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**"It's about having exposure to this": Investigating the training needs of therapists in
relation to the issue of anomalous experiences**

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Anomalous experiences (AEs) 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, 2012, p.107). Several different types of AEs have been reported in the literature, including synchronicity experiences, out-of-body experiences (OBEs), near-death experiences (NDEs), mystical or peak experiences, extrasensory perception (ESP), and contact with the deceased (see Appendix A for a list of AEs used in this research). Surveys have shown that the general population consistently report high levels of belief that such phenomena are real and frequently claim to have had personal experience of them (Cardeña, Lynn, & Krippner, 2014). For example, a UK poll with 1001 British adults found that 47% believed in life after death and 42% believed in telepathy, with similar figures reported in terms of direct experience with the paranormal, as 49% reported contact with ghosts and 41% said that they had experienced telepathy (Ipsos MORI, 2003). Likewise, a USA opinion poll, based on a sample of 1002 adults, found that three in four Americans believe in the paranormal (Moore, 2005).

In the therapeutic context, there have been a number of clients who have sought support for AEs, at least in specialist counselling services in Europe: mainly France, Holland, and Germany that have been set up specifically to support such issues (see Kramer, Bauer, & Hövelmann, 2012). At the Institut für Grenzgebiete der Psychologie und Psychohygiene (IGPP: Institute for Border Areas of Psychology and Mental Hygiene), for example, Belz and Fach (2012) recorded the types of AEs that clients sought support for between 1996 and 2006, and found that out of 1465 cases, 53% were related to poltergeist and apparition phenomena, 41% to be related to ESP, 38% to be associated with internal presence and influence (e.g., spirit possession), 15% to be associated with external presence and nightmares (e.g., sleep paralysis), 10% to be related to synchronicity experiences, and 7% to be associated with mediumship. However, recent research with clients who have disclosed

AEs in mainstream therapeutic contexts has found that they often do not feel listened to, accepted or understood (Roxburgh & Evenden, in press; Taylor, 2005).

In one of the few studies to investigate the experiences of health professionals, Corbeau (2004, as cited in Eybrechts & Gerding, 2012) found that out of a sample of 129 health professionals in the Netherlands, more than half reported to have been in contact with a client that had problems associated with spirit contact (59%), extrasensory perception (55%) or psychic healing (51%). Moreover, they also found that 83% of health professionals had not taken part in any courses about these topics and that 35% expressed a need for more training in this area. This is similar to research conducted on the prevalence and phenomenology of synchronicity experiences (SEs) in the therapeutic setting, which found that 44% of a sample of 226 therapists had experienced SEs in the therapeutic setting and that 67% felt that SEs could be useful for therapy, but that these experiences came as a shock to therapists and challenged their concept of reality (Roxburgh, Ridgway, & Roe, 2015; Roxburgh, Ridgway, & Roe, 2016). As such, there seems to be a need to provide accurate and reliable information about AEs for mental health professionals who might counsel clients who report such issues (and who might also have these experiences themselves).

Guidelines have been published on the topic of counselling individuals who have AEs (e.g., Grof & Grof, 1989; Hastings, 1983; Siegel, 1989), and these texts suggest that it is important to provide clients with sufficient information about the process they are going through, and to explain what is known about the phenomenon. However, to do this effectively, we would argue that there is a need for mental health professionals to be provided with accurate and balanced information about the nature and origins of AEs and their consequences for the experient, in addition to existing counselling skills. Indeed, some have proposed that there is a need for a new kind of professional that has training in counselling,

psychotherapy, clinical psychology, or psychiatry on the one hand, but also has knowledge of the theoretical and research material on AEs on the other (Ianuzzo, 2012).

Despite AEs appearing to be relatively common in the general population, and a proportion of individuals seeking support for such experiences, little is known about the training needs of therapists who may work with such clients. We therefore aimed to conduct focus groups with students undertaking counselling and clinical psychology programmes to investigate how useful they have found any training on working with clients who report AEs, and if this training has not been provided, whether there is a need for such provision.

Method

Design

A qualitative study consisting of two focus groups was designed to explore the training needs of students in relation to the issue of AEs. "Focus groups are a method where data are collected from *multiple* participants at the same time. They involve a relatively unstructured, but guided, discussion focused around a topic of interest" (Braun & Clarke, 2013, p. 108). They are particularly useful when investigating an under-researched area and with participants whose views about a topic or phenomenon are unknown (Frith, 2000).

In making a decision about what method of data analysis would be most appropriate for our aims, a range of qualitative approaches were considered. We felt that thematic analysis (Braun & Clarke, 2006) was the most suitable as it would enable us to establish if there were any commonalities in participants' data (i.e., whether there were any common themes when discussing their training needs). We ruled out other qualitative approaches such as discourse analysis, as it is more concerned with the role of language in the construction of social reality, and grounded theory as it is an approach that has more commonly been adopted in sociological research to establish theoretical insight (for an overview of qualitative research approaches see Willig & Stainton-Rogers, 2013).

Participants

For pragmatic reasons, we restricted our recruitment of participants to two professional bodies. We selected the British Association of Counselling and Psychotherapy (BACP) since both authors are BACP registered counsellors and are familiar with BACP accredited training programmes. We also selected clinical psychology training programmes accredited by the British Psychological Society (BPS) given that 'clinical parapsychology' is an emerging field intended to address the interface between anomalous experiences and mental health (for an overview see Kramer et al., 2012). We contacted 48 BACP accredited counselling programmes and 30 BPS accredited clinical psychology programmes in the UK by email, letter, and by telephone to ask if they would distribute information about the study to their students. In an attempt to facilitate participation, we stated that we would be able to visit the training providers and hold the focus groups at their place of training or reimburse students for their travelling costs and run focus groups in a private room at our university. We also offered to visit the training programmes and provide a talk about the research, but only one training programme responded to this. In addition, we posted a call for participants on the BACP research noticeboard, which is a free resource for members, but were unable to do so for the BPS¹. After posting a call for research participants on a social media site forum, two focus groups with counselling/psychotherapy students were organised which each had six participants ($N = 12$). The participants were fairly diverse in terms of age (ranged between 32 and 59 years), ethnicity (Mexican, Indian, Mixed Race, British), spiritual/religious orientation (Catholic, Hindu, Agnostic, Christian), but not gender (one male, 11 females) which perhaps reflects the gender imbalance inherent within the therapy professions.

¹ The Division of Clinical Psychology informed us that they could not send out our request for research participants on the Pre-Qualification Group announcement list because they do not circulate individual research requests in line with the DCP's email announcement list policy. We were also unable to post on the discussion forum of the DCP website as neither author is a member of this division. We could have posted a notice in *The Psychologist* to recruit participants but this incurs a charge and no funds were available to do so.

Data collection

Two focus groups were facilitated by both of the authors (i.e. both authors were present at each focus group) who have experience of moderating groups and interviewing, and were held in rooms available at the participants' place of study. They were organised on a date that coincided with students' teaching and were approximately one hour in duration. A non-directive approach was taken by the facilitators and we tried to ensure that all members of the group had an opportunity to contribute to the discussion (Stewart, Shamdasani, & Rook, 2007). The focus group schedule included the following topics:

1. Whether they had taken part in any training on AEs as part of their programme and how they found this
2. How well equipped they felt with regards to working with clients reporting AEs
3. What information, if any, they would like to see included in training
4. If they had any clients who had reported AEs, how did they address this in therapy
5. How easily they felt clients were able to disclose AEs
6. How they would feel about disclosing their own AEs to clients

Participants were asked to ensure that the focus group discussion remained confidential and to respect any diverse opinions within the group.

Data analysis

With the participants' permission, the focus groups were recorded, transcribed, and analysed using inductive thematic analysis (Braun & Clarke, 2006). Transcripts were read multiple times by both authors until familiarity with the content was achieved. Any interesting observations about the narrative, in relation to the implications for therapists and their training needs, 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

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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.

Ethics

Ethical approval was obtained by the Social Sciences Ethics Committee at the University of Northampton. Participants were provided with participant information sheets and asked to sign a consent form to take part in the research. They were assured that participation would remain anonymous but that selected quotes from the focus group discussion may be used in the write-up and presentation of findings. If there was anything that they said in the focus group that they did not want to be used or shown to other people, they were asked to notify us within one month of taking part in the study.

Reflexive statement

Both authors are academics as well as BACP registered counsellors. 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 also teach on counselling programmes and feel it is important that students are aware of how they might respond to the range of AEs that could be reported in therapy. 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. It is possible that the participants' knowledge of us being tutors on similar programmes to the ones they were training in at the time could have influenced how they responded. This could have been a drawback in terms of participants not wanting to disclose information about their training programme and being concerned about how we might perceive them or a facilitator in terms of participants being reassured that we had gone through similar training and were aware of the importance of confidentiality and group dynamics. On reflection we believe we

developed a good rapport with participants at the time and they appeared to share their thoughts and feelings freely and openly.

Findings

Thematic analysis elicited four themes:

1. "Quite often we get taken by surprise because it's a subject we don't talk about"
2. "It's just having this in our vocabulary"
3. "Demystifying and valuing AEs as normal human experiences"
4. "To ask or not to ask?"

Prototypical statements from the focus group transcripts are used to reflect themes.

Theme 1: "Quite often we get taken by surprise because it's a subject we don't talk about".

The majority of participants said that they felt unequipped to work with clients who report AEs and that this was because they had not talked about AEs in training or supervision. However, most of the participants in one focus group said that they would try to still work with clients in a person-centred way despite not having any specific training on their programme. Some participants had worked with clients who had reported AEs and those participants said that the experience had taken them by surprise when their client had shared it with them. One participant revealed that she felt scared when her client reported an AE as it came as quite a shock to her.

I've got a 17-year-old client and his father passed away four months previous[ly] and he's been describing poltergeist activity and the unusual death related experiences on your list. And I must admit it did throw me a bit.

Another participant reflected on how common it was for therapists in a bereavement counselling service to see clients who had sensed the presence of the deceased, and that this

was normalised in training, but acknowledged that in another setting it might be more of a shock to therapists.

When you're sitting with a bereavement client, you're kind of prepared for it, where I suppose if you're in a placement and someone comes in and they bring in some kind of supernatural experience, there's that moment of not feeling prepared.

Theme 2: "It's just having this in our vocabulary".

When discussing what they felt would be useful in training, all participants agreed that it would be helpful if AEs were normalised in training and that being introduced to the topic would help them to feel better prepared for working with clients who have experienced AEs and want to talk about them in therapy. They stated that they found the focus group useful and that this could be extended to a group discussion and/or a forum as just talking about AEs whilst in training would help. They also said that they found the list of AEs helpful (included here as an Appendix) as it introduced them to experiences that they had not heard about before. Other suggestions that participants made included discussing case studies and doing an independent learning group session on AEs that would involve a small group of students investigating a topic or particular AE, developing a portfolio containing relevant articles and information, and then presenting findings to the larger group. They also felt it would be useful if they were introduced to spiritual/religious and cultural belief systems, since without that context some experiences may be seen as 'bizarre' (one participant gave the example of glossolalia) or misinterpreted. The following statement from one participant exemplifies the theme:

Perhaps exploring what these things are, possibly giving some case study examples so that it puts it in that counselling scenario, of what somebody brings. And I think it's just that kind of being familiar enough with it that I suppose if

we're in a counselling session, we're not going to be thrown. I mean we're prepared for, like, suicide and we're prepared for a lot of these other things but how prepared are we if somebody starts to tell us about some of the things on this list, to be accepting and to not feel shock or to be scared even. Oh God, they're talking about this, you know, where's the door? So take the fear out of them I think and maybe an opportunity to share some of our own experiences, I think that can be quite valuable as well.

Theme 3: "Demystifying and valuing AEs as normal human experiences".

Participants felt that it was important to value the individual's experience and to acknowledge that AEs are real for the client. As one participant stated:

It's about valuing the person's experience, so when I've experienced some of these in my life, are they, they've been embarrassing to share or they've been dismissed so it's about valuing them, because they're real for the person.

They also said that AEs needed to be demystified so that they were seen as normal human experiences rather than being automatically perceived as symptoms of a 'mental disorder':

I think it's also about demystifying...making it part of normal experience, not seeing it as being something that is alien and that it, if our client brings it, it's abnormal, or if we experience it, it's abnormal, so it's that kind of, putting it in there with other human experiences that can come upon us at life, in life, because a lot of these are very positive...So for example, the one that's, where is it now? Peak experiences, we might think somebody's high, we might think they're in a manic phase, you know, because they're unusually euphoric.

There was also a discussion about differential diagnosis as one participant said "it is difficult to draw the line of when it becomes a mental health issue or a psychosis".

However, the majority of participants felt that what was relevant was the level of distress experienced by clients and any associated risks rather than necessarily making a distinction between what is 'abnormal' or 'normal'. As one participant stated in reference to a client who had sensed the presence of the deceased after bereavement:

He's only 17, some might say this is him hallucinating. Personally I didn't think it was, he seemed quite comfortable with it, he wasn't distressed by his experiences, he was getting a lot of comfort from it.

Theme 4: "To ask or not to ask?"

There were mixed views amongst the participants in terms of whether AEs should be enquired about at the assessment stage. Some participants felt that it was best to wait and ask about such experiences after the therapeutic relationship had been established, as they felt it would take a lot of trust to discuss such issues at the assessment stage. As one participant stated:

I think it takes a lot of trust to bring it out, maybe it's almost best left to the counselling room rather than in assessment because I'm not sure, once they've said 'no' in a perhaps not very safe environment of doing the assessment, would they then feel they want to go back and change their answer.

However, other participants pointed out that therapists ask about other sensitive issues, such as abuse and suicide, at the assessment stage, and felt that it could be normalising for clients if they were asked about AEs as part of a routine question as it showed clients that we are accepting of all their issues. This is exemplified by the following participant extracts:

If you ask that at assessment, it might allow the client to think "that was asked of me, dare I?" It just sort of, it allows them to be a bit braver doesn't it?
Yeah, and they would potentially know that that's just some routine question, which gives it that feeling of it being usual.

Participants added that they would prefer to use the term 'unusual experiences' (although they acknowledged that some AEs could be common) as they found the term 'anomalous' to be a bit daunting.

Discussion

Most of the participants that took part in the focus groups felt that they were unequipped to work with clients who reported AEs and stated that they had not received any training on these issues. This finding is similar to previous research undertaken in the Netherlands which also found that health professionals had not taken part in any training on the topic of AEs (Corbeau, 2004, as cited in Eybrechts & Gerding, 2012). This is perhaps not that surprising given that the topic of spirituality, which could be considered as integral to some AEs, particularly spiritual crisis, mediumship, NDEs, and reincarnation, is rarely discussed in the UK training context (Crossley & Salter, 2005); though research suggests that this may be changing in the US (Brawar, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002).

Participants said that they were taken by surprise when they had worked with a client who had disclosed AEs, and some mentioned feeling scared and fearful. This finding could have an impact on the therapeutic process in terms of disorienting the therapist, and future research may find it fruitful to explore the implications of this, for both therapist and client. We know relatively little, for example, about the effect that working with AEs might have on the therapist in terms of somatic resonance, countertransference, and vicarious trauma. Likewise, given that some research has shown a link between AEs and other issues such as abuse, trauma, and dissociation (for an overview see Dein, 2012), it is crucial that therapists feel able to explore the meaning of these experiences with clients to help them to make sense of their experiences and to identify any precipitating factors that might be involved. It is also important for therapists to be aware that for some individuals AEs can be comforting, life-enhancing, and adaptive, and can contribute to better psychological wellbeing (e.g., Braud,

2012; Grof & Grof, 1989; Kennedy & Kanthamani, 1995; Roxburgh & Roe, 2011; Wilde & Murray, 2009).

Participants also said that the shock they felt upon hearing clients report AEs depended on the context in which AEs were shared by clients as they believed that some counselling settings better prepared therapists for managing particular types of AEs; for example, bereavement work normalising client's experiences of sensing the presence of the deceased. This may be a consequence of research having an influence on practice as a recent narrative review showed that bereaved people often sense the presence of the deceased and that this can be a natural and adaptive part of the grief process (Keen, Murray, & Payne, 2013). Nevertheless, participants also felt that they should be introduced to AEs whilst training so that they would be better prepared to work with such issues in generic settings, and that this could include relatively straightforward activities such as group discussions, case studies, having a list of AEs, and independent learning group tasks. Based on these findings we recommend that training providers consider incorporating some of these activities into their teaching but also that organisations responsible for the dissemination of information on therapeutic practice could include information on their websites; for example, the BACP currently has an information sheet on working with spirituality and a similar resource could be designed for AEs². Likewise, it is anticipated that the emerging field of clinical parapsychology (see Kramer et al., 2012) will contribute to more reliable and accurate information on AEs for members of the general public and mental health professionals.

Another finding that arose from the focus group discussions was that participants questioned whether they needed to be able to distinguish between what was considered pathological and a mental illness and what was considered a normal human experience. This

² The authors would be happy to design such a resource in collaboration with the BACP.

finding draws attention to current debates within mental health, particularly in relation to psychosis, in terms of the validity, reliability and utility of making such an either/or distinction about individuals' experiences and mental health by use of psychiatric diagnoses that adopt a medical model (Boyle, 2007; Cooke, 2014). Some participants reflected on the importance of considering the clients level of psychological distress and any associated risks, rather than the necessity of making such a distinction between what is 'normal' and 'abnormal'. This corresponds with the 'continuum model' of mental health which argues that individuals vary along a scale of poor mental health and good mental health, and that this can depend on various personal and external factors. In terms of AEs, for example, recent research has shown 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, perceived levels of social support, and whether or not there are opportunities to reduce stigma in a context that normalises and validates the experience (Brett, Heriot-Maitland, McGuire, & Peters, 2014; Heriot-Maitland, Knight, & Peters, 2012; Roxburgh & Roe, 2014; Taylor & Murray, 2012).

Participants were divided in terms of whether AEs should be enquired about at the assessment stage, with some feeling that such issues would be better discussed when a therapeutic relationship had been established, and others reflecting on how normalising it could be for clients to be invited to talk about such issues with what could be conveyed as a routine assessment question. Similar considerations were highlighted by participants in Crossley and Salter's (2005) study exploring the experience of addressing spiritual beliefs in therapy as some participants said that they routinely enquired about spiritual beliefs, whereas others said that they waited for the client to initiate discussion. Clearly, more research is needed in this area in terms of the potential benefits or drawbacks of the therapist directly enquiring about AEs at the assessment stage or within the therapeutic session.

One of the challenges of this research was arranging focus groups with students. Although we tried to emphasise the benefits of taking part in the research in our recruitment documentation, which included gaining insights into how to support clients who have AEs and the potential to improve training courses, we speculate that some of the challenges we faced might have been the result of students' training commitments or the subject matter of the research not being seen as relevant. Widdowson (2012) found that trainee therapists are reluctant to utilise or participate in research due to competing demands on their time as well as perceptions that psychotherapy research is not relevant to clinical practice. It should also be pointed out that we had better success recruiting participants for the focus groups via social networking sites than via training organisations and therefore counselling/psychotherapy researchers might want to consider this as a valuable strategy when designing future studies. We were disappointed that so few training organisers accepted our offer of presenting a short talk on the research, which may have helped recruitment, though as both authors are lecturers on counselling programmes we can appreciate the time restraints involved in fitting this into a busy schedule. In terms of the implications for future counselling/psychotherapy research, we propose that training providers consider a participant pool attached to courses for students to take part in approved research related to counselling/psychotherapy. This would be an opportunity for students to gain experience of taking part in research which may, in turn, increase their interest in research and enhance their personal and professional development.

In terms of the limitations of this research, we note that the sample was restricted to counselling/psychotherapy trainees and that future research could also be conducted with trainees enrolled on other courses, for example, counselling or health psychology programmes (accredited by the BPS), psychotherapy programmes (accredited by the UKCP) or medical training programmes to see whether there are any similarities or differences in

findings. Likewise, results may have been different if the sample had consisted of qualified therapists rather than trainees as it is possible that therapists might feel more confident working with AEs the more experienced they are. However, previous research conducted by the authors with therapists who had been practising for between 4 and 27 years still felt it would be useful to have accurate and reliable information about AEs and for trainees to be introduced to the topic whilst training (Roxburgh & Evenden, 2016).

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Appendices

Appendix A. List of AEs used in the research

- 1. Psychic experiences** are those in which we learn about or influence the world through means other than the conventionally recognised senses (e.g., extrasensory perception/ESP, mind over matter)
- 2. Mystical experiences** are those in which there is a strong sense of greater connection, sometimes amounting to union, with the divine, other people, other life forms, objects, surroundings, or the universe itself. Often, this is accompanied by a sense of ecstasy.
- 3. Peak experiences** are moments when people experience, more closely than usual, all that one can be. One may feel in the flow of things, self-fulfilled, engaged in optimal functioning, and filled with highest happiness. They may be triggered by art, sport, music, the natural world, tragedy or noble acts.

4. Out of body experiences (OBEs) involve a sensation of being outside one's body and, in some cases, perceiving the physical body from a place outside the body.

5. Hauntings are characterized by subjective visions ('ghosts') and sometimes noises in a particular location.

6. Poltergeist activity is usually associated with a person rather than a place and involves phenomena, such as destruction/relocation of furniture, levitation of cutlery, knocking on doors, unusual noises.

7. Experiences of unusual healing include instances of recovery, cure, or enhancement of physical, psychological, or spiritual well-being beyond what is usually experienced or expected on the basis of conventional medical or psychological knowledge (e.g., psychic healing or distant healing).

8. Encounter experiences are those in which the person is confronted with something that is actually there but is awesome and wondrous (e.g. a glorious mountain peak) or something that is not supposed to be there (e.g., UFOs, angels, mythical beings, spirit guides).

9. Reincarnation/past life experiences include the belief that the soul or spirit has been reborn into another body.

10. Therianthropy is the belief that one can transform into an animal and often involves experiencing phantom limbs (feeling as though a body part is missing) or mental shifts (altered state of consciousness).

11. Synchronicity experiences are defined as meaningful coincidences between an inner event (e.g., thought, vision, dream) and one or more external events occurring at the same time. For example, thinking about someone and that person then phoning you to tell you something important.

12. Spiritual crisis often occurs after a spiritual experience or after intense spiritual practice (e.g., meditation, Yoga) and can cause the person to question their beliefs, values, and meaning system.

13. Alien abduction involves memories of being taken by apparently nonhuman entities and subjected to physical and/or psychological procedures.

14. Near death experiences (NDEs) typically occur to individuals close to death or in dangerous situations and often involve sensations of detachment from the body, feelings of levitation, and the presence of a light.

15. Unusual death related experiences include strange experiences associated with the moment of death, such as clocks stopping, mediumship, apparitions of the deceased, feeling a sense of presence, and communication with the deceased.