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"Most people think you're a fruit loop": Clients' experiences of seeking support for anomalous experiences

Anomalous experiences (AEs)¹ are those that "depart from our own familiar personal experiences or from the more usual, ordinary, and expected experiences of a given culture and time" (Braud, 2010, p.1). Some of the AEs that have been reported in the literature include meaningful coincidences, out-of-body experiences (OBEs), extrasensory perception (ESP), near-death experiences (NDEs), mystical or peak experiences, and contact with the deceased (see Table 1). Surveys have consistently shown that a high proportion of the general population believe in or experience AEs. For example, Pechey and Halligan (2012) found that in a British sample of 1,000 individuals, 75% reported AEs at any frequency (rarely, sometimes, often), with 13% reporting one or more AEs 'often' and 48% reporting one or more AE having occurred 'sometimes' or 'often' Likewise, Dein (2012) cites surveys conducted across the world in which over half the general population have reported at least one AE.

AEs can occur after negative life events (Rabeyron & Watt, 2010) and common reactions can include fear, anxiety, depression, and distress (Greyson & Bush, 1996; Kramer, Bauer, & Hövelmann, 2012; Parra, 2012; Siegel, 1986; Stevenson, 1970). In addition, individuals may have existential questions following the experience (Heriot-Maitland, Knight, & Peters, 2012) and not know where to seek support, or worry that if they do they will have the experience devalued or labelled as 'mad' (Davis, Lockwood, & Wright, 1991; Eybrechts & Gerding, 2012; Steffen & Coyle, 2012). However, it is interesting to note that it is not necessarily the AE itself that has an impact on whether or not the person experiences psychological distress, but rather how they appraise such experiences, their perceived levels of social support, and whether or not there are opportunities to reduce stigma in a context that

¹ We note that AEs are also sometimes referred to as exceptional human experiences, out of the ordinary experiences, paranormal experiences, or unusual experiences in the literature.

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normalises and validates the experience (Brett, Heriot-Maitland, McGuire, & Peters, 2014; Heriot-Maitland et al., 2012; Roxburgh & Roe, 2014; Taylor & Murray, 2012).

Notwithstanding this, some individuals actually report health and wellbeing benefits associated with AEs and experience profound personal transformation and enhanced human potential as a result (Braud, 2012; Grof & Grof, 1989; Wilde & Murray, 2009).

Despite the reactions elicited by AEs, few studies have explored the perspectives of clients who report them, particularly with respect to the process of therapeutic intervention and how volunteering such information is managed by therapists. For example, a recent study in the UK investigating the counselling experiences of bereaved people who reported instances in which they sensed the presence of the deceased found that the majority of participants felt their counsellors were not accepting of their experiences or neglected to explore their cultural and spiritual aspects (Taylor, 2005). Likewise, Eybrechts and Gerding (2012) found that 16% of a random sample of 736 Dutch individuals sought support after experiencing contact with a deceased person and 53% of those seeking support considered the help they received as inadequate. In addition, more than half of a sample of 84 individuals reporting a NDE were keen to seek support from a counsellor so that they could make sense of their experience, but almost half of those that did so reported a worsening of problems. Perhaps not surprisingly, satisfaction with their therapist was related to their 'impression of being taken seriously', 'the feeling of being accepted', and 'the perceived time and opportunity dedicated to discussing the NDE during counselling'.

As such, we believe that there is a need to investigate the experiences and perceived needs of clients who have reported AEs in the therapeutic setting by interviewing a sample of clients who report such phenomena in counselling services in the UK. Furthermore, Manthei (2005) points out that counselling research in general has tended to neglect the client's perspective in favour of the counsellor's so we intend to fill a much needed gap in the

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literature. We aim to explore the thoughts, feelings, and experiences of clients in terms of the support-seeking process, how counsellors reacted to clients disclosing an AE (did clients feel accepted, listened to, understood?) and what they have found helpful or unhelpful in terms of therapeutic intervention. Given that we are interested in clients' experiences and perceptions, we do not aim to establish the veracity of AEs or theorise on the ontology of such experiences. Findings may generate a better understanding of how therapists can support clients who report AEs and could help to inform the design of healthcare services that meet the needs of diverse clients.

Method

Design

This study adopted a qualitative method to explore the experiences of clients who have reported AEs in a secular counselling service. Guidelines for reporting qualitative research were followed (Tong, Sainsbury, & Craig, 2007).

Insert Table 1

Participants

Purposive sampling was used to recruit clients who had experienced at least one AE that they had discussed in counselling. As part of a separate survey study investigating the range and incidence of AEs in a secular counselling setting over a one year period, information about the interview study was distributed to clients at two charity organisations. All clients who had experienced an AE and had discussed this in counselling were invited to take part in an interview and were assured that participation in either study was voluntary and that their participation would remain confidential to the researchers. The researchers had not counselled any of the participants. Sample size was determined by a number of factors including access to participants, the richness of data, data saturation, and guidelines for

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conducting thematic analysis (Braun & Clarke, 2013). Eight clients took part in the study and consisted of three males and five females aged between 21 and 52 years with a mean age of 37 years. Their religious/spiritual beliefs included Buddhist, Christian, Pagan, Spiritualist, and None (see Table 2). Clients saw counsellors from a range of therapeutic orientations and had at least six sessions following the experience. Pseudonyms have been used to protect the identity of the participants and any personally identifiable information has been changed or removed to ensure anonymity.

Insert Table 2 about here

Data Collection

Participants took part in semi-structured interviews with either the first or second author at a time and place convenient to them (e.g., at a counselling service where they had been seeking support, a university room, or at their home). Before starting the interview we engaged in an initial period of general conversation in order to build rapport. Participants had the option of reviewing the interview schedule before agreeing to take part in the study, but we highlighted that additional questions may be asked due to the semi-structured nature of the interview format. It was emphasised that there were no right or wrong answers and that we were interested in participants’ own views and opinions on AEs and of discussing their experiences in counselling. The duration of interviews varied between 38 and 59 minutes (see Table 2). The main interview questions were open-ended and non-leading, and there were various prompts to encourage discussion (see Table 3).

Data Analysis

Interviews were transcribed verbatim and an inductive thematic analysis was conducted on the entire data set as outlined by Braun and Clarke (2006). This approach was considered appropriate for our research aims as it is a “useful method when you are investigating an

under-researched area, or with participants whose views on the topic are not known" (p. 11).

We adopted a realist epistemology which argues that the thoughts, feelings, and experiences of individuals can be inferred from the language they use. In order to maximise the validity of themes, both authors analysed the data independently and then came together to discuss and refine findings. The first stage in the analytical process consisted of both authors immersing themselves in the data, reading the transcripts several times, and exploring their deeper meaning in terms of the implications for clients and counselling practice. Any interesting observations about the narrative, in relation to the research questions, were noted on the transcripts and initial lists of potential themes were generated. Both authors then reviewed these lists and began a process of clustering themes in order to develop a final table of themes that accurately reflected repeated patterns of meaning within the data. Short participant extracts were used to name the themes. Participants were given the option of receiving a summary of the findings upon request. They were also informed that if there was anything that they said that they did not want to be used as a quote in the write-up of the results, then they could notify the researchers within one month of taking part in the study.

Ethics

Ethical approval was obtained from the School of Social Sciences Ethics Committee at The University of Northampton and ethical guidelines of the British Association of Counselling and Psychotherapy (BACP) were adhered to. We were aware that participants may be concerned about our reaction to their AEss so we were mindful to reassure participants that we were open to such experiences and that it was not our intention to pathologise. We also stressed that participation in the research was confidential and that participation (or non participation) would not affect access to any future counselling. Participants were fully informed about the nature of the study and gave consent for quotes from their interviews to be used in dissemination of the findings on the condition that any personally identifiable data

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were changed or removed. Participants had the right to withdraw their data within one week of taking part in the interview.

Reflexive statement

Both authors are academics and members of the Centre for the Study of Anomalous Psychological Processes (CSAPP), which is a centre for research excellence at the University of Northampton. The mission of CSAPP is the scientific understanding of anomalous, spiritual or transpersonal experiences through careful application of a range of interdisciplinary methodologies. We believe it is important to research the actual impact and interpretation of AEs and are interested in the interface between AEs and mental health. Both authors are also BACP registered counsellors (who have had training in integrative approaches) and volunteer for charity organisations. In terms of our own experiences of working with clients who have reported AEs, we note the importance of respecting different explanatory models and to acknowledge the experience as subjectively real for the individual. We do not have any fixed beliefs about the ontology or legitimacy of such experiences and were mindful in the analysis to be objective and open-minded. This information was shared with participants before the interview.

Findings

Four key themes were derived from participants’ data: “Why are you looking at that airy fairy crap?”, “It was like banging your head against a brick wall”, “It kind of shut the door”, and “Having someone to normalise and say you’re not crazy, you’re not weird” (see Table 4).

Insert Table 4 about here

“Why are you looking at that airy fairy crap?”

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Although not directly asked about, participants talked about the negative reactions of others in wider society, such as friends and family members in response to revealing their AEs which made them guarded about sharing experiences with counsellors. They used derogatory terms such as 'odd', 'crazy', 'barmy', and 'mad' to describe what others had said to them about their experiences (or beliefs). For example, participants stated:

I generally find that in the past, whenever I've ever spoken about my experiences, people have, think that I'm barmy, that I'm a bit mad (Yvonne).

You do get a lot of people who obviously just think you're crazy (Lucy)

These reactions tended to dissuade participants from talking about AEs to others for fear of stigma or prejudice or not being believed:

I would talk to one or two people but there was well "that's a load of rubbish it doesn't exist sort of thing" (...) It's the stigma, that people won't be believed, they don't understand it they just want to put a cover over it, that didn't happen (laughs) and wipe their hands of it (Billy).

This seemed particularly relevant to participants who had Pagan or mediumship beliefs who said that their experiences were construed by others as the "devil's work" (Ally), "airy-fairy" (James), "cult based" (Jenny) or "schizophrenic" (Yvonne). Participants felt that this was because other people have negative views of these beliefs and experiences and some are misinformed or fearful:

The moment some people actually sort of realise that, you know, you are a Pagan, you get treated very, very differently. If you try and talk about the experiences that you actually go through, it does scare a lot of people (Mary).

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I mean my family has always been quite secular and somewhat dismissive of spirituality. I think in general they're very sort of practical people you know, "what are you looking at that airy fairy crap for" sort of thing. So there just wasn't really any opportunity to talk to them about it. (James)

Some participants went so far as to say that they feared being labelled with a mental disorder if they talked about their experiences of mediumship:

I read somewhere I can't remember if it was a YouTube video or I read it erm but there was some lady and she had been diagnosed with all these mental illnesses she had been sectioned the lot and hearing voices and all the rest of it but turns out she was actually a medium so the voices she was hearing like some of the stuff she was getting was so specific to the people they just thought she was mad which is so worrying for me (Ally).

"It was like banging your head against a brick wall"

Participants talked about their initial experiences of seeking support after they had encountered an AE. There seemed to be a dilemma about who to discuss the experience with and participants spent some time contemplating this and searching for an appropriate person or service so that they could share the experience with someone. This is best exemplified by James who, in his deliberations about where to seek support, wonders about whether he will have the opportunity to discuss his AEs with a counsellor:

I was always quite torn between "do I go and see a counsellor?" or "would I be better off going to see or trying to find some sort of Buddhist group and joining there?", but at the same time I felt my personal problems were so big and difficult that going to see a counsellor made more sense than... But at the same time I still needed to discuss this stuff.

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He later talks about feeling as though there is a void in mainstream healthcare services as some counsellors he met in his search for support didn’t help him and made him feel lost and confused:

It’s not mainstream and you know I think my experience with the early counsellors really hit that home that they didn’t have a clue what I was on about and it made me feel that the world of counselling was a little narrower than I had expected.

Participants also talked about the lack of availability of counselling services and how they found it difficult to access support.

“It kind of shut the door”

When participants were asked to share their experiences of discussing AEs in counselling, the majority mentioned feeling dismissed and silenced or said that their experiences were “brushed under the carpet” (Ally) by their counsellor, which left them unable to explore the experience further and confirmed the fears they had about seeking support. Some participants talked about how they tried to “test the waters” with something like meditation but that “the reaction to that was kind of closed down so I was like oops right okay I won’t go any further then” (Ally). When Kian discussed synchronicity experiences with his counsellor he said that the reaction he received “shut the door”:

I had a counsellor about, be about three or four years ago. Yeah, about three or four years ago, and he was, I mentioned, like, synchronicity to him, and he just said, “I don’t believe in that synchronicity, you know, meaningful coincidences,” so it kind of shut the door then. I couldn’t talk any more, you know, about that kind of thing, so it was a bit negative (Kian)

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Similarly, when Lucy tried to explain to her counsellor that she could sense the presence of her deceased husband she felt really frustrated at not being heard or understood:

Every time I tried to say anything about that I can feel him with me, she'd sort of turn it around and say things like, "Oh, yes, I think about my loved ones all the time." I'm not talking about thinking about him! I just thought, oh, I'm so sick of trying to explain, you just don't want to hear, it's just so tiring, and you just think, I really can't be bothered with this, you know? (Lucy)

In some cases the dismissal felt by participants resulted in them ending counselling. As James avowed:

I felt quite dismissed outwardly and I didn't have the knowledge or the experience to challenge what she had said and erm so at that point I made a decision not to do it anymore (James).

"Having someone to normalise and say you're not crazy, you're not weird"

When participants talked about what helped or would help in terms of discussing AEs in counselling they mentioned having someone to normalise and validate their experiences. They also mentioned that it was helpful if their counsellors were open-minded, accepting, and non-judgemental about AEs so they could explore the meaning of the experience with them. Aspects that participants found unhelpful included the counsellor imposing their own values or interpretations about the experience:

Obviously, it's somebody who is understanding, somebody who is open to the experiences that I've had, that they may never have had, and to not to judge, not to ridicule me on experiences, and not to make assumptions that the reason I'm having this is derived from something else (Yvonne)

To be able to normalise AEs and be open-minded, participants felt that it was important for counsellors to possess some knowledge of AEs and to take responsibility for educating themselves. Kian felt that this would enable counsellors to be better prepared to address AEs in the therapeutic setting:

Become educated, really, you know (...) and then if someone comes along, you're not going to be, like, "Oh crumbs, you know, what's this about, I can't do this", you know, you're going to be, like, "Oh I know about that, okay, you've had this, you know, your mother, you know, she died and then the next week she came back to you and you saw her and she spoke to you", you're not going to be, "Oh, what's that about, kind of thing," you know? "I can't deal with this, this person's mad", maybe (Kian)

Likewise, Billy felt that there was a need to demystify AEs so as to counteract some of the sensationalist portrayals:

I think if we get the understanding that not all paranormal experiences are scary and things are gonna attack you and kill you and want to feast on your soul sorta thing, again Hollywood movie style, we may get to a more realistic understanding that maybe there is something beyond our understanding.

Discussion

One of the key findings from this study is that participants were reluctant to discuss AEs for fear of being ridiculed or seen as 'crazy', which echoes the findings of previous research with individuals reporting, or contemplating reporting, a range of AEs, including peak experiences (Davis, Lockwood, & Wright, 1991), NDEs (Eybrechts & Gerding, 2012) and sensing the presence of the deceased after bereavement (Steffen & Coyle, 2012). Participants talked about the negative reactions they had received from friends and family and how they had

been 'closed down' in counselling. This finding is similar to research conducted with clients who reported the experience of sensing the presence of the deceased (Taylor, 2005) or NDEs (Eybrechts & Gerding, 2012) in counselling as participants in those studies also felt misunderstood or not listened to. Participants in the current study also mentioned how they had faced stigma and prejudice in response to disclosing their AEs and felt that this was to do with the misrepresentation of AEs in society and the media. This finding highlights the need to demystify AEs and provide both the general public and professionals with more reliable information about AEs as well as the importance of departing from a 'pathologising discourse' that devalues or 'explains away' AEs and views them as 'life-depotentiating' rather than 'life-potentiating' (Braud, 2012; Evrard, 2012).

We surmise from these findings that some individuals who have AEs may not seek support for fear they will be misunderstood or labelled with a mental disorder. In order to explore this supposition, further research is being conducted by the authors on the help-seeking behaviours of individuals who have AEs and where they seek support from, if indeed they do.

Another prominent finding was that participants did not know where to seek support or deliberated on where to seek support for AEs. This was an unexpected finding as the participants in our study had already had counselling where they had discussed AEs. Manthei (2005) contends that individuals seeking counselling simply go to a counsellor or counselling agency that has been recommended to them. However, the participants in this study appeared to spend a bit of time searching for the best counsellor or service for them as they feared that they would not have the opportunity to discuss their AEs. It seemed important for participants to find a counsellor who was sympathetic and open-minded about AEs, and there was apprehension about whether generic counselling services would be able to fulfil this.

Participants also mentioned wanting to explore the meaning of AEs in counselling, and they emphasised what factors they found helpful in terms of facilitating this. Of particular importance was an open-minded counsellor who was accepting and non-judgemental, and who did not impose their own explanations for clients' experiences. This finding is similar to research that has investigated the experiences of clients who wanted to address religious or spiritual beliefs in therapy (Knox, Catlin, Casper, & Schlosser, 2005) in which participants mentioned particular hindrances to exploration such as the therapist passing judgment and imposing their own beliefs, and particular facilitators such as the openness of the therapist, not being judged or pathologised, and feeling comfortable and safe. Taylor and Murray (2012, p. 14) argue that "understanding, engagement and the attribution of personal meaning to experiences seen as being anomalous as defined at the outset may be important factors in promoting better adjustment to, coping with and even recovery from difficulties associated with them". Likewise, Braud (2012) believes that the act of sharing AEs with others not only provides a cathartic release but also allows for reconceptualization of an experience. Some people do just want to share their experiences and are not always desperate for an explanation. This is similar to findings that have shown that initially distressing experiences that are interpreted as pathological by mainstream Western psychiatry, such as hearing voices, can be reframed in more positive terms by individuals who later identify with the mediumship role (Roxburgh & Roe, 2014; Seligman, 2010). Participants in the current study also said that they wanted someone to normalise and validate their experiences. Similar beneficial effects have been reported in the bereavement literature in terms of supporting individuals who report sensing the presence of the deceased (Keen, Murray, & Payne, 2013; Steffen & Coyle, 2012), hearing voices research (e.g., Roxburgh & Roe, 2014), and with those who are experiencing a spiritual crisis (Bragdon, 2006; Grof & Grof, 1989; Lucas, 2011).

A further finding was that participants said it would be helpful if counsellors had some knowledge of AEs so that they were better prepared to work with clients who report such experiences. This need has been the impetus for the growing field of 'clinical parapsychology' which proposes that professionals trained in clinical psychology, psychiatry, psychotherapy, or counselling should also be educated in the theoretical and research material on AEs (Klimo, 1998; Kramer, Bauer, & Hövelmann, 2012). There are also various resources that practitioners can draw upon when working with clients who have had AEs (for an overview see Braud, 2012; Kramer et al., 2012; Murray, 2012; Simmonds-Moore, 2012), but we argue that there is a need to supplement this with more process-oriented and outcome-based research that investigates different types of AEs; for example, are certain ways of working more effective in terms of therapeutic outcome for clients who report particular types of AEs? It might also be useful if future research explored the counselling experiences of clients who report particular types of AEs. This would enable us to establish whether clients who have had certain types of AEs have different needs or preferences.

Knox et al. (2005) also found that participants in their study felt that it was helpful if they shared similar religious and spiritual beliefs or experiences with their therapist. We also know that clients from marginalised groups (e.g. LGBT clients) and clients with strong values seem to do better in counselling with therapists who have similar characteristics (Cooper, 2008). However, participants in our study did not mention whether they felt it was important that their counsellors also had similar beliefs or experiences regarding AEs. It would be interesting if further research could investigate this in terms of whether client outcome is related to being matched with a therapist who has also had an AE.

Conclusion

Limitations

One of the limitations of this research was that, although it was not our intention to restrict our sample, only White European clients came forward to be interviewed. Future research should explore the perspectives of a more diverse range of clients. This is especially worthwhile given that some AEs and beliefs, such as spirit possession and altered states of consciousness, might be more prevalent within certain cultures or religions (Bourguignon, 1973; Dein, Alexander, & Napier, 2008; Khalifa & Hardie, 2005; Lata, 2005). Moreover, Black and minority ethnic communities (BME) are reported to access services less due to the Western model of illness tending to ignore cultural and spiritual explanatory models of psychological wellbeing (SCMH, 2002).

Another limitation was that participants had seen a range of different counsellors and so we do not know the experiences of clients seeking support from counsellors who have specific orientations (e.g., CBT, person-centred, psychodynamic, and integrative). It might be fruitful if future research compared the views of clients who had seen counsellors from particular orientations, however, we note that this might be challenging as participants in this study mentioned having to see several counsellors before they were comfortable discussing AEs. Similarly, future research could also explore the experiences of clients reporting AEs to other types of professionals (e.g., GPs, psychologists, psychiatrists) since there may be differences in how clients are responded to or in preferred explanations for AEs (Roxburgh & Roe, in press).

Implications for Practice

These findings have implications for clients in terms of accessibility of services, engagement with therapy, and psychological adjustment following AEs. Firstly, there is a risk that some individuals who believe they have had AEs and are distressed by them, or have existential questions they want to explore, may not seek support for fear of their experiences being misunderstood or pathologised. Secondly, there is a risk that individuals who do seek

support and report AEs in counselling may feel dismissed which could result in them terminating therapy and thus unable to process the experience. Thirdly, clients may not have the opportunity to explore the meaning of the experience or any potential health benefits if counsellors are uncomfortable discussing AEs or where their explanatory models are incompatible with the beliefs of some clients. For example, Taylor and Murray (2012, p. 11) have argued that "differences in explanatory frameworks may lead to dissatisfaction and disengagement from medical services if the individuals' understanding of their experiences is incompatible with a medical understanding". This highlights the importance of reaching a 'shared explanation' which addresses cultural, ethnic, religious, and spiritual differences in beliefs about the causes of AEs and mental health issues. It also accentuates the need for therapists to have access to accurate and balanced information about AEs.

Likewise, there are implications for counsellors in terms of counselling practice, working with diversity, and training. It has been argued that there is a need for more culturally competent counsellors who can draw upon a holistic approach when working with clients from diverse backgrounds (SCMH, 2002). Given that most participants in our study felt unable to discuss their AEs with some counsellors they had seen, we suggest that there might be a need for training opportunities in this area or greater awareness of where to refer or signpost individuals to. Further research has been conducted by the authors in terms of how counsellors have addressed AEs reported by clients as well as the training needs of therapists (Roxburgh & Evenden, submitted).

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