Clinical psychologists' use of transformative models of psychosis

Cooke, A. and Brett, C.

Clinical Psychologists' Use of Transformative Models of Psychosis

Word count (excluding abstract, tables and references): 4727

Key Practitioner Message:

- Evidence suggests that some 'psychotic' crises, whilst painful, can also be transformative, leading to personal growth and valued outcomes.
- Professionals who are mindful of this possibility may be more open to discussing the potential meaning and value of psychotic experiences.
- The transformational approach represents an extension of conventional psychosocial approaches to psychosis rather than a departure from them.

Key words:

Psychosis

Psychosocial intervention

Crisis intervention

Transformative Crisis

Post-traumatic growth

Clinical psychology

Abstract

Theory and evidence suggest that some psychotic crises, whilst distressing, can also be transformative, leading to growth and valued outcomes. However, little is known about the extent to which this idea informs mainstream mental health care. Clinical Psychologists are influential advocates of psychosocial approaches more broadly: this study explored their use of transformative models. Twelve UK CPs were interviewed: transcripts informed a grounded theory. No participants saw psychosis as a purely biological problem where the content of experiences is irrelevant. Two held a 'biopsychosocial' model, viewing psychosis as an illness with psychosocial elements. Most either held a continuum view (i.e. schizotypy), in which psychosis-proneness was also associated with positive attributes such as creativity or sensitivity, or a 'fully psychological' view, seeing experiences as meaningful and/or as adaptive responses to events. Many believed that psychosis can be transformative in a broad sense i.e. lead to 'post-traumatic growth'. Some went further, believing that it can be a purposeful (e.g. an attempt - albeit painful and sometimes unsuccessful - to solve problems), or even a spiritual phenomenon. Participants' perspectives influenced their therapeutic approach: those who saw experiences as purposeful were more likely to facilitate direct engagement with them and to support clients to explore their potentially transformative aspects. However, this represented an extension of conventional approaches rather than being qualitatively different. More research is needed to clarify how widespread this approach is, to explore its utility, and to establish for whom and when it may be appropriate.

(245 words)

Introduction

The journey of awakening…can also be a fast admission ticket into the world of psychiatry

EmergingProud, 2018

Only in the Western world have we developed this bizarre idea that hearing voices and having strange ideas has no meaning at all

Prof John Read, 2017

Psychosis involves… an attempt to reorganise to address problems

Ron Unger, 2017

Debates about the Nature of Psychosis

There is a debate about the nature and meaning of the experiences sometimes called 'psychosis' (Cooke, 2017). The dominant, medicalised approach conceptualises them as resulting primarily from brain pathology (e.g. American Psychiatric Association, 2018). The last thirty years have seen extensive critique of this idea on both theoretical (e.g. Williams, 2012; Morrison, 2001) and practical grounds (Cooke & Kinderman, 2017). Recent evidence also suggests that antipsychotic medication may be less effective than previously thought, and its potential adverse effects greater (see, Moncrieff, 2013; Morrison, Hutton, Shiers & Turkington, 2012). Some of the strongest criticism has come from the psychiatric survivor movement (e.g. Burstow, 2015; Russo & Sweeney 2016). An alternative, psychosocial approach (see Cooke, 2017) has gained in popularity over recent years. This proposes that the way people interpret anomalous experiences is affected by their previous life experiences and the way that they have responded to and made sense of them.

Psychosis as Meaningful and Potentially Transformative

An experience of psychosis is often traumatic, and frequently constitutes a crisis both for the person involved and for their family and friends (Chisholm et al, 2006). However various sources, particularly first person accounts, suggest that psychosis can also have positive aspects (e.g. Borges, 2017; Kiser, 2004) and that psychotic crises may have the potential to bring about positive change for the person concerned (Brett, 2010). Some writers emphasise its potential role in the processing and healing of past traumatic experience (Dillon, Johnstone & Longden, 2012). Jackson (2010) has suggested that psychotic phenomena may occur as a form of 'cognitive problem-solving' process, such that situations of psychological impasse may trigger anomalous experiences that create shifts in the individual's cognitive schema and help resolve the dilemma.

Psychosis and Spiritual Crisis

Spiritual content and meaning are frequently ascribed to psychotic experiences by those who experience them (Clarke, 2010; Geekie & Read, 2008). Some view episodes as profound spiritual or existential crises that can lead to important insights and positive change (Borges, 2017). Others describe their personal spirituality as a source of strength and meaning within suffering which is important to their recovery (Campbell, 2010).

In addition to personal accounts there is also a body of theoretical literature linking psychosis and spirituality (e.g. Assagioli, 2000; Clarke, 2010; Brett, 2010; Hartley, 2010). The Spiritual Crisis Network suggests that 'a mental health crisis can be a wake-up call, our psyche's attempt to heal itself…an opportunity for healing and growth' (Maisel, 2016).

Some theorists view *all* forms of psychosis as inherently transformative. Others consider that some 'psychoses' are misdiagnosed spiritual crises whilst others are better explained using a psychiatric or psychological framework.

The extent to which phenomena are experienced as positive – or as painful but ultimately helpful - rather than just distressing appears to depend to a large extent on the context. If those around someone are accepting of their experiences, the person is less likely to become distressed or to need help from services (Brett, 2010; Jackson, Hayward & Cooke, 2011; Heriot-Maitland, Knight & Peters, 2012). Examples of such contexts include some religious groups and other subcultures such as the spiritualist movement. Many non-distressed voice-hearers in Jackson et. al's (2011) study, for example, identified as mediums. The person's beliefs about their experiences appear to play an important role: those who see their experiences as normal and understandable are less likely to be distressed by them (Lovatt, Mason, Brett & Peters, 2010).

It is not always the experiences themselves that are seen as helpful or transformative: for some people it is the clarification of values and priorities that can follow a profound experience of suffering and disintegration (Razzaque, 2014).

Therapeutic Approaches

The above theoretical developments have generated number of related approaches to crisis intervention and therapy.

Mainstream psychological approaches. Current guidelines recommend that people experiencing psychosis should be offered Cognitive-Behavioural Therapy (CBT or CBTp) (NICE, 2014). This focuses on the person's interpretation of events, supporting them to

check out their fears (Steel & Smith, 2013). 'Third wave' approaches that incorporate mindfulness are also gaining popularity (Cupitt, 2018; Clarke & Nicholls, 2018).

Therapeutic approaches based explicitly on a transformative crisis model.

A number of clinicians have developed novel treatment approaches based on experience of helping people in acute crisis (e.g. Mosher, 1999; Calton, Ferriter, Huband & Spandler, 2008). These often advocate the suspension of psychiatric interventions directed at eliminating the psychosis, in order to allow the transformative process to reach a natural resolution. Sometimes this is only deemed appropriate for a subset of individuals (Ciompi et al. 1992). Milieu therapy is often used, involving home-like settings and compassionate, accepting interpersonal contact (Cole, 2013; Mackler, 2014).

Both the first-person and the professional literature emphasise the importance of supporting the individual to find their own meaning within their experiences: the personal meanings and symbolism in 'delusional content' are explored and discussed (Coles, Diamond & Keenan, 2013), together with possible connections to traumatic life experiences and existential concerns. The 'Open Dialogue' approach (e.g. Razzaque & Stockmann, 2016; Bergstrom et. al, 2018) focuses on working with the different and at times conflicting narratives about the crisis within the person's social circle. The aim is to provide a space where a narrative and solution acceptable to all can emerge, rather than the 'experts' being expected to provide one.

Rationale for the Current Study

Despite the existence of innovative approaches, mainstream mental health services are still largely based on a medical model (Cooke, Smythe & Anscombe, forthcoming) and the ideas outlined above would be new to many clinicians. Clinical psychologists (CPs) have been influential in developing, evaluating and disseminating new theoretical and therapeutic

approaches to psychosis (see e.g. Cooke, 2017; Bowden, Davis, Nairne & Shepherd, 2015). Their views on these developments are therefore likely to be indicative of their potential for wider acceptance. The current study explored CPs' views about transformative models of psychosis.

The research questions were:

- What are clinical psychologists' beliefs about the nature of psychosis, and specifically about 'transformative crisis' models?
- How, if at all, do they draw on these approaches in their clinical practice?

Methodology

Design

In view of the relatively unexplored nature of the territory, the study utilised an exploratory qualitative methodology, Grounded Theory (Glaser & Strauss, 1967).

Participants

The participants were CPs working in a variety of National Health Service (NHS) settings. They were recruited via the British Psychological Society and also, for reasons of theoretical sampling (see below), via the UK Spiritual Crisis Network[1] and via a clinical psychology discussion list focusing on psychosis and spirituality. In order to guide theoretical sampling, volunteers answered a brief questionnaire and participants with a range of views were selected. Theoretical sampling was based particularly on (a) level of awareness of and interest in transformative models of psychosis; (b) service setting: e.g. early intervention compared to inpatient unit or community rehabilitation team Of 15 respondents, 12 were interviewed. Psychologists with a stated interest in transformative models of psychosis were recruited in the first instance, with 'negative cases' (i.e. those who subscribed to illness

[1] A charity and networking organisation set up to promote understanding and support of *spiritual crisis*: a term used to denote transformative crisis seen within a transpersonal or spiritual paradigm.

models) being interviewed to test emerging hypotheses Table 1 summarises participant characteristics. The confidentiality of participants and their clients has been maintained.

(Insert Table 1 about here)

Data collection

Telephone interviews conducted by the second author (CB) were recorded and transcribed. Data collection was continued until theoretical sufficiency (Charmaz, 2006) was achieved.

Data analysis

The data analysis followed Charmaz' (2006) procedural guidelines for Grounded Theory. The data were systematically coded in order to identify theoretical constructs that could explain them. Methods of constant comparison, memo writing and field notes were also used to help in the generation of conceptual insights, and relationships and disparities in the data. Quality assurance procedures followed Yardley's (2000) guidelines and included reflective 'bracketing' interviews (Rolls & Relf, 2006), and participant feedback on the emerging analysis.

Epistemological Position

The epistemological position adopted was one of critical realism (Bhaskar, 2013). This stance acknowledges that the statements made by the participants are just that, statements. They are inevitably affected by situational and other factors. However, unlike its more radical cousin social constructionism, critical realism sees participant statements as also containing valuable information about the 'real world' - the phenomena being described - albeit seen though a particular lens. Accordingly, the assumption here is that participant statements do reflect, albeit imperfectly, psychologists' actual beliefs and practices.

Results

The results are presented in two parts. The first describes participants' beliefs about the nature of psychosis. The second describes the ways that these were reflected in their clinical practice as reported in the interviews. The findings are summarised in Table 2.

(Insert Table 2 about here)

Beliefs about the nature of psychosis

As might be expected given the recruitment strategy, participants held a spectrum of views ranging from those who accepted an illness model to those who saw psychotic experiences as inherently purposeful.

No participants saw psychosis in purely biological terms (i.e. as a brain problem where the content of beliefs and experiences is largely irrelevant). Two held a **'biopsychosocial'** view, explaining it as an illness or disorder, albeit with a significant psychological component which explained the context of onset and the particular form of the unusual experiences and beliefs involved. These participants saw psychosis as meaningful in the sense that the content of symptoms could be fruitfully linked with events or situations in the client's life. A second group held a '**continuum/trait'** view (i.e. schizotypy: Mason & Claridge, 2015) in which psychosis-proneness was seen as a trait, often associated with others such as creativity and interpersonal sensitivity. A third group held what might be called a '**fully psychological'** view, seeing psychotic experiences as understandable responses to life situations, particularly trauma. Finally, some went further, believing that the experiences had a particular **function**, for example helping to resolve dilemmas or unbearable feelings.

I think people sometimes journey into other worlds to try and find ways to deal with this world.' (P7).

A number of the latter group believed that psychosis had **spiritual** aspects or that a 'breakdown' often represented a spiritual crisis.

Beliefs about transformative approaches to psychotic crisis

Similarly, participants held a range of views about the extent to which psychotic crises are likely to be transformative. Beliefs varied in terms of the way participants understood the term (**broad vs specific meanings of 'transformative**'), in terms of what might **distinguish** a transformative crisis from other forms of psychosis, and in terms of terms of the **utility** of a transformative approach.

Broad versus specific meanings of 'transformative'. Many participants saw psychosis as potentially transformative in a broad sense, in the same way that any crisis could lead to learning and positive change given the right support:

'*It doesn't have to be psychosis, any personal crisis can lead to a transformation, or not'* (P2).

Others subscribed to a more **specific view of the transformative potential** of psychosis, seeing the phenomena themselves as inherently purposeful:

'*The experience of psychosis would be both the indication of the need for personal development…and partly I guess as a way of doing it in its own right'* (P5).

Of the latter group, some emphasised the way that trauma can re-emerge into awareness through psychotic experiences, thereby presenting an opportunity to process or resolve it. Some felt that psychosis often represented a spiritual crisis:

'*I got interested in spirituality and psychosis because of doing therapy with people who told me of their breakdown experiences which included mystical experiences'* (P3).

Many participants stressed that despite its transformative potential, psychosis could also be extremely distressing and destructive:

'*I think it can be very transformative in the long term and in the short term it can be incredibly destructive.'* (P5).

Distinguishing transformative crisis from other forms of psychosis. Many participants felt that the transformative crisis idea was either only relevant to a minority of their clients, or that it might no longer be relevant by the time an individual had experienced significant input from services:

'*There's nobody I work with whose psychosis really fits a spiritual emergency, it's gone beyond that, but there could well have been a spiritual emergency at the onset and there's a strong flavour of spiritual issues in the ongoing psychosis.'* (P10).

Those working in early intervention or acute services were more likely to think that some of their clients' experiences might be understandable as a spiritual crisis. None felt that their service was appropriate in those cases:

'*Is this person having a spiritual crisis… what we have to offer doesn't seem to be…useful.'* (P8).

Some appeared to view experiences as transformative only where the person was not distressed by them:

'It's …rare that I come across that because the people that I will see are people that are distressed by their psychotic experiences…' (P9)

Others had a broader definition:

'*I don't separate out the experiences in a dualistic way, so like, some people have psychosis, some people have spiritual emergence…I'd see all mental health problems as potentially transformative, if people get the right support*.' (P7)

Utility of a transformative approach. Many participants were drawn to transformative models because they had experienced these as more helpful for clients. They felt that the idea of illness could lead to passivity and hopelessness, and that transformative

models provide a helpful framework that integrates experiences into people's lives and can reduce anxiety and provide hope.

'*There's a lot of really helpful metaphors in spiritual thinking…that sometimes are less painful ways to look at people's problems'* (P7).

Aims and methods of therapeutic intervention

Even those participants who endorsed a transformative model rarely used specific therapeutic approaches based on it such as those described above. However, it did often impact their general approach: they were more likely than other CPs to offer clients the opportunity to explore and integrate their experiences through making links to biographical factors and looking for lessons inherent in the crisis.

Sense-making: containment, explanation, choice and integration. All participants felt it was important to offer people the opportunity to make sense of their experiences. Many felt that this provided containment and reduced anxiety:

'*If you contextualise it for people it can reduce their distress, it's a way of normalising or making sense of it for them so they've got a narrative of it'.* (P5)

Many, including those who were comfortable with the idea of psychosis as an illness, created a formulation with the person, linking biographical information to the content of unusual beliefs in order to explain how the belief arose:

'*A Tony Morrison or Philippa Garety model of psychosis, that somehow your early experience leads you to have unusual views about yourself and the world, and that you interpret things within the context of that'* (P2).

Those who saw psychosis as transformative (in either a broad or specific sense) saw therapy as an opportunity to reflect, to discover any links between life events and the content of the psychosis, and to clarify hopes and goals.

'*People get onto the treadmill and end up somewhere in life they don't want to be… But any crisis, any illness, gives you time to reflect on your life, your values and goals, it can be a transforming experience and I would always include that in the therapy'* (P2).

Participants also felt that making biographical connections helped to position psychotic experiences as products of the past, allowing the person to have more choice over their reactions:

'If we…notice …where they've come from, [that creates] … a bit of room to reflect, and choose…do something different than just reacting.' (P8)

Participants who viewed psychosis as purposeful also talked about making links to life experiences. Here the aim was not only to understand the origin of the experience but also its purpose, and to promote integration. They described facilitating engagement with relevant traumatic or emotional issues, exploring the function of the unusual beliefs and looking for other ways of meeting these needs. They also offered people the opportunity to reflect on and learn from their experiences:

'*If you can learn the lessons...– a meaning - you can turn the crisis into something transformative*' ' (P7).

Several participants mentioned the importance of appropriate timing and of the therapeutic relationship:

'*It's being very supportive and not trying to undermine beliefs but perhaps if you've got a really good relationship with someone then you can… suggest alternatives'.* (P7)

Differing approaches to validation. Some participants drew on ideas that provide a normalising rationale for experiences while not validating their content at face value: for example paranoid experiences as self-protective mechanisms, or dissociative experiences as adaptive responses to trauma (see Read & Bentall, 2013). Others, often but not exclusively those who had themselves had unusual experiences, or ones they viewed as spiritual – had a validating attitude towards anomalies:

'*I'm very interested in those experiences, so probably my interest shows! I tend to go forward at that point because I think often people are desperate to discuss them…and they need attention.'* (P4).

These psychologists were more likely to see the psychotic state as potentially giving rise to novel insights that might help the client move on. They might facilitate direct engagement with experiences in order to explore them more closely and to consider aspects that might be causing difficulties. However, this was held in balance by a focus on the importance of timing (see above) and of engagement with 'real world' activities in line with the client's goals.

Many CPs felt that their remit was to address clients' own concerns, and would not refer to transformative models unless clients mentioned them first. Others sometimes did and felt that many people welcomed the perspective and benefited from it in terms of self-esteem and hopefulness.

Engaging with the world. All participants aimed to help people engage with 'real world' goals and activities. Some felt that the content of beliefs was often less important than opportunities to pursue real world goals that might help make them less preoccupying.

'*I like to help the person …get… involved in real world things because I think for some … there is a danger that the ordinary world has got little to offer them, and the psychotic world is so much more attractive and there's very little motivation to leave it.'* (P3)

Reducing the negative impact of experiences and beliefs. Many participants talked about helping people find ways to reduce the negative impact of unusual beliefs or experiences. Some saw this as often more important than addressing them directly. A number highlighted the possibility of working within the client's belief system:

'*I can work with someone who believes their voices are a product of dissociation, or… someone who believes that they are hearing the voice of the devil…In both cases I'm trying to help people make peace with that experience and increase their power, choice and control.'* (P7).

Positioning: 'expert' to 'not knowing'

The CPs positioned themselves in differing ways in terms of expertise. This was related to their beliefs about psychosis in that the minority who viewed it as illness were more inclined

to use a psycho-educational approach, drawing on a standard model to offer the client a possible formulation of their experiences. In comparison, others held an explicitly 'not knowing' position (Anderson, 2005) and worked more from the clients' own understanding:

'*I think I'm much less willing to give advice, I'm more interested in facilitating people to make their own decisions… I try very hard to get alongside people and facilitate the process that they go through rather than having a very strong agenda myself about what I think's right for them'* (P4).

However, even those who espoused a 'not-knowing' or 'non-expert' position were balancing two concerns: avoiding invalidating the person's experiences and beliefs, whilst also being aware of the distress these were sometimes causing.

Others explained their approach as presenting information and thereby increasing the options available to the client. This was a way of introducing new ideas (including, for example, the idea of transformative crisis) without presenting them as the 'truth' about the person's experiences.

Factors Constraining Practice

Two factors constrained the extent to which psychologists felt able to draw on transformative crisis models in their work: views about what was appropriate in the role, and the service context.

Views about the clinical psychologist role. Only three of the six participants who believed that a 'breakdown' often represented a spiritual crisis, drew on this idea in their work with service users. The others avoided conversations about spiritual issues since they felt this was not within their remit or training. Where spirituality was important in the psychologist's own life, this sometimes presented a dilemma. Some felt that there could be a role for faith leaders, although they felt that some may lack necessary clinical skills.

Service context. The service context played a central role in determining the types of interventions offered. All participants who held non-illness models experienced difficulties working within teams where colleagues did not share their perspective. Many felt that the hegemony of the medicalised approach with its idea of 'insight', its emphasis on reducing or removing experiences rather than understanding them, and its frequent use of compulsion, undermines trust between service users and professionals. They felt it makes clients less inclined to be honest with workers; that it promotes a more passive attitude; and that clients in acute crisis are often too heavily sedated to engage in therapeutic conversations. Those who worked in more 'open-minded' teams felt less constrained.

Discussion

Summary of findings

The analysis elucidated subtle differences in participants' beliefs about the nature of psychosis. No participants saw it as a purely biological problem where the content of experiences is irrelevant. Two held a 'biopsychosocial' model, viewing psychosis as an illness with psychosocial elements. Most either held a continuum view (i.e. schizotypy), in which psychosis-proneness was also associated with positive attributes such as creativity or sensitivity, or a 'fully psychological' view, seeing experiences as meaningful and/or as adaptive responses to events. Many believed that psychosis can be transformative in a broad sense i.e. lead to 'post-traumatic growth'. Some went further, believing that it can be a purposeful, i.e. an attempt, albeit painful and sometimes unsuccessful, to solve problems and grow. Some of this group believed that at least some 'psychotic' crises are existential or spiritual experiences that can be profoundly transformative for the person concerned.

Participants' perspectives influenced their therapeutic approach: those who saw experiences as purposeful were more likely to facilitate direct engagement with them and to address their possible significance and meaning. However, participants' approaches had much in common. All aimed to offer a space where people could discuss and attempt to understand their experiences in the context of their lives and values. All also focused on concrete opportunities to re-engage with life and pursue 'real world' goals. Not all those who personally believed that some psychotic experiences may have spiritual content or relevance presented this perspective to clients.

Application of transformative models in the NHS context

Many participants reported that in their NHS work they rarely came across people whose current experiences met their criteria for transformative crisis. The Grofs' (e.g. 2012) model of spiritual emergency would indeed rule out many of the people presenting to services as it

specifically excludes, for example, those with 'delusional' beliefs. However, others (e.g. Geekie and Read, 2008; Wagner & King, 2005) have argued that a crisis can be simultaneously both very distressing and profoundly transformative, even spiritual. It is possible that some CPs may be excluding some who might benefit from the transformative crisis approach.

One difficulty is the service context: psychologists with an interest in transformative crisis are often working with teams where colleagues do not share this approach. Counteracting the dominant illness narrative demands energy (Cooke, Smythe & Anscombe, forthcoming) and dilemmas can arise regarding the ethics of introducing conflicting models.

New approach or extension of current practice?

Another notable finding was the overlap between CPs who did and did not view psychosis as purposeful, when it came to intervention. Interventions based on the transformative crisis model (validating experiences, working to integrate insights into everyday life) were often integrated with approaches derived from a more traditional psychological approach (making links between psychotic experiences and life circumstances; addressing trauma; increasing opportunities for engagement with 'real world' goals). This suggests that the adoption of a transformative approach does not represent a radical step, but rather an extension of current practice. In this sense it does not seem crucial to make a 'differential diagnosis', i.e. spiritual emergence *or* psychosis. Psychologists are already offering clients information and choice about approaches, so information about spiritual crisis could be more widely utilised in this way. Geekie and Read (2008) found that people experiencing psychosis identified existential needs (the search for meaning and the need for spirituality) as the most pressing. They note

that ‘explanations of causality, which may have helped answer the question of *how* the experience came about, did not seem to quell the need to answer the pressing concern of *why* the psychosis occurred, and (what it) implied for the nature of the individual’s world (p.192). They encourage clinicians to embrace the notion of ‘essential contestedness’: ‘a shift on the part of clinicians, away from the position of believing that we already *know* what the experience means, to recognising that we bring one way of understanding psychosis, but that this is but one among many useful and valued ways’ (p.195).

Where people are preoccupied with the spiritual significance of their experience, it would seem helpful validate this whilst also addressing its distressing or disabling aspects. Unger (2017) argues that services should adopt a ‘recovery *and* transformation’ approach which encompasses both. ‘Open Dialogue’, an approach to psychosis currently undergoing a large scale UK trial (Razzaque & Stockmann, 2016) explicitly bases all therapeutic conversations on the priorities and beliefs of the person concerned and their loved ones: professionals act as facilitators rather than as experts charged with explaining what is going on (Seikkula & Olson, 2016).

Spirituality and the role of psychologists

Many CPs did not feel comfortable engaging with spiritual aspects of their clients’ experiences. Some felt this was not within their remit, although those who themselves had had spiritual experiences were more willing to explore it. Evidence suggests that the presence of someone who feels comfortable with conversations about spirituality can be helpful to individuals in crisis, as long as they do not impose their own views (Clarke, 2010). This raises the question of whether CPs should have some means to develop competency in this

area. Alternatively or additionally, service users or faith specialists could be more closely and routinely integrated into services. CPs could also usefully support peer networks and user/survivor run services such as the Hearing Voices Network (www.hearing-voices.org), the Spiritual Crisis Network (www.spiritualcrisisnetwork.uk/) and EmergingProud (https://emergingproud.com; see also Moynihan, 2014).

Training

Few of the CPs had received any training in transformative models of psychosis or their associated interventions. It is also striking that some of the participants' views of transformative crisis used the presence of distress or de-adaptation as exclusion criteria. This suggests that training could usefully include more explicit presentation of transformative models.

Limitations and future research

This study has examined CPs' accounts of their work, considering them in the light of extant data and first person accounts. However, it cannot answer questions about the relative value or efficacy of the therapeutic interventions that the CPs describe. Future research could usefully involve case studies based on information from both the therapist and the client on the aims, process and benefits of their work together.

This study only addressed NHS settings. Future research could examine the potential application of these approaches in different settings, for example non-medical approaches to acute crisis (Cooke, McNicholas & Rose, forthcoming). In such settings the possibilities for

offering help may be less constrained and it could be more possible to work towards realising the transformative potential of crises, at least for some.

This was a small, qualitative study which specifically recruited CPs with an awareness of transformative models, and did not aim for generalisability. It would be useful to carry out a wider survey in order to establish the representativeness of the current findings. Research based on direct observation of therapeutic practice would also be useful.

Finally, this analysis was constructed subjectively, and will inevitably have been influenced by the researchers' own assumptions. Both believe that some psychotic crises can be transformative and the reader is invited to take this into account in evaluating our interpretation and conclusions.

References

American Psychiatric Association (2018). *What is Schizophrenia*? (web page). Retrieved from https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia

Anderson, H. (2005). Myths about "Not-Knowing". *Family Process, 44,* 497-504. doi: 10.1111/j.1545-5300.2005.00074.x

Assagioli, R. (2000). *Psychosynthesis: a collection of basic writings*. New York: Synthesis Centre. Bragdon, E. (1993). *A Sourcebook for Helping People with Spiritual Problems*. (2nd Edition). California: Lightening Up Press.

Bergstrom, T., Seikkula, J., Alakare, B., Maki, P. Kongas-Saviaro, P., Taskila, J. J., …, & Aaltonen, J. (2018). The family-oriented open dialogue approach in the treatment of first-episode psychosis: Nineteen–year outcomes. *Psychiatry Research, 270,* 168-175. https://doi.org/10.1016/j.psychres.2018.09.039.

Bhaskar, R. (2013). *A realist theory of science.* London: Routledge.

Borges, P. (2017) (director) Crazywise. (film). Retrieved from www.crazywise.com

Bowden, G., Davis, F., Nairne, K. & Shepherd, G. (2015). Clinical psychology in adult mental health services. In J. Hall, D. Pilgrim & G. Turpin (Eds.) *Clinical Psychology in Britain: Historical Perspectives*. Leicester: The British Psychological Society.

Burstow, B. (2015) Psychiatry and the Business of Madness: An Ethical and Epistemological Accounting. Basingstoke: Palgrave.

Brett, C. (2010). Transformative crises. In I. Clarke (Ed.) *Psychosis and Spirituality: Consolidating the New Paradigm* (2nd ed.). Chichester: Wiley-Blackwell.

Calton, T., Ferriter, M., Huband, N., & Spandler, H. (2008). A Systematic Review of the Soteira Paradigm for the Treatment of People Diagnosed with Schizophrenia. *Schizophrenia Bulletin, 34* (1), 181-192. doi: 10.1093/schbul/sbm047.

Campbell, P. (2010). Surviving the system. In T. Basset & T. Stickley (Eds.) *Voices of experience: Narratives of mental health survivors.* Chichester: Wiley-Blackwell.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications.

Chisholm, B., Freeman, D., & Cooke, A. (2006). Identifying potential predictors of traumatic reactions to psychotic episodes. *British Journal of Clinical Psychology* 45 (4), 545-559

Ciompi, L., Dawalder, H.P., Maier, C.H., Aebi, W., Trfitzsch, K. Kupper, Z. & Rutishauser C.H. (1992). The pilot project 'Soteria Berne' clinical experiences and results. *British Journal of Psychiatry, 161*, 145-153.

Clarke, I. (2010). *Psychosis and Spirituality: Consolidating the New Paradigm* (2nd ed.). Chichester: Wiley-Blackwell.

Clarke, I. & Nicholls, H. (2018). *Third Wave CBT Integration for Individuals and Teams.* New York: Routledge.

Cole, K. (2013, April 23). Carina Håkansson: Family Care Foundation. *Mad in America Foundation.* Retrieved from: https://www.madinamerica.com/2013/04/carina-hakansson-family-care-foundation/.

Coles, S., Diamond, B. & Keenan, S. Clinical psychology in psychiatric services: the magician's assistant? In Coles, S., Keenan, S. & Diamond, B. *Madness Contested: Power and Practice*. Ross-on-Wye: PCCS books.

Cooke, A. (2008) Problems associated with the use of the concept 'mental illness'. In: Stickley, T. and Bassett, T., eds. *Learning About Mental Health Practice*. Chichester: Wiley. pp. 329-346. ISBN 9780470512265

Cooke, A. (Ed) (2017) *Understanding Psychosis and Schizophrenia* (revised edition). Leicester: British Psychological Society. ISBN 978-1-85433-748-1

Cooke, A. (2015, October 28). 'I'd rather die than go back to hospital': Why we need a non-medical crisis house in every town. [Blog post]. Retrieved from: https://www.madinamerica.com/2015/10/id-rather-die-than-go-back-to-hospital-why-we-need-a-non-medical-crisis-house-in-every-town/.

Cooke, A. & Kinderman, P. (2018) "But what about real mental illnesses?" Alternatives to the disease model approach to 'schizophrenia'. Journal of Humanistic Psychology 58 (1), 47-71

Cooke, A., McNicholas, S. & Rose. (forthcoming) A. Women and Power: the Drayton Park Women's Crisis House. Commissioned chapter accepted for inclusion in Sidley, G. *Inside out – Outside in: alternatives to mainstream mental health services.* PCCS Books.

Cooke, A., Smythe, B. & Anscombe, P (forthcoming). Conflict, compromise and collusion: Dilemmas for psychosocially-oriented practitioners in the mental health system.

Cupitt, C. (2018). *CBT for Psychosis: Process-oriented therapies and the third wave.* London: Routledge.

Dillon, J., Johnstone, L., & Longden, E. (2012). Trauma, dissociation, attachment and neuroscience: A new paradigm for understanding severe mental distress. *Journal of Critical Psychology, Counselling and Psychotherapy*, 12(3), 145–155.

EmergingProud (2017). What's it all about? Retrieved 27 November 2018 from: https://emergingproud.com/whats-it-all-about/.

Geekie, J. & Read, J. (2008). Fragmentation, invalidation and spirituality: personal experiences of psychosis – ethical, research and clinical implications. In Gleeson, J., Killackey, E., & Krstev, H. (Eds.). *Psychotherapies for the Psychoses: theoretical, cultural and clinical integration*. Hove: Routledge.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory.* Chicago: Aldine.

Grof, S. (2012). *Healing our deepest wounds: The Holotropic Paradigm Shift.* Newcastle: Stream of Experience Productions.

Hartley, J. (2010). Mapping our madness : the hero's journey as a therapeutic approach. In I. Clarke (Ed.) Psychosis and spirituality Consolidating the New Paradigm (pp. 139-153). (2nd ed). Chichester: John Wiley & Sons.

Heriot-Maitland, C., Knight, M. and Peters, E. (2012). A qualitative comparison of psychotic-like phenomena in clinical and non-clinical populations. British Journal of Clinical Psychology. 51, 37-53. doi: 10.1111/j.2044-8260.2011.02011.x.

Jackson, M. (2010). The Paradigm-Shifting Hypothesis: A Common Process in Benign Psychosis and Psychotic Disorder. In I. Clarke (Ed.) *Psychosis and spirituality Consolidating the New Paradigm* (pp. 139-153). (2nd ed). Chichester: John Wiley & Sons.

Jackson, L. J., Hayward, M. & Cooke, A. (2011). Developing positive relationships with voices: a preliminary Grounded Theory. *International Journal of Social Psychiatry, 57* (5), 487-495. doi: 10.1177/0020764010368624.

Kiser, S. (2004). An existential case study of madness: encounters with divine affliction. *Journal of Humanistic Psychology, 44* (4), 431-454.

Lovatt, A., Mason, O., Brett, C., & Peters, E. (2010). Psychotic-Like Experiences, Appraisals, and Trauma. *Journal of Nervous and Mental Disease*, 198, 11, 813 - 819. DOI: 10.1097/NMD.0b013e3181f97c3dDOI: 10.1097/NMD.0b013e3181f97c3d

Mackler, D. (2011) (producer/director) Healing Homes: recovery from psychosis without medication (film). https://www.youtube.com/watch?v=JV4NTEp8S2Q&t=783s

Maisel, E. R. (2016, April 21). Catherine Lucas on the Spiritual Crisis Network: On the future of mental health. *PsychologyToday* [online]. Retrieved from: https://www.psychologytoday.com/blog/rethinking-mental-health/201604/catherine-lucas-the-spiritual-crisis-network.

Mason, O. & Claridge, G. (2016) Schizotypy: New Dimensions. London: Routledge

Morrison, A. P. (2001). The interpretation of intrusions in psychosis: an integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy, 29*, 257-276.

Morrison, A. P., Hutton, P., Shiers, D. & Turkington, D. (2012). Antipsychotics: is it time to introduce patient choice? *The British Journal of Psychiatry, 201,* (2), 83-84. https://doi.org/10.1192/bjp.bp.112.112110.

Mosher, L.R. (1999). Soteria and other alternatives to acute psychiatric hospitalization: a personal and professional review. *The Journal of Nervous and Mental Disease, 187*, 142-149.

Moynihan, P. J. (2014). Director Statement. *Healing Voices.* Retrieved from: https://healingvoicesmovie.com/director-statement/.

NICE (National Institute for Health and Care Excellence) (2014). *Psychosis and schizophrenia in adults: treatment and management. NICE clinical guidelines*. London: National Institute for Health and Care Excellence. www.nice.org.uk/nicemedia/live/14382/66534/66534.pdf

Razzaque, R. (2014). Breaking down is waking up: The connection between psychological distress and spiritual awakening. London: Watkins Publishing.

Razzaque, R. & Stockmann, T. (2016). An introduction to peer-supported open dialogue in mental healthcare. *BJPsych Advances, 22* (5), 348-356. doi: 10.1192/apt.bp.115.015230.

Read, J. (2017). Interview in 'Crazywise' film. Retrieved from: https://crazywisefilm.com.

Rolls, E. & Relf, M. (2006) Bracketing interviews: addressing methodological challenges in qualitative interviewing in bereavement and palliative care, *Mortality, 11,* 286-305. DOI: 10.1080/13576270600774893 .

Russo, J. & Sweeney, A. (2016). *Searching for a Rose Garden: challenging psychiatry, fostering mad studies: Challenging Psychiatry, fostering mad studies.* Monmouth: PCCS Books Ltd.

Seikkula, J. & Olson, M. (2016). Therapists' responses for enhancing change through dialogue: Dialogical investigations of change. In: Borcsa M., Rober P. (Eds.) *Research Perspectives in Couple Therapy.* Basel: Springer International Publishing Switzerland.

Steel, C. & Smith, B. (2013). CBT for Psychosis. In C. Steel (Ed*.) CBT for Schizophrenia: Evidence-Based Interventions and Future Directions*. John Wiley & Sons, Ltd, Oxford. doi: 10.1002/9781118330029.ch1

Unger, R. (2017, December 4). From "Recovery" to "Transformation and Recovery". *Mad in America Foundation.* Retrieved from: https://www.madinamerica.com/2017/12/from-recovery-to-transformation-and-recovery/.

Wagner, L.C. & King, M. (2005). Existential needs of people with psychotic disorders in Porto Alegre, Brazil. *British Journal of Psychiatry, 186*, 141-145.

Williams, P. (2012). *Rethinking Madness: Towards a Paradigm Shift in Our Understanding and Treatment of Psychosis*. San Francisco*:* Sky's Edge Publishing.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*, 215–228. doi: 10.1080/08870440008400302.

Table 1:

Details of Participants

Participant	Working Context	Years since qualification	Age band	Gender
P1	Assertive Outreach	2.5	26-35	F
P2	Early intervention in psychosis	11	46-55	F
P3	Acute Inpatient Unit	16	56-65	F
P4	Assertive Outreach	16	36-45	F
P5	Early intervention in psychosis	14	36-45	M
P6	Acute Inpatient Unit with community follow-up	1	26-35	M
P7	Assertive Outreach and Community Rehabilitation support team	10	36-45	M
P8	Early Psychosis: community teams and Acute Inpatient unit	14	36-45	M
P9	Early Intervention & Community Team	8	36-45	M
P10	Assertive Outreach with Psychosis, substance misuse, and personality disorder	7	36-45	M
P11	CMHT	36	56-65	M
P12	Assertive Outreach	12	36-45	F

Note: P= Participant; F=Female; M=Male

Table 2: **Clinical psychologists' beliefs about psychosis, effects on clinical practice and constraining factors**

Beliefs about psychosis in general

Spectrum of views: illness → continuum/trait → understandable → purposeful

Beliefs about transformative approaches to psychotic crisis

Broad vs. specific meanings of 'transformative': All crises have transformative potential and psychosis is no different *vs.* Psychosis is inherently purposeful

Distinguishing transformative crisis from other forms of psychosis: Long duration or high distress level is compatible *vs.* incompatible with a transformative approach

Utility of a transformative approach: Service users often find a transformative approach helpful

Aims and methods of therapeutic intervention

Sense-making/formulation: Making sense of experiences reduces anxiety and distress, and enables integration and choice

Differing approaches to validation: Normalising *vs*. actively valuing psychotic experiences

Engaging with the 'real' world is important

Reducing the negative impact of experiences and beliefs does not always involve challenging them

Positioning: Psychologists are experts *vs*. Psychologists should adopt a 'not knowing' approach

Factors constraining practice

Views about the clinical psychologist role: It is *vs*. It is not appropriate to discuss spiritual issues in therapy

Service context: Medicalised settings reduce opportunities for transformational approaches