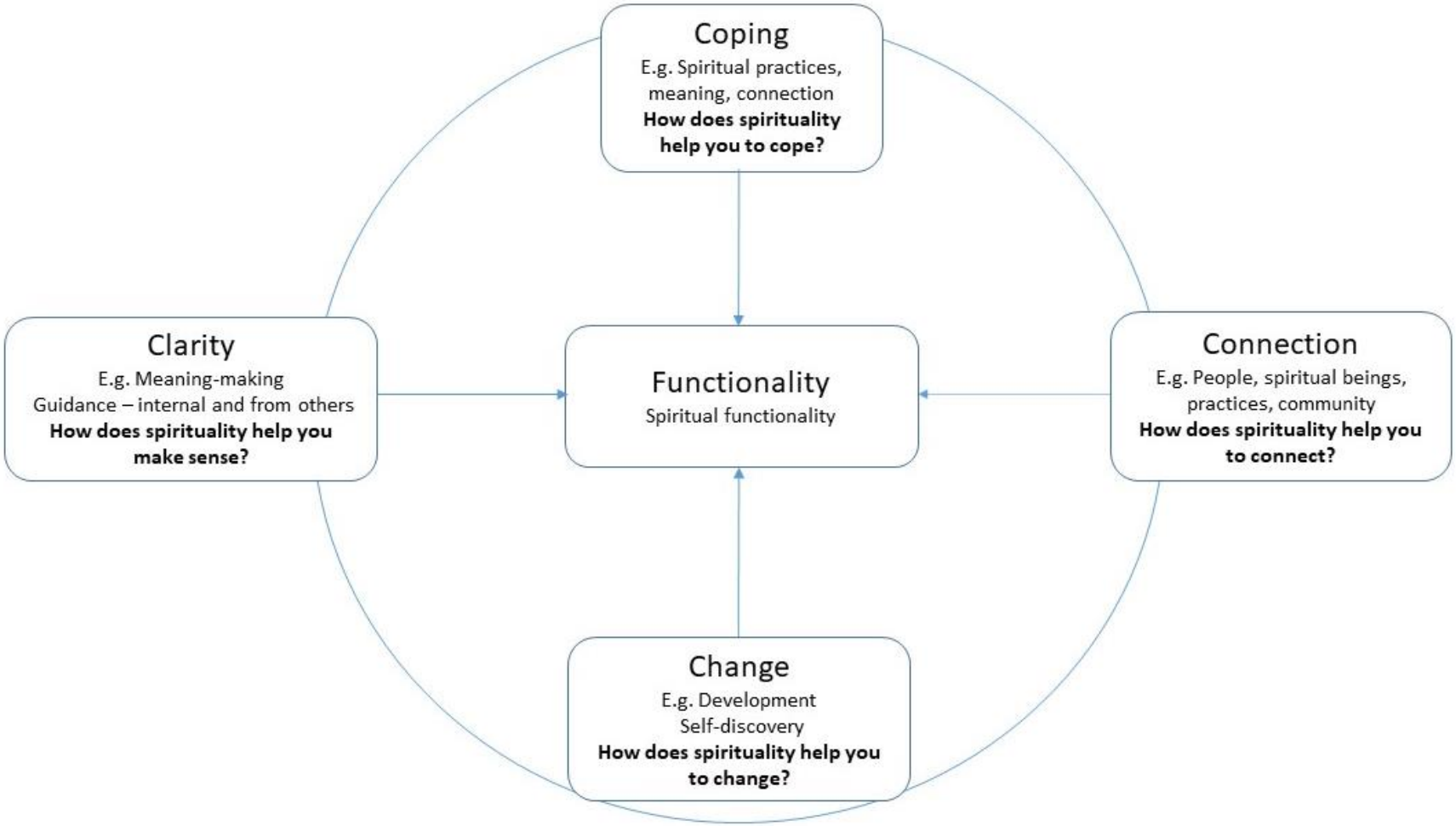

Figure 9.2 Spiritual functionality guidance framework for mental health contexts

The domains presented in the diagram could be viewed as four key themes derived from MISTIC and narrative studies, and could be helpfully and memorably captured as the 4Cs of spiritual functionality. The following Table 9.1 provides further details about each domain and a reflection for practitioners to consider when working with clients who wish to discuss spirituality. A simplified resource would require sufficient training so that the potential complexities of working with people's spirituality are not overlooked and care can be provided in the context of spiritual competence as outlined in Chapter 1. This would include firstly assessing whether discussing spirituality is relevant for an individual and gaining permission that they wish to do so with a practitioner. It would require an open, gentle and person-centred approach with awareness of the sensitivities and personal nature of spiritual experience.

The emphasis upon spiritual functionality would encourage a clinician to explore the role spirituality plays within a person's mental health and recovery, rather than focussing on the nature of the belief itself. This would include ways it may be helpful and contribute towards key aspects such as coping, meaning making, connection and development. It would also include ways in which a person's spirituality may be challenging and create confusion, isolation or have been rooted in traumatic experiences. Ellis et al. (2022) highlight the importance of clinicians better understanding the potential impacts of religious and spiritual trauma and abuse, to validate such experiences and provide appropriate support and resources for recovery. They also highlight that working with such themes can be potentially triggering for practitioners and therefore it is important to attend to such potential reactions. This might be the case when working with spirituality generally, as practitioners may feel conflict between their own spiritual identity or belief system and that of the client. These would be important considerations in clinical training programmes, as well as emphasising the importance of on-going clinical supervision and staff wellbeing when working with potentially sensitive topics as spirituality and mental health. Similarly to clients, practitioners may also require safe and non-judgmental spaces to discuss and share their own experiences and best practice when working with such themes.

Table 9.1 Spiritual functionality guidance framework for mental health contexts

Domain	Description
Spiritual functionality	Respecting the potential importance and effects of spirituality within someone's life. Considering spirituality in relation to how it may function, including in relation to mental health, recovery and wellbeing. Influenced by a number of factors e.g. Coping, Clarity, Connection, Change. **Reflection: How does spirituality function within and effect various aspects of someone's life, including their mental health and recovery?**
Coping	Considering spirituality in relation to ways it may support or hinder coping in mental health and recovery. Spiritual practices, meaning making and spiritual relationships can impact coping, mental health and recovery. **Reflection: How does spirituality support or hinder coping and how does this impact mental health and recovery?**
Clarity	Considering spirituality in relation to ways it may support or hinder clarity or meaning making. Spiritual meaning making may not always be rational or logical. It can provide guidance, either internally from within or a spiritual source, or externally from others. Experiences of spiritual meaning making and guidance can impact mental health and recovery. **Reflection: How does spirituality support or hinder clarity and meaning making and how does this impact mental health and recovery?**
Connection	Considering spirituality in relation to ways it can help or hinder connection. Spiritual connection can happen through other people, through a relationship with a spiritual being, through engaging with spiritual practices or through spiritual communities. Such relationships can impact mental health and recovery. **Reflection: How does spirituality support or hinder connection and relationships and how does this impact mental health and recovery?**

Change	Considering spirituality in relation to ways it may influence change, transformation and development. This may include a progression towards authenticity and self-discovery, and also periods of doubt, dissonance and crisis. Such changes may impact spiritual beliefs, identity and mental health and recovery. **Reflection: How does spirituality relate to change and development and how does this impact mental health and recovery?**

9.6.3 Future applications and research

1) *Public engagement and promotion of MISTIC and narrative study findings*
   As well as publishing PhD findings within relevant peer reviewed journals, further efforts could be made to promote the MISTIC resource and toolkit and other study findings through impact and engagement activities. These might include public speaking at conferences and various organisations including mental health services and clinical contexts, media outlets and academic institutions.

2) *Development of best practice assessment, toolkits, teaching and training programmes, interventions and resources for mental healthcare practitioners and clients*
   Both MISTIC and narrative studies created rich, novel and in-depth data and frameworks which have the potential to contribute towards assessment, interventions, teaching and training programmes and resources. For example, specific training workshops or programmes could be created utilising the frameworks as accessible and memorable focal points around which to open up further discussion and in-depth explorations about applications and challenges within practice. These could also provide opportunities for practitioners to give feedback on these frameworks and their views on their applicability to practice, with a view to further refinement and development. They could also address MISTIC themes Service provision and Talk about it by creating opportunities for safe non-judgmental spaces to share, explore and discuss openly, such as workshops and discussion groups. These could include practitioner or client groups and

provide ways to share learning and destigmatise understanding around these topics.

Training packages in spirituality and spiritual care could also be incorporated into existing approaches, for example, peer-support training offered by organisations such as ImROC (Implementing Recovery through Organisational Change) or spiritual care education in nursing practice explored within the EPICC project which seeks to develop a Spiritual Care Education Standard (Ross et al., 2022). Training and intervention could also be incorporated into or modelled around existing recovery-oriented practices. A key example is REFOCUS, a trialled staff training intervention which has been promoting personal recovery and supporting organisational change in mental health services (Slade et al., 2011). Specific topics of interest or bespoke areas of importance could be focussed upon, which may arise from consultation with stakeholders, staff and people with lived experiences. These might include areas less explored within this thesis, such as challenges and vulnerabilities of people experiencing mental health crisis with spiritual themes, and areas of caution for clinicians. Effectiveness of such training and interventions would then require exploration through further research.

Applying research into practice is however a sophisticated and complex process so time and resources would be required to do so effectively. This might include co-production, so that resources and training are created with people with relevant lived experiences, utilising their expertise in this process. It may also involve implementation science which addresses barriers and facilitators to the uptake of evidence-based innovations. These include contextual factors and considerations around the change of individual, social and organisational behaviour (Bauer & Kirchner, 2020). These may include evaluation of some of the limitations of implementation of both recovery and spirituality approaches into practice already highlighted in Chapter 1.

3) *Further research into spirituality functionality, meaning making and psychospiritual development*
Future research can be identified. Firstly, spiritual functionality could be explored as a potential mechanism within the context of spirituality, mental

health and recovery. For example, a critical realist approach could be utilised involving a mixed methods design to enable triangulation of findings. Research may also be required to further illuminate and clarify the nature of spiritual functionality and its potential measurability. Secondly, quantitative studies could be employed to illuminate the efficacy of meaning making frameworks, including use of logos and mythos approaches upon health and wellbeing variables. Thirdly, Internal spiritual guidance, Developmental qualities and Authenticity could be explored more rigorously by undertaking quantitative or qualitative research focussing specifically upon these characteristics, and to ascertain whether they generalise to other populations, including from more diverse cultures and belief systems. If they involve a psychospiritual developmental component, methods could be utilised to ascertain more accurately than a narrative account, chronology and potential developmental stages and trajectories. Longitudinal studies could provide measurements of such qualities over time rather than relying on a retrospective account of personal development. Fourth, narrative or other types of qualitative studies could be undertaken to focus specifically on certain characteristics which may have been important yet under-represented in this thesis. These might include stories of spiritual abuse and trauma, spirituality in the context of accounts which do not highlight recovery, and experiences of spirituality and mental health within specific cultures, sub-cultures or contexts (e.g. LGBTQ+, BME, gender). Research designs could include co-production so that there is a greater degree of input and involvement from people with lived experiences of spirituality and mental health difficulties.

9.7 Reflections and strengths and limitations of study

Reflexivity was described earlier (Section 3.6) as requiring deep and critical considerations about the research problem and how these contribute towards learning, both academically and in relation to self-development (Lincoln et al., 2018). This has been the case in my own experience of conducting the research for this study, which has taught me a huge variety of new skills. I have learned very much about myself during this time and I do not consider myself to be the same person I was when I started. It is a great privilege to conduct a PhD and to engage in knowledge-creation, especially when it involves the lives and experiences, the pains and struggles and the personal vulnerabilities of individuals.

Completing this thesis has illuminated some of the complexities and intricacies of conducting research systematically, methodologically and with the intent to follow a rigorous approach, whilst focussing upon a topic area which can be challenging to deeply think about, analyse and sometimes conceptualise clearly. In addition to the intellectual, academic and skill-learning processes, conducting this research has felt like a deep personal journey, a rite of passage or personal initiation. Although I strived towards a reflexive approach throughout, doing this within the context of a topic like spirituality could be difficult at times. I inevitably brought my own experiences or challenges in relation to this topic to the research. These will have influenced in some ways the kinds of themes I interpreted to be salient, despite the attempts to adopt systematic and rigorous methods and analytical approaches. Topics such as spirituality may cultivate particular challenges in relation to reflexivity because of their very personal and subjective nature and which require grappling with interpretations of belief systems and meaning making.

I aimed to analyse and understand the stories collected in a way which could honour them and their narrator as closely as possible, which was why I chose the methodological approach of a hermeneutic of restoration. I did not want to overlay the story with rigid methods or an interpretive lens which might lose sight of the story. I wanted the story to have space to breathe, dance, speak to me in different ways, and even, to allow me to feel, intuit and sense as I interacted and co-created with it. At the same time, I did not want to get lost in the story, so attempted to find a way through the density of information to then see patterns, clarify, condense, prioritise and find ways to logically, systematically and coherently structure the information. This could be framed as working with both the mythos and the logos in balance, and utilising reflexivity and supervision to try to maintain that balance and to cultivate further layers of critique upon my thinking, interpretations and writing style. For example, within the process of conducting data analysis, I learned to become increasingly aware of distinguishing between what the participant had said, and personal interpretations of their story and experiences, such as ‘beautiful’, ‘striking’ or ‘surprising’. I would attempt to be aware of such personal evaluations, and then come back to the participant language and ways of describing as closely as possible.

Although the methods employed in this thesis allowed me to conduct a very thorough and in-depth analysis, a potential weakness is that they were very time-consuming and therefore may not be viewed as easily applicable to highly time-

limited research contexts. It may however be possible to simplify and reduce the number of stages within the analysis as there was an element of repetition between the first two stages. The development of the Sequential analysis method and the Story map document was highly beneficial to the analysis however, and supported the organisation of data and understanding of the sequence and overall trajectories of the stories including important turning points. This allowed for greater clarity in analysis both within a story and discerning patterns across stories. These documents may be of interest to other narrative researchers within a methodology which may not always lend itself well to computer software programmes such as NVivo, and can be notorious for challenges concerning the organisation and analysis of vast amounts of data.

Although utilising a narrative methodology supported the collection of rich in-depth data, a challenge was that developing a suitable analytical method was sometimes difficult to navigate. Narrative research can be criticised as being less systematic and clear in its approach than other methodologies and as producing findings which are very specific and not generalizable to other contexts. Although generalisability is not viewed as meaningful within qualitative research, a critical realist epistemology encouraged me to take seriously the idea of transferability of findings, and to look for overall patterns across stories as well as focussing in detail on specific ones. I believe that a good balance was attained between these, in both developing a deep understanding about individual subjective meanings, as well as summarising overall patterns across stories and considering their applicability to practice.

Despite the strengths of narrative research in illuminating deeper meanings and temporal aspects of a story, it is an interpretive approach within the context of a critical realist epistemology which means that all findings are tentative and context-dependent. They are based upon the specific stories that the participants chose to share with me at a particular point in time in their lives within the context of taking part in a research project. As Riessman (2008, p. 105) points out;

> *'Stories don't fall from the sky… they are composed and received in contexts… Stories are social artefacts, telling us as much about society and culture as they do about a person or group.'*

A criticism of this research is that it may not have emphasised social and cultural factors as much as other narrative approaches and methods which may particularly

illuminate the contextual and co-constructed aspects of narratives. The emphasis however within this study was psychospiritual and therefore although social and cultural aspects were mentioned within participant accounts, these were not given as much emphasis as the person's individual experience.

The unknown constraints placed upon individual and contextual factors within the telling of stories, has relevance for the hermeneutic of restoration approach chosen to analyse them. An alternative approach towards analysis such as the contrasting hermeneutic of suspicion, does not view experience as transparent to itself. This may be taken for granted within a hermeneutic of restoration which can be criticised for lacking a sceptical attitude towards the data and giving too little attention to what may be hidden or unsaid (Josselson, 2004).

Although narrative thematic analysis suited well the study's research objectives, this approach can be limited in overly generalising across stories and obscuring the particularities of meaning-in-context (Riessman, 2008). In addition, Frank (2010) warns about the use of typologies within narrative research in which stories are classified into groups. Although they can assist the reader, they risk putting stories into boxes and the organisation of the data becoming more real than the stories themselves. Although this study's findings did not emphasise typologies, there were some categorisations of story trajectories, and thematic analysis could be viewed as a form of typology. However, despite this limitation, in line with the critical realist approach of considering practical applications, thematic representations seemed both pragmatic and clarifying whilst the presentation of findings simultaneously attempted to consider the whole-story individual contexts as far as possible.

Another limitation of the narrative study is that the unexpectedly strong interest in people wishing to take part led to the unanticipated consequence that participants were recruited from less diverse sources. As promotion strategies started within and around the universities this led to a larger number of interested participants than expected taking part sourced from this context. Although I did not collect educational level within the demographic information form, this could have been useful information to determine as it seemed like the sample had a high educational attainment level overall. To obtain a more diverse sample, including potentially of wider ethnic origin and religious affiliation, it may have been effective to more specifically target different populations within the sampling strategy. In addition, certain aspects about this research project, such as it being university-based, and

approaches towards recruitment such as the image and wording on the poster, may have appealed to certain people over others. It is notable that the majority of stories provided by the sample had an overall positive trajectory in relation to spirituality, mental health and recovery. Although challenging experiences were reported, these were rarely narrated as on-going, perhaps partly because participants were specifically recruited to be in recovery and not currently in crisis or using in-patient mental health services. Participant stories may have highlighted more unresolved, chaotic or confusing narratives if they had been currently experiencing more challenging mental health difficulties. In addition, those who might have had less positive or functional experiences in relation to spirituality, mental health and recovery may have been less likely to participate in this research. Utilising alternative recruitment strategies to try to elicit a greater diversity of stories could be a fruitful direction in future research.

In relation to methodological factors, pluralist approaches are sometimes critiqued because of the complexity which can arise and the care needed to ensure that they align and integrate, including in relation to the epistemological position. I hope that I achieved this as a novice to pluralist research, utilising reflexivity and transparency as well as supervisory input to check rigour across the whole research process. Wertz et al. (2011) argue that within the field of social sciences, breakthroughs are made by working closely with empirical realities not by employing a preconceived ideology. Employing critical realist, narrative and hermeneutic of restoration approaches, provided a helpful balance of staying close to the meanings of the stories, whilst attempting to also look across and beyond them, to the consideration of how they might be useful and support change within clinical contexts.

Key strengths of this study include the thoroughness of the analytical methods which supported the process of attaining rich in-depth findings utilising a reflexive and rigorous approach to illuminate personal lived experience. The methodology and methods supported the creation of findings which aimed to nuance personal meaning across a narrated temporal dimension, as well as highlighting patterns across a fairly large sample number for a narrative study. The resulting thematic representation of findings provided clarity and organisation of salient concepts within sometimes very complex and difficult to articulate experiences. Themes were interpreted and languaged utilising a psychospiritual approach which provides the advantage of being accessible to a variety of audiences including clinical contexts. It is also potentially bridge-building in integrating spiritual, mystical and mythos types

of experiences with logos frameworks of understanding including professional contexts. In addition, the study has a strong potential to contribute towards a variety of mental health and wellbeing contexts, and it has already produced a number of important outputs including a toolkit resource which has received interest in Australia and a publication (Milner et al., 2020) which has to date been cited 58 times (Google Scholar, accessed 15/03/23).

Providing an opportunity for participants to speak about the depth, complexities and nuances of their experiences of spirituality, mental health and recovery in ways which may not always be easily accessible was another study strength. Many participants expressed enjoyment, gratitude and value about the interview experience and research project. A few participants also said participating in the interview was the first time they had shared their story.

An additional strength of this thesis, is that it provides a number of knowledge contributions, as outlined below.

9.8 Primary knowledge contributions

This thesis has six primary knowledge contributions.

First, the MISTIC study, a qualitative systematic review comprising a thematic synthesis of 38 studies is the first of its kind. It presents six key themes, conceptualised as the MISTIC Framework, characterising important experiences of spirituality among people with mental health difficulties. The study offers a framework and corresponding evidence-based user friendly resource and toolkit for holistic, strengths-focussed and recovery-oriented approaches towards interventions, teaching and training in mental health care.

Second, this thesis strengthens the empirical evidence that spirituality can contribute towards meaning making which can support mental health and recovery. It additionally provides original insights into ways meaning making can function in the context of spirituality, mental health and recovery:

a) Contributing towards the construction of frameworks of meaning which can help to reframe perspectives in ways which support understanding.
b) Providing a contrasting perspective to more prevalent and dominant rational ‘logos’ forms of meaning making by emphasising the importance

of sometimes culturally denigrated spiritual or symbolic ‘mythos’ frameworks of meaning.

c) Providing an internal guidance system often based upon mythos forms of meaning making which include experiences such as spiritual signs, messages, synchronicities, dreams, visions, imagination and intuition. Sometimes the integration of mythos and logos frameworks can support discernment within meaning making and thereby contribute towards mental health recovery.

Third, the thesis strengthens the empirical evidence that spirituality in the context of mental health and recovery is potentially transformational and can contribute towards psychospiritual development. It provides original preliminary evidence of the importance of:

a) Different phases of development over a specific trajectory which may include doubt, confusion, dissonance, crisis, awakening and growth.
b) Overall trajectories of development, often from restrictive or oppressive patterns towards self-discovery and authenticity.
c) The cultivation of developmental qualities which may support psychospiritual development, such as experiences of increasing levels of awareness, empowerment, self-care, self-acceptance and compassion.

Fourth, this thesis strengthens empirical evidence that spiritual connection is a key component of spiritual experience and is often supportive of spirituality, mental health and recovery. It provides new insights into the importance of four main areas of spiritual connection in the context of mental health and recovery: a) Spiritual relationship with another person; b) Relationship with a spiritual being; c) Spiritual practices and d) Spiritual community. These often facilitate mental health and recovery by providing for example guidance, love, a sense of belonging or safety. Sometimes they can be challenging or harmful, such as if they involve loss or abuse.

Fifth, the Spiritual functionality guidance framework provides an original model of key areas highlighted by people with lived experience. Based upon the integration of both MISTIC and narrative studies, it refines and simplifies findings into a framework suitable for clinical practice. It highlights the novel yet under-researched concept of spiritual functionality. This concept has the potential to help bridge a gap in clinical

practice of better understanding and supporting subjective experiences of spirituality and how they can interact with mental health and recovery.

Finally, the thesis develops a refined methodological approach which highlights lived experience and personal meaning making and systematically explores the content of sequential features within narratives. It does this through a novel staged method termed ‘Narrative thematic and sequential analysis’ which emphasises both rich in-depth story-specific data which privileges the voice of the participant, as well as exploring patterns across the stories. Original forms of documentation are generated, such as the creation of Story maps, which could assist narrative researchers seeking non-computer based forms of organising and making sense of their data.

9.9 Final conclusions

This thesis amplifies previous literature by highlighting some of the key themes pertinent to people who experience spirituality in the context of mental health and recovery. It provides original insights not only of the importance of meaning making, psychospiritual development and spiritual connection but of specific ways they may function within this context. These include, for example, the nature of different kinds of frameworks of understanding which can support sense-making, the importance of sometimes varied and challenging phases and trajectories of development, and the role of different types of spiritual connection within mental health and recovery. The depth and richness of such themes provides knowledge and evidence which could be utilised in a range of different kinds of interventions, resources and training. They could provide signposts to potentially important experiences which may have implications for a person’s mental health and recovery. They could contribute towards more comprehensive maps of internal psychospiritual realms of experience, which can be stigmatised and difficult to articulate.

Perspectives of lived experience highlight the need for spirituality in the context of mental health and recovery to be validated. Whatever form of intervention may be suitable for any individual person, opportunities can be created to give people safe spaces to talk about their spirituality and mental health experiences, should they wish to. However people may conceptualise such experiences, being able to effectively navigate processes of sense making seems fundamental to recovery. There is a need to listen and provide space to dialogue about such experiences

from a non-pathologising stance, exploring what can be learnt from them in relation to mental health recovery. The development of effective mental health care provision would therefore benefit from incorporating interventions that are inclusive of the spiritual dimension and support processes of meaning making. They might encourage people to tap into resources they already have, and to reflect upon what may be helpful or not in relation to their mental health and recovery.

Spirituality is a challenging concept to define, to understand, to talk about and to analyse. It could be seen as an intrinsic aspect of human nature and something which impacts mental health, recovery, and spiritual functionality more generally. Participant descriptions about how they understand and characterise spirituality suggest that surveys including the census need to update their questions to capture the depth, diversity and nuance that a concept like spirituality taps into. It might be, for example, that spirituality for some is characterised more meaningfully by its functions and relationship with self-development than static narrow tick-box categories adequately define. Spirituality may be about religion for many people, and for many others it is not. And for others still it is not an either/or question but a both/and, being influenced by a diverse array of religious and spiritual traditions, experiences or approaches. The quest to understand the spiritual in the context of mental health and recovery can involve many changeable and distinct phases of searching, uncertainty, disillusion, doubt and yearning. It also can be characterised by strikingly in-depth and wise approaches towards making meaning from often painful and confusing experiences.

Spirituality in the context of mental health may also sometimes represent a wound. It may highlight something that is avoided culturally and institutionally for various reasons including that it can arouse strong perspectives or emotions, or it can seem too illogical, nebulous or subjective to have value. It may be triggering due to its personal and subjective nature and the way it points to the realms of internal experience which are not always easy to make sense of, navigate or talk about. Clinicians may have reluctance to address this topic which could at times seem like a ‘can of worms’ or a ‘Pandora’s box’ into an unsettling unknown territory. From a Jungian perspective this could be because spirituality can both illuminate personal growth, but also the unconscious shadow aspects of the psyche or culture that have not yet been adequately brought into the light of awareness and understanding. This may particularly be the case when the epistemological stance upon understanding can over-emphasise logos frameworks at the expense of mythos. From the

perspective of lived experience however, both seem to be important in making sense of spirituality and mental health experiences and in supporting recovery.

Although spirituality may be challenging to address, for some people it can also hold important keys to the kinds of understanding which can effectively facilitate mental health recovery. As Tacey (2013b) highlights, a cultural and institutional tendency to ignore or pathologise this aspect of human nature, does not make it go away. There is a need for evolving understanding and education surrounding the ways in which spirituality functions psychologically in both supportive and challenging ways, as well as the effective implementation of this understanding towards improving mental healthcare practice.

It is important to also note that the notion of recovery may not always be pertinent or relevant for people experiencing spirituality and mental distress. In addition, not all people with spirituality and mental health experiences will want to talk about them or have these addressed within health care provision. And for some people spirituality or mythos experiences may be so overwhelming or dysfunctional that their rejection or dismissal may be important, at least for a certain period of time, to support mental health recovery. However, even in the midst of the most nebulous and disorientating experiences, participant narratives were often marked by a passionate motivation to navigate these as effectively as they were able at the time. In these uncertain and sometimes fearful places, spirituality for some was just about being able to 'be' in that darkness. Some joined the dots in a constellation of stars to bring clarity to a feeling or to try to illuminate something troublingly invisible or uncertain.

The difficulty in defining and understanding spirituality may be important in a world striving for certainties. As helpful as adopting a psychospiritual approach has been for supporting the process of clarification within participant stories, John O'Donohue (1996) author of books on Celtic Irish spirituality, provides a warning against such perspectives. He says:

> *"The world of the soul is a secret and sacred world and you can't shine in on that world a light that is aggressive and bright… The soul was never meant to be seen completely with brightness or with too much clarity. The soul is always more at home in a light which has a hospitality to shadow."*

Returning to the children who visited the river in the old Plain's People's story, Hyemeyohsts Storm (1972) adds:

> *"Within our time of the night… we know that the children within us are crying, and that they are alone and frightened. During one of these nights, while we are feeling lonely and afraid and wondering why everything seems so terrible, we hear a voice speaking inside us."*

This voice is depicted as the voice of our spirituality which has the potential to warm and calm us. This may seem a simplistic notion of the role of spirituality in mental health and recovery considering the complexities and challenges, the confusions and the many phases of story participants have depicted. Mental health challenges can be harrowing, and spirituality is not a kind of sugar-coated pill solution to problems. Instead, it seems as though mental health experiences operate alongside spiritual ones, integrating and illuminating, clashing and disrupting, and sometimes invoking crisis and breakdown. And yet with great potential for transformation, for igniting clarity after times of troubled journeying, of motivating deeper ways to navigate, cope, connect and understand.

As participant Helen so eloquently narrated, which, as well as inspiring the title, will be the concluding comment for this thesis, the light of the stars only makes sense in the context of darkness. Both seem to play an important role together, in supporting progression and learning through life.

> *"…making meaning of my existence is, you know, a challenge. I think lots of people find it a challenge* [sighs]*. So spirituality - the spiritual perspective addresses that really. I just see I was given a challenge in that experience. And the ultimate one being about, if I left my body and I went out into outer space or down this black hole, you know into the blackness of space and I had, there was no air, there was nobody there, there was no food, there was no warmth, there was just nothing, did I look at the blackness or did I look at the stars? Which way do you face when you have nothing? Do you look at the nothing or do you look at the lights that are always there? Because there's always light within the dark, and that's been my journey - I mean for years I was depressed… heavily heavily weighed down. And, you know, I was looking at the blackness. I was looking at what wasn't there. And now I've made a conscious decision to look at what is there.*

Acknowledge the blackness, but not see it as - alien. I guess that's the challenge I've got at the moment is not to see the blackness and the emptiness as alien, but just - it's just part of the stuff of what actually is. You can't have the stars if you don't have the space to have the stars." Helen

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Appendices

Appendix 1: Systematic review exclusion criteria

Exclusion Criteria	Further Details and Examples
Under 18 years	Children, teenagers, adolescents.
Organic disorders	Dementia, Alzheimer's.
Learning disabilities	e.g. Autism spectrum disorders.
Drug and Alcohol	Where this is primary focus, including recreational drug use and psychedelic/entheogenic substances.
Physical Illness	e.g. cancer, HIV, Aids, cardiac health.
Forensic	Crime, homicide, offenders, violence, psychopathy, sociopathy, terrorism.
War related	Veterans, soldiers, military, war related trauma, prisoners of war.
Natural and Geographic	Natural disasters, geography/earth related events, general disasters, catastrophes, holocaust, slavery, migration, immigration, refugees.
Death-related	Death-related anxiety, palliative care, grief, bereavement, suicide, suicidal ideation, self-harm.
Birth-related	Pregnancy, motherhood, post- and peri-natal depression.
Sexuality-related	Abuse, rape, transgender, gay, lesbian, homosexuality.
Relationships	Relationship problems, couples counselling, domestic violence.
Specific religious/ spiritual phenomena	Religious conversion, possession, exorcism, paranormal themes, ghosts, spirits, psychic phenomena.
Staff or carer perspectives	Expert/clinician/clergy perspectives, where primary focus is not perspectives of people with mental health difficulties.
Work/Employment	Including staff and professional perspectives.
Intervention	Therapy, group.
Information Sources	Opinion pieces, autobiographies, theoretical studies, dissertations, theses, books, book chapters, book reviews, quantitative studies (including questionnaire/scale/ assessment studies), case studies involving three or less participants, studies comprising data prior to 1980.

Appendix 2: Medline search strategy (searched on 20/09/18)

Medline

Database: Ovid MEDLINE(R) and In-Process & Other Non-Indexed Citations <1946 to September 20, 2018>

Search Strategy:

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1 exp Mental Health/ (31669)
2 exp Mood Disorders/ (112171)
3 exp SCHIZOPHRENIA/ (98367)
4 exp Anxiety Disorders/ (74689)
5 exp DEPRESSION/ (103696)
6 exp Bipolar Disorder/ (37525)
7 exp Personality Disorders/ (39219)
8 exp Mental Disorders/ (1134218)
9 exp "BIPOLAR AND RELATED DISORDERS"/ (37533)
10 exp Neurotic Disorders/ (17936)
11 exp "trauma and stressor related disorders"/ (35801)
12 ("mental health problem*" or "mental health disorder*" or "mental disorder*" or "mental illness" or "mental health recovery" or "psychiatric disorder*" or "mental distress" or "emotional distress" or "mental health difficult*" or "mental health service user*" or "mental health patient*" or "mental health consumer*" or "mental health survivor*" or "psychiatric patient*" or "chronic mental illness" or psychosis or schizo* or "PTSD" or "spiritual crisis" or "spiritual emergency").ti,ab. (261875)
13 or/1-12 (1287750)
14 exp Spirituality/ (6621)
15 exp "RELIGION AND MEDICINE"/ or exp RELIGION/ or exp "RELIGION AND PSYCHOLOGY"/ (58866)
16 (spiritual* or religio* or faith or God or transcendent).ti,ab. (48577)
17 or/14-16 (86869)
18 13 and 17 (11224)
19 exp Personal Narratives/ (6876)
20 (experience* or "lived experience*" or belief* or view* or perception* or perspective* or attitude* or story or stories or narrative* or account* or "service user perspective*" or "patient perspective*" or "consumer perspective*").ti,ab. (2298991)
21 or/19-20 (2304706)
22 18 and 21 (4492)
23 exp Qualitative Research/ (41212)
24 exp INTERVIEW/ (28102)
25 exp Focus Groups/ (25202)
26 ("qualitative research" or interview* or "focus group*" or phenomenology or phenomenological).mp. (384775)
27 or/23-26 (384818)
28 22 and 27 (1150)
29 limit 28 to english language (1101)

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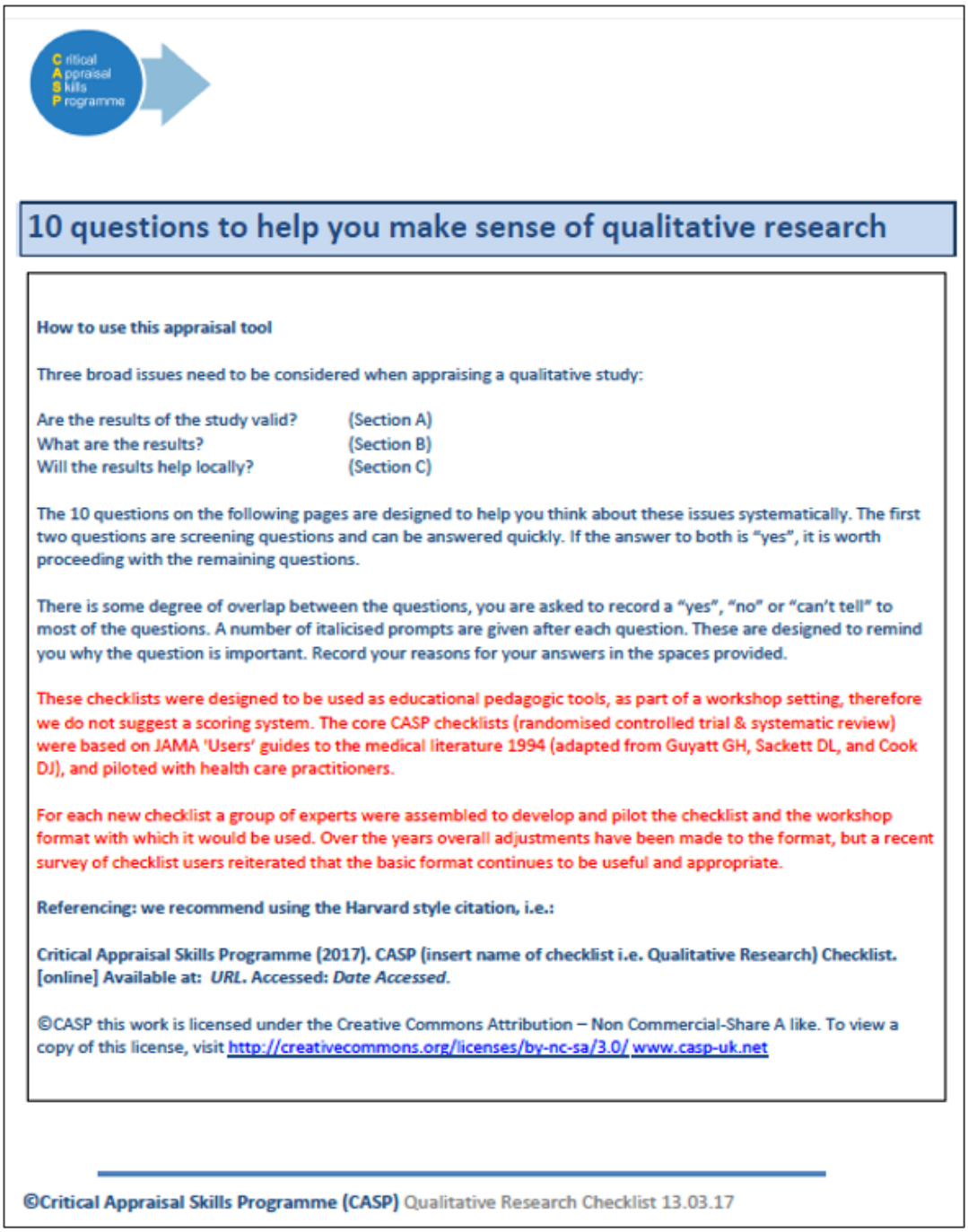
Appendix 3: CASP Quality Appraisal form



10 questions to help you make sense of qualitative research

How to use this appraisal tool

Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid? (Section A)
What are the results? (Section B)
Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.:

Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Qualitative Research) Checklist. [online] Available at: *URL*. Accessed: *Date Accessed*.

Screening Questions

1. Was there a clear statement of the aims of the research? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

2. Is a qualitative methodology appropriate? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?

Detailed questions

3. Was the research design appropriate to address the aims of the research? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- If the researcher has justified the research design (E.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research? ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue? ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered? ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
  (a) Formulation of the research questions
  (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration? ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous? ❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings?

❒ Yes ❒ Can't tell ❒ No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Appendix 4: Project recruitment posters

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

The Spirituality Project

Researching stories of spirituality and mental health

Seeking volunteers to share their personal stories of spirituality and mental health difficulties or recovery for research.

Must be 18 years of age or older, have current or past experience of mental health problems and have spiritual or religious beliefs or practices, however these make sense to you.

An aim of the study is to help mental health services and professionals to better understand people's spiritual needs and experiences.

For further information please contact Katja Milner at the University of Nottingham on:

Email: Katja.Milner@nottingham.ac.uk
Tel: 0115 7484310

Katja Milner, School of Health Sciences
Institute of Mental Health, Triumph Road
Innovation Park, Nottingham NG7 2TU

The MISTIC Study – Poster 1 Version 1.0 07/09/18

the institute of mental health
Nottingham
research excellence
for innovation

The Spirituality Project:

Seeking volunteers for research

exploring the role of spirituality in mental health and recovery

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

What is the research about?

The purpose of this study is to develop a better understanding of the experiences of spirituality and religion from the perspectives of those who experience mental health difficulties. The research aims to find out how people understand spirituality in their own personal ways, however they make sense of it. It can be spiritual, religious, spiritual but not religious or something else. The reason this subject is important is because spirituality and religion can be important for people's mental health and recovery. It can be helpful, challenging or a mixture of both. A better understanding of the role that spirituality plays in people's mental health could be helpful for clinicians and professionals who provide mental health care.

What is involved?

If you are interested please contact the researcher, Katja Milner based at the University of Nottingham for further information. If you are eligible to take part in the study, you will meet for an interview and will be asked to share your own story of your experiences of spirituality and mental health, whatever you feel comfortable sharing.

Who can take part?

Are you an adult aged 18 or over?
Do you have current or previous experience of mental health difficulties?
Do you have current or previous experience of spiritual or religious beliefs or practices, however these make sense to you?
Are you happy to share your story of these experiences for a research project?
Can you speak English?

If you answer "yes" to all of the above questions, please contact Katja Milner, contact details below:

How to take part

Please contact Katja Milner:
Email: Katja.Milner@nottingham.ac.uk
Tel: 0115 7484310

School of Health Sciences, University of
Nottingham, Institute of Mental Health, Triumph
Road, Innovation Park, Nottingham, NG7 2TU

Katja Milner, Institute of Mental Health
Spirituality and mental health
Email: Katja.Milner@nottingham.ac.uk
Tel: 0115 7484310

Katja Milner, Institute of Mental Health
Spirituality and mental health
Email: Katja.Milner@nottingham.ac.uk
Tel: 0115 7484310

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Tel: 0115 7484310

Katja Milner, Institute of Mental Health
Spirituality and mental health
Email: Katja.Milner@nottingham.ac.uk
Tel: 0115 7484310

The MISTIC Study – Poster 2 Version 1.0 07/09/18

Appendix 5: Interview Schedule

Interview Schedule

The role of spirituality in mental health and recovery

Introducing the Research

Thank you for agreeing to take part in this study exploring the role of spirituality and religion in mental health and recovery.

- Go through participant information sheet to check understanding and wellbeing
- Go through consent form
- Go through participant demographics information to collect initial basic information from participant

During this interview which might take anything from roughly 30 – 90 minutes, please share just whatever you feel comfortable sharing. This topic can feel personal and sensitive so please take care of yourself and let me know if there is anything I can do to help you at any point such as pausing for a while for a break or to focus on something different. There is never any pressure to say anything you don't feel comfortable saying and you are free to stop at any time or to withdraw from the research altogether.

The interview will be audio-recorded and I may make some notes during the interview to help with the process of data collection. This information will also be kept confidential and anonymous. I may also look at the clock or check the recorder is working at certain points. Please don't take this as a sign I am not interested or listening, please try to ignore me and continue with your story.

I am interested in your own story, in your own words and ways of describing. Please feel free to use whatever language or imagery might be helpful. I use the word 'spirituality' in a general sense to mean religious, spiritual, spiritual but not religious, or what gives you meaning and purpose in life but use whatever language you prefer. I am interested in what spirituality or religion means to you, your experiences of spirituality, the role spirituality has had in your life and how this might have changed over time. I am also interested in whether your spirituality or religion has affected your mental health at all, if it has played a role, been helpful or challenging or something else.

I want to emphasise that there is no right or wrong way of understanding this word or idea of 'spirituality'. This interview is all about your understanding and experiences but you are welcome to reflect on these too. I am interested in your own ideas, thoughts and beliefs and what these mean to you.

Do you have any questions about this research or the interview you would like to ask me?

Does this all sound ok to you and are you happy to start?

Interview Questions/Themes

Main Question/theme 1

Please would you tell me about your understanding and experiences of spirituality or religion.

Main Question/theme 2

What role has spirituality/religion played in your mental health difficulties or recovery?

Has this changed over time?

If possible please tell me about this like a story and about any changes or developments through your life, starting earlier on in your life, leading up to the present time.

Prompt Questions:

Has your spirituality/religion had any impact on your mental health?

Can you tell me more about this?

Were there any changes or turning points?

How did these impact your life? What happened then?

What did that mean to you?

How did you experience/understand that?

Has it changed over time?

Main Question/theme 3.

How has spirituality or religion helped you to make sense of your life and experiences of mental health difficulties or recovery?

Prompt Questions:

Has it been confusing – if so how?

Do you have any examples?

Has it changed? If so how?

What or who has influenced this?

Have there been any events which have influenced this?

Question 4.

Have you had any experiences of having your spiritual needs addressed or not if you have used mental health services?

Prompt Questions:

What was this like?

How did that make you feel?

Was that helpful or not?

What would have been helpful?

Question 5.

Reflecting back on what you have said, is there anything else you would like to say or add? Is there anything which hasn't been said which you would like to or you feel is important?

Prompt Questions:

Is there anything we have missed out in your story?

How do you feel about the story you have shared – any learning or reflections?

Appendix 6: Patient and Public Involvement information

Patient and Public Involvement Information
The Spirituality Project: Exploring the role of spirituality and mental health

Katja Milner, ESRC Doctoral Researcher, School of Health Sciences, University of Nottingham
Supervisors: Paul Crawford, Mike Slade and Alison Edgley

Thank you so much for your interest in my PhD research project.

Please would you read the form if you are interested in being involved.

What is PPI?
PPI stands for 'Patient and Public Involvement' and is increasingly a pre-requisite for much research these days, particularly research into topics such as mental health. The reason for this is that it can offer important insights from people of diverse backgrounds, who might have lived experience within the particular area that is being researched. Additionally, for those working/practicing within that field it can offer insights about potential applications to practice. Research that includes PPI is considered to be of better quality because the design and methods can be tested by people with a wide variety of perspectives and to ensure any questions are asked in the right way and that are relevant to the needs and priorities of the general public. It can also be beneficial for communication and dissemination, to make sure that all aspects of the research are communicated about in ways that make sense and engage people.

What is being asked of me?
Ideally people are paid for their time, however, as is often the case for PhDs, for my project there are no funds allocated for this so I am asking for voluntary input. This would mean of course that everything would be very much on your terms and the amount of input you could give would be determined by your own schedule and what is convenient for yourself. I would also keep requests for time and input minimal and flexible. You could opt out of meetings or input and withdraw from the PPI group altogether at any time without any concerns. There would never be any obligation apart from letting me know if you couldn't commit to something and we would have a general group agreement to keep what was shared if we met as a group confidential and cultivate an ethos of care and respect for each other's views.

What would the role entail?
The role would be kept simple and could be tailored around your own interests, skills and time to a degree. I would get an indication of how much and what kind of input you would be happy to give (this can change of course at any time) and tailor this

around that. More specifically, the role might entail sending you an e-mail on occasion asking for your ideas about, for example, interview questions and what you think about how they are worded, or a poster advertising for recruitment. We could meet one to one at particular points during the research, or as a small group perhaps 2 - 3 times a year depending on what is feasible and preferable for everyone.

What are the benefit and drawbacks?

Apart from asking for your time voluntarily I would hope that the experience of PPI would be an enjoyable and interesting one, particularly if people are happy to meet up as a group and discuss and learn together, sharing ideas and talking about and being involved in a research topic which is still relatively under-researched and under-explored. It would be important to note however that I would not be obligated to take any particular ideas on board and that this PPI group is very much advisory rather than more actively participating in co-producing the research with me. I would value greatly however all your time and input whatever final decisions were made and it is my hope and intention that this research can ultimately benefit people both working within mental health services to gain a better understanding of the importance of spirituality and mental health and those using services for whom spirituality is a key part of their recovery.

Appendix 7: Participant Information Sheet

School of Health Sciences
University of Nottingham

Participant Information Sheet

The role of spirituality in mental health and recovery

Name of Researchers:
Principal Researcher: Katja Milner
Supervisors: Professor Paul Crawford, Professor Mike Slade and Dr Alison Edgley

You are invited to take part in this research study. Before you decide please read through this information which explains why the research is being done and what it would involve for you. If you decide to take part, the principal researcher will go through the information sheet with you and answer any questions you may have. Talk to others about the study if you wish. Please ask if there is anything that is not clear.

What is the purpose of the study?
The purpose of this study is to develop a better understanding of the experiences of spirituality, religion or faith from the perspectives of those who experience mental health difficulties. The research aims to find out how people understand spirituality in their own personal ways, however they make sense of it. It can be spiritual, religious, not religious or a mixture of these. The reason this subject is important is because spirituality and religion can be important for people's mental health and recovery. It can be helpful, challenging or a mixture of both. A better understanding of the role that spirituality plays in people's mental health could be very helpful for clinicians and professionals who provide mental health care.

Why have I been invited to take part?
You are being invited to participate in this study because you have shown an interest in this research, either from seeing a poster advert or because someone you know has told you about this study. In order to participate in the study people are required to meet the following criteria for participation:

a) Are an adult of 18 years or older.
b) Have current or previous experience of mental health difficulties, however this makes sense to you.
c) Have current or previous experience or background/beliefs in spirituality or religion, however these concepts make sense to you.
d) Are happy to voluntarily share your stories of your own experiences of spirituality and mental health difficulties.
e) Are happy to have your stories audio-recorded and used anonymously for a PhD thesis and possibly for subsequent publications.
f) Can speak and understand English
g) Feel well and stable enough to share a personal story at the time of interview.

A total of 25 – 30 people will be invited to take part in this study who will all be sharing their own unique stories of spirituality and mental health.

Do I have to take part?

No, it is entirely your choice if you chose to take part in this study or not. You are never under any obligation to take part and can withdraw from the study at any time without giving reason. This would not affect your legal rights or if relevant your medical treatment or employment. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form.

What will happen if I agree to take part?

If you do decide to take part in the study, please contact the principal researcher, Katja Milner using the contact details provided at the end of this information sheet. You will first have a brief telephone conversation with her, to check you understand the research and that you are eligible for the research by checking through the criteria for participation listed above. You will also be invited to ask any questions you may have.

If both yourself and researcher are happy for you to take part at this point, a convenient date, time and venue will be agreed to meet for the interview. You will only need to attend one interview, which will last on average about an hour, depending on how much information you wish you share. The interview will take place at a location that you are comfortable and happy with and will most likely be a private room in a public space such as within the University of Nottingham or another location you may know of. If it would help you to think about the topic before the interview you can be given a few simple pointers about what you will be asked if you wish and you are welcome to bring notes or visual aids to the interview if that might be helpful. However, you are equally welcome to answer the questions spontaneously at the interview if you prefer.

Before starting the interview there will be an opportunity to chat again with the researcher, to check understanding and ask any further questions. You will then be asked to sign a consent form and the interview will begin. During this time you will be asked questions relating to the topic and you can use any prepared notes or not, whatever you prefer. You are invited to share whatever you feel comfortable sharing and will never be under any pressure or obligation to share anything you would rather not. During the interview you will have space to share your own story in your own words and ways of describing. Some follow up questions may be asked towards the end of the interview.

The interview will be audio-recorded and a few notes may be made during the interview.

Expenses and Payments

Unfortunately payment is not available for participation in this study. Travel expenses up to £10.00 will be offered however for any travel expenses incurred as a result of participation.

What are the possible disadvantages and risks of taking part in the study?

No specific risks are anticipated for taking part in this study. Sometimes, however, people can find talking about their personal experiences distressing, particularly those which are very sensitive and personal. Please consider carefully how you would feel about sharing your personal experiences with a researcher. It is up to you to share how much you feel comfortable sharing and you can stop at any time. The researcher who talks with you will be experienced in talking and listening with people about these topics.

What are the possible benefits of participating in the study?
The information you provide from participation in this study will contribute towards gaining a better understanding of the role that spirituality can play in people's lives from the perspective of someone who experiences mental health difficulties. This is an area in which there is still little understanding and your contribution to this research project could help to develop better future mental health clinical training and practice which may improve the experiences of those who use mental health services in the future.

Some people enjoy the experience of sharing their stories and having the time and space to do so with minimal interruption and with a trained listener.

What happens after the interview?
You will only be asked to attend one interview. After that, the interview will be transcribed from the audio-recording, that is, written down word for word. The findings from all the interviews together will form the basis of the principal researcher's PhD thesis. Any published data will be thoroughly anonymized, i.e. details will be changed to ensure you cannot be identified through it.

What if there is a problem?
If you have a concern about any aspect of this study, please speak to the principal researcher, Katja Milner who will do her best to answer any questions or concerns you may have. The researcher's contact details are given at the end of this information sheet. If you remain unhappy, or have a complaint about your treatment by the researcher or anything to do with the study, you can initially approach the principal researcher or her lead supervisor, Paul Crawford (contact details below). If you wish to make a formal complaint you can do this by contacting Louise Sabir, Faculty of Medicine and Health Sciences Research Ethics Committee, c/o School of Medicine Education Centre, B Floor Medical School, QMC Campus, Nottingham University Hospitals, NG7 2UH.
Email: fmhs-researchethics@nottingham.ac.uk

Will my taking part in this study be kept confidential?
If you join the study, all identifiable information collected from you will be held and stored strictly confidentially following ethical and legal practice. Digital data will be held on secure servers and password-protected databases owned by the University of Nottingham. Physical data will be held in secure and locked cabinets and offices at the University. Any information about you which leaves the University will be anonymised and have your name and address removed and a unique code will be used so that you cannot be recognized from it.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant.

Your contact information will be kept by the University for 12 months after the end of the study so that you can be contacted about any potential outcomes of the study (unless you advise that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (your interview transcript) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality and only members of the research team will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies,

with your permission, we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. It is your choice however if you are happy for us to do this and can let us know on the consent form. Data sharing in this way is anonymised (so that you could not be identified).

Although what you share with us is confidential, should you disclose to us anything which indicates that you or others may be at risk, the researcher will discuss with you whether there is a need to involve and/or to inform appropriate others.

What will happen if I don't want to carry on with the study?
Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights, or if relevant your medical treatment or employment, being affected. To withdraw from the study please contact the principal researcher (contact details provided at the end of this information sheet) providing your name and stating that you wish to withdraw from the study.

What will happen to the results of the research project?
The data collected from all the interviews will be used in writing a thesis for an educational qualification (PhD) for the principal researcher. This thesis will be published online and material from it will also be published in articles submitted to academic journals, articles, presentations and conferences in order to share the findings with others. They may also be used in other materials such as clinical training and educational resources. If we include any quotes from your interview in these publications or materials, then they will be sufficiently anonymized so it will not be possible to identify you through them.

What should I do if I feel distressed?
If you feel distressed during the interview, please inform the researcher interviewing you who will offer to pause or conclude the process. If you continue to feel distressed after leaving, you might wish to consult the following for support:

- Speak with someone you trust
- Speak with someone from a support, mental health or spiritual/religious group you already belong to
- Seek advice from your GP
- Rethink Mental illness – Tel: 0300 5000 927
- Mind Information line - Tel: 0300 123 3393
- Nottingham Wellness in Mind – Tel: 0800 561 0073, Web: www.wellnessinmind.org
- Nottinghamshire Help Yourself – Tel: 0300 500 80 80, Web: www.nottshelpyourself.org.uk, e-mail: enquiries@nottscc.gov.uk
- Consider counselling or psychotherapy in your local area (can be searched using the internet or ask your GP for further information).
- Consider seeking support from religious or spiritual community, leader or members you trust.

Who is organising and funding the research?
This research is being carried out by Katja Milner, a PhD student at the University of Nottingham under supervision of Professor Paul Crawford, Professor Mike Slade and Dr Alison Edgley within the Faculty of Medicine and Health Sciences. It is funded by the Economic and Social Research Council (ESRC).

Who has reviewed the project?
All research at the University of Nottingham is reviewed by an independent group of people called a Research Ethics Board to protect your interests as a research participant. This study is reviewed by the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of Nottingham.

Further information and contact details

Principal Researcher:
Katja Milner
School of Health Sciences
Faculty of Medicine and Health Sciences
Room D17, Institute of Mental Health
Triumph Road
Innovation Park
University of Nottingham
Nottingham, NG7 2TU
Tel: 0115 7484310
Email: Katja.Milner@nottingham.ac.uk

Lead Supervisor:
Professor Paul Crawford
Room 421 Derby Education Centre
Royal Derby Hospital
Uttoxeter Road
Derby
DE22 3DT
Tel:01332 724 925
Email: paul.crawford@nottingham.ac.uk

Appendix 8: Consent form

University of Nottingham
UK | CHINA | MALAYSIA

School of Health Sciences, University of Nottingham

CONSENT FORM
V1.0 07/09/18

Title of Study: The role of spirituality in mental health and recovery

Name of Researchers: Katja Milner
Professor Paul Crawford, Professor Mike Slade, Dr Alison Edgley

Name of Participant:

Please initial box if you agree 'yes' to the following:

1. I confirm that I have read and understand the participant information sheet version number V1.0 dated 07/09/18 for the above study and have had the opportunity to ask questions. I understand I can ask for further explanations or questions at any time. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that my data will be held by the University of Nottingham and kept in a secure database. ☐
3. I give permission for the interview to be audio-recorded. ☐
4. I understand that the content of the interview is strictly confidential except in the event that I disclose a clear indication that myself or others are or may be at risk. In this case the researcher will discuss with me whether there is a need to involve and/or to inform appropriate others. ☐
5. I voluntarily agree to take part in the above study. ☐
6. **[OPTIONAL]** I give permission for anonymous direct quotes from the interview to be used in the principle researcher's PhD thesis and subsequent study reports or publications. ☐
7. **[OPTIONAL]** I consent to the use of an anonymised version of my interview transcript to be used to support other research in the future and shared anonymously with other researchers. ☐
8. **[OPTIONAL]** I consent to the use of an anonymised version of my interview transcript to be deposited securely in the UK data service (funded by the Economic and Social Research Council, part of Research Councils UK) so it can be used for future research and learning. ☐
9. **[OPTIONAL]** If there are any events or summaries of the results of the study I would like to be informed of these and consent for my contact information to be kept for up to 12 months after the completion of the study. If yes please complete preferred contact information over the page. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 9: Participant demographic information form

Participant Demographic Information

Participant study identity number:_____

Date:_____

Please complete as many questions as you are happy to. Please write clearly or print. Completion of all questions is **optional** and if you prefer not to answer any of the questions you may leave them blank.

Please ask the researcher if anything is unclear or you would like them to help you better understand any of the questions. Thank you.

1. **Age:**

Please provide your age below.

Age: _____

☐ Prefer not to say

2. **Ethnic Group:**

How would you describe your cultural background, nationality or ethnicity? If you are happy to please describe below:

_____

_____

3. **Gender:** What best describes your gender?

☐ Female
☐ Male
☐ Prefer to self-describe _____
☐ Prefer not to say

4. **Clinical diagnosis**
Please describe your primary mental health diagnosis/diagnoses if you have one.

_____

_____

☐ Prefer not to say
☐ None

5. **Your own description of your mental health difficulty**
Please briefly describe your mental health difficulty in your own words if you would like to.

Please include if this is current or in the past or both.

_____

_____

_____

_____

6. Have you ever used mental health services?

☐ Yes currently
☐ In the past but not currently
☐ No never
☐ Prefer not to say

If yes, and you are happy to give further details, please describe briefly (e.g. primary or secondary care, community, inpatient unit, duration, how long ago, how often).

_____

_____

_____

7. **Your spiritual or religious beliefs:**
How would you briefly describe your religion or spirituality?

Please indicate your religion(s) and type(s) of tradition or denominations if you have them.

Please indicate any spiritual beliefs, practices or other ways of describing your spirituality, religion or faith below:

_____

_____

_____

_____

Thank you for taking the time to complete this information.

Appendix 10: Analytical Mind Map 2

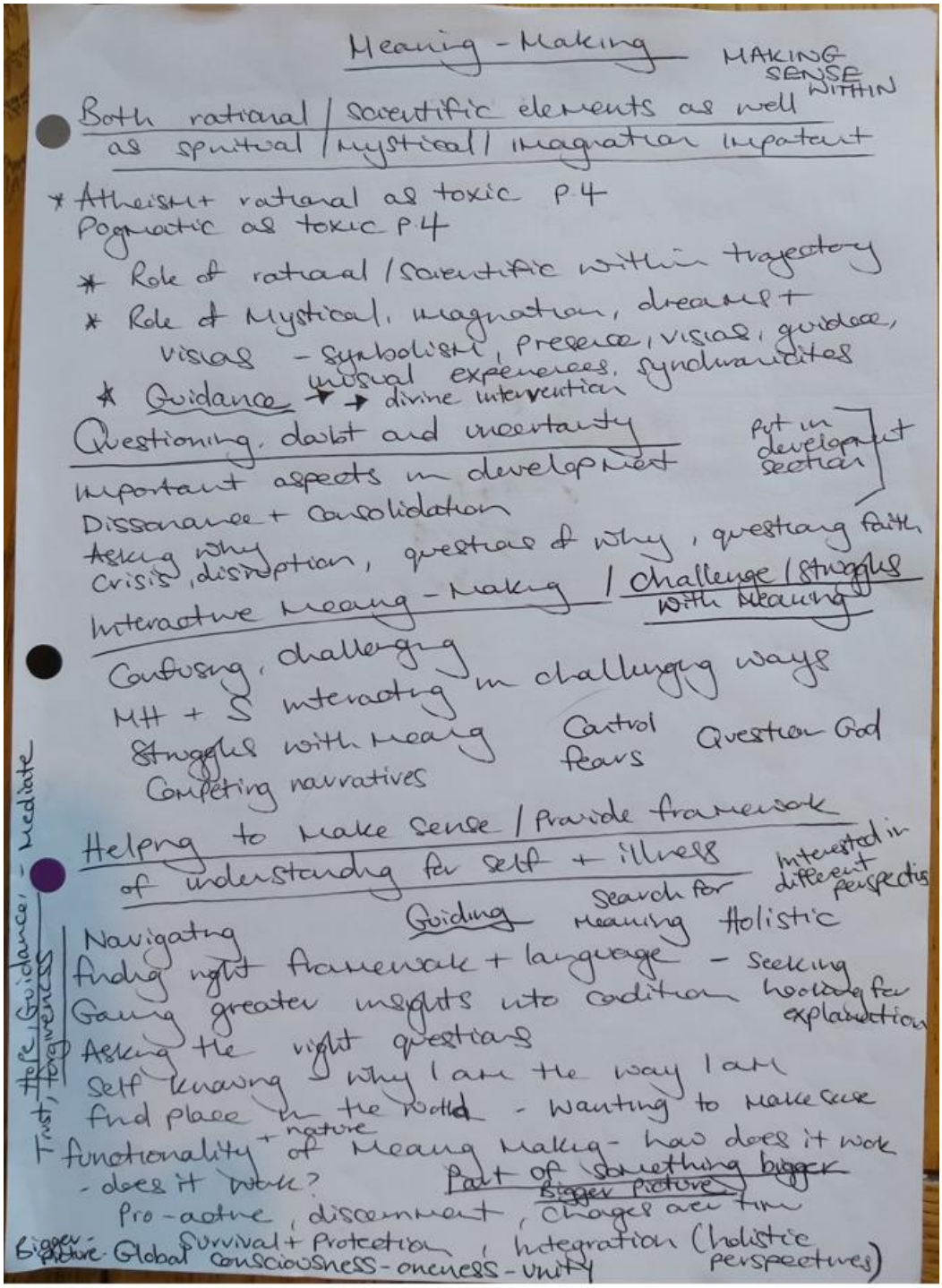
Types of process Not separate – people may experience more than one.	Often mediated by mental illness or episode of mental distress or crisis: Suggests role of mental illness in spirituality, belief and development	**Characteristics within process**	**Process characterised by**	**Outcomes**
Oppression → Liberation, healing, emergence from (may involve period/s of questioning, doubt). Oppressive factors in earlier story include: culture, family, parents, tradition, religion, institutional, social conditioning, conventionality, abuse, trauma and oppressive tendencies towards self/within mental health. **Seeking** → Searching, seeking, finding, quest Finding the right framework/community/ approach, personalising spirituality, unfulfilled explorer, not having to conform, different approaches, need; yearning, seeking authenticity versus looking without direction ('darker' side of spirituality?)	↓	Working with practices and coping. Support of S/R for mental health and recovery as well as challenges. Development of self/faith, maturation, spiritual healing or progress. Mystical, other-dimensional or unusual spiritual experiences. Finding the right framework, approach, language or community – e.g. personalising spirituality. Being with the pain/experience rather than 'fixing'. Being with	Periods of doubt and questioning. Oscillating – no linear (particularly before leaps forward?) It is pro-active rather than passive. Cognitive dissonance: -Clashes of identity -Grappling/struggles with belief/frames of understanding e.g. old or traditional versus new. -Interconnection and confusion between spiritual and psychotic or	Often towards greater levels of: Authenticity (key). Self-knowledge. Self-discovery/ understanding. Greater openness of spiritual beliefs or ideas. Self-awareness. Self-acceptance. Less rigidity or negativity towards self. Openness. Sense of freedom Softening emotionally Wholeness – coherence, integration. Empowerment and sense of control.

Awakening ⟶ May be more thrust upon person. May be instigated by single event, can be more dramatic with mystical elements, Spiritual crisis, transformation, post-breakdown. **Oscillating** ⟶ Exploring, but back and forth, movement towards personalisation of spirituality but with interruptions, spiritual disruption from mental health problems, a little chaotic. **Progressive** ⟶ A continual steady development of spirituality throughout life. Mental health issues may push healing further and coping deepens. Even though the same approach of spirituality may be utilised, it may be personalised along this journey of development. **Emerging** ⟶ Slower process over life-time. Spiritualty almost creeps up upon.	↓	things as they are, letting go, acceptance. Empowerment and taking control. Relational and interpersonal aspects: -Spiritual relationship with God/Spirituality or another person (friendship/spouse) -Spiritual community -Divine intervention – guidance, communion with spirituality (part of meaning making). -Loneliness, isolation and being alone -Culture, family and mental health – including spiritual challenge, stigma, oppression and bullying.	other confusing beliefs within mental illness. Not static – dynamic, changing process. Opening – diversifying or broadening. Role of science or rational, critical or philosophical frameworks of understanding in relation to spiritual ones. Being forced to stop – having to take time out e.g. of work, stay with parents and rest, reconvene or reassess.	Sometimes less control and a sense of letting go. Exception = chaos story with negative outcome, unresolved, confused, isolated, depressed (But a minority in this sample, N= 1).

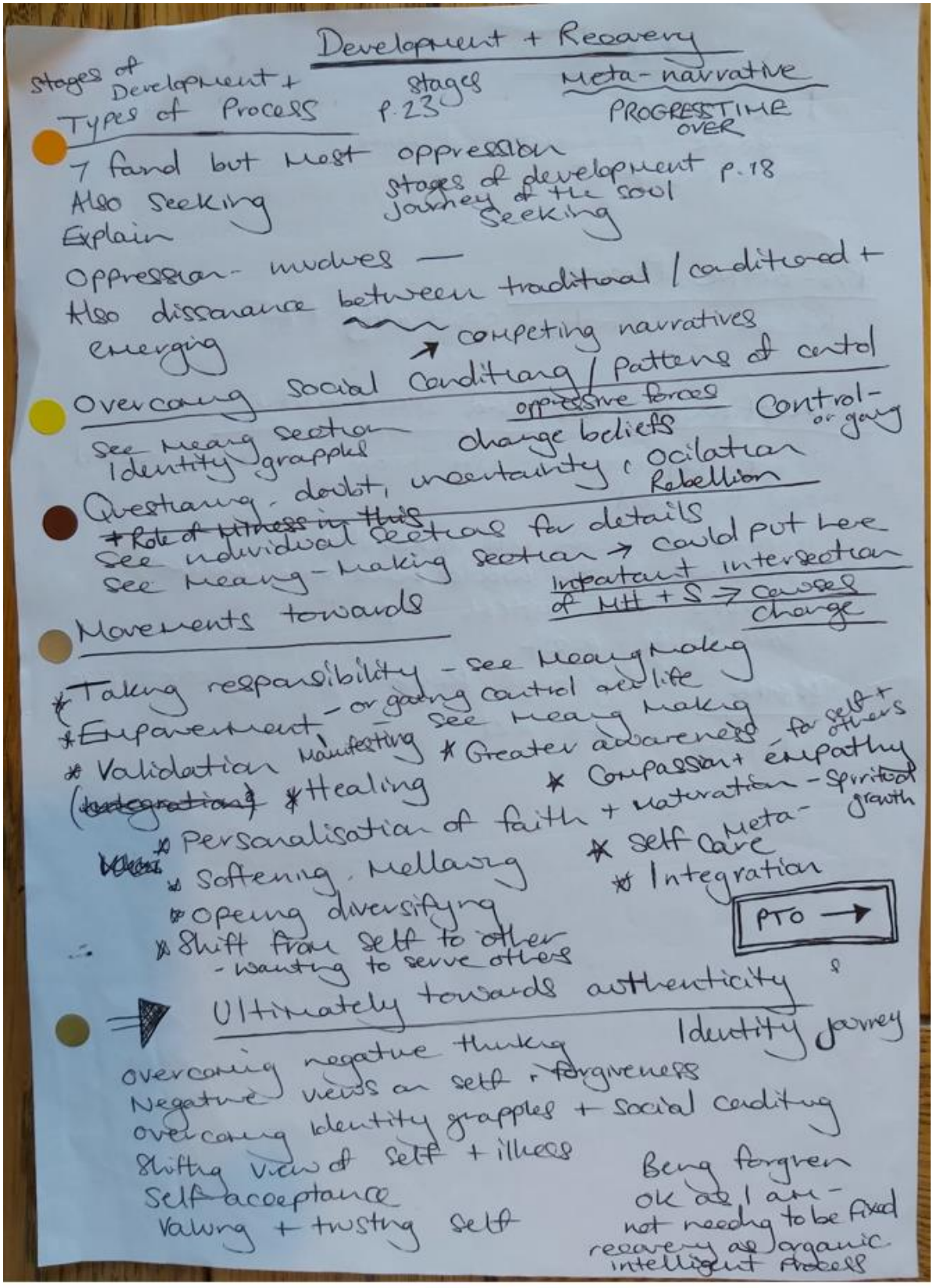
Devotional  Ever-deepening relationship in service and healing. Warrior-style, wounded-healer. **Chaos** Negative trajectory story, stuck, confusing, uncertain, unable to more forwards.				

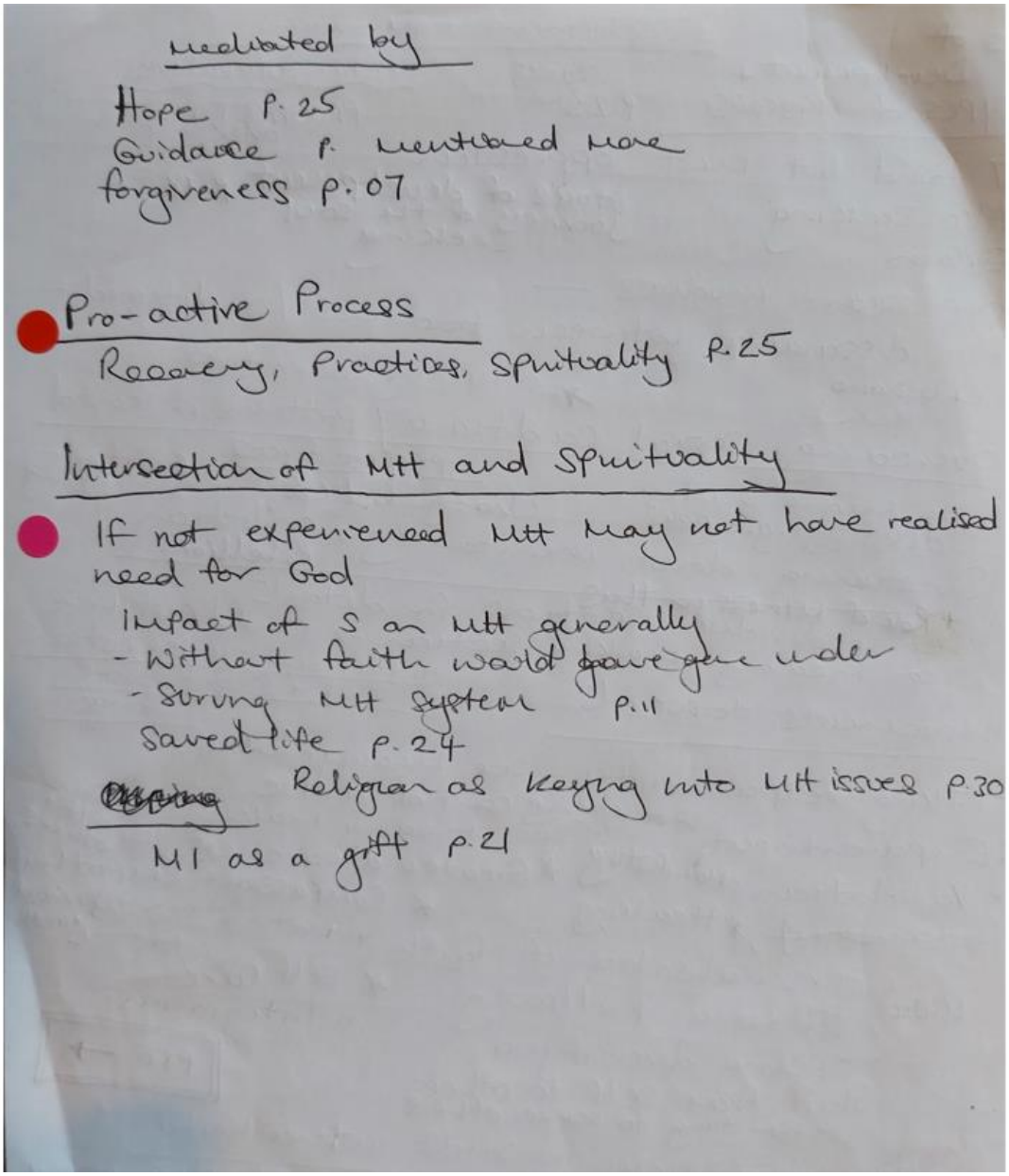
Appendix 11: Initial coding frameworks for each superordinate theme

Initial coding framework for 'Meaning making' superordinate theme



Initial coding framework for 'Psychospiritual development' superordinate theme





mediated by

Hope p. 25
Guidance p. mentioned more
forgiveness p. 07

Pro-active Process

Recovery, Practices, Spirituality p. 25

Intersection of MH and Spirituality

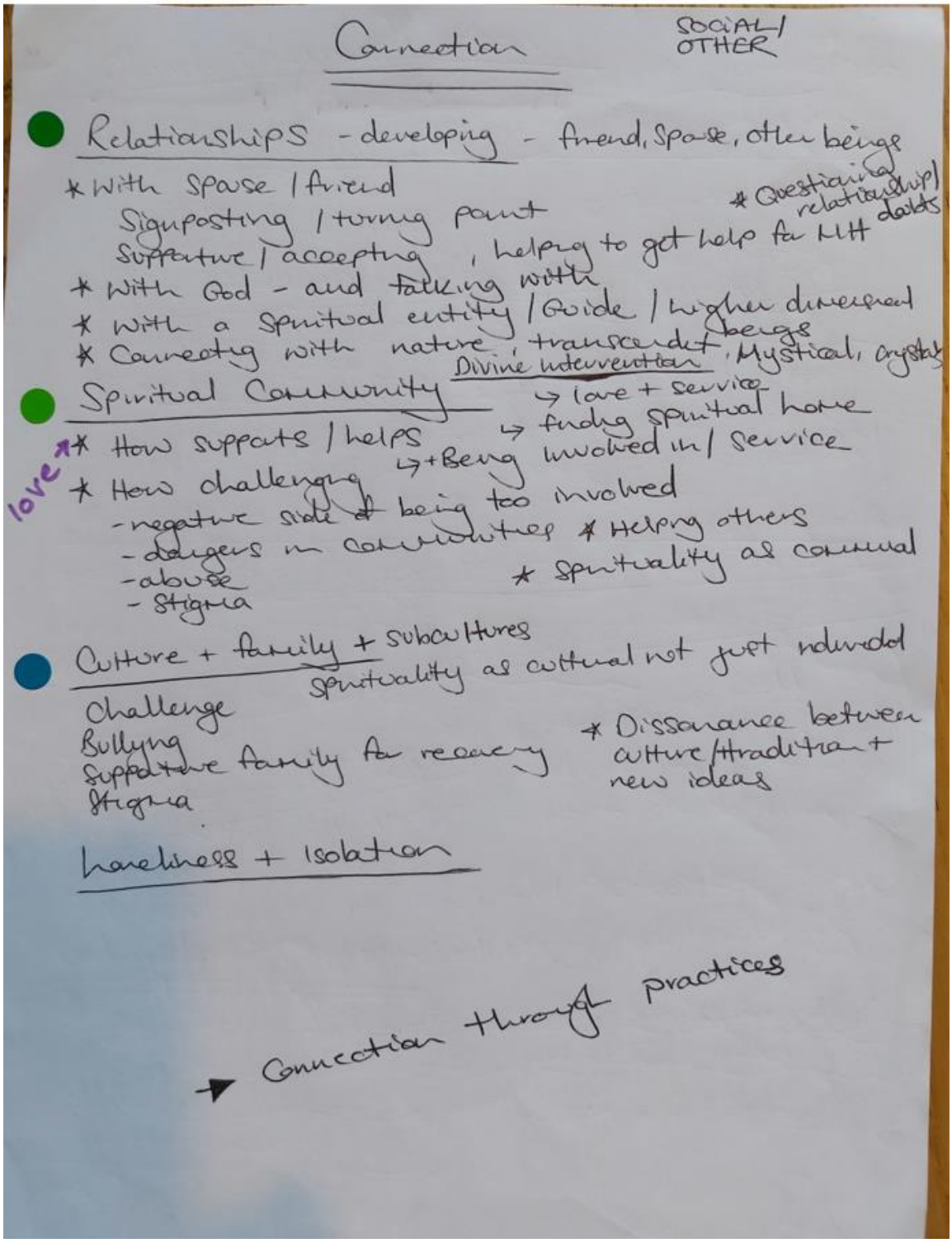
- If not experienced MH may not have realised need for God

Impact of S on MH generally
- Without faith would have gone under
- Serving MH system p. 11
Saved life p. 24

Religion as keeping into MH issues p. 30

MI as a gift p. 21

Initial coding framework for 'Connection' super-ordinate theme



Initial coding framework for ‘Spiritual practices and coping’ super-ordinate theme

This theme was later omitted as described in Chapter 4, Section 4.7.2.