Spiritual understandings of psychosis

Al taher, Reham; Fox, Andrew; Wilson, Carol

DOI:
10.1080/19349637.2023.2239799

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (Harvard):
Al taher, R, Fox, A & Wilson, C 2023, 'Spiritual understandings of psychosis: the perspectives of spiritual care staff', *Journal of Spirituality in Mental Health*. https://doi.org/10.1080/19349637.2023.2239799

Routledge
Taylor & Francis Group

Journal of Spirituality in Mental Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/wspi20

Spiritual understandings of psychosis: the perspectives of spiritual care staff

Reham Al Taher, Andrew Fox & Carol Wilson

To cite this article: Reham Al Taher, Andrew Fox & Carol Wilson (02 Aug 2023): Spiritual understandings of psychosis: the perspectives of spiritual care staff, Journal of Spirituality in Mental Health, DOI: 10.1080/19349637.2023.2239799

To link to this article: https://doi.org/10.1080/19349637.2023.2239799

Published online: 02 Aug 2023.

JOURNAL OF SPIRITUALITY IN MENTAL HEALTH
https://doi.org/10.1080/19349637.2023.2239799

Routledge
Taylor & Francis Group

Spiritual understandings of psychosis: the perspectives of spiritual care staff

Reham Al Taher[a], Andrew Fox[a,b], and Carol Wilson[b]

[a]Centre for Applied Psychology, School of Psychology, University of Birmingham, Birmingham, UK; [b]Psychological services, Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, UK

ABSTRACT

Pathologizing spiritual beliefs has been an ongoing challenge in mental health services. Spiritual care services have been working alongside clinicians in discerning psychosis-like experiences that present with a spiritual or religious content. This study aimed to explore how spiritual care staff make sense of experiences otherwise termed as "psychosis" by interviewing a multi-faith sample of six participants using Interpretative Phenomenological Analysis (IPA). Participants acknowledged "psychosis" as a label applied to certain experiences that are spiritual in nature, emphasizing holisticism. Mental health services were described as predominantly biomedical and that spiritual care integration requires conceptual, collaborative, and practical considerations.

KEYWORDS

Psychosis; spirituality; chaplaincy; IPA; spiritual care; voice-hearing; qualitative

Introduction

Within UK mental health services, attempts from service users to understand and articulate experiences of psychosis in ways that deviate from conventional biomedical diagnostic categories can be viewed as a lack of insight (Caspi et al., 2020; Marriott, Thompson, Cockshutt, & Rowse, 2018). However, there is increasing recognition of the importance of approaches that accommodate both service-users' needs and their personal meaning-making as part of their care (Atapattu, Gonzales, & Williams, 2022; Boardman & Shepherd, 2012; Jacob, 2015; Lysaker, Yanos, & Roe, 2009; Noiseux et al., 2009; Skar-Fröding et al., 2021; Tranulis, Freudenreich, & Park, 2009). The UK's government strategy "No health without mental health" (2011) called for healthcare practitioners to focus less on psychotic symptom reduction and more on recovery-oriented approaches that integrate service-users' relationships, education, and "purpose". Given reports of "spirituality" being missing from services, one such integration has been the inclusion of spiritual care services (Milner,

CONTACT Reham Al Taher reham.altaher@nhs.net Centre for Applied Psychology, School of Psychology, University of Birmingham, Birmingham, UK

Crawford, Edgley, Hare-Duke, & Slade, 2019; Raffay, Wood, & Todd, 2016; Saleem, Treasaden, & Puri, 2012).

Spirituality, psychosis, and spiritual care services

Spirituality can be generally understood to mean personal practices that increase one's sense of meaning, connection, and purpose (Gilbert & Parkes, 2011; Milner, Crawford, Edgley, Hare-Duke, & Slade, 2019). If people describe a religious or spiritual aspect to their experience of psychosis, many prefer to seek help from faith healers before mental health services (Dein, Cook, & Koenig, 2012; Islam, Rabiee, & Singh, 2015; Suhail & Ghauri, 2010). This has led to a growing call for integrating spiritual care services into mental health services (Friedli, 2000; Leavey, 2010; Ministry of Housing, Communities, and Local Government, 2018; Wood & Alsawy, 2017).

Currently, spiritual and pastoral care services within mental health services are often comprised of staff who integrate spirituality and/or religion into care with an aim to enhance overall wellbeing (Koenig, 2014). Evidence suggests that service-users have found such integration beneficial to their recovery (Koslander & Arvidsson, 2007; Rashid, Copello, & Birchwood, 2012). However, although Raffay, Wood, and Todd (2016) found that participants in the UK expressed benefit from chaplaincy involvement, they also noted that spiritual care services were not widely used as part of patient care. Indeed, healthcare providers have expressed a lack of confidence in the ability to integrate spiritual aspects into care (Milner, Crawford, Edgley, Hare-Duke, & Slade, 2019). This disparity has been referred to as the "religiosity gap" in mental health services (Van Nieuw Amerongen-Meeuse, Schaap-Jonker, Schuhmann, Anbeek, & Braam, 2018).

Rationale and aims

Where spiritual care services are being included in multidisciplinary mental health teams, there is an opportunity to develop our knowledge around how staff in spiritual services understand and work with people experiencing psychosis. Therefore, this study aimed to explore the following question:

How do spiritual care staff understand their work with service-users who experience "psychosis[1]"?

Materials and methods

Epistemological and spiritual position

The author of this study adopted a critical realist stance. This stance acknowledges that not everyone that experiences or works with psychosis makes sense

of it in the same way (Cooke, 2020). It also acknowledges that statements about either psychosis or working with psychosis is based on perspectives in a socially constructed world. As such, statements by participants will be treated as perspectives rather than objective facts.

For this study, the authors took an *agnostic* position regarding the causes of psychosis in order to bracket their own beliefs, biases, and attitudes to ensure participants' perspectives are conveyed in a conscientious and thorough manner.

Ethical approval

The study complied with all necessary ethical and regulatory frameworks (Ethical approval number: ERN_20-1260S). It received ethical approval from the University of Birmingham and was organized through the National Health Service's (NHS) Health Research Authority (HRA), as participants were staff working in the NHS.

Design

The method of this study was qualitative, and data collection involved a semi-structured interview and discussion of three case vignettes. These methods were chosen to facilitate a detailed, explorative interview, with case vignettes

Table 1. Interview questions and topic guides.

Topic	Questions
Participant's experiences of providing spiritual consultancy within a mental health framework	Could you give me a brief description of how you got involved in spiritual work? Could you describe what usually happens in chaplain services, in your own words? What do you do as a [faith leader]? How do you feel when you are guiding someone on spiritual concerns? *(emotionally, physically, mentally)* What do you think about experiences that are difficult to explain in other kinds of ways, such as in science? If you had to describe what spirituality means to you, what words/images come to mind?
Participants views on psychosis and current psychosis interventions	What does the term "psychosis" mean to you? What do you think about the current way people with psychosis receive treatment? How have your experiences been in helping to manage people that have these experiences? What do you think is most important for recovery in psychosis?
After the participant has read each case vignette	How would you describe, in your own words, what is happening with this person? How would you explain the causes of this? How would you decide what to do with this person to help them through these difficulties? How would you offer your support? What do you know about experiences similar to this? What do you think the professionals in this case should do now?

used to explore the ways spiritual care staff made sense of psychotic experiences. The semi-structured interview consisted of pre-written interview questions and topic guides (Table 1). The case vignettes were developed by the researchers to reflect some of the common psychospiritual themes that can present in such services.

Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) was chosen for the study as its dynamic processes allow for detailed explorations of potentially complex or ambiguous topics, like spirituality, whilst also examining meaning-making and subjective experiences, namely spiritual care, mental health services, and psychosis (Smith & Osborn, 2014). Also, IPA's commitment to an idiographic approach to analysis facilitated the use of a multi-faith sample, which was favorable given most empirical studies on spirituality have been on single-faith samples (Weber & Pargament, 2014).

Setting

Interviews took place online using a secure video-conferencing software.

Participants

Recruitment

To have a balance between detailed description of experience with comparison across cases, a sample of four to 10 participants was aimed for (Smith, 2004).

Recruitment took place between February and March 2022. A non-randomized convenience sampling method was employed: an e-mail consisting of a brief outline of the research aims, participant information sheet, participant consent sheet, and contact details of the researcher was emailed

Table 2. Inclusion and exclusion criteria.

Inclusion Criteria	Exclusion criteria	Rationale
Faith leaders, spiritual practitioners, chaplains	Spiritual/faith practitioners and chaplains in training	The study aimed to find participants that have already had experiences and perspectives working with psychosis.
Over the age of 18	Under the age of 18	The study aimed to recruit people employed as spiritual care staff (i.e., will be working age).
Based in the UK	Not based in the UK	The study was interested in exploring working with psychosis in a UK mental health service.
Access to the internet	No access to the internet	Data collection was conducted entirely online.
Fluent in English	Requires an interpreter	Due to the limitations of research sponsorship for this study, there were no resources available to support the recruitment of an individual who did not speak fluent English.
Voluntary participation	Practitioners that charged fees for spiritual/faith/religious consultancy	The study did not provide monetary or otherwise benefits for participating.

to a Spiritual Care team within in a UK mental health service. Interested potential participants contacted the researcher to discuss an invitation to interview. Participants met the inclusion criteria in Table 2.

Sample

Eight potential participants emailed the researcher expressing their interest. Six were included in this study, while two dropped out at recruitment (i.e., did not respond to follow up contact). Those who went on to participate in the study (the sample) were all employed NHS Chaplains who were also faith leaders, representative of different polytheistic and monotheistic beliefs, with two females and four male participants. The age range was 42–68 years.

Data collection method

Procedure

Participants met the researcher on a secure video-conferencing software and the interview was audio-recorded and transcribed for analysis. Principles of continuous consent were used throughout.

Data analysis

The first part of the analysis consisted of gathering how participants understood their work with people experiencing psychosis, identifying the phenomenological concerns of the participants and their claims about it. This was done to produce an informed description that was as "close to the participants' view as possible" (Larkin, Watts, & Clifton, 2006). The second part consisted of developing a more interpretive analysis by relating this informed description to a wider, social, and/or cultural context. This helped provide more conceptual understandings of how participants make sense of and work with psychosis-like experiences (Smith, Flowers, & Larkin, 2009).

The table below illustrates the step-by-step process of how IPA was used for this study. An example of one of the participant's ("Wilma") is demonstrated to further highlight the process.

Reflexivity and monitoring quality in the analysis

To monitor research quality for IPA, the researcher followed the guidance of Nizza, Farr, and Smith (2021), using four "quality indicators" for IPA studies: adherence to IPA principles, transparency, coherence, and richness. This was applied to each theme, sub-theme, quotes used, and any analytic commentary by the researcher. The table below illustrates this process in Table 3 and Table 4.

Table 3. The steps taken to carry out an IPA analysis.

IPA Steps	Rationale (in accordance with Smith, Flowers, & Larkin, 2009)	An example: "Wilma"
Reading and re-reading	Each transcript to be read several times to begin the process of understanding participant narratives	Interview was re-read throughout the transcribing process. Once completed, it was continuously re-read over several days to immerse the researcher into the data.
Initial noting	Each transcript to be explored in-depth: the semantic content, language, contents, and concepts used	The author generated a three-column table: "Interpreted themes," "Original Transcript," and "Exploratory comments." Under "Exploratory comments" the researcher explored the content, language, metaphors, and concepts used in transcript "Wilma," as well as her own reflections.
Developing emerging themes	To begin generating interpreted themes for each transcription that reflect individual participant narratives and the researcher's interpretations	Using the same three-column table, under "Interpreted themes" the author wrote down the interpreted themes of "Wilma" line-by-line, which was also guided by the notations made under "Exploratory comments."
Searching for connections across emergent themes	To generate interpreted themes across transcriptions that reflect both individual and collective participant narratives, as well as the researcher's interpretations	"Interpreted themes" of each transcript were compared and explored both to gain an overall descriptive summary of participants' narratives, as well as to make interpretations of participants experiences, narratives and reflections.
Identifying quotes to illustrate themes	To make clear connections between each theme and participant.	Quotes from transcripts were printed out and physically charted until we reached clear interpreted themes with distinct voices

Alongside this, the researcher kept a reflective diary, as well as reviewed the quality, rigor, transparency, and trustworthiness of her findings with both her supervisor and a qualitative analysis support group, which consisted of doctoral trainees and qualified research supervisors.

Results

Table 5 consists of the three case vignettes that were provided to each participant. These are referenced throughout the findings.

Table 6 provides a summary and overview of the findings. Each subtheme is discussed within the broader theme and the participants that contributed to each subtheme is made clear and distinct. This was part of developing an understanding of how participants conceptualized and understood their work with people with "psychosis."

Theme I: spirituality transcends and connects the individual

All participants acknowledged "psychosis" as a label applied to certain experiences that can occur within a wider context of spirituality. As such, participants understood psychosis as a spiritual experience where people

Table 4. Quality indicators as guided by Nizza, Farr, and Smith (2021)..

Quality Indicators	Rationale (as provided by Nizza, Farr, & Smith, 2021)	How this was applied to this study
Constructing a compelling and unfolding narrative	Findings should convey a "narrative" that is not only coherent to the analysis but expresses the hermeneutic circle that links to how the researcher understood the findings as a whole.	Each quote was used to contribute to the narrative of the overall findings. Analytic commentary by the researcher about these quotes were aimed to not only add to data richness, but be interconnected, accessible, and easy to follow.
Developing a vigorous experiential and/or existential account	The quality of the analysis is increased depending on the depth and insight it can offer, which is the primary of aim of phenomenological inquiry in exploring lived experiences.	Data was explored in-depth: what "psychosis" means to participants, how participants work with it, where experiences differ and/or complement the other, and how the findings generate reflective activity by participants.
Close analytic reading of participant's words	IPA follows Heidegger's (1962) hermeneutic phenomenology, which considers phenomenological enquiry as inherently interpretive. This makes IPA a double hermeneutic challenge: participants make their own interpretations and meanings of their world, and the researcher interprets their interpretations (Smith & Osborn, 2008).	Ensured steps in Table 8 were followed so data could be grounded in its trustworthiness, used a reflective diary, and reviewed the quality, rigor, transparency, and trustworthiness of the researcher's findings with both her supervisor and a qualitative analysis support group.
Attending to convergence and divergence	IPA aims for an idiographic analysis where each case is examined on an individual and detailed level. Therefore, small purposeful samples are valued.	The sample used was accessed purposefully to ensure participants were able to engage fully with the interview and case vignettes as part of illuminating their experiential world and associated sense-making. Each case was compared to identify similarities and differences with particular attention paid to nuanced interconnections between and across experiences.

are often trying to make sense of what is happening to them and around them.

This was not to be confused with religion; participants stated that religion is a part of spirituality but contains specific "practices and rituals" (Kareem; p.6, line 254). Spirituality on the other hand is a "generality" (Mick; line 38) that can accommodate various experiences and beliefs, like psychosis. Due to spirituality's broad definition, "lots of people can fall into [this] category" (Mick; line 173/4), which can make it difficult to discern psychosis-like experiences from others. Jason, however, argued that this is precisely why this framework is important, as it can yield a more thorough understanding of how experiences can be affecting several areas of a person's life:

> *"Because my experiences is that sometimes people who are deemed to have experienced psychosis, that can be an aspect of what of what they are experiencing that that is mental. But that can be an aspect that is tied up in their spirituality . . . .I think the danger is, is that the spiritual aspects, just gets missed, because . . . sometimes, medical practitioners don't*

Table 5. Case vignettes that were presented to participants.

Name	Vignettes
Hannah (Vignette A)	Hannah is a 31-year-old woman who works as an Accountant part-time. For the last 2 weeks she has not been coming into work. A few months ago, she was talking to her husband about seeing faces and shadows on the walls and hearing someone whisper her name. She once tried to record it on her phone but found she could not and told her husband she was afraid of "going mad." Hannah told her husband she did not know what this was and felt afraid. Since quitting her job, Hannah has grown more aloof and detached, often avoiding talking to her family. Her husband stated that she can also suddenly become argumentative and aggressive for no apparent reason. Sometimes her husband hears her talking to herself when nobody is around. She has also been refusing to eat and has explained that she suspects the neighbors are poisoning her food. When speaking with Hannah, she says that she thinks someone – possibly the neighbors – has "cursed" her and she is now being "tormented" by evil spirits. Hannah does not feel much hope about her future and believes she must have done something wrong in order for her neighbors to have cursed her. She has had some suicidal thoughts but has never tried to harm herself. Hannah is attending spiritual care as she would like help to remove the curse.
Nadeen (Vignette B)	Nadeen is a 25-year-old teacher who was very close to her father before he passed away from a terminal illness with a life expectancy of just a few short months. Before her father passed, he told her that they would remain in contact after death. According to Nadeen's husband, she went through a complicated mourning period when her father died, as she first was completely devastated before becoming more cheerful and more interested in returning back to work about 6 months later. Curious about the dramatic shift, her husband began observing her around the house and noticed that she was talking to herself in their bedroom at least once a day for an hour each time. When he asked who she was talking to, she told him that her father likes to visit her once a day to see how she is doing. Aside from that, he has not noticed any deterioration in her mental health or her personality worthy of note, but he has asked her to visit a service to talk about this. She told him that talking to her father makes her happy and keeps her life normal and balanced. They both disagree about the source of this experience and it is causing frequent arguments between them. Nadeen has attended spiritual care as she wants her husband to understand that she finds the visits from her father's spirit comforting, and she is happy that these continue for as long as her father wishes to visit.
Jimmy (Vignette C)	Jimmy is a 28-year-old Master's student who was diagnosed with schizoaffective disorder when he was 25 years old after hearing voices that told him he was evil and was going to suffer, as well as believing that he is being used as a vessel by a demon to purge the world of evil. Terrified, Jimmy joined a spiritual/religious support group and spent most of his savings with the religious group in an effort to manage the unpleasant experiences. However, Jimmy's thoughts grew worse, so he eventually sought psychiatric support, following which he was he was diagnosed and started on treatment for psychosis. Since then, Jimmy has stopped believing in any higher power and said he feels bittersweet about the entire experience and diagnosis. He now feels he can attribute all of these experiences to the diagnosis and can orient himself better to reality. However, his medication needs to be changed and Jimmy is worried that the voices may return to try to convince him that they are "real." Jimmy is visiting spiritual care to see if they can offer any help with these worries and stop him "slipping back."

understand how deeply embedded people's spiritual thought and spiritual framework is within their whole being" (line 208–213)

Here we see Jason describe potential pitfalls that may occur if psychosis-like experiences are only made sense of through discrete frameworks (e.g., medical), divorced from other ways of making sense of these.

Psychosis is seen as intertwining and it is why participants like Jason disagree with notions that "divide" (line 356) psychosis from the mental, physical, and spiritual experiences when "the truth is we are one entity, and those things are intertwined" (line 358). Participants described how psychosis is connected and functions as a part of spirituality. Wilma, for example, drew a direct relationship between psychosis, subjective experiences, and

Table 6. Summary table of themes.

Theme	Subtheme	Participants contributing
7.1 Spirituality transcends and connects the individual	*We are one entity, and things are intertwined*	*Jason, Wilma*
	Science as a part of spirituality	*Kareem*
	The negative aspects of spiritual experiences	*Mick, Nadiyah, Jason*
7.2 Locating "psychosis" within a wider context beyond an individual	*The importance of understanding the potential harm of psychosis*	*Wilma, Jason, Jerrod, Nadiyah, Kareem*
	Psychosis can sometimes be a mental health issue (but other times not)	*Wilma, Jason*
7.3 Chaplaincy as a holistic and bespoke approach to recovery from psychosis	*Providing a holistic care package*	*Kareem, Jerrod*
	Using religious and non-religious activities as a part of tailored spiritual care	*Mick, Nadiyah, Jason, Kareem, Jerrod*
	Working with the views that people bring	*Wilma, Jerrod, Nadiyah, Mick, Jason*
	Chaplaincy work is "not a magic wand"	*Mick, Jerrod, Wilma, Kareem, Jason*
	Challenges in implementing chaplaincy work within services that emphasize a medical framework	*Mick, Jerrod, Jason*

spirituality. The quote below highlights the importance of understanding the subjective experience between people:

> *"[The impact of psychosis] depends on the service-user. Because some people might hear and see things that other people can't and be totally freaked out by that . . . and then there are other people who will experience the same thing, and . . . actually quite enjoy it . . . they've got, I don't know spirit guides or what they call spirit guides, or friends who are in spirit" (line 322–328)*

The majority of participants also likened science to a type of spiritual experience, seeing it is another way humans make sense of experiences like psychosis. Kareem stated that while spirituality and science "both [go] hand in hand" (p.6, line 227), they are usually used for separate purposes, with science being used for experiences that can be explained "rationally with your intellect" (line 166–167) and spirituality used for those that cannot. According to participants, acknowledging this link was important when working with psychosis-like experiences because of the possibility that a biologically-based illness may be occurring alongside other experiences. Science being a part of spirituality means that medical-based reasonings underlying psychosis would not negate other spiritual experiences happening as well.

All participants acknowledged that spiritual experiences occurring within this framework were not always helpful or beneficial. Due to some spiritual experiences being negative, Mick emphasized the need to "proceed with caution" (p.7, line 308–309) when exploring psychosis-like experiences from a spiritual perspective. Nadiyah shared a similar view to Mick, explaining that some spiritual experiences can include "evil whispers" (p.8 line 315). Jason gave an example of a service user where spiritual interests started off as helpful, but led to having a negative impact:

> *"He was really into something called biblical numerology, which was . . . making sense of . . . the use of numbers . . . in the Bible, which is a whole particular area of theological study . . . his desire to try and interpret the future seen through numbers is a practice that's been practiced theologically for hundreds of years. But where it led him was to a place where one but virtually, "I am the 'Sent One' . . . these medical staff have got absolutely nothing to say to me, because they're all damned, and they're going to hell"" (line 222–240)*

This example demonstrates that it is how spiritual ideas are used that is what makes them helpful or unhelpful. Mick discusses this with foxgloves:

> *"Nice flower to look at. But actually, if you take a very small amount of it, it can help with heart disease. But if you take more than a very small amount of it, it will kill you. And so you have in God's creation, both potential for Good and Evil dependent upon what we do with it." (line 689–692)*

This also highlights the importance of understanding the intertwining nature of psychosis-like experiences and how it can help to explore it multidimensionally, such as through spirituality.

Theme II: locating "psychosis" within a wider context beyond an individual

According to participants, psychosis-like experiences being intertwined means that the co-occurring physical, spiritual, psychological, and environmental aspects need to be explored in order to make full sense of the experience. What *is* psychosis, however, was difficult for participants to explain and there was no universally agreed definition among them. Wilma, for example, defined psychosis both clinically and non-clinically:

> *"Okay, so obviously, you've got the clinical, uhh the clinical definition of that. So that's hallucinations, auditory and visual hallucinations, delusions of grandeur, etc . . . .and then from my perspective, in my spiritual circles, people will often say that shamans experienced psychosis . . . because they are feeling, and they are connecting to a different dimension and a different realm" (line 72–79)*

This demonstrates two qualities participants highlighted when defining psychosis: that psychosis can have more than one definition, and that psychosis occurs within a wider context. Mick commented that the word itself refers "generally just mental illness" (line 242), but alluded to how it is usually applied depending on when, where, and how psychosis-like experiences occurred:

> *"And she said to me, she said, "If I go into church and I talk to God, people call me 'Holy.' If I go into church and God talks to me, Doctor so and so calls me 'Paranoid Schizophrenic' again and puts me back into hospital"" (line 285–286)*

This emphasizes the impact and effect of context by drawing a comparison between two environments, both in which the same behaviors are being exhibited, but only one receiving a "psychosis" label. When it comes to

defining psychosis, participants appear to allow for multiple explanations and possibilities, rather than one definition.

In general, participants considered psychosis harmful only if "it [became] disruptive for someone" (Wilma; p.7, line 288). However, participants differed on which experiences were considered harmful or not. With case vignette "Nadeen" Jason, Mick, and Wilma did not view her presentation as harmful. Jason came to that decision by considering the wider cultural and societal understandings of family, bereavement, and death when examining her case:

> *"... in Western society, the tendency is, is that sense of death is final or that person is dead. And that's it. But, but certainly certainly in African and also Afro-Caribbean kind of culture [...] I would say that, that sense of connection to your ancestors is a really important aspects of of of life, and a little bit like, perhaps people in this country might go and visit a gravestone and speak to their mother or their father who's buried in the ground. Well, what what Nadeen here is doing is not any different from that. And my you know, my, my view would be as long as it it didn't become overbearing, or, you know, I think that, you know, you just, it's part of the grieving process..." (line 394–415)*

In contrast, Jerrod, Kareem, and Nadiyah viewed the case vignette of "Nadeen" as a harmful presentation that requires support. They emphasized less of the vignette's co-occurring factors and more on their faith-based positions. Jerrod suggested that Nadeen needed help because "Dead don't talk to people and cannot talk ... you cannot talk to a deceased person" (line 401–403). Likewise, Nadiyah characterized "Nadeen" as one of "extreme connectivity ... extremism ... a very huge illness" (p.10, line 418–420), as it prevented the grief and "sadness [that] comes naturally" when someone dies (p.11, line 438). Kareem shared the same perspective:

> *"... every being has to taste the death. That is a reality which no one can deny ... so she is having some mental health issues" (line 432–434)*

Interestingly, with the case vignettes "Hannah" and "Jimmy," five of the six participants characterized their experiences as severe mental illness. With "Hannah," for example, Wilma characterized her experience as "acute psychosis" (line 315). However, Jason indicated that attempts to distinguish mental health from spirituality may not be easy (or helpful):

> *"... those two things are so intertwined .... .the idea that you can extract one from the other is, is you know, you're in danger of actually doing more damage and so and so the person needs help from a mental health perspective, but the person also needs help from a spirituality perspective" (line 354–361)*

The case study of "Jimmy's" spiritual abuse was highlighted by all participants as an important reminder of how spirituality can be exploited to become a harmful experience.

Theme III: chaplaincy as a holistic and bespoke approach to recovery from psychosis

When working with psychosis, participants described their approach in spiritual services as holistic, validating, empowering, and tailored to the service-user's goals and needs. Kareem suggested:

> *"Chaplaincy department can provide help [in] other therapy, you know, provide health [in] all that contribute to the wellbeing. It's the whole package… 'Cause sometime, social aspects are crucial, you know, sometime their matrimonial problems making them, you know, possessed. It all depends" (288–290)*

All six participants emphasized holisticism in psychosis recovery. Jerrod explained:

> *" … you have to be there for them in a fair [way] and try to keep it balance and just support them on making sure that they, you know, they have access to resources that they need to help them on their journey. And just making sure that they are getting a holistic care package, so to speak" (line 73–77)*

These resources could be religious; five out of six participants indicated using prayer and religious objects or totems, such as amulets, prayer cards, water, and holy books to help bring a service-user "peace" (Mick; p.12, line 484) and "heal" (Nadiyah; p.3, line 95). Non-religious resources on the other hand were described more generally, such as being a "listening ear" (Jason; p.1, line 25), but also:

> *"Some people they just need company … some people they like to discuss their family problems. Some people, they have some social issues, and some even they have some you know, social services issues" (Kareem; line 252–255)*

According to Jason and Jerrod, the variety of resources also allows them to provide tailored support for people experiencing psychosis that come from diverse backgrounds, paying particular attention to individual and cultural differences:

> *"Different strokes for different folks, everybody will be, um, be different. And bring in their culture. Try to identify with some of their culture and what they're used to. Especially with some of those who are very culture-orientated. And try to adapt to some of the culture from, you know, from Africa, from India, from the West Indies, and try to reflect and adapt some of that" (Jerrod; line 203–206)*

Validation and acceptance were also part of holistic care for people experiencing psychosis, according to all participants. This included "supporting them whatever stage they're at" (Wilma; line 611), "[letting] them be themselves" (Jerrod; line 199), "believing them" (Wilma; line 387) and "[listening to] them" (Nadiyah; line 25). Mick explained this as different from enabling and agreeing with service-users' views:

"There are times when people told me of experiences and I would say I believe them in terms of their undoubted sincerity. I do not understand how I have to accept that in effect in faith. And that has to be because we can't know everything . . . .But just because I don't know doesn't mean it cannot be" (line 192–199)

This illustrates a distinction whereby staff can validate service-user's beliefs about what they are perceiving without accepting it to be objectively true. Jason expressed a similar perspective:

"People can have views that are warped, but you can't just dismiss those views. You've got to work with them. And you've got to help that person to make sense of them and, and also help to level with them so that they can come to a more considered understanding of the stuff that they're reading, taking in or believing" (line 241–244)

Validation and acceptance were most apparent with case vignettes "Hannah" and "Jimmy." With "Hannah," Jerrod characterized it as such:

"You're accepting what she's saying . . . We are not shunning it, we are not pushing it away. We are accepting. Because sometimes they can be very adamant and argumentative. And we say 'We know you are feeling suicidal. We know that sometimes, um, you you you your neighbor has cursed you. So we believe what you're saying, Hannah" (Jerrod; line 369–372)

With "Jimmy" Jerrod added that having a conversation with about his options to engage with his spirituality or chaplaincy can be helpful:

"I would say to Jimmy . . . 'I'm not gonna try to indoctrinate in any shape or form. Whatever this is gonna take, I'm happy to support you. But if anytime in your journey you do think, you know, you want to know more about God, you know, I am still here to support you. And I will be still praying for you.' So, you know, I still give him, I still leave the option for for for Jimmy to visit and to get spiritual care if he do need help. So I don't shut it down. I don't shut him down. I say, 'Eh, I'm still here to support you. I'm still here with you on your journey. You really want to continue what you're doing and I will continue doing what I'm doing but whenever you're ready'" (line 519–525)

In this example, we see the provision of validation, acceptance, and tailored support. Emphasizing it is an "option" to work with chaplaincy, Jerrod reiterates that support from chaplaincy is available to those who want it as part of their recovery.

There appears to be exceptions to which beliefs or perceptions can or cannot be accepted or validated. Since views were split on whether "Nadeen" was having a harmful experience or not, participants also differed on what chaplaincy approach to use. The participants that characterized her beliefs as not harmful described an acceptance-based approach: "[giving] her space" (Jason; line 427), offering support only if "Nadeen wanted [their] help and support" (Wilma; line 526), and being available to support "Nadeen's" significant others. Participants that characterized "Nadeen" as having a harmful experience chose approaches based on their faiths. Kareem, for instance, said that with "Nadeen" he would be "sympathetic [and] not judgmental" (line 454) but would "need to explain to her

[religious] teachings about death" (Kareem; line 454–455). Although approaches differed, participants were still able to demonstrate how they would work within the spirituality framework to make sense of these experiences holistically.

Empowering service-users to be actively involved in their own care was also characterized by all participants as part of spiritual care for psychosis. Mick noted:

> *" . . . I can't come in necessarily wave a magic wand and bless you, and everything is going to be okay . . . it's got to be about what are you going to be able to do to bring yourself to peace with that . . . This is not a 'Get Out of Jail Free' card" (line 514–521)*

Chaplaincy support was described as encouraging self-management, responsibility, and empowerment rather than paternalism. Empowerment could also include being "upfront" (Jerrod; line 409), as well as through affirmations with service-users that "they're stronger than they think" (Wilma, line 388) and "giving [them] alternative[s]" (Kareem, line 476) about the types of resources they can request from chaplaincy.

Similar to an acceptance-based approach, Jerrod described not only validating "Hannah's" views, but focusing on facilitating self-improvement skills. Whether these tools are applied by the service-user or not, participants emphasized supporting them in "[making] their own decision[s]" (Jerrod; p.5 line 207), as chaplaincy is not necessarily about " . . . [guiding] people. But certainly . . . to give a religious perspective and then leave people to make their decisions" (Jason; p.3, line 110–111).

All participants noted that holistic work with psychosis often includes medical support. As "God has given us [gifts] in terms of creation [which] includes pharmaceuticals" (Mick; p.16 line 682–683), all participants supported an integrated approach, where "prayer and medication [work]" (Jerrod; p.3 line 109) in combination. However, this was seen as a challenge to implement in services, and all participants characterized mental health services as favoring more medical frameworks for psychosis recovery than a holistic one.

Some participants like Jason noticed that services have improved in their "acknowledgment of spirituality" (line 54–55), however, there is still "room for improvement" (Jerrod; line 174). In the following extract, Wilma describes her experiences of working holistically with psychosis alongside medical doctors:

> *"Well, I think sometimes, just like everywhere, there are some doctors that are better than others, shall we say, and you will get some that are, 'No, no, no. It's definitely a chemical imbalance,' won't look at anything else. That's it. Medication, medication, medication, and then you'll get some that are more open minded shall I say, you know, and I have, I've worked with both kinds of doctors really, you know, and the doctors that are more open minded, tend to be more, um, sympathetic and listen" (line 296–301)*

Wilma explained that when medical practitioners include more of the service-user's perspective in their care, this made it easier to integrate into a holistic approach to their care.

Jason added that healthcare providers often find it difficult to navigate spirituality-related topics with service-users, but that spiritual care can and has helped:

> *"... working with other clinicians to ensure that the spiritual care of the services users part of their overall care plan ... sometimes I will be invited into sorts of clinical supervision meetings with service-users to to input because I had been sort of one of the health professionals kind of inputting into the, the, the, the well being of that patient or of that service-user. I will be asked my advice on a variety of different things that perhaps come up kind of in clinical supervision. So for example, it might be a psychiatrist or a psychologist has a conversation about spirituality, and, erm, and then relays that conversation back to me a conversation that they've had with a service-user and just wanting my advice" (line 33–38)*

Here, we see the role that chaplaincy can play in supporting other services to make sense of spirituality and the role of this in their own work. It also shows how a holistic approach can be helpful beyond the boundaries of spiritual care services.

Discussion

The aim of this study was to explore how spiritual care staff make sense of their work with service-users who have psychosis-like experiences.

Summary of findings

All participants acknowledged the term "psychosis" as a label that is applied to certain experiences. These experiences were characterized as a part of spirituality, as they relate to or affect a person's overall awareness, wellbeing, or quality of life in both positive and negative ways. Therefore, psychosis is not an independent event, but co-occurs and overlaps with environmental, psychological, biological, and spiritual factors. What exactly *is* psychosis was not universally defined, which appeared to be a deliberate choice made by participants who often work with a diverse range of service- users, altering the definition to suit different cultural, ethnic, or spiritual understandings of psychosis. They all described a holistic approach when working with psychosis, including medical involvement. While they reported improvement in services in acknowledging spirituality, they said more can be done to include spiritual care staff in consultation and collaboration with service-users.

Clinical and research implications

Psychosis

Psychosis not being defined appeared to be neither barrier nor priority for participants. While this could be because defining psychosis in services is usually delegated to diagnosticians, it could also be because their holisticism does not necessitate a definition for psychosis in order to work with it. This is interesting, as how psychosis and spirituality is researched seems to be very

different from how the participants in the study described working with spirituality and psychosis. There is a range of literature on theoretical underpinnings, attempting to discern psychosis from spiritual experiences (Fulford & Jackson, 1997; Greyson, 2014; Randal, Geekie, Lambrecht, & Taitimu, 2018), which differs from the participants' emphasis on holistic working and accommodating service-users' perspectives and needs, regardless of whether these experiences can or should be discerned. This indicates the relevance of research attempts to better illuminate spiritual care perspectives and work with psychosis *in practice*, as opposed to a focus on theoretical literature.

The perspective that psychosis can be understood within a spirituality framework has also been previously considered in research, such as in Positive Psychology models (Carr, 2011). However, it is unclear to what extent members of spiritual care services have been involved in these. Therefore, future research could usefully focus on the applicability and efficacy of integrated psycho-spiritual models that incorporate spiritual care perspectives, especially as these are predominately explored according to Judeo-Christian concepts of White, North American populations (King et al., 2013).

Spiritual care within mental health services

Participants described the spiritual care approach toward psychosis as being holistic, validating, and empowering. Similar to psychosis and spiritual care, research on chaplaincy in mental health care has mostly focused on theoretical writings (Pesut, Reimer-Kirkham, Sawatzky, Woodland, & Peverall, 2010), with practice-based research mostly found in either nursing or palliative care. This may explain participants' experience of healthcare providers lacking confidence when working with spiritual-related topics. This not only contributes to the "religiosity gap" but highlights participants' reports of mixed reactions from staff on spiritual care. Therefore, as "Jason" and "Kareem" suggested, it may be beneficial to enhance communication between spiritual care and mental health services such as through consultation or supervision. In fact, there has been some evidence suggesting that spiritual consultancy may be protective against burnout for staff, preventing emotional exhaustion (Ho, Nguyen, Lopes, Ezeji-Okoye, & Kuschner, 2017; Sinclair, Bouchal, Chochinov, Hagen, & McClement, 2012).

Evaluation

This study was evaluated through guidance by the Critical Skills Appraisal Programme (CASP) Checklist (CASP, 2018) for qualitative studies and the four "quality indicators" for appraising an IPA from Nizza, Farr, and Smith (2021).

Strengths and limitations

A limitation to this study could be that it is not "generalizable." However, qualitative studies often do not aim for generalizability but rather on exploring very particular perspectives on a particular topic. Given the little research on spiritual care staff in both qualitative and quantitative research, generalizability may not be desirable until both breadth and depth on this topic has been achieved. Another difficulty with interpreting the findings is that they are drawn from a multi-faith sample with diverse backgrounds and beliefs, with some views that contrasted. A single-faith sample may have yielded greater homogeneity; however, multiple levels of experiential significance were considered throughout the analytic process to ensure that themes were relevant to the whole group.

The IPA was conducted by one person (the first author), which enhances the risk of researcher biases throughout the study including interview and analysis. Although biases are impossible to eradicate, a reflective diary was used to enhance the researcher's awareness of her biases and the analysis was regularly reviewed in a qualitative peer-support group for transparency and trustworthiness.

Using both case vignettes and a semi-structured questionnaire as part of the research design helped facilitate nuanced discussions and reflections from participants. This allowed the researcher to conduct data collection in a way that helped yield detailed and complex data by exploring meaning-making experiences in more depth than either an interview-only or vignette-only data collection method could allow.

Conclusion

The aim of this study was to explore how spiritual care staff work with service-users who are having psychosis-like experiences. Participants characterized psychosis as one of many experiences that are intertwined with the person's biology, psychology, environment, and spirituality. Integrating spiritual care within the work of existing mental health services requires ongoing conceptual and practical considerations that were recognized and discussed by participants. Overall, the approach requires a holistic appreciation of the service user, and this can be considered supportive and complementary to established approaches to providing care for people with psychosis.

Note

1. Terms such as "psychosis" and its associated diagnostic definitions are currently being contested and debated on its appropriateness, cultural relevance, and suitability. For the purposes of convenience for this study, experiences that involve hearing voices, perceptions, or beliefs that others may consider "delusional" or

"odd" will be classified as either "psychosis," "psychosis-like experiences," or "people with psychosis." This should not imply a biomedical causal understanding of psychosis.

Acknowledgments

We would like to thank Dr. Shazma Thabusom, Dr. Nick Zygouris, Dr. Darrelle Villa, Dr. Juliane Kloess, and the Centre for Applied Psychology qualitative research methods group for their support throughout.

Disclosure statement

All authors worked in mental health services at the time the research was undertaken, which included working with some patients that have psychosis.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

ORCID

Reham Al Taher http://orcid.org/0000-0002-9176-5142
Andrew Fox http://orcid.org/0000-0002-4312-7453

References

Atapattu, M. S., Gonzales, H. M., & Williams, N. (2022). Recovery from psychosis: An integrated model of interpersonal and intrapersonal factors from the perspective of psychologists. *Journal of Psychosocial Rehabilitation and Mental Health*, *9*(4), 379–393. doi:10.1007/s40737-022-00274-8

Boardman, J., & Shepherd, G. (2012). Developing successful recovery-oriented mental health services. *Empowerment, Lifelong Learning and Recovery in Mental Health*, 69–81. doi:10.1007/978-0-230-39135-2_6

Carr, A. (2011). *Positive psychology: The science of happiness and human strengths*. London: Routledge.

CASP Checklist. (2018). CASP - Critical Appraisal Skills Programme. Retrived from https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Caspi, A., Houts, R. M., Ambler, A., Danese, A., Elliott, M. L., Hariri A, Harrington H … Moffitt, T. E. (2020). Longitudinal assessment of mental health disorders and comorbidities across 4 decades among participants in the Dunedin birth cohort study. *JAMA Network Open*, *3*(4), e203221. doi:10.1001/jamanetworkopen.2020.3221

Cooke, M. (2020). Ethics and politics in the Anthropocene. *Philosophy & Social Criticism*, *46* (10), 1167–1181. doi:10.1177/0191453720903491

Dein, S., Cook, C. C., & Koenig, H. (2012). Religion, spirituality, and mental health. *Journal of Nervous & Mental Disease*, *200*(10), 852–855. doi:10.1097/nmd.0b013e31826b6dle

Friedli, L. (2000). A matter of faith: Religion and mental health. *Journal of Public Mental Health*, *2*(2), 7–13. doi:10.1108/17465729200000010

Fulford, K. W., & Jackson, M. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry, & Psychology*, *4*(1), 41–65. doi:10.1353/ppp.1997.0002

Gilbert, P., & Parkes, M. (2011). Faith in one city: Exploring religion, spirituality and mental wellbeing in urban UK. *Ethnicity and Inequalities in Health and Social Care*, *4*(1), 16–27. doi:10.1108/17570981111189551

Greyson, B. (2014). Differentiating spiritual and psychotic experiences: Sometimes a cigar is just a cigar. *Journal of Near-Death Studies*, *32*(3). doi:10.17514/jnds-2014-32-3-p123-136

Heidegger, M. (1962). *Being and time*. Germany: HarperOne.

Her Majesty's Government [HMG]. (2011). *No health without mental health*. UK.

Ho, J. Q., Nguyen, C. D., Lopes, R., Ezeji-Okoye, S. C., & Kuschner, W. G. (2017). Spiritual care in the intensive care unit: A narrative review. *Journal of Intensive Care Medicine*, *33*(5), 279–287. doi:10.1177/0885066617712677

Islam, Z., Rabiee, F., & Singh, S. P. (2015). Black and minority ethnic groups' perception and experience of early intervention in psychosis services in the United Kingdom. *Journal of Cross-Cultural Psychology*, *46*(5), 737–753. doi:10.1177/0022022115575737

Jacob, K. S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian Journal of Psychological Medicine*, *37*(2), 117–119. doi:10.4103/0253-7176.155605

King, M., Marston, L., McManus, S., Brugha, T., Meltzer, H., & Bebbington, P. (2013). Religion, spirituality and mental health: Results from a national study of English households. *British Journal of Psychiatry*, *202*(1), 68–73. doi:10.1192/bjp.bp.112.112003

Koenig, H. (2014). The spiritual care team: Enabling the practice of whole person medicine. *Religions*, *5*(4), 1161–1174. doi:10.3390/rel5041161

Koslander, T., & Arvidsson, B. (2007). Patients? conceptions of how the spiritual dimension is addressed in mental health care: A qualitative study. *Journal of Advanced Nursing*, *57*(6), 597–604. doi:10.1111/j.1365-2648.2006.04190.x

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102–120. doi:10.1191/1478088706qp062oa

Leavey, G. (2010). The appreciation of the spiritual in mental illness: A qualitative study of beliefs among clergy in the UK. *Transcultural Psychiatry*, *47*(4), 571–590. doi:10.1177/1363461510383200

Lysaker, P., Yanos, P. T., & Roe, D. (2009). The role of insight in the process of recovery from schizophrenia: A review of three views. *Psychosis*, *1*(2), 113–121. doi:10.1080/17522430902948175

Marriott, M. R., Thompson, A. R., Cockshutt, G., & Rowse, G. (2018). Narrative insight in psychosis: The relationship with spiritual and religious explanatory frameworks. *Psychology & Psychotherapy: Theory, Research & Practice*, *92*(1), 74–90. doi:10.1111/papt.12178

Milner, K., Crawford, P., Edgley, A., Hare-Duke, L., & Slade, M. (2019). The experiences of spirituality among adults with mental health difficulties: A qualitative systematic review. *Epidemiology and Psychiatric Sciences*, *29*. doi:10.1017/s2045796019000234

Ministry of Housing, Communities, and Local Government. (2018, November 14). *Belief in Communities: Bridging the Divide*. GOV.UK. Retrived from https://www.gov.uk/government/publications/belief-in-communities-bridging-the-divide

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in Interpretative Phenomenological Analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*, *18*(3), 369–386. doi:10.1080/14780887.2020.1854404

Noiseux, S., St-Cyr Tribble, D., Leclerc, C., Ricard, N., Corin, E., Morissette, R., & Lambert, R. (2009). Developing a model of recovery in mental health. *BMC Health Services Research*, *9* (1). doi:10.1186/1472-6963-9-73

Pesut, B., Reimer-Kirkham, S., Sawatzky, R., Woodland, G., & Peverall, P. (2010). Hospitable hospitals in a diverse society: From chaplains to spiritual care providers. *Journal of Religion and Health*, *51*(3), 825–836. doi:10.1007/s10943-010-9392-1

Raffay, J., Wood, E., & Todd, A. (2016). Service user views of spiritual and pastoral care (chaplaincy) in NHS mental health services: A co-produced constructivist grounded theory investigation. *BMC Psychiatry*, *16*(1). doi:10.1186/s12888-016-0903-9

Randal, P., Geekie, J., Lambrecht, I., & Taitimu, M. (2018). Dissociation, psychosis and spirituality: Whose voices are we hearing? *Psychosis, Trauma and Dissociation*, 333–345. doi:10.1002/9780470699652.ch24

Rashid, S., Copello, A., & Birchwood, M. (2012). Muslim faith healers' views on substance misuse and psychosis. *Mental Health, Religion & Culture*, *15*(6), 653–673. doi:10.1080/13674676.2011.613072

Saleem, R., Treasaden, I., & Puri, B. K. (2012). Provision of spiritual and pastoral care facilities in a high-security hospital and their increased use by those of Muslim compared to Christian faith. *Mental Health, Religion & Culture*, *17*(1), 94–100. doi:10.1080/13674676.2012.749453

Sinclair, S., Bouchal, S. R., Chochinov, H., Hagen, N., & McClement, S. (2012). Spiritual care: How to do it. *BMJ Supportive & Palliative Care*, *2*(4), 319–327. doi:10.1136/bmjspcare-2011-000191

Skar-Fröding, R., Clausen, H. K., Šaltytė Benth, J., Ruud, T., Slade, M., & Sverdvik Heiervang, K. (2021). The importance of personal recovery and perceived recovery support among service users with psychosis. *Psychiatric Services*, *72*(6), 661–668. doi:10.1176/appi.ps.202000223

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*(1), 39–54. doi:10.1191/1478088704qp004oa

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE Publications.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. *Doing Social Psychology Research*, 229–254. doi:10.1002/9780470776278.ch10

Smith, J. A., & Osborn, M. (2014). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain*, *9*(1), 41–42. doi:10.1177/2049463714541642

Suhail, K., & Ghauri, S. (2010). Phenomenology of delusions and hallucinations in schizophrenia by religious convictions. *Mental Health, Religion & Culture*, *13*(3), 245–259. doi:10.1080/13674670903313722

Tranulis, C. S., Freudenreich, O., & Park, L. (2009). Narrative insight: Rethinking insight in psychosis. *International Journal of Culture and Mental Health*, *2*(1), 16–28. doi:10.1080/17542860802560363

Van Nieuw Amerongen-Meeuse, J. C., Schaap-Jonker, H., Schuhmann, C., Anbeek, C., & Braam, A. W. (2018). The "religiosity gap" in a clinical setting: Experiences of mental health care consumers and professionals. *Mental Health, Religion & Culture*, *21*(7), 737–752. doi:10.1080/13674676.2018.1553029

Weber, S. R., & Pargament, K. I. (2014). The role of religion and spirituality in mental health. *Current Opinion in Psychiatry*, *27*(5), 358–363. doi: 10.1097/yco.0000000000000080

Wood, L., & Alsawy, S. (2017). Recovery in psychosis from a service user perspective: A systematic review and thematic synthesis of current qualitative evidence. *Community Mental Health Journal*, *54*(6), 793–804. doi:10.1007/s10597-017-0185-9