

**UNDERSTANDING EXPERIENCE
AND CONSTRUCTING IDENTITY
IN
'SPIRITUALLY TRANSFORMATIVE'
ACCOUNTS OF 'PSYCHOSIS':**

**A Study of First-Person
Narratives on the Internet**

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ABSTRACT

Psychosis and Schizophrenia have been associated with severe disruptions in self-narrative, which may be driven by a medical model which denies meaning to psychotic-like-experience (PLE), and negatively positions 'patients'. Alternative understandings of PLE exist cross/sub-culturally, and have been associated with good outcomes. Furthermore, a marginalised but significant body of theory proposes that PLE may represent an adaptive problem-solving or paradigm-shifting mechanism, reconfiguring redundant conceptualisations of 'reality'.

Drawing on Positioning theory, and the critical work of Michel Foucault, to inform a Critical Narrative Analysis, this thesis interrogates the potentially transformative impact of understanding out-of-the-ordinary experiences, such as seeing visions, or hearing voices, from a 'spiritual' or 'mystical' rather than 'medical' perspective. Taking a multiple case-study approach, three publicly available self-narratives of 'spiritually' transformative 'Psychosis' are explored. The nature of the 'self' produced, narratives drawn upon and implications for the medical model are considered.

All three accounts draw on an idiosyncratic 'bricolage' of narrative resources to integrate their PLE into richly developed self-narratives. PLE is understood as profoundly meaningful, external to the self and universally accessible. The experience drives a reconstruction of 'reality' which repositions the narrator, and allows them to transcend unwanted aspects of their 'prior-selves'. A dichotomy is introduced between enlightened and unenlightened minds, which necessitates restricted communication, and tactical silencing.

From a Foucauldian perspective (2006a) the accounts are seen to function in a fashion comparable to the 'mystical/spiritual' 'counter-conduct'; troubling the dimorphism between 'patient' and 'professional'; reversing the medical 'gaze'; and drawing on the counter-readings of 'spiritual' sub-communities to reverse the hierarchy of 'truth' and determine their own 'reality'.

Implications for further research, and professional practice, are discussed in light of the analysis.

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1. INTRODUCTION

1.1. The Current Study

This thesis explores the impact of understanding out-of-the-ordinary experiences, such as seeing visions, or hearing voices, from a 'spiritual' or 'mystical', rather than 'medical', perspective (see *Glossary* 7.1). Within the mental health (MH) medical narrative, such 'psychosis-like-experiences' (PLEs) are generally pathologised; I am interested in how this pathologisation is resisted by those who come to understand their experiences as 'spiritually' significant. Both my introduction and analysis employ a narrative lens; the analysis is supplemented by Foucauldian theory (see Method, 2.3.2.2.), which enables consideration of the conditions of possibility of such tellings, and the operations of knowledge-power.

1.2. Researcher's Position

I will first consider how aspects of my own experience may have shaped this thesis:

While I do not hold any firm religious or spiritual conviction, I have a long standing interest in Buddhist philosophy, and an (irregular) meditative practice. Perhaps as a result, I identify with the notion of peak experiences, and the meaningfulness of different 'levels' of 'reality'. The closest I have come to PLE is occasionally hearing voices in the space between sleeping and waking. I am a member of the Spiritual Crisis Network, and have discussed spiritual aspects of PLE at their London meeting many times. In addition, I am openly critical of the medical model of 'mental illness'; a position I developed working alongside critical psychologists, which has become more firmly established through my training at UEL, my clinical work (particularly with those who describe PLE), and my reading of critical

scholars such as Michel Foucault and Michael White. I intend to take an agnostic stance on such issues, and to treat all notions of 'truth' and 'reality' critically.

Foucault would challenge us to look at what the particular 'truth' I offer below is doing, and how it relates to power. In this light, this thesis could be understood as an attempt to position psychology in general, and myself in particular, favourably in relation to traditional psychiatry. It is important then, that I aim to be transparent in my analysis, but also in the way in which I address the literature (for literature review strategy, see Appendix 7.1).

1.3. Narrative

The Narrative turn in academic psychology is well documented (e.g., Squire, Andrews & Tamboukou, 2008). Here, I introduce some key concepts briefly, and only insofar as they are directly relevant to justifying my focus on narrative.

Approximately three decades ago, “psychologists became alive to the possibility of narrative as a form not only of representing but of constituting reality” (Bruner, 1991:5). Sarbin (1986) suggested that narrative could, and should, be understood as the organizing principle for all human action. Our narrative structures are central to the way we understand the world; it is through narrative that we interpret our experiences and interactions and, thus, constitute 'reality'.

Narratives are simultaneously general and idiosyncratic; being both individually produced, and constrained by shared understandings (Somers, 1994).

Depending on our cultural context, particular 'shared understandings' are more credible and influential; I will refer to these as 'dominant narratives'. Dominant narratives are important because events that fit the dominant plot tend to be more closely attended to, and seen as more credible, thus shaping our experience of 'reality' (Ridgway, 2001).

1.4. Narrative Construction of Self

The 'post-modern turn' de-centred the human subject (Seidman, 1994). One of the key contributions of the so called post-humanist, or post-structuralist, writers (to include Derrida, Foucault and Nietzsche) was in troubling the concept of a unitary and coherent self; and in demonstrating how this 'fiction' emanates from the humanist discourse itself. Individuals could no longer be understood as having identity independent of their position in the social order. The self came to be understood as multiple, and continually, discursively produced within specific socio-cultural contexts.

Narrative provides a means by which our notion of identity can be structured, allowing us to make sense of long sequences of events, and facilitating the management of extreme complexity. Narrative identities are never complete, nor are they ever entirely our own; they are always in the process of being formed, unfolding in a flow of temporally and spatially specific social relationships (Somers, 1994). Self-narratives are shaped by the social world in two important ways: through interaction, which occurs between speaker and audience – what Bakhtin (1986) called 'polyphonia'; and through the cultural repertoire of stories available to the speaker – Bakhtin's 'heteroglossia'. Heteroglossia implies that every story is assembled from multiple codes and genres, i.e., our narratives are cultural patchworks. Hence, for MacIntyre (1984:213), “we are never more (and sometimes less) than the co-authors of our own narratives. Only in fantasy do we live what story we please.”

Bruner (1991) suggests that by examining our stories, particularly those we tell about ourselves, we may achieve insights into the specific cultural 'rules' that govern how we interact with others, and who we can be, i.e., how narratives shape identity (e.g., Brockmeier & Carbaugh, 2001). I am influenced by studies

which examine the situational production of identities through narrative co-construction (Antaki & Widdicombe, 1998; Bamberg, De Fina & Schiffrin, 2010; Bamberg & Georgakopoulou, 2008). Bamberg et al. (2011:178) describe identity “as constructed in discourse, as negotiated among speaking subjects in social contexts”.

In addition, Andrews (2004) suggests that, although narrative is influential in shaping our interactions with others, its true power derives from internalisation, when it is taken within the self as 'real'. Together, the narratives available for internalisation, and those deployed by others about us (which well may be the same), come to determine the kind of 'self' we construct (Burr, 2003). I adopt this outlook in examining how identities are performed, co-constructed, and constrained by context.

1.5. The Medical Model and Self-Narratives in 'Psychosis'

The 'medical model' is the dominant narrative of 'mental distress' in what we call 'the West' (Kerr, Dent-Brown & Parry, 2007). The 'medical model' positions those experiencing PLE as suffering from a range of chronic brain diseases (e.g., 'Schizophrenia' or 'Bipolar Disorder'), best responded to by medical intervention but, nevertheless, of poor prognosis. Within this 'reality', 'recovery' is traditionally construed “in terms of symptom reduction and long-term maintenance of 'normality', understood only as an absence of symptoms” (Adame & Knudson, 2007:160). What implications does this have for the self-narrative of the 'patient'?

One practical implication may be that those exhibiting PLE are forcibly treated, including detentions and forced injections, in accordance with the law (Mental Health Act, 2007). Medical intervention for 'psychosis' may well be experienced as traumatising, or for many, re-traumatising (Read, van Os, Morrison & Ross, 2005); and involves shame, humiliation and entrapment, as the 'psychosis

'patient' is relegated to one of the least favourable categories in society (Birchwood, Fowler & Jackson, 2001).

Furthermore, within the medical narrative the content of PLE is meaningless; alienating the experiencer and denying them opportunities to integrate these episodes into self-narrative. Johnstone (2000:81) has argued that “personal meaning is the first biggest casualty” of 'Schizophrenia'. This deficit of personal meaning may contribute to what has been described as “a profound disturbance to a person's sense of self” in 'psychosis' (Karatza & Avdi, 2011:215). For instance, Raffard et al. (2010) compared the narratives of a group of 'patients with Schizophrenia' to 'healthy controls'. They demonstrated that 'patient' narratives were less coherent and elaborate; and this increased the longer the 'patient' identity was inhabited. The authors attributed this deficit to the disease process, but such findings are also in line with a narrative interpretation which highlights the absence of meaningful narratives available to the 'patient'.

The medical narrative has negative consequences beyond stripping meaning. The diagnosed also become recipients of the negative effects of a 'taboo identity' (May, 2012). A diagnosis of 'Schizophrenia' is particularly problematic (Knight, Wykes & Hayward, 2006; Schulze & Angermeyer, 2003); as a 'Schizophrenic' is perceived as being more likely to be violent (Angermeyer & Schulze, 2001). This dominant narrative is supported by media reports which often draw a connection between diagnosis and the risk of violence (Harper, 2002). This understanding is so influential that such negative images have been shown to be internalised by the 'Schizophrenic patient' (Rogers et al., 1998). Furthermore, the 'illness' metaphor renders futures uncertain, thereby compromising 'recovery'; as, even in the absence of ongoing PLE, 'patients' are concerned that 'ill-health' might return, which compounds feelings of shame and hopelessness (McCann & Clark, 2004).

The medical model metaphor also has implications for embodiment: if a body is “broken” by disease, then “to be fixable the body has to be some kind of

machine” (Frank, 1995:88). Applied to emotional distress, “the mind is cast as computer, with 'mental illness' as a virus that infects functions and disrupts outputs” (Adame & Hornstein, 2006:136). Within the physical illness narrative the distinction between the broken body and the individual is preserved, e.g., “People say 'I have cancer', they don't say 'I am cancer' (Manning, 1994:169). For 'mental illness', the distinction between body and individual breaks down, which “reduces a multi-faceted human being to a diagnosis” (ibid:170).

How does this process unfold in a system designed to support people? White (1995:14) suggests that “ways of speaking and acting make it possible for MH professionals to construct people as the objects of psychiatric knowledge, to contribute to a sense of identity which has 'otherness' as its central feature”. Psychiatric knowledge also allows the clinician to speak 'truth' about their 'patients'. Being positioned as a 'patient', means defining one's experiences in accordance with the psychiatric model, “thereby influencing both the types of subjectivity and identity that are brought into being” (Parker et al., 1995:73). Thus, psychiatric 'truth' constructs 'reality' for those experiencing PLE in a medical context (House, 2003). The medical model is a 'terministic screen' (Burke, 1966), a narrative which creates a world, but denies alternative realities; blinkering both the recipients and benefactors of care.

Recently, it has been suggested that a “crucial [and] unique” (Roe & Lysaker, 2012:10) aspect of 'recovery' from 'psychosis' is the development of a “coherent and consensually valid personal narrative” (e.g., France & Uhlin, 2006; Smorti et al., 2008; Saavedra, Cubero & Crawford, 2009). Lysaker et al. (2010:271) suggest that such a recovery “may involve the recapturing or developing [of] one's personal narrative”; and demonstrated that 'patients' with more “developed” narratives had greater “wellness in daily life”, independent of “positive and negative symptoms, self report of hope and self-esteem and a test of general intellectual function” (ibid.). Lysaker and colleagues focussed upon the dialogical level, and suggested that those diagnosed with 'psychosis' are suffering a

biological narrative-making deficit. However, they did not attend to how cultural discourses (meta-narratives) may position the 'psychosis' self, and deprive the 'patient' of narrative-making resources.

I have argued that the search for narrative in 'psychosis' is frustrated by a subjugating story which denies meaning. Nevertheless, narratives of 'recovery' have become increasingly common; in the 'grey' and academic literature, as well as online and in popular press (Adame & Hornstein, 2006). These accounts are heterogenous, but tend to reinstate 'meaningfulness'; a reversal which returns 'symptoms' to 'experiences'. They suggest that the “rhetoric of scientific sadness” (Duffy & Dörner, 2011:201) of the medical model is radically overstated, and that very positive lives can follow PLE. In so doing, they represent a 'counter-narrative', in resistance to dominant cultural narratives (Bamberg, 2004); often this resistance is achieved not in isolation, but through alliance with 'out groups'. The stories held by these groups produce a “counter reality” (Delgado, 1995:64) and represent a potential narrative reservoir, which might facilitate meaning-making for those with similar pre-narrative experience, and offer a way to reclaim a preferred subject position.

I am not suggesting that distress can be sidestepped by the selection of a new narrative. In many contexts the subjugating story may be so powerful as to effectively inhibit alternative meaning-making. Many factors push back against a self-selected narrative (e.g., the response of others, or material limitations). Nevertheless, counter-narratives do problematise the medical model, and in doing so raise the question of what enables the construction of more hopeful accounts, and whether the nature of available meta-narratives might influence this process (Thornhill et al., 2004).

The 'counter-narrative' I aim to address in this thesis frames PLE as 'spiritual' or 'mystical'. In McCann and Clark's (2004) study 'spirituality' emerged as an important counter-balance to the negative identity implications of 'Schizophrenia':

“Having spiritual beliefs helped give meaning to the illness, provided a sense of inner warmth, and relieved the burden of being mentally ill” (p.790), whilst spiritual communities, identified as more accepting of these individuals, provided opportunities to develop supportive relationships.

How 'spiritual' or 'religious' understandings act upon the experience is not well understood. A recent systematic review (Bonelli & Koenig, 2010) examined the relationship between religion/spirituality and MH. Of the 43 studies identified, 72.1% found that increased religiosity/spirituality predicted less 'mental disorder'. Only five studies specifically addressed 'psychotic disorders', of which four suggested that increased religiosity/spirituality was associated with improved wellbeing. These findings suggest spiritual understandings may be associated with better outcomes, but fail to illuminate the nature of this relationship.

1.6. Evidence Based Medicine?

Given the medical model's appeal to scientific authority, we might expect it to be empirically well-supported. However, despite huge investment, evidence of a biological basis to 'Schizophrenia' is lacking (Bentall, 2004, 2009). Research into abnormalities in brain structure have produced inconsistent results, with most 'patients' appearing normal (Lewine, 1998). Research into genetic linkages have suffered similar inconsistencies, and failed to identify specific loci, such that “there is no replicable support for any of the candidate genes” (Crow, 2007:13). Meanwhile large meta-analyses identify consistent environmental influences, particularly an apparently causal link with childhood abuse, which further troubles medical accounts (Read et al., 2005).

A central tenet of the medical model is that discrete 'mental illnesses' exist (Bentall, 2004), for 'psychosis' this seems not to be the case. The BPS (2000) suggest that, rather than consider the various psychiatric disorders as discrete

phenomena, we should imagine them as sitting along a continuum of 'madness'. In fact they argue that “mental health and 'mental illness' [...] shade into each other and are not separate categories” (ibid:18). A recent systematic review by van Os et al. (2009) supports the notion of a 'psychosis continuum'. Their meta-analysis found a prevalence of 5.3% for psychotic symptoms across the general population; up to 90% of these experiences “are transitory and disappear over time” (p.179). The authors suggest their findings support a “proneness-persistence impairment model” of 'psychosis', such that “psychotic disorder may be conceptualised as the rare poor outcome of a common developmental phenotype” (ibid.). They explain persistence of 'psychosis' in 'poor outcome' cases as best accounted for by environmental risk factors such as 'social adversities'. This is important research as, in addition to validating the 'psychosis continuum' construct, their analysis suggested that 'normal self-resolving psychosis' is vastly more prevalent than so called 'psychotic disorder'.

The authors' 'sub-clinical psychosis' construct implies that PLE is, at best, only mildly problematic; a position troubled by large-scale population studies, which demonstrate the high-incidence of apparently benign PLE. For instance, approximately 10-15% of people report having had 'hallucinatory experiences' (Tien, 1991), whilst 17.5% of a Dutch sample (n=7076) rated positive for at least one of the seventeen 'Composite International Diagnostic Interview' psychosis items (van Os, Hanssen, Bijl & Ravelli, 2000). Even higher incidence rates have been identified amongst individuals who believe in the paranormal (Thalbourne, 1994), have profound religious experiences (Jackson, 1997), or are members of 'new religious movements' (Day & Peters, 1999). Romme and Escher (1989) demonstrated that many individuals 'hear voices' outside of a psychiatric context, and construe this as a positive life experience. More recently, Karlson (2008) studied 'voice-hearing' in a non-clinical sample, and demonstrated that most participants considered their voices meaningful, and “more real than reality” (p.370).

Evidence suggests that medical interventions for 'schizophrenia' and 'psychosis' are harmful (Breggin, 2008; Galynker & Nazarian, 1997), and associated with poor long-term outcomes (e.g., Bola & Mosher, 2003; Harrow & Jobe, 2007; Harding, Zubin & Strauss, 1987). Within the medical narrative, such 'treatments' are justified by the severity of the 'disease state' they seek to address, and by the assumption that people would never 'recover' naturally. In light of this, comparing outcome data for medical and alternative approaches is revealing. A major series of longitudinal studies by the World Health Organisation (Hopper et al., 2007) examined global outcomes for 'Schizophrenia'. Data collection went well beyond clinic settings in the 'developing' countries, where traditional and religious healers (including *Ayurvedic* practitioners in India, and *babalawo* healers in Nigeria) were recruited to identify participants. This provided an opportunity to compare outcomes between medical and traditional explanatory models. Approximately two thirds (63%) of those identified in the 'developing' world experienced a benign 'psychosis', leading to full remission, as opposed to one third (37%) in the 'developed' nations. Better outcomes in the 'developing' world were not the result of more intensive treatment as 55% were never hospitalized, (compared to 8% in the 'developed' nations); and only 16% of the former were taking antipsychotic medication (compared to 61%). Follow up studies demonstrated that these positive outcomes had been maintained, and individuals in 'developing' nations were still consistently better off (Hopper & Wanderling, 2000).

Thus 'recovery' appears to be inversely correlated with involvement in the psychiatric paradigm. This may be related to the reduced use of antipsychotics in 'developing' nations, or the validating collective responses of the non-medical communities (Williams, 2012). For instance, collective responses address social isolation, which has been shown to be amongst the strongest predictors of poor outcome (Warner, 2005).

Finally the deficit-oriented medical model has no clear way to account for the apparent healing and growth sometimes seen following 'recovery'. For instance,

Tooth et al. (2003) in a study of 57 individuals identifying as being 'in recovery' from schizophrenia, found that 66% described their functioning as better, and 44% as much better, than prior to the onset of the 'illness'. We need to look to alternative narratives to understand these findings.

1.7. Alternative Narratives

1.7.1. Historical narratives

Narratives of PLE in 'Western' culture have always been contested, caught up in the operations of power, and debates around the authority of 'inner experience'. PLE could be empowering or highly stigmatising, dependent on the individual's relationship with the available narratives and power structures of their period. Detailed examinations of the variety of historical understandings of PLE are available. For example, Leudar & Thomas (2000) take a multiple case study approach, spanning 2,800 years of human history, to examine how the experience of 'hearing voices' has become transformed, from being associated with divine intervention, to becoming a symptom of insanity. Further historical work explores the development of the conditions that shape experience in various contexts. Leigh Schmidt's (2002) work offers a more localised account, examining the impact of the contestation between American Christianity and Enlightenment discourses and its impact on the hearing voices experience in America. Meanwhile, Tony James (1995) explores the problematic relationship between dreams and madness as they were understood by notable French philosophers, doctors and writers of the 19th century. Each of these works demonstrates the essentially contested nature of 'truth' within this arena of human experience, and speaks to the complexity of the conditions of possibility of PLE. Whilst a full account is not presented here; I will now offer some historical arguments to make the claim that PLE has previously been “culturally integrated and semantically pregnant” (Berrios, 2002:35) – although, such meanings were not uniformly

positive – and that one implication of the medical model is the marginalisation of these cultural understandings.

There is extensive description of PLE in the classical period. Some have gone so far as to argue that experiences like 'hearing voices' were universal in humans until around 1000BC (Jaynes, 1986), although this claim has been cogently disputed (McCarthy-Jones, 2012). Nonetheless, PLE is widely described in historical documents. Dodds (1951) suggests that the most common 'hallucinations' in Ancient Greece were visions of gods, or hearing divine voices commanding or prohibiting the performance of certain acts. Although the context for PLE at this time was one in which the 'reality' of ghosts, daemons, and deities was generally accepted, there is evidence that the meaning of such experience was already contested by a newly emerging medical framework (McCarthy-Jones, 2012). So, whilst Socrates, who was guided by a 'daemon', accepted this, and considered madness and sanity to have equal value; Aristotle made attempts to explain such 'Phantasms' as the result of faulty perceptual processing; and both Hippocrates (460-370 BC) and Galen (AD 129-199) sought to explain PLE in relation to the humoral medical theory (ibid.).

Socrates' 'daemon' told him what not to do. Leudar & Thomas (2000) suggest that this experience was phenomenologically comparable to contemporary 'voice hearing', being private, auditory in content, influential on action without being compulsive, and not under direct control of the experiencer. Such phenomena were not common in Ancient Athens, leading Plato and his contemporaries concluded that it was a sign from the divine, and evidence of his wisdom (ibid.). Socrates acted on the advice of his daemon, but not without consideration. He was able to make use of his daemon to publicly justify his actions and provide advice, and was not, in his time, seen as mad on account of this experience (ibid.). Nevertheless, the daemon was problematised at his trial, supporting the notion that our understandings of these kinds of inner experience have always been both important and contested. The challenge for Socrates was that,

although he lived in a society in which direct communication with gods and other 'spiritual' figures was believed possible, such relationships (conferring power and status) were reserved for priests and spiritual authority figures; lacking such status, the validity of Socrates experience was eventually denied (Long, 2009).

Two millennia after his death Socrates experience continues to be contested. Beginning in the nineteenth-century France, Psychiatrists (then a newly emergent professional group), seeking to establish the timeless validity of their constructs in explaining the human condition, retrospectively diagnosed Socrates (alongside numerous other historical figures with similarly unusual subjective experiences) as victim of 'hallucinations' or worse (James, 1995). The value of such labels to Socrates is doubtful; Leudar & Thomas (2000) argue that whilst aspects of Socrates experiences do seem to fit with the modern concept of 'hallucination' this concept would not have been useful to him, as, in taking it up, he would necessarily have to give up much of his own worldview, and way of being that made him who he was. Socrates experience demonstrates the importance of historical and cultural context in the expression and reception of PLE, because his experience, whilst potentially categorisable as 'mad', was clearly not considered so during his period.

It is important to note that it is not only medical narratives which have had negative implications for those who exhibit PLE. In the spiritual context of the classical period such individuals were often stigmatised, being viewed as possessed or cursed. At that time, the humoral theory of disease offered a non-stigmatising basis for the explanation of a whole range of presentations (including physical illness), previously attributed to divine retribution. We begin to see the complexity of the operations of power over inner experience here – whilst the medical narrative challenged the power of religion to determine 'reality', the theory also allowed the physician to define a professional area, which excluded other practitioners, and allowed him to define 'reality' for the emergent 'patient' (McCarthy-Jones, 2012).

Jumping forward to the early Christian period, in the Old Testament, PLE was positioned as potentially divine, and as a way in which God would communicate with humanity, and, later still, in the New Testament, PLE continued to signify divine communications. Such experiences were frequently reported by significant spiritual figures associated with the Church, and often bestowed significant status to those considered eligible (McCarthy-Jones, 2012). At the time of Thomas of Aquinas (1225-1274), the Church was open to both spiritual, and more mundane physical explanations for PLE. Whether an experience was received as divine or mundane was determined by the Church, who also held the ultimate right to decide what the experience meant (McCarthy-Jones, 2012). This was a problem for those who represented a threat to the patriarchal church, for instance, women attempting to claim religious authority on the basis of PLE, whose experiences were frequently responded to with silencing, invalidation and persecution; which reached a frightening peak during the witchcraft craze of the fifteenth century (ibid.). Thus, in both the classical and early Christian periods, the power associated with PLE experiences, in offering an insight into divine 'reality', was oftentimes responded to by a mobilisation of existing authorities against such experiencers, and a refusal to allow them to determine their own meaning.

The Reformation in the sixteenth century led to a questioning of the Church's traditional interpretations of scripture, and an emphasis on individual interpretations (ibid.). This opened a space for PLE once again, as individuals made sense of their experiences in relation to the divine, and positioned themselves as prophets, mystics and visionaries. Foucault identifies in these alternate readings, particularly in collective readings, a 'counter-conduct' resistance against the Christian pastorate, which facilitated new ways-of-being (2006a). In response to this challenge, the Anglican Church adopted a new position, arguing that the age of supernatural intervention had come to an end, and re-positioning those claiming spiritual understandings of their PLE as misled fanatics (McCarthy-Jones, 2012). In denying the 'reality' of these experiences,

they found it necessary to take up and promote medical accounts of this phenomena, claiming that such experiences were the false perceptions of the insane. Thus, oddly, the Anglican Church became an early champion of the medical model of PLE.

This account was not immediately accepted by the general population, in part because medicine was very poor at treating its patients. However, the momentum was with medicine, and by the middle of the 18th century PLE was generally understood by the educated elite as meaningless other than as a sign of pathology (MacDonald, 1983). As 'rationality' became an increasingly important concept throughout the 18th Century, PLE experience, as 'madness', became detrimentally associated with 'unreason', and was increasingly understood as a medical matter (Foucault, 1967).

Kraepelin provided the first clear articulation of the system of assumptions that underlies biological psychiatry's medical conceptualisation of 'mental illness'. He offered the world a systematised classification system of 'madness', to include dementia praecox, which would eventually develop into the constructs of 'Schizophrenia' and 'Psychosis'. The meaning of these concepts, which seek to define PLE, has shifted over time. For instance, Bleuler (1950), in contributing to the development of the concept of Schizophrenia, gave descriptions of a condition that was nuanced, sensitive to the role of trauma, and to the notion that the symptoms are a response to intolerable situations (Watkins, 2010). Whereas advocates of a neo-kraepelinian movement, beginning in the 1970s and arguably continuing into the present, have used successive iterations of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association to articulate a medical understanding of PLE which, it has been argued, reduces the experience to a symptom checklist (Bentall, 2009).

These shifting, more-or-less-shared meanings shape our experience (Hacking, 1995). Hacking has shown how new kinds of scientific classification can have the

effect of 'making up' or bringing into being “a new kind of person, conceived of and experienced as a way to be a person” (2006:2). The contested concepts of 'Psychosis' and 'Schizophrenia' are of what Hacking calls interactive kind, that is, the existence of these labels has implications for how those so classified are treated, and treat themselves. Hacking suggests that interactive kinds involve 'looping effects', that is “ways in which the classification may interact with the people classified” (ibid:2). For instance, today we may think of people who experience what I am calling PLE as of a particular kind, e.g. Schizophrenic, and defined by a particular properties, e.g. symptoms, “but they are moving targets because our investigations interact with the targets themselves, and change them. And since they are changed, they are not quite the same kind of people as before. The target has moved. That is the looping effect” (ibid:2). Drawing on Hacking's work, we can see that the historically contingent development and cultural propagation of the concepts of 'Schizophrenia' and 'Psychosis', by offering new ways of being and describing a person, by creating a 'thing' that somebody could have (and be), shaped a new kind of personhood, strongly associated with PLE. This in turn created a new object of study, the Schizophrenic, the study of whom led to the ongoing development of the concepts which defined her. Hacking is not concerned with which descriptions are 'true', but with how the available discourses affect how we act, that is, we 'act under a description', and that which descriptions we can act under depends upon which is available to the society in which we reside, at the time in which we reside in it.

Today we have multiple expert narratives about 'Schizophrenia' and 'Psychosis', including, but not limited to, neurological or biochemical abnormalities, the sequelae of trauma, 'inadequate' parenting, existential crisis and spiritual transformation (Lavender, 2000). For many decades in the 'West', psychiatry has been seen as the highest authority on 'madness', and thus, for many, on PLE (Williams, 2012). We have already seen, in section 1.5, the implications of the dominance of this narrative (which reifies boundary between the mentally sick

and normal people, and argues that medical treatment is essential) for 'patient' self-narratives, and material experiences.

Whilst the medical narrative is generally dominant, particularly in clinical contexts, it remains, as ever, contested. Probably the most significant direct contestation of current times is demonstrated by the increasing political and social influence of various groups who collectively are described as experts-by-experience (Adame & Leitner, 2008), and who offer various counter-narratives to psychiatry (e.g., Hearing Voices Network, Survivor movement). The Survivor movement is far from a unified body, and encompasses many narratives (Campbell, 2008). Despite their lack of uniformity (or because of it), these movements have had significant implications for the medical model. For instance, in developing and promoting the 'recovery model' of mental illness (Anthony, 1993), which was quickly adopted by the MH system (Pilgrim, 2008). However, critical scholars argue that the way 'recovery' is deployed in MH settings fails to challenge the medical narrative, in that it individualises suffering, simplistically reframes deficits as strengths, and requires individuals to change their own 'inappropriate' behaviours, feelings and beliefs, rather than effecting necessary social change (Harper & Speed, 2012).

Another modern day contestation of the medical narrative can be found in the academic literature. Classic examples abound, with Laing (1990) and Szasz (1976) being perhaps the most notable in standing critically opposed to the realism of psychiatry. More recently, Leudar and Thomas (2000), Watkins (2010), and Williams (2012) all offer examples of contemporary problematisations of the medical narrative. Troubling the medical framing of PLE as dysfunction or disease Williams and Watkins both present understandings of 'psychosis' as essential functional, whilst Leudar and Thomas argue that the experience is essentially ordinary and unhelpfully mythologised or pathologised. These understandings, as well as the persistent existence of spiritual and religious discourses, and the aforementioned activities of experts-by-experience, contribute to a modern day narrative landscape that remains diverse, albeit

dominated by medical discourse.

The purpose then, of this brief review, is to demonstrate that over time PLE has been understood in very different ways. As Hacking's (2006) work suggests, it is important to recognise these shifting narratives as more than simply stories. Each one represents an entire 'reality', of course vastly simplified here, which determines the lived experience of the individual, and how they are responded to.

1.7.2. Cross-cultural narratives

“The mystic [...] enters the waters and finds he can swim; whereas the schizophrenic, unprepared, unguided and ungifted has fallen or unintentionally plunged and is drowning.”

Campbell (1972:216)

Tobert (2007) draws on anthropological evidence to argue that which narratives are dominant and which subjugated, in relation to mystical-spiritual-psychotic-like experience, varies between cultures. Unfamiliar knowledges are sometimes described as 'culture-bound beliefs', unfortunately, we are not always reflexive enough to question whether our own rational-material beliefs might also be 'culture-bound' (Tobert, 2010). From a spiritual perspective, modern mainstream psychiatric beliefs about the psyche have been criticised for being overly narrow, and demonstrating limited awareness of their own historical and cultural contingency (Harner, 1990). The current Western/medical/dominant model is 'ethnocentric'; based upon a western-material world-view which considers its own perspective superior to any other. Within this narrative matter is primary, with life, consciousness and intelligence accidental by-products; whilst spirituality reflects ignorance and primitive magical thinking. The narrative is also 'cognicentric', basing its theories wholly upon ordinary states of consciousness, and systematically avoiding or misrepresenting non-ordinary states (ibid.).

These biases of the dominant narrative suppress alternative 'belief' systems. Good (1994) argued that when we use the word 'belief' we really connote 'falsehood', and mean to dismiss the point of view as primitive or irrational, although this is seldom made explicit. From a narrative perspective this is a serious analytic failing for, as we have seen, the narratives available to us structure our experience of 'reality' (Sarbin, 1986). Supporting the role of narrative in determining 'reality', Warner (2005) suggests that societies which value the spiritual realm have better 'Schizophrenia' prognosis. I will review two 'cultural narratives', selected because they demonstrate the central and varied role narrative plays in shaping experience.

1.7.2.1. Shamanism

Narratives determine how individuals *and communities* understand and respond to PLE. Warner (2005) describes how certain understandings mobilise broad community involvement, and aid social reintegration. This kind of 'social sanction' of PLE is structured and supported by the ancient Shamanic narrative; it demonstrates the kind of community response an alternative understanding can mobilise, and the material implications for all involved.

A Shaman is a healer, who regularly enters non-ordinary states of consciousness (Kalweit, 2000). The career of many Shamans begins with a 'calling', a powerful and involuntary visionary episode – a PLE. Some Siberian Shamans “during the period of the call, are violently insane for several years” (Benedict, 1934:267). Once the initiation is complete, the Shamanic narrative supports a return to the community, and the opportunity to re-define oneself as a fully-functioning and revered figure (Kalweit, 2000). Following the initiatory crisis PLE often remains, but this is expected and culturally sanctioned; the Shaman is typically able to enter non-ordinary states of consciousness at will (doing so to heal others, obtain information, or influence the material world), and is able to control these states

(Tobert, 2010).

This narrative shapes madness, sickness and suffering as spiritual transformation. In this 'reality', PLE signals a metamorphosis, which, once survived, acts positively on identity. The community confers onto the Shaman recognition, status, and the power to define 'reality'; all denied to the 'mental patient'. The community also supports the initial 'reading' of PLE within the Shamanic narrative as “other members of the tribe must help him to disentangle what he has seen and heard” (Kalweit, 2000:87). Shamanic initiates are typically supported by an experienced Shaman, and their transitions are reinforced by rites of passage which celebrate and solidify the spiritual dimension (ibid.).

Silverman (1967:29) suggested that this level of support is “all too often completely unavailable to the schizophrenic in our culture”, which is still true today. Whilst the Shamanic narrative is increasingly available to the 'West', (as revivalists draw on historical and cultural descriptions of Shamanism to produce online resources, books, workshops, trainings, groups and therapies), such understandings are distinctly marginalised in our current context, and do not engender broad community support. 'Western' Shamanic sub-communities have the potential to be influential for those who recognise in their PLE something like 'a calling', and wish to reject a medical understanding, but rarely offer a culturally sanctioned Shamanic role.

1.7.2.2. Kundalini Awakening

Narratives which are culturally compatible may be more likely to be taken up. I now explore how the physiological focus of the Kundalini narrative makes it potentially more accessible to a 'Western' audience.

Classical Kundalini Awakening, described in historical Indian yogic literature from the eighth century BC, is a movement of internal energy through 'chakras' in the

body, said to mark 'spiritual' purification, and to bestow a state of enlightenment (Turner et al., 1995). Within this tradition, practitioners work for many years, under expert tutelage, to learn to guide, control or release this energy; finally achieving an 'awakening' said to represent the practitioners reintegration with 'atman', one's 'true' self (Selby et al., 1992).

The Kundalini narrative was significantly altered as it travelled west. For instance by Krishna (1970), who used Kundalini to describe his own turbulent spiritual awakening; contributing to a 'Western' understanding of Kundalini which incorporated relatively extreme PLE, probably beyond that typical of the classical experience. Following its popularisation during the so-called counterculture movement, a 'new age' Kundalini narrative developed, “connected with the classical kundalini awakening of Eastern spiritual traditions only by theory and circumstantial evidence” (Greyson, 1993:288). As Kundalini was repackaged for a 'Western' audience, previously requisite ascetic practices were marginalised, and personal enlightenment and out-of-the-ordinary experience promoted.

The yogic focus on observable physiological responses provides a meaningful, nuanced and self-verifiable framework for comprehending the out-of-the-ordinary 'pre-narrative' qualia of PLE. Being grounded in physiology may also have facilitated Kundalini being co-opted into medical, and pseudo-medical, discourse – which lends the narrative sub-cultural credibility. Bentov (1977) integrated the yogic descriptions with modern anatomical knowledge, creating the 'physio-kundalini syndrome'; which included “strong and unusual bodily reactions and unusual psychological states”. Both Krishna and Bentov note the resemblance between an early stage Kundalini awakening and 'psychosis'; for instance, a 'physio-kundalini' episode might involve 'internal voices' and 'observing oneself, including one's thoughts, as if one were a bystander' (Greyson, 1993). These authors, and many Transpersonal psychologists, argue that Kundalini awakenings are 'spiritual emergencies' and must be distinguished from 'psychosis' (e.g., Grof, 2012).

The importation and 'westernisation' of the Kundalini narrative facilitates storytelling some kinds of PLE outside of the medical frame (supported by a literature which lends credibility), and potential sub-cultural validation and co-construction opportunities. Storyed thus, PLE marks the beginning of a spiritual 'purificatory process', leading to the healing of unconscious psychic material. Kundalini awakening is universally accessible, and necessary for enlightenment, thus, the experiencer is positioned as more in touch with 'reality' than 'normal' individuals. Conventional psychiatric knowledge is undermined, as it is the psychiatrist who 'lacks insight', reversing the dilemma of the MH 'patient'. Indeed, psychiatric responses to Kundalini are seen as frustrating the process and, therefore, actively harmful (Sanella, 1987). Naturally, the Kundalini narrative also offers hope and meaningfulness, as the expected end result is profound spiritual development (ibid.).

House (2010) suggested that all experiences currently labelled 'psychotic' might be more usefully understood and responded to within the Kundalini narrative; and that those who experience PLE without such a theoretical framework may well fear for their sanity. House contends that PLE is actually less of a 'problem' than is our lack of understanding of its 'spiritual' importance, and our attempts to suppress it; which lead us to offer treatments which cause "profound violence" by retarding a meaningful process.

In summary, PLE experiences can be narrated in different ways, with significant implications for self-narrative; and alternative cultural narratives can be drawn upon in 'Western' contexts. The extent to which this is possible may be determined by the level of community support and the goodness-of-fit between the narrative, pre-narrative experience, and the local narrative landscape.

1.7.3. Alternative psychological narratives

The notion that madness and spirituality share common ground entered the psychological field in its infancy, with William James (1902:337):

“Religious mysticism is only one half of mysticism. The other half has no accumulated traditions except those which the text-books on insanity supply. Open any one of these, and you will find abundant cases in which 'mystical ideas' are cited as characteristic symptoms of enfeebled or deluded states of mind.”

Since James, a number of researchers have addressed the spiritual and transformative aspects of PLE, and tried to account for overlapping phenomenology of spiritual and psychotic experiences. This body of theory positions 'psychosis' as a natural growth-oriented process, thickening the medical model counter-narrative. Furthermore, in doing so it offers a narrative framework that seeks to reconnect spiritual and rational ways of knowing, and to reinstate the meaning of PLE by bridging it back into 'consensus reality'. This literature offers yet another narrative reservoir for those with PLEs, and one potentially more accessible within the MH context.

Carl Jung (1960) might be identified as the forerunner. Jung experienced a period of something very like 'psychosis' himself, and subsequently asserted that 'psychoses' are potentially constructive, image-driven intrusions of unconscious material into the ego. He maintained that PLE was a universal part of human experience, and saw the process as typically functional, i.e., as the beginning of a healing process to correct unbalanced beliefs which were out of line with the collective unconscious. Nevertheless, Jung did not completely reject a medical understanding of PLE; he felt that the 'Schizophrenic' could not maintain ego integrity in the face of such an intrusion, resulting in “self destruction... a disintegration of the means of expression and communication” (p.253), introducing a binary distinction that has persisted throughout the literature.

Perry (1999) was a Jungian-oriented psychiatrist and clinical director of a medication-free residential facility for young adults diagnosed with 'psychosis'. He developed Jung's ideas, suggesting that 'psychosis' is intentionally initiated by the unconscious "when a person finds herself in a state of acute distress, in circumstances that have assailed her most sensitive vulnerabilities" (p.21). Thus, Perry's narrative offers a re-conceptualisation of 'psychosis'; not as the original problem, but as an attempted solution to a serious problem which pre-existed it. He believed that this process drew a disproportionate amount of energy into the 'organismic system', leaving little energy for higher functions, causing the individual to be flooded with 'archetypal affect-images', and inner and outer 'reality' to become confused. Understood this way, 'psychosis' is a process of 'renewal of the self', potentially culminating in greater 'lovingness', 'compassion' and 'unity'. Perry claimed that around 80% of his residents completed this process, and went on 'developing' after leaving the facility. He believed this 'renewal' necessitated a profound disintegration, leaving the individual temporarily 'vulnerable'; and identified the cultural reception to 'Schizophrenia' in Western society as likely to block this natural process, leaving the individual indefinitely confused.

Laing (1960; 1967; 1970) further 'thickens' this narrative. He suggested that if one's sense of being is compromised by external insult, such that one lacks existential solidity, a certain permeability of the self is created. This openness may have advantages in terms of increased creativity, sensitivity, and potentially, access to spiritual experiences – but problematises 'normal' existence, and is occasionally terrifying. Laing argued that what Freud called the 'unconscious' is merely what we, in our culture, are 'unconscious' of; he saw the process of entering the inner world of the unconscious as natural, but culturally-unaccommodated. In line with cultural understandings like Kundalini, which position experiencers as in touch with a 'higher reality', Laing argued that those who enter such domains, through transcendental experiences, or 'Schizophrenia',

have access to something which is 'real' in a different way from a dream, imagination or fantasy. His central thesis being that our modern world, in pursuing a deeper knowledge of the outer world, has lost touch with 'inner realities', and that 'Schizophrenia' was best understood as a sane reaction to an insane world.

More recently Jackson's (2010) 'paradigm shifting process model' proposed that both benign 'mystical' experience and 'psychosis' are instantiations of a "basic, adaptive psychological process, which is also observed in artistic and scientific creativity" (Jackson, 2001:185). Both experiences begin with the same underlying intention of resolving an intractable existential problem: PLE is triggered in the response to conflict, with the intended function of 'paradigm shifting', i.e., radically adjusting firmly held beliefs. PLEs have sufficient emotional intensity to effectively destabilise existing intransigent beliefs, and the content of the experience may offer insights into the original conflict; thus, the process is understood as "a form of creativity which reflects unconscious processing of the problem" (Jackson, 2010:142). Jackson suggests that the difference between the two phenomena is that, whilst in the case of 'mystical' experience the process resolves the conflict (a negative feedback loop), in the case of a 'psychotic' experience no resolution is found (and an escalating positive feedback loop is initiated, creating a 'florid psychotic disorder').

Transpersonal psychology is relatively unique amongst the current psy-disciplines for taking seriously 'spiritual' and 'mystical' experiences. Some kinds of PLE, from this perspective, become "Spiritual emergencies" – "manifestations of the deep recesses of the human psyche that are not ordinarily accessible", and can be "healing and transformative" (Grof & Grof, 1989:6). Grof (2012) argues that because psychiatry fails to differentiate between 'mystical' states and 'mental illness', many are misdiagnosed, and inappropriately treated. Referencing alternative cultural narratives of 'psychosis', including Shamanism and Kundalini, he suggests that, properly supported, these states can lead to an evolution of consciousness. However, Transpersonal psychologists generally avoid

contestation with mainstream psychiatry, instead focusing their attention on distinguishing 'mystical' experiences from 'genuine psychosis', maintaining the validity of both constructs, and the necessity of medical intervention for 'psychosis'. Thus, the spiritual emergency narrative is only officially available to those who receive psychiatric sanction.

Jackson (1997) troubled the notion that these two types of experience can be straightforwardly distinguished. He compared the accounts of individuals diagnosed with a 'psychotic disorder', who reported 'spiritual' experiences, to those who were undiagnosed but reported benign 'spiritual' PLE. Within his limited sample, he found counter-examples for each of the criteria suggested by the literature for differentiating 'spiritual' and 'psychotic' experience. Jackson concluded that the primary distinguishing factor was “the way in which psychotic phenomena are embedded in the values and beliefs of the person concerned” (Jackson & Fulford, 1997:41). Developing this research, Brett et al. (2007), and Lovatt et al. (2010), examined the appraisals and experiences of undiagnosed and diagnosed groups reporting PLE. Intensity of PLE failed to determine group membership, with the undiagnosed group frequently reporting more intense experiences. Supporting Jackson's findings, the key differentiating factor was that the undiagnosed group were more likely to have started having experiences in socially congruent contexts, or within 'spiritual' practice. Understanding experiences as 'spiritual', and having social support, predicted lower levels of distress for both groups, whilst trying to control or suppress the experience was predictive of greater distress.

Extending this work further, Heriot-Maitland, Knight and Peters (2012) attempted to distinguish the factors involved in initiating a PLE, from those determining its outcome. The researchers once again compared a diagnosed to an undiagnosed group. For both groups PLE began following a period of 'negative emotion', generally accompanied by 'isolation' and 'deep contemplation'. Both experienced the PLE as providing 'emotional fulfilment' and 'deep insights', leading the authors

to suggest that their findings provide evidence for 'psychosis' as a “psychological problem solving process” (p.50). However, once again, undiagnosed participants had been better able to incorporate their PLE into their lives. This was, in part, because they had prior conceptual knowledge and open attitudes towards PLE, and, in part, because they were accepted and validated by others. The diagnosed group reported less validation, and saw their PLE as less desirable, and more permanent. The authors suggested that PLE is “adaptive and generally enhancing”, and that the subsequent development of 'psychosis' is determined by whether the experience is coherently incorporated into one's life. So, not only does the psychological literature offer an alternative way of understanding PLE, it also demonstrates the centrality of how the individual and their community understand PLE in determining its consequences.

Advocating for a paradigm shift in the way we understand 'psychosis', Clarke (2010:101) argues that 'psychosis' and 'spirituality' are different faces of a “universal human experience”. She positions herself against the historical agenda, which has been to distinguish healthy 'mysticism' from madness: arguing that the most evidenced distinction, “the disaster that characteristically follows” (p.102), is not particularly stark; and further, that such a dichotomising approach results in an impoverished understanding of both phenomena. Instead she adopts the term 'transliminal' (i.e., that which is beyond the boundary of the self), to encompass both constructs.

Clarke distinguishes two possible modes of being accessible to humans: “ordinary consciousness”, and a “less focussed state” (p.104) associated with spiritual and 'psychotic' experience, but also more ordinary reveries, which is 'the transliminal'. Clarke seeks to support her narrative by integrating the 'transliminal' with mainstream psychology's cognitive theory; for instance, drawing on the Interacting Cognitive Subsystem theory (Teasdale & Barnard, 1993) to suggest that transliminal experiences occur when the propositional subsystem (which represents the 'logical mind') is in asynchrony with the implicational subsystem

(representing the perception of 'the whole'), meaning that “a different quality of experience becomes available” (Clarke, 2010:108), one driven by the implicational system, crucially this experience is no less 'real' or valuable than 'ordinary consciousness'.

Clarke suggests that a “jolt” is required for most of us to move into such transliminal experience, but that for the 'psychotic' the barrier is “dangerously loose” (p.108). She suggests that crossing this barrier results in a state of groundlessness, experienced by some as blissful. For 'mystical' experiences in 'spiritual' contexts the transition back to ordinary consciousness is a natural process. In 'psychosis' this orderly return does not happen; separated from their constructs, it becomes very difficult for the individual to operate in the world; subsequent grasping for meaning within this state can lead to the formation of delusions (Clark, 2010).

Once again the centrality of narrative is suggested when Clarke argues that the valorisation of productive scientific logic in 'Western' society, and the resultant cultural denial of “the logic of archetypes [...] full of paradox and a sense of mystery” (p.110), marginalizes the transliminal, and problematises the transition back to ordinary consciousness, resulting in 'psychosis'. Hence, a society illiterate in the discourse of 'spiritual' experience isolates those with PLE. However, she does not develop this argument further, and, along with other writers (e.g., Jung and Laing), concludes that it is 'ego strength' which determines whether these experiences are temporary and transformational or damaging and hard to escape.

Williams (2012) offers a final variation of this psycho-spiritual narrative of 'psychosis' which frames PLE as universally accessible, and generally transformative. He explicitly integrates several models of PLE, including those discussed above, with 'Eastern' understandings. Williams proposes two universal existential dilemmas: “the need to maintain the survival of a dualistic self with a

world that is fundamentally non-dual"; and, "the need to maintain a balance between autonomy and connection with others" (p.192). How psychologically flexible we are is determined by the width of our 'window of tolerance' (WOT) between these conflicting 'isolation' and 'engulfment' anxieties. When we have experiences outside of the WOT, the psyche "utilizes whatever strategy is necessary to bring one's experience and one's WOT back into alignment" (ibid.). When adjustments directly to the environment are not possible, the psyche initiates 'psychosis'; destabilizing one's cognitive constructs in order to change one's perception of the environment, and opening one up to unitive experiences, "with the intention that these experiences will be fully integrated" (p.181). Personal growth in this model is represented by the resultant diminishment of both isolation and engulfment anxiety as the WOT widens. Williams argues that it is essential that this process be allowed to unfold, and suggests that the nature of the support given during an episode may to some extent impact upon the outcome. However, Williams (like Clarke), suggests that a strong observing ego differentiates 'peak experiences' from what gets labelled 'genuine psychosis', although he is clear that he does not consider them fundamentally different experiences.

Returning to narrative theory, since we are not understood as having identity independent of our position in the social world, the discourses available to us, and the discourses used by others about us, restrict and shape how we construct our 'self' (Burr, 1995). Rather than deferring to the construct of 'ego strength', which has the potential to be deployed in a pathologising fashion, we might usefully consider the role of local narrative resources, that is, what ways of storying their PLE are available to the individual? What can be said (and becomes 'true') about the individual who experiences PLE in a given context? It seems that the potential explanatory value of narrative has been overlooked in favour of more traditional psychological theorising, which, in attempting to offer totalising explanations, marginalises context.

1.8. Spiritually Transformative Self-Narratives

We have seen that, from a narrative perspective, understanding 'psychosis' as medical can be harmful, and that 'spiritual' and transformative understandings of PLE lead to positive outcomes. However, very little attention has been given, even in the qualitative literature, to the stories of those who describe transformative experiences of 'psychosis', nor to the self-narratives of those who realise these alternative narratives in the face of a dominant medical paradigm.

McCarthy-Jones et al., (2013) identified 97 (n=1942) qualitative studies of some aspect of 'psychosis' published between January 2000 and May 2010. Their meta-analysis generated four themes, synthesising the principle findings of the literature as a whole. First, most studies described how 'unshared perceptions' led to disruptions of shared 'reality'. Second, most studies identified a transition from feeling that one was having unusual but manageable experiences, to coming to believe that support of some kind was needed; although most individuals only accessed professional systems once they felt they could no longer cope, and did so with trepidation. Third, they found that sense-making, detachment from experiences, and for some medication, could support participants in re-establishing a sense of self, and either re-joining consensus 'reality' or otherwise coming to a 'meaningful reality' of their own. The final theme, supporting the notion of 'psychosis' as potentially transformative, was 'better than new', so called because, for many, 'recovery' represented not simply a restoring of the old self, but the development of an enhanced self.

Thus, despite the 'rhetoric of scientific sadness', 'better than new' represents a prevalent theme in the qualitative literature. These 'better and new' accounts generally appear as tangential to the overall purpose of the studies they emerge from. Whilst many studies have examined 'recovery' narratives in the MH context, few published studies directly examine this 'better than new' experience, and

fewer still 'spiritual' or 'mystical' narratives of 'psychosis' (Nixon et al., 2009). It seems the medical paradigm is restricting researchers from looking beyond clinical settings, despite such accounts being readily available, and potentially paradigm-shifting. Adame and Hornstein (2006) highlighted that nearly 600 English-language first-person narratives of madness had already been published. These accounts represent an untapped resource, offering an underutilised alternative to medical conceptions of 'mental illness', wherein the apparent simplicity of diagnosis is replaced with complexity and meaningfulness. In line with much of the research above, many of these accounts describe a transformative experience of 'psychosis', often framing this as spiritual or mystical experience (Hornstein, 2011). I will now review the few studies that examine this phenomenon directly.

Peter K. Chadwick, a clinical psychologist, who has also “been psychotic” (2010:64) offers his own PLE narrative as a 'self-case study' (1997, 2010). He describes a childhood filled with hatred from all sides, and subsequently developing an “utterly wretched” self-identity (2010:67). Chadwick describes his first 'psychotic' experience, in 1979, as a portal opening; he was “a vessel being filled with the divine light of god” (ibid.). Some months later, he experienced the reversal of this state, when 'mystical' thoughts warped into 'psychotic' ones. Chadwick, continues to view his experiences as meaningful, and describes having been transformed by the experience of what he calls 'positive permeability', which opened him up to creativity, art, spirituality, and sexuality. He offers a theoretically informed view of his experience which acknowledges both 'spiritual' and biological aspects. Chadwick urges us not to ignore the 'spiritual' aspects of 'recovery', and warns against the damaging potential of pessimistic clinicians, who fail to see the positive side of 'Schizophrenia'. He insists that no one perspective; be it biochemical, cognitive, or spiritual, could ever fully encompass 'psychosis'.

Kaiser (2004) offers another transformative self-case study. He shares his story in

the hope of making a contribution to “healing our deeply wounded humanity” (p.432), and acknowledges the contribution of others' stories in his own journey. He argues that meaninglessness was the most awful aspect of his experience, leading him to feel that he did not really exist; hence, creating meaning was crucial to his survival. He refuses to define himself in relation to psychiatric labels, arguing that his experience of a “seemingly eternal, lived death” (p.443) was transformational. He feels able to live more fully now, because he has known the anguish of the absence of life, which has developed his presence and empathy. Kaiser notes influences on his thinking from existential philosophy, psychology, and literature and suggests that the meaning contained in these works rescued him from 'psychosis'. This meaning “is the liberating truth that suffering does not have to be experienced as irreparably damaging and meaningless but, rather can be experienced as enlivening, meaningful, and sacred source of transformation and healing” (p.451).

These self-case studies, alongside self-narratives outside the psychological literature, offer valuable insights into the subjective experience of 'psychosis' and transformation, and seem to support the theory reviewed above. Arguably though, the self-case study approach is limited by its lack of critical distance. Several broader studies, examining similar phenomena, have been conducted.

Thornhill et al. (2004) were amongst the first to examine interview-produced narratives of those who self-identified as 'recovered', or 'recovering', from 'psychosis'. One of three core 'genres' they identified was 'enlightenment'; a central element of which was “the sudden or gradual dawning of understanding, bringing a new perspective” (p.189). Enlightenment narratives positioned PLEs as part of an ongoing journey. Often these experiences involved facing and reconceptualising previous trauma or abuse. 'Psychotic' processes were seen as offering insight into important psychological and existential issues so that “the psychosis itself can herald the start of a journey of self-discovery” (p.194). The authors did not attend in any detail to the production or co-construction of the

narratives themselves, but did suggest that meaning-making was important to 'recovery'; that spiritual narratives can be transformative; and that current MH practice impedes this process.

Nixon, Hagen, and Peters (2009) conducted a small, but ground-breaking, phenomenological analysis of narrative interviews with six individuals who considered themselves to have had a 'transformative experience' of 'psychosis'. They identified three 'phases' in these accounts. The 'Pre-Psychosis Phase' comprised themes of childhood foreshadowing and negative events common to all participants. The 'Psychosis Phase' included compromised day-to-day functioning, relatively sudden onset of 'psychosis', psychic intuitiveness and unusual visual experiences. All of their participants also reported experiences of dying and being close to the divine. The final phase, 'Transformation of Psychosis', seemed to be driven by 'mindfulness and detachment', 'accepting the dissolution of time into now', 'realignment of career path' and 'embracing a spiritual path'. They concluded that all of their participants "chose to understand their [PLE] as an invitation to embark on a transformational journey" (p.541) rather than accept a medical identity, and, as a result, benefited from the experience. Once again, how these understandings were constructed, and what facilitated this, was not examined.

Williams (2012) conducted a multiple-case study thematic analysis of six individuals who self-identified as transformed by a 'long term psychosis', aiming to explore changes in his participants' 'personal paradigms' from onset to full recovery. He identified parallels in their experiences in relation to six preconfigured categories of experience (e.g., 'the onset and deepening of psychosis' and 'lasting personal paradigm shifts'). The onset was associated with an overwhelming existential threat to the self; to which, Williams suggests, 'psychosis' was a response, initiated by the psyche, to re-establish equilibrium. 'Recovery' involved reconnecting with hope, meaning, and a sense of agency; and psychiatric involvement generally frustrated this process. Finally, resolution

of the process entailed a profound reorganisation of the self. Most of his participants drew on 'spiritual' and 'mystical' understandings to organise their narratives (e.g., around 'enlightenment', 'spirit quests', or 'mediumship'), but this was not the focus of Williams' study (which was to establish the coherence of his own model); and the role of narrative, or implications of available discursive resources, was not considered in any detail.

1.9. The Proposed Study and Rationale

The proposed study will take a Critical Narrative Analysis (CNA) approach to phenomena explored by Nixon et al. (2010) and Williams (2012). I extend their work by drawing on Positioning theory to explore, in-depth, how three individuals narrate their PLE as 'spiritually transformative' and reject the 'patient' identity. I am interested in how 'spiritual' or 'mystical' narratives shape the experience of PLE, and the responses of others to it. In particular, how such a position is taken up; that is, what discursive work is done in the maintenance of that position. Drawing on Foucauldian theory, I explore the discourses they draw upon in constituting themselves as subjects; and what such a position affords them in relation to the MH narrative.

By attending to how people construct 'spiritual' or 'mystical' narratives in relation to dominant narratives which shape their social worlds (particularly when these storylines become oppressive), we might come to understand more about the construction and operations of the medical model narrative itself.

I will make no claims as to the representativeness of the sample, rather I am interested that such a narrative can exist in our culture, and in understanding its operations. Restated, I am concerned with the actual realisation and deployment of spiritual-transformative narratives in our current cultural context.

1.10. Research Questions

In examining these narratives I will attempt to address the following questions:

1. How do individuals who have had spiritually transformative PLEs, story these experiences?
2. What kind of identities are created?
3. Which narrative resources do they draw upon?
4. What does this afford them in relation to the medical narrative?

2. METHOD

Having presented a rationale for my research questions, the following chapter describes how they have been addressed within this study. The research questions, being both explorative and process-orientated, lend themselves to a qualitative approach (Willig, 2008). The questions are concerned with the subjective interpretation of experience by individuals drawing on culturally available discursive resources to create narratives which in turn establish 'selves' that have functions in the social world. They are, therefore, suited to a narrative approach, which considers positioning and the discursive context. This chapter describes the process through which three publicly available narratives were identified online, and subjected to a Critical Narrative Analysis (CNA) grounded in Positioning theory, and supplemented by a Foucauldian critique.

2.1. Research Aims

This study aims to explore three case-studies; public narratives of individuals who offer understandings of their 'Psychosis-Like-Experiences' (PLE) within 'spiritual' or 'mystical' frameworks, in spite of dominant psychiatric discourses; and who make the additional claim to have been beneficially transformed by this PLE. I am interested in how the narrators draw on various narrative resources to make sense of their unusual experiences, how they position themselves in communicating this to others, and what this makes available to them. More specifically I am interested in the implications of these factors for the process of subjectification, i.e., the identities they are able to construct. I am also interested in the relationship between these problematising narratives and the dominant medical model, that is, what are the conditions of possibility of these narratives, and what this might reveal about the operations of a supposedly dominant psychiatric discourse?

2.2. Epistemology

The position taken in this project can be described as critical-realist social-constructionist. This is a complex stance which I will briefly unpack. Social constructionism is not a “single and unified position”, but should be understood as a developing dialogue, comprised of multiple positions and points of origin (Gergen & Gergen, 2003:2). Similarities between social constructionist approaches are perhaps best considered 'family resemblances' (Burr, 2003:2). Broadly, following Burr (2003), social constructionists approaches are brought together through their adoption of one or more key assumptions: They are interested in how phenomena are seen, rejecting an underlying 'reality'; They are interested in the generation of knowledge – its construction; They reject the universal knowledge claims of direct realists, and set out to question these, as well as more 'everyday' assumptions. To do so they privilege the social, historical and cultural context of such knowledges.

Social constructionist approaches take varying position on ‘truth’ and ‘reality’ (Burr, 2003). Critical realist thinkers argue for a 'reality' outside of discourse (Willig, 1999). Whereas 'relativist' thinkers maintain that “there is nothing outside of the text” (Derrida, 1976:158). By taking up a critical realist position I hope to avoid the potential perils of 'naive social constructionism' which can minimize the importance of materiality and embodiment, and become politically paralysing (Smail, 2004). Perhaps more pertinently, I hope to go beyond the text by situating my analysis in a broader historical, cultural and social context. In doing so, I hope to be able to include in my analysis factors 'critical realists' would consider to be of extra-discursive ontology, experiences 'outside the realm of language' and within 'material practices', thus positioning the text 'within the materiality' that must be negotiated (Sims-Schouten, Riley & Willig, 2007).

Thus, in claiming that PLE can be best understood as a social construction, I do not mean to deny that experiences like 'psychosis' exist. Instead I mean to

examine the 'reality' of PLE produced by specific narratives in particular contexts.

2.3. Methodology

The method is designed to identify narratives online which satisfy my inclusion criteria, without unduly restricting which accounts might be included. To subject the suitable accounts to a rigorous and novel analysis which explores the narrative work being done in these accounts, and to ask these accounts to speak back against the discursive environment in which they are situated.

2.3.2. 'Critical Narrative Analysis'

“As it turns out, simply using the notion of narrative as an organising principle does not tell us how to undertake narrative analysis. Narrative-based analysis is not a method as such but rather a theoretical approach to interpreting people’s talk.”

Stephens and Breheny, (2013:14)

Whilst narrative analysis may be suited to a study focused on the co-construction of self through autobiography, it is necessary to determine how such an analysis should be organised. I employed a method of narrative analysis modified from Langdrige's (2007) CNA for two principle reasons: Firstly, CNA, being idiographic, with a strong emphasis on understanding 'life stories' is well suited to case-study work; Secondly, the key distinction of CNA is “the inclusion of a critical moment, where an attempt is made to interrogate the text using aspects of social theory as a hermeneutic of suspicion” (p.130), which allowed me to bring into my analysis some concepts from Foucault's 'toolbox', but more on this later.

Langdrige (2007) suggests that his method should be adapted to fit the data. It should be noted that, herein, it is substantially altered by removal of the 'realist'

phenomenological 'hermeneutic of empathy', which is replaced by an understanding of 'selfhood' rooted in 'relativist' Positioning theory. In many ways it may be simpler to consider this an independent Critical Narrative Analysis, although I am indebted to Langdridge for providing a comprehensive and flexible analytic structure.

2.3.2.1. Rationale for Positioning theory

Positioning theory (Davies & Harré; 1990, 1999) explores how selves are discursively produced in social interaction. Positioning is defined as “the discursive process whereby people are located in conversations as observably and subjectively coherent participants in jointly produced storylines” (Davies & Harré, 1999:37). For Moghaddam et al. (2003:140) it is “concerned with the process by which short-term and small-scale moral orders are established and maintained, and with the way the actions of participants are constrained to flow in accordance with sharply delimited schemata or conventions.” Positioning theory can be contrasted with Role theory (Goffman, 1959); *roles* are relatively fixed, formally defined and stable, whereas *positions* are constantly negotiated.

Positioning theory states that the identity is 'ongoingly' produced, and always in relation to the 'ongoing' production of other selves (Harré & Moghaddam, 2003). We understand ourselves and others through idiosyncratic narratives, *storylines*, which enable us to make sense of actions as *social acts*. By positioning one's self within a storyline, one opens a complimentary position for the audience (which they may accept or reject). The delimiting attributes of the discursive environment (the *moral order*), and the power of the *speech-act*, determine whether one is able to legitimise a *position*, i.e., *one's illocutionary* force. Thus, storyline, or narrative, is a principle determining factor in how individuals position themselves, or are positioned. Positioning theory also attends to the rights and duties associated with taking up a particular position, which influence how an identity is enacted. A triangular relationship between position, storyline, and speech act is central to meaning-making; an understanding of this relationship underpins

Positioning theory (van Langenhove & Harré, 1999).

Hence, within Positioning theory, 'identity' means being “recognized as a certain kind of person by others” (Gee, 2001:99). Bringing analytic attention to roles, duties and alignments gives us an insight to the 'identities' created, and the work that they do. We can see that identities must be situated and produced with an audience in mind; and investigate how a narrator tailors their story to their audience. Positioning theory offers a conceptual tool to explore the selves presented in the narratives, their 'functions' and the duties and rights that these identities confer.

2.3.2.2. Rationale for a Foucauldian “hermeneutic of suspicion”

Ricouer (1996) states that we always see, and speak, from a particular position, whether or not this is acknowledged. Langdrige (2007) takes up this idea in developing his CNA method. He argues for the inclusion of a “hermeneutic of suspicion”, i.e., a critical theory deployed as “an alternative way of seeing: not a way that reveals the truth hidden beneath the surface, but rather a way of taking up an alternative position” (ibid:136), and thereby allowing the analyst to look at the material in a new way. To this end I employed a Foucauldian 'hermeneutic of suspicion' in my analysis. It is worthy of note that this affected the way I connected with and understood the data. However, to return to Ricouer, our understanding is necessarily shaped by the lens through which we view the world. All approaches to data analysis, quantitative and qualitative, require that the data is viewed from a particular position, whether this be explicit or implicit. What is crucial, particularly for the qualitative researcher, is to acknowledge the lens through which the data has been seen.

Adopting a Foucauldian lens will illuminate certain aspects of the data and obscure others. Indeed a central feminist critique of Foucault's work is that his theorising on subjectivity is limited, and that he has little to say about subject positioning (McNay, 1992). In taking up this approach these aspects of

experience might be obscured. What the inclusion of Foucauldian theory brings to this analysis is a nuanced consideration of material-discursive factors, hidden structures and cultural dynamics often beyond the scope of more embodied approaches, and a focus on power. This allows for the problematisation of ideas which might otherwise seem self-evident. Recently a combination or dual-focus approach has appeared in the qualitative literature which demonstrates that analytic methods with different foci and epistemologies can be usefully drawn together to produce more comprehensive analyses (Colahan, Tunariu & Dell, 2012); this current research follows in that tradition.

I will not attempt a summary of Foucault's oeuvre, which is very complex, and of shifting emphasis, instead I defer to his own summary:

“My objective [...] has been to create a history of the different modes by which, in our culture, human beings are made subjects. My work has dealt with three modes of objectification which transform human beings into subjects.

The first is the modes of inquiry which try to give themselves the status of sciences; for example, the objectivizing of the speaking subject in *grammaire generale*, philology, and linguistics. [...].

In the second part of my work, I have studied the objectivizing of the subject in what I shall call “dividing practices”. The subject is either divided inside himself or divided from others. This process objectivizes him. [For example] the mad and the sane [...].

Finally, I have sought to study [...] the way a human being turns himself [*sic*] into a subject. For example, I have chosen the domain of sexuality—how men have learned to recognize themselves as subjects of “sexuality”.

Foucault, (2003a:126)

Foucault produced a massive body of theory; in calling on this theory to support my analysis it is necessary to be selective, and to adopt a 'toolbox' approach to this selection:

“I would like my books to be a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area”

Translation, O’Farrell, (2005:50)

Foucault’s ideas changed over time, and there are countless ways in which these ideas might be employed in an analysis. Indeed, modern day Foucauldian approaches use these 'tools' in many different ways to drive their analyses. For instance, Mary Gordon (2011) utilises his focus on pastoral power and technologies of the self in her analysis of the relationship between teachers and Irish traveller pupils; whereas Jean O’Callaghan (2009) developed a method drawing on his notion of an ethical fourfold to make visible the discursive terrain of students ethical relationships with themselves in relation to procrastination. Willig (2008) argues that there is no single correct method in conducting a FDA, and that this heterogeneity is a strength of the approach. The particular 'tools' drawn upon must be determined by the fit between 'tool', data, and research question, as perceived by the researcher. In taking up a 'toolbox' approach, and adopting only specific Foucauldian concepts, I am following in this tradition. I will now outline key ideas or 'tools' I have taken up in bringing part of Foucault's thinking to bear on the narratives.

Each period of his work lends something to the analysis. In the first period his objective was to understand how people were made subjects through “regimes of truth”. Of particular relevance to my analysis is his exposition of how psychiatry transformed human beings into a particular kind of subject.

In his second period Foucault studied “dividing practices” - those manipulations

which combine 'scientific' discriminations and practices of exclusion, to produce docile and regulated subjects. He came to believe that “power and knowledge directly imply one another [...] there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations” (Foucault, 1977:27). His nuanced exploration of technologies of power illuminated the “micro-physics of power” at the level of the body; how it operates diffusely, and is made up of “dispositions, manoeuvres, tactics, techniques, functionings” (ibid:26). Of particular relevance is the productive nature of 'power-knowledge':

“We must cease once and for all to describe the effects of power in negative terms: it “excludes”, it “represses”, it “censors”, it “abstracts”, it “masks”, it “conceals”. In fact, power produces; it produces reality” (Foucault, 1977:194)

My analysis attends to the normalising/disciplining practices of medicine and the “psy-complex” (Rose, 1979), which act upon identity construction, within the contested sphere of the mental health system. Further, I consider what other productive forms of power are drawn on throughout the narratives (e.g. religious authority, popular science).

Foucault's final period focussed on subjectification, and is most relevant to this analysis. At this time Foucault became “interested in the interaction between oneself and others, and in the technologies of individual domination, in the mode of action that an individual exercises upon himself by means of the technologies of the self” (2003a:147). Technologies of the self “permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves” (Foucault, 2003b:46).

Foucault developed his conception of 'resistance' through technologies of the self. For him, 'resistance' is enacted through a self-constitution grounded in

critique (Thompson, 2003). “Critique will be the art of voluntary inservitude, of reflective indocility. The essential function of critique would be that of de-subjectification in a game of what one could call, in a word, the politics of truth” (Foucault, 1996:386). It “consists in seeing on what type of assumptions, of familiar notions, of established, unexamined ways of thinking the accepted practices are based” (Foucault, 2003a:172).

Foucault (2007) further developed his ideas around resistance, in relation to the processes of governmentality (as opposed to, for instance, revolts against economic oppression), through the concept of 'counter-conduct'; this will be drawn on extensively in the analysis. Foucault described counter-conduct as “the will not to be governed thusly, like that, by these people, at this price” (ibid:75). 'Counter-conduct' highlights the intertwining of resistance with the forms of governmentality it opposes (Black, 2010). In this way it draws on a key Foucauldian insight: that power is relational, rather than something monolithic, something that might be possessed. Thus, 'counter-conduct' is a “struggle against the processes implemented for conducting others” (Foucault, 2007:201), but not a total rejection of government. Foucault highlights that resistance, as 'counter-conduct', involves a preoccupation with the proper and preferred way to be governed, or “how not to be governed like that, by that, in the name of those principles, with such and such an objective in mind and by means of such procedures, not like that, not for that, not by them” (ibid:44). Foucault explored 'counter-conduct' in relation to historical examples of resistances to early forms of pastoral Christianity, and suggested that, rather than rejecting its modes of government, 'counter-conduct' communities mobilized border-elements, marginalized by the early Church (such as asceticism, mysticism, and direct engagement with the scripture), to establish new relationships of 'truth' and power, and to produce a new governmentality for themselves and others. In adopting 'counter-conduct' as a key 'tool' in my analysis I am able to examine how the resistance demonstrated by my narrators can be seen to mobilize the strategies, techniques and power relationships they oppose.

This research draws on the above in examining how would-be-patients redefine, and renegotiate the 'truth' of their experiences and identities in the face of the mental health establishment. Following Foucault, I assume that the formation of the subject cannot be separated from the macro discursive context. Taking up a Foucauldian critique allows me to link personal experiences, in the shape of narrative accounts, to the discursive resources they draw upon, and to the power structures in which they are situated.

2.4. Procedure

2.4.1. The sample

I collected narratives online. My primary data mining tool was 'Google' (www.google.co.uk), which I complimented by repeating the process on additional search engines. I used simple keyword searches (e.g., 'psychosis and spirituality'; see Appendix 7.2.) to identify useful websites. I then 'snowballed' this data identification by following hyperlinks within these pages. I searched manually within this corpus for first-person accounts which met the following criteria:

1. An autobiographical account
2. From the UK
3. In which the author interacts with the psychiatric system, even if only briefly or tangentially
4. In particular with the 'psychosis' or 'schizophrenia' construct.
5. And describes understanding their experience as having been wholly or partially 'spiritual' or 'mystical' in nature.

Many narratives were identified, the vast majority of which failed to meet these criteria. This was largely due to two principle restrictions. Firstly, in identifying stories at the nexus of the medical and 'spiritual' discourses, where many accounts were rooted in one or the other. This restriction was necessary as it is the interaction of these two discourses that is the primary concern of this study.

The second principle restriction on the sample was in finding narratives that explicitly identified a UK context, as location of author and account was typically ambiguous. Given my use of online data I might sensibly have included accounts from around the world, as these all contribute to the unique discursive landscape online. However, as an employee of the NHS I chose to focus on UK accounts, in the hope that my findings can be most easily located within the idiosyncratic NHS medical context, and may carry most weight here. Moreover the treatment, reception and viability of 'spiritual' and 'medical' discourses varies cross-culturally, and this has implications for the material experiences of the narrators, in selecting only UK accounts I have attempted to examine cases which shared a similar meta-narrative landscape. Thus, this research particularly addresses the experience of 'spiritually' transformative experiences in the UK context (although I acknowledge a great degree of cross-cultural discursive interaction is all but inevitable given my use of internet retrieved data).

Just three accounts were identified which fully satisfied these criteria. I will introduce each of these briefly now, and these details will be thickened as each narrative is introduced in the analysis chapter. Note that I am only drawing on information available online, and as a result, complete biographies and full demographic details are unavailable. Each of the narrators asked to be identified, and their works referenced.

2.4.1.1. Sarah

Sarah describes a long career as a psychiatric nurse working with “regressive psychosis” in the UK prior to her “transformative” PLE, which she eventually comes to understand, through a 'spiritual' lens, as a “Kundalini Awakening”. Sarah actively avoids contact with the psychiatric system immediately following her PLE, and may never have come to interact as a 'patient' within the psychiatric system. However, some years after her experience she elected to give a speech to the Spirituality Special Interest Group of the Royal College of Psychiatry. I considered that this speech itself represented an interaction of the medical discourses, and for this reason was considered to meet the selection criteria. This

speech is the only text available from Sarah, and is used in full in the analysis.

2.4.1.2. Spoon

Spoon is 40-year-old Scottish man, he has an MSc in Computer Science, works as a programmer, and has a wife and child. His PLE occurred over several months in 2007, one year after his wedding, although he only came to write the narrative selected in 2009. Throughout the episode he draws on science-fiction metaphors to story his experience, although he also makes use of 'spiritual' and 'enlightenment' constructs, and considers himself transformed by his PLE. Spoon sought to avoid medical interference, however he finally, involuntarily, spent a whole week on a psychiatric ward. The narrative selected was found on his personal website, amongst a collection of other writings; this text was selected amongst others because Spoon identifies it as the most complete description of the events surrounding his PLE.

2.4.1.3. Philip

Philip is a self-confessed “composer, writer, nature photographer/recordist, and promoter of self actualisation”. He describes a long history of involvement with 'spiritual' and 'esoteric' traditions and practices, and considers himself to have become 'enlightened', or, as he prefers, to have attained “fundamental clarity” in 1997. He now rejects all notions of 'spirituality' as flawed or misleading, but continues to promote his own 'reality' challenging notions of “clear mindedness”. He has experienced four hospitalisations resulting from PLE since 2004, which amongst other things, have given him insight into the operations of a universally malignant force, “the garbage”. He describes being transformed by these experiences, and by his own personal development work, or “inner inquiry”. Philip has produced a very large volume of works which might be considered relevant to this research, the narrative selected is his fullest account of his first experience with psychiatry, as it is here that he treats the subject in most detail, and here that we can witness most clearly how his 'spiritual' (for want of a better word) understandings help him to make sense of his experience of the medical model.

2.4.1.4. Sample size

Potter and Wetherell (1987) argue that the success of a study is not dependent upon sample size, a position that contrasts with positivist approaches, which require large samples to achieve approximations of 'generalisability' and 'validity'. The main determinant of sample size should be the research question. A case-study approach is justifiable here, where my aim is to understand how 'spiritual' and 'mystical' narratives operate in relation to psychiatric discourse and PLE.

To this end, I completed a detailed analysis of each narrative. In doing so I was able to preserve and present some of their original structure; and to avoid “getting bogged down in too much data” (Potter & Wetherall, 1987:161).

Following McCarthy and Rapley (2001:159), I work on the premise that the narrative operations I identify in these accounts can logically be anticipated to speak to common features of our culture:

“Cultures are such that their features can’t simply be aggregated or counted. Instead, even very small fragments of them [...], must (as with holograms) display the order inherent in the whole.”

2.4.1.5. Naturalistic data

I am employing publicly available data, an example of “naturally occurring talk”, which may be more appropriate for qualitative analysis than interview transcripts (Potter & Hepburn, 2005). An advantage of this approach is in minimizing researcher influence on the data collected. This might be contrasted with more commonly employed interview data, which is a co-construction between participant and researcher.

2.4.1.6. Online data

Data retrieved from the internet might be criticised as potentially unreliable, and as such, unsuitable for analysis, or less relevant than interview data. My counter to this is two-fold. First, unproblematically assuming 'truthfulness' from either interview, or internet-retrieved, data would be an error. Second, the utility and ubiquity of online information in our society is such that we must take these discursive resources seriously. Online accounts form part of a “vast informational flow” which serves to organise biographies in late modernity (Jones, 2005:293). Individuals experiencing PLE, or positioned as 'mentally ill', may turn to the internet for accessible information. This has significant implications for how they will come to understand their experience. Online information is treated as credible by the 'lay' community; and is increasingly being used to challenge the traditional doctor-patient relationship (Higgins et al., 2011). Moreover, new subject positions have become possible; many who experience PLE share this online, and seek validation from supportive niche communities made possible by the vast numbers of people connected to the network.

2.4.2. Reading the narratives

Ricouer (1981:174) compares reading a text to “the performance of a musical piece”. Freed from direct interaction with the narrator, the reader takes on a powerful and final interpretive role. Therefore, I aimed to engage with the text in as transparent a manner as possible. To do so I adopted Gee's (1991) poetic stanza approach, which requires the analyst to segment the original text into theorised component parts. From base components, or 'idea units', (separated from each other by a forward slash, “/”), through lines (each made up of a single “topic” or “argument”) and stanzas (groups of lines making up a vignette, a particular description of a character, action, or claim). Sets of stanzas addressing the same broad topic constitute strophes; and grouped strophes make up the parts. Working on texts already formatted by the authors occasionally required me to modify this approach so that I privileged their editorial decisions, for instance, over what constituted a 'part'.

I will not claim that meaning 'exists' in the structure of the text; but argue that the creative process of analysis is facilitated by a consideration of structure. Gee (1991:15) argued that narrative research had “greatly undersold how much meaning is, in fact, available in the structure of the language of a text”, and offered his method as a remedy. This method facilitated a consideration of the function and operations of parts of the text beyond the level of word or sentence, and beneath the level of the text as a whole. It also allowed me to demonstrate some aspects of my reading of the text, so that my readers can assess this, and consider what they might have read differently. Finally, free from the labour of transcription, this method provided an opportunity for a deep engagement with the text.

2.4.3. Analytic procedure

The process of reformatting within Gee's framework, like transcription, can be considered the first stage of analysis. I followed a further five phases based upon Langdridge's CNA (2007). It should be noted that my analysis did not proceed through discrete stages, and is better understood as a series of overlapping, iterative phases. Throughout the analysis period, and particularly during the process of synthesising my findings, each 'phase' of analysis fed back into and informed every other 'phase'.

2.4.3.1. Phase 1: “A Critique of the Illusions of Subjectivity”

Langdridge (2007:134) encourages the researcher to turn their 'hermeneutic of suspicion' upon themselves, in what is “effectively a moment of reflexive engagement”. This I did, focussing my reflections on aspects of my own experience which impact upon my reception of the key topics identified as I reformatted the narratives, in light of a Foucauldian consideration of power. These reflections were presented in the introduction (section 1.2).

2.4.3.2. *Phase 2: Identifying narratives, tone, and rhetorical function*

My first reading of the three narratives aimed to identify the 'master narrative', and any distinct additional narratives. I paid attention to the emotional tone of the text which might reveal information not apparent in the content, in particular I attended to changes in perceived tone. I was also interested in the rhetorical function of each part of the text. The rhetorical functions of each strophe, and the narratives as a whole were considered by asking: "What is this particular story doing at this point? And, how?"; and "How are the narrators positioning themselves and to what end?"; I primarily drew on Harré's Positioning theory in responding to these questions.

2.4.3.3. *Phase 3: Identities and identity work*

My second reading of the text examined the 'self' that was being brought into being. Here narratological theories of self were most relevant. Additionally, I was once again drawing on Positioning theory. I attended to the "particular self being brought into being" (Langdrige, 2007:138), how these related to the narratives invoked by the narrator, how the narrators were positioned by their audience and others, and how they chose to position themselves.

2.4.3.4. *Phase 4: Thematic priorities and key constructs*

In this third reading I sought to identify the major themes in the text without losing a sense of the narrative being presented. Langdrige states that this aspect of the analysis is similar to thematic analysis, but here one aims to identify key themes directly, rather than breaking the text apart in order to code meaning. My approach to this stage was to identify the key constructs being deployed by the narrator (e.g., 'Enlightenment'), and to ask what work these were doing with regards to self-narrative, identity work and positioning.

2.4.3.5. *Phase 5: Destabilizing the narrative*

“This stage involves the analyst engaging directly in a political critique of the text” (Langdridge, 2007:136). This is potentially controversial, in that it goes beyond the text; but also, potentially, illuminating. Central to this move is the recognition that we must have “a view from somewhere” (Ricouer, 1996) within ideological structures, and formally taking up another position may allow us a perspectival shift beyond the apparent. Thus, at this stage I brought a Foucauldian “hermeneutic of suspicion” (ibid:139) to bear upon the analysis produced during phases 2 to 4. In this context a 'hermeneutic of suspicion' is a critical theory deployed as “an alternative way of seeing: not a way that reveals the truth hidden beneath the surface, but rather a way of taking up an alternative position” (ibid:136).

This phase began when I made a concerted effort to expose myself to the works and modes of analysis of Michel Foucault. I read his works on the histories of madness, disciplinary, and psychiatric power, and was particularly interested in his readings of practices of resistance and counter-conduct. I re-read the developing analysis and the original texts holding in mind the concepts briefly unpacked earlier (section 2.4.2.2). The claim here is not to have uncovered some hidden 'truth' within the narratives, but rather to offer an alternative perspective.

2.5. Ethics

Each of the narratives exists in the public domain, and the authors were not involved in the study as 'participants'. As such, ethical approval was not sought from the NHS or any other committee. To respect the authors ownership of the narratives, and ensure compliance with copyright law, I obtained consent from each author and the 'Webmaster' of each website (Appendix 7.4). With regards to confidentiality and anonymity, each author requested that they be identified as the creator of the account, and the address of the websites made public, this information is presented in the analysis as each narrative is introduced.

2.6. Evaluative Criteria

In evaluating this study I followed Yardley (2000:215), who proposes attending to the following issues: “sensitivity to context; commitment and rigour; transparency and coherence; impact and importance”. These criteria will be revisited in the discussion.

2.7. Presentation of the Analysis

The analysis is presented in two parts. In the first part I present each of the three narratives. Seeking to retain their integrity, I have preserved each narrative's structure, and sought to integrate the results of phases 2 to 4 of the analysis into this retelling. I introduced themes, constructs, and performative movements as exemplars appear within the narratives. Each narrative is made to speak to the others as common themes and divergences are highlighted.

In the second part my Foucauldian 'hermeneutic of suspicion' functions as a second-order analysis of the initial analysis, and also as an initial discussion.

3. ANALYSIS

3.1. Sarah's 'Kundalini Awakening'

Bakhtin (1986) insists that all talk is dialogic, even monologue, and must be understood within the particular conversational context. Sarah first presented her narrative to a meeting of the Spirituality Special Interest Group (SIG) of the Royal College of Psychiatry in 2007. A written version of the talk was available (retrieved January, 2014) on the SIG webpage. Sarah is presenting to a group of psychiatrists, her only open interaction with Mental Health (MH) professionals as an 'experiencer'. The presumed SIG audience tolerance towards spiritual or mystical discourses may have allowed her to say more than she might have done in a more traditional psychiatric setting.

Sarah titles her talk "A Personal Experience of Kundalini". A single narrative is presented: Sarah is dissatisfied with her life until she begins to experience unusual visual and sensory stimulation, with clear religious overtones. These initial experiences are so intense that they become difficult to manage. By drawing on her own rationality, expertise as a psychiatric nurse, selected confidants, and understanding of alternative spiritual and psychological literature, she was able to "incorporate" this experience, which she primarily constructs as a "Kundalini Awakening", and thereby process negative emotional material. The outcome for Sarah is increased compassion, a new and very personal relationship with God, and a new way of being.

In her opening line Sarah gives us a neat summary of the 'master narrative' she will lay out:

"This talk is my personal account / of a brief psychotic episode / that seems to fit with the classical description of a Kundalini spiritual awakening."

The early tone of the narrative is upbeat, hinting at revelations to come:

“I would now say that it has improved my life beyond all recognition.”

Later her tone becomes more scholarly or educative, e.g. drawing on academic material, before finally rising to a celebratory climax:

“Kundalini is really a beautiful love story”

For the purposes of analysis, I segmented the text into five parts, further subdivided these into eleven strophes, which together made up twenty-seven stanzas. I will take each part in turn, examining the rhetorical function, positioning and identity work, and highlighting key themes and constructs within the text.

3.1.1. Part 1: Introduction

In the first strophe Sarah introduces two key constructs: 'Regressive Psychosis' and 'Spiritual Awakening'. She tells us the story is about a positive transformation, and will be explained in relation to supporting literature.

“After a long career as a psychiatric nurse, / I felt there was something different about my own experience / compared to most regressive psychotic states I have witnessed in others, / and instead of leaving me ill and damaged / I feel transformed.”

Sarah's rhetorical intent is establishing a 'footing'; claiming the right, both as nurse and experiencer, to speak authoritatively about her 'psychosis like experience' (PLE). She seeks a position which grants sufficient illocutionary force to carry the message which follows; and which avoids her being 'malignantly

positioned' (Sabat, 2003). The dialogical nature of the text is demonstrated by the anticipation of critique, and work to counter it. Sarah is preparing to deliver a message which may be difficult to hear.

Sarah describes her own “brief psychotic episode”. Deployed here, the label bolsters her credibility, positioning her as an 'expert by experience'. Refusing the undifferentiated, objectified position of 'patient', she distinguishes her PLE from “regressive psychotic states”; instead her experience “seems to fit with the classical description of a kundalini spiritual awakening”, and has been personally transformative. This differentiation avoids direct contestation inside the psychiatric frame, instead she searches for a vacant position free from pre-established right and duty assignments (Lee, Lessem & Moghaddam, 2008). She positions her original audience outside of their area of psychiatric expertise, and stakes her claim to be able to speak to them authoritatively. She demonstrates a gap in their knowledge, and offers conceptual building blocks to fill it. The audience are ascribed the duty to listen.

In the second strophe Sarah sets the scene for her 'awakening'. She dismisses the medical narrative, and shifts to a spiritual frame. Sarah's description of her “mid-life crisis” serves to demonstrate the coherence of her experience with “Assagioli's Psychosynthesis framework”, thereby drawing credibility from an academic authority, which itself draws on ancient spiritual traditions.

Sarah positions her prior-to-psychosis-self as undeveloped; retroactively reconfiguring this period of her life as a journey towards her transformation. Sketching a “desperately unhappy” prior-self demonstrates the extent of her transformation later in the narrative. Major events, such as divorce, are treated cursorily – where many different tellings were possible, this one denies significance to the lived-experience of the prior-self.

“Despite experiencing an outwardly successful life in material terms, / I was desperately unhappy inside / and I sensed I was not living life in a

way that was right for me.”

“Unresolved grief” introduces a third, apparently psychological frame, setting the scene for the 'awakening'. The last line of the strophe returns to the medical frame, as she works to differentiate her own background from the typical 'patient':

“One major issue was an unresolved grief reaction / I experienced
when my 27 year old partner died in a plane crash, / when I was 25
years old.

As soon as I grieved for him / I experienced my Kundalini awakening.

I was 42 years old / and I was not ill / or taking any medication at the
time / and I do not have any personal or family history / to explain the
crisis.”

3.1.2. Part 2: Kundalini awakening

Sarah describes her 'awakening': from the acute phase, which lasted two weeks (including one week trekking in Nepal); to finding a crack in her “delusion state”, which allowed her to return (albeit permanently altered) to consensus 'reality'; then later, learning to manage less extreme but continuous sensations.

Having differentiated herself from a 'Regressive Psychotic', Sarah begins with the rhetorical intent of establishing 'Kundalini' as credible. Drawing on the Transpersonal Psychology literature she details her physical experience of 'Kundalini':

“The whole thing started with a powerful energy snaking around my
body / and intense heat coming out of my feet.

I was wondering if I was becoming physically ill / but I had no clues as

to what the heat and energy might be / and I did not feel unwell
anyway.”

Sarah emphasises the purifying qualities of 'Kundalini'. Within this storyline PLE is not pathological, but is transformed into a healing of consciousness. Instead, everyday consciousness is in need of 'awakening':

“It passes through / every part of the organism / removing blocks / and
awakening consciousness... / the entire process can be seen as one of
purification... / and may mark the beginning of a process of
enlightenment.”

Sarah seeks to demonstrate how well-contained she was. Unusual thinking characterised her experience, but sharing this problematises her credibility. In response she positions herself as a reflexive observer, open to multiple interpretations, and led in an empiricist fashion by the information of her own senses. Her competence is reinforced as she disavows the more 'delusional' aspects of her thinking, not incorporated within the 'Kundalini' storyline. Competence is achieved, in part, by demonstrating how her ideas were open to review, in part through humour, highlighting the 'absurdity' of her prior-beliefs, and in part by demonstrating ongoing concern for the self:

“On the second night / I had got it into my head / that it was my time to
die.

Needless to say, after a good night's sleep, / I was most surprised
when I woke up the next day.”

Sarah plays down any 'functional impairment' as a rational response to the situation, i.e., by making short-term adjustments to her life, such as choosing not

to go to work, she was able to “function as usual”. In fact, rather than suffering, Sarah was the fortunate witness of PLE, as something profound:

“I also got the general sense that I was not alone / and started to see a variety of beautiful colours swirling around my room at night, / as well as the most exquisite miniature angels flying around me.”

In Strophe five Sarah presents herself as “overwhelmed” by an experience that would meet the psychiatric criteria of a 'delusion':

“Eventually, I felt my crown chakra open / and saw a massive white light surround me; / an archangel came to tell me / that I was to have a union with God, / and give birth to Christ.”

Having previously reported, and repaired, 'delusional' thinking now allows Sarah to describe PLE and to be received as a rational speaker: We are expecting a repair, and are less likely to dismiss this speech act immediately. Sarah instead introduces another theme - communicating PLE. That is, selecting to whom, and when, to speak; thereby avoiding the psychiatric gaze:

“On reflection, perhaps keeping quiet about the whole thing was to my advantage / as it meant I was left alone / to go through the psychotic process / without any medical intervention of any kind.”

Sarah's description of talking herself down from a 'psychotic' brink, of reality checking, and of a considered decision to avoid medical support, demonstrates to the audience her ongoing connection to 'reality', and control over her conduct. She works to demonstrate her familiarity with the medical narrative, effectively positioning against the suggestion that her experience might be better understood as 'illness'.

3.1.3. Part 3: Moving on

Sarah draws again on academic writings to thicken her 'Kundalini' narrative. In the first line she forecloses further use for the medical frame, or the psychiatric 'gaze'; stating that she experienced no "further symptoms". From herein PLE is interpreted within the 'Kundalini' frame. Amongst other things the passage of time since this episode serves to justify this foreclosure:

"This crisis occurred nearly six years ago now / and I have not experienced any further symptoms / or difficulties of any nature / since this time."

She describes having explored the 'Kundalini' literature, and outlines her findings. Her own experience and this literature become mutually reinforcing as a narrative structure from the literature is superimposed upon, and thereby re-positions, prior experience:

"It is clear to me now / that the pattern of my experience / was recognisably consistent with my chakras opening up / one by one from the root to the crown."

Sarah's 'Kundalini' is vulnerable to psychiatric interference. Any "negative effects" become the "result of resistance to purification". A different response is required, which retrospectively justifies having not sought medical attention. Drawing on the Transpersonal literature, the psychiatric response to Sarah's PLE is positioned as damaging. The communication theme is elaborated; Sarah must communicate her experience, and this requires a receptive context:

"I was lucky enough to have a friend to confide in after this episode, who was a medium herself and so did not find my story as strange as

most others would have done.”

This suggests something about Sarah's local discursive environment; we might speculate she has heard similar stories before, and was at least receptive enough to these to remain in contact with her “medium” friend (who may well have 'heard voices' or 'seen visions' herself).

It is interesting that she explores the theme of helpful and unhelpful communication before revealing her “new found paranormal abilities” – potential 'symptoms' within the psychiatric frame. Her statement that, due to lack of understanding from others, she was made to feel “a freak at times” reverses the 'gaze' and positions her audience as potential re-enactors of such persecutory incidents; instating upon them a supererogatory duty to avoid this.

Sarah also takes up new duties with regards to communicating her experience. Those experiencing 'Kundalini', as opposed to 'Regressive Psychosis', are more “interested in sharing what is going on in them”. This bolsters the illocutionary force of the talk: the act of communicating supports the proposition that the experience is 'Kundalini'.

Reorienting the storyline to focus on failed communication, and denied realities, positions Sarah as duty-bound to educate; and the audience as duty-bound to attend with open minds.

3.1.4. Part 4: Integrating experience

The rhetorical function shifts, as Sarah seeks to convey the positive experience and implications of PLE as 'Kundalini', particularly its universal importance. She describes a developing understanding of her PLEs, as newfound “psychic abilities”, which connect her to “higher levels of consciousness”. This “expanded consciousness” revealed repressed “negative emotions”, and allowed her to overcome these, facilitating the development of a new relationship with her

“higher self”.

“Although the acute aspect of this crisis happened over a two-week period, / I would judge that the whole process continued on for a further two and a half years.

It culminated in my heart chakra opening, / which I now understand / to be the ultimate purpose behind the Kundalini rising anyway.”

Sarah's 'Kundalini' is one aspect of a “path we are all on to reach the highest levels of human spiritual development”. Citing spiritual texts, she claims that the level of consciousness she has attained is likely not accessible to those who have not had a “dramatic experience” like 'Kundalini'. Despite this, 'Kundalini' is universally meaningful. 'Kundalini' constructs PLE, not as 'delusion', but as an external stimulus received at a higher level of perception. This 'unreal' experience is a window into previously unseen 'reality'. In this 'reality' Sarah has privileged access to 'truth'.

Sarah introduces her “new found paranormal abilities” in this context; i.e., as at least potentially universally accessible. Even so, these are offered tentatively, in a graded fashion, from sensing spiritual energy in a church, to hearing and seeing spirits. These are positive experiences:

“This is a beautiful feature for me / as now just a walk in the park can be a very moving experience.”

Through PLE 'Kundalini' has made possible the formation of a new relationship with her “higher self”. A developing 'self' does a lot of work in the narrative, positioning Sarah as a key agent. Her storied 'self' demonstrates agency in self-development, in particular when she introduces her recent training in “Psychosynthesis Psychotherapy”, which enabled her to process “negative

emotions and mental vibrations” quite unlike the “regressive psychotic”. As narrator she demonstrates agency through creativity in combining psychological and spiritual discourses in a novel way. This establishes an ongoing duty for Sarah, who must work on herself:

“An unintegrated Kundalini / [...] would have left me impoverished rather than transformed, / I'm sure this would have happened if I hadn't taken the steps I did to work on my inner life after the event.”

Within her 'Kundalini' narrative Sarah is able to deal with phenomena such as “earthbound spirits” as wholly spiritual. She returns briefly to her initial messianic PLE and reclaims privileged aspects. Re-storied these become a window through which Sarah was able to “begin to know what love means”. This retrospective revision stresses the meaningfulness of PLE, regardless of how it was understood at the time. Sarah describes herself as having been privileged enough to temporarily experience herself as Mary, perhaps the closest she will ever get to “Human as realised divinity”. In her PLE Sarah finds joy, pride and compassion.

3.1.5. Part 5: Transformation

Part five serves as an epilogue. Sarah went on to form a new, and direct, relationship with god; and found a supportive 'new age' spiritual community. The central message of the story is presented explicitly – 'Kundalini' should be understood as “a beautiful love story”, and “integral to all our lives”. Once again our ordinary consciousness and 'consensus reality' are positioned as impoverished.

After outlining the development of a “much deeper” relationship with her 'self', the world and other people, Sarah makes a revelation:

“My guardian angel introduced himself to me in July 2006 and I have

now had direct communication with Jesus himself.

From this, I gauge that the subtle level has finally arrived and established itself within me.”

This potential 'symptom' now serves to reinforce Sarah's sense of ongoing development of consciousness. 'Evidence' of psychopathology becomes 'evidence' of achievement of the “subtle level of consciousness”.

Finally, Sarah introduces her new found supportive community, and returns to the theme of communicating experience:

“I have found it vitally important to have my experiences validated / by others who I consider to be sound, trustworthy, in touch with reality and with a good track record / or I would have been in danger of becoming isolated by my changed reality / and worse still left feeling that I was mad.

The White Eagle Lodge [*a global spiritual community*] also provided meaning about the episode itself, / which helped with the process of integration.”

Having a supportive spiritual forum helped Sarah to re-story, or “integrate”, her PLE. Her experience is validated by others who have access to her “changed reality”. This is a shared 'unreality' that organises the conduct of the community. The community offer a counter-reading of her original episode within a spiritual frame. Given that she has only had contact with White Eagle Lodge for two years when delivering the talk, we might question how stable the spiritual narrative was before this time, and whether Sarah had been feeling “mad”.

Overall then, the rhetorical function of the narrative appears consistent – to

describe and define a misunderstood spiritual experience, and to argue that this fits her 'reality' better than the alternative of 'regressive psychosis'. Sarah carefully controls the flow of information that might be considered diagnostically significant. Through a process of release and repair she anticipates her audience's potential diagnostic inclination, and counteracts this. As she establishes a footing this process of repair fades, and her narrative is more consistently spiritual. She is able to use evidence from her direct experience, her reading of the literature, and her competence as a nurse, to make credible her interpretation of this experience as 'Kundalini'. Understood as 'Kundalini' PLE is 'integrated' into a transformative self-narrative. In doing so, she presents a self whose compassion is radically enhanced, and who carries the "Christ child at heart centre".

3.2. Spoon's Enlightenment

Spoon is Scottish, 40-years-old, and married with one child. He studied electrical Engineering at University, and has a Masters in Software Engineering. During an extended period of travel he "attuned to reiki Level 1", and later became a "Reiki Master" upon his return to Scotland. Spoon's narrative appears on his own website (www.iamthespoon.org). The website was created in 2007 to host a number of his writings, produced following the "spiritual experience" described below. The URL is a reference to a line in the film 'The Matrix', when a young boy informs Neo that "the truth is that there is no spoon". In fact, pop-culture references, particularly to 'Sci-Fi', are present throughout the text. Spoon deploys these in the same way as Sarah did academic literature, in creatively interpreting experience.

Multiple texts exist on the site. A single narrative has been chosen for analysis (retrieved January, 2014), which was uploaded two years after the website was registered. We might assume that the text was prepared for publication on the website, and with this readership in mind. Titled "Spiritual Psychosis", the text

represents the fullest account of the events leading up to, and following, a week long psychiatric hospitalisation. Unlike Sarah, Spoon never presented this narrative to a live audience. However, the audience still shapes the text through the narrator's expectations about how the account might be received, and his aims in relation to this.

For the purposes of analysis I followed Spoon's segmentation of the text into ten parts, and Spoon's titles are retained. These I further subdivided into 16 strophes, containing 37 stanzas.

3.2.1. "Part 1: Introduction"

The tone of the text shifts distinctly between parts, as positioning and rhetorical functions vary. Spoon begins on a reflective note:

"At the time this whole experience seemed like a profound spiritual insight to me, / but now seems like an attempt to explain an acid trip / by a bloke who's read one too many Sci-Fi novels."

Two constructs are introduced that will interweave throughout the narrative: "spiritual insight" or 'Enlightenment'; and "consensual reality" (which I read as an idiosyncratic construction of 'consensus reality'). A figure-ground relationship is evident between these two, generally 'Enlightenment' is unfolding on a backdrop of 'consensual reality'. Conversely, this opening statement seems to centre the 'consensual reality' storyline. Demonstrating 'insight' appears to be part of the moral order of 'consensual reality'. The social force of the speech act above is to demonstrate insight as to a possible sceptical 'consensual' reception of the narrative that follows. Spoon pre-positions himself as aligned with this sceptical worldview, as one engaged in critical reflection. In sharing his story he is seeking "integration and closure".

3.2.2. “Part 2: Energy Overload”

Spoon describes the impact of attending a course whilst jet-lagged, opening up to pure joy, and coming to believe he is 'Enlightened':

“The door opened for me in April [2007] / at the age of 33 / when I was on a personal development course in London / and had the insight that various situations that I blamed other people for, / I actually caused to happen myself.”

The door opening marks a biographical disruption, and the beginning of an 'Enlightenment' experience. The prior-self is positioned as flawed - broken by “Dad, School and Society” - and in need of transformation. These experiences are presented within the 'Enlightenment' frame. From this position, the events that follow take on a purposeful quality – the unfolding of a healing process. Spoon is as an active agent; it is his 'insight' which opens the door.

While the tone at the outset is sombre, it rises to near ecstatic by the end of the part as Spoon presents a story-self in transformation; experiencing pure joy as a catalyst, which initiates his “Enlightenment” process. The Spoon shared this experience with the group, saying:

"I am Joy.

I am Love.

Whatever I do, is meaningless.

Whatever I do not do is meaningless. [...]

I am Joy.

I could leave now...

but I'm feeling a bit shaky."

This drew the attention of the course facilitators, who privately asked him to leave.

"I said that I'd been meditating for 15 years / and hadn't gained as much as I had in those few days of the course."

By positioning himself as an experienced meditator Spoon increases the illocutionary force of the ecstatic experiences he has already described, increasing his credibility as arbiter of his own 'Enlightenment':

"As this point, I was fully convinced that I'd become Enlightened / and was somewhat concerned about how I was going to support my family, / not being at all sure that I was going to be able to hold down a job."

Spoon's 'Enlightenment' construct operates upon his PLE, and thus upon the self. Here 'Enlightenment' functions as a discrete stage or achievement: The ecstatic experiences described are part of (and potentially prerequisite for), the path to 'Enlightenment', but are not the same as 'Enlightenment'. Being 'Enlightened' entails a transformation of duties and rights; the new self should not operate in the same way as the old one. For instance, Spoon describes saying something which "weeks later I regretted / as it showed that my ego was very much still in attendance". "Enlightenment" requires Spoon to conduct his own conduct, in order to seek dissolution of his ego. Further, it compels him to review his actions, thoughts, and feelings. There is a splitting function at the level of the self, parts of the former self are being labelled 'ego', and should be transcended – this facilitates the disavowing of undesired aspects of the self. The ultimate duties of an 'Enlightened' self are suggested later, in Spoon's treatment of homeless people:

“I wondered if they too had released all attachment and, / with no need for attainment, / pride, / or desire, sat homeless”

Perhaps the key operation of 'Enlightenment', like 'Kundalini', is in establishing a hierarchy of 'realities'. A single experience can be legitimately within both 'realities', thereby generating separate subjectivities. Spoon narrates not one, but two coexistent selves, which can be tactically deployed. The 'Enlightenment'-self is positioned as 'esoteric', outside of, and implicitly above, the mundane self, which should be disavowed:

“Conversations [with the course leader] took on a strange dualistic quality / in that on one hand they were ordinary mundane conversations that one person would have with another, / and yet at the same time they took on a dual layer of esoteric meaning / as one Enlightened being communicates with another Enlightened being.”

3.2.3. “Part 3: All beings are enlightened”

Homeward-bound, Spoon becomes disorientated; the majority of the text is given over to description of his subjective experience:

“I walked down the street towards the train station / and laughed out loud as I heard a voice in my head say "Welcome".

Three people - my wife, / my reiki master / and a friend from university
- / spoke to me in turn, / congratulating me on my achievement / and welcoming me into a group of enlightened minds.”

The utility of the 'Enlightenment' narrative, and its construction of PLE, are

evident. Like Sarah, Spoon's potential 'symptoms' ('auditory hallucinations') are transformed into profound experience, which confers access to higher levels of reality, and a window onto 'truth'. The voices are confirmation of his transformation, rather than a diagnostic marker. Inhabiting the 'Enlightenment' storyline Spoon is able to respond joyfully. However, 'hearing voices' transgresses the moral order of his 'consensual' storyline, which serves as the background for the unfolding of 'Enlightenment' experience:

“However I also realised that there must be many Enlightened people in the world, / and that in order to live their lives, they behave completely normally / and don't talk about the experience.

So it was with some dismay / that I put away my thoughts of international stardom / and stopped laughing out loud.”

Spoon's 'consensual' moral order is revealed – “in order to live [our] lives” we have a duty is to “behave completely normally”. This includes a compulsion not to speak about PLE, which serves to avoid direct contestation between opposing discourses. Within the 'Enlightenment' storyline this silence is necessitated by the inability of the 'unenlightened' receiver to comprehend. Again any communication breakdown, is externalised - located within the 'unenlightened'.

“I experienced a great web of beings awakening to their true natures, / passing the experience on to another / and then falling back into sleep, / into normal existence.”

This final line summarises the rhetorical function of this part. “Enlightenment” experiences are universal, but generally fleeting. “Normal” and “sleep” are synonymous; those operating only within “normal existence” are viewed as potential but inactive participants in a more meaningful interaction.

“Enlightenment” renders PLE universal, reversing the profound disconnection of

madness. A hierarchy of 'realities' is evident once more. Spoon is closer to 'truth' than those limited to 'consensual reality'.

3.2.4. “Part 4: Death”

Spoon describes how, exhausted and disoriented, he lay down to sleep/die inside the station:

“I watched myself / as I walked around and around a pillar, / wondering if my body would keep doing that until I died of hunger, / or if someone would stop me.”

Two aspects of self are presented, actor and observer. The observer-self exists in the story present, not as a device of retrospective reflection. The observer-self distances Spoon from the outwardly irrational actor-self. Self and action are separated. Thus the act of circling comes to represent exploration, not madness. 'Enlightenment', which distinguishes 'awareness' and 'higher self' from more mundane behaviour, and unpleasant ego, allows one to be rationally and competently aware of one's body acting irrationally – in this way 'mad' action is made unproblematic (or at least understandable).

Remembering advice from the course leader that "Sleep is good", Spoon lays down to rest by the pillar:

“My breathing slowed, / and I felt my heart stop, / my body crumbled into dust / which was blown away by the wind.

After a short time / I opened my eyes, / and was able to continue my journey.”

We can read this as a metaphorical death within the 'consensual' storyline;

however, the experience becomes meaningful as 'reincarnation' within the 'Enlightenment' frame. An appreciation of tone is important; the narrator is serene in the face of death. The supposed existence of a community of “enlightened beings”, who have made this journey before, eases the acceptance of PLE which might elicit fear within the 'consensual' narrative. Again meaning is invested into anomalous experience as 'Enlightenment' facilitates the integration of PLE as part of a transformative journey.

3.2.5. “Part 5: The Underworld”

Spoon enters the London Underground and experiences it as the “Underworld” - the mythical land of the dead. Here the tone is more chaotic, as he struggles to integrate his experience.

“The pendulum swung back again, / or rather, / what remained of my ego / was putting a judgement interpretation / on my experience / and decided it liked what was going on.”

Pendulums swing, circles rotate; a process is in motion, transforming the self, impacting directly on the “ego”. What remains of the ego are those parts which will not to be disavowed. Spoon himself is not disappearing; disavowing elements of the prior-self enables the generation of a new subjectivity.

“The pendulum swung back again / and I realised that I was going to experience / burning to death in one of the railway tunnels...

Again the moment passed / and I realised that however intensely good the highs / and however terrifying the lows, / I'd never be asked to experience more than I was capable of withstanding.”

Within this frame all experience of PLE is meaningful, and enjoyment is de-

centred. Above, Spoon seems to understand his experience in relation to a benevolent 'other' who is 'asking' him to continue and assuring his safety. The 'Enlightenment' narrative governs Spoon's conduct as he takes up a duty to answer the request, in order to be transformed.

Particularly here, in his description of the Underworld, Spoon draws on science-fiction narratives. Doing so connects his account to discourses comprehensible within 'consensual reality'. He draws on the relativist philosophy implicit in much science-fiction to problematise the 'consensual' understanding of 'normal' experience, e.g., when he quotes from *The Hitchhikers Guide to the Galaxy*:

“we will soon be restoring normality, / just as soon as we are sure what is normal, / anyway.”

As time passes underground Spoon's experiences become increasingly celestial:

“One Self, / one soul, / experiencing everything that anyone has / or will every [sic] experience.

So then at that instant / I realised how I am God, / we're all God, / living out these different experiences / one after the other in progression.”

This self is infinite. Not only every experience Spoon has had, but everything experienced in any time or place, is integrated into his Pantheist 'Enlightenment' narrative. Like Sarah, Spoon's prior-self is submitted to a universalising 'higher' self. There is profound utility in realising that he is “God”, and connecting to this ultimate authority – again PLE provides access to 'truth'.

3.2.6. “Part 6: Rebirth”

Driven by an urge to urinate, Spoon makes his way to the surface. In doing so, he leaves the more celestial aspects of his new self underground:

“I jumped up and reality seemed to split.

In one reality, / I took flight and sped off down the tunnel.

In another reality, / I came back to the ground with a thump / - still very much on this plane of existence.”

Multiple 'realities' allows both biographies to continue uninterrupted. Two storylines are juxtaposed in one moment. Both are 'real' in this telling, both happened. The dynamic nature of the relationships between alternate 'realities' and selves is elaborated three stanzas later. Again two selves are present simultaneously, one rooted in 'consensual reality', the other in 'Enlightenment'. Action driven by the biological imperative of urination entails stepping back from 'Enlightenment'. This enables a reconnection with 'consensual reality', at the cost of diminishment of the self:

“As my two selves split further apart, / my experience of myself in consensual reality / because [sic] more vivid and present, / speeding up to match the movement of people around me, / while my other self, / the Enlightened me that had chosen to leave, / slowed down, / thoughts coming less frequently, / quieter and more distant, / slowing into infinity.

Allowing me to remain here / by becoming less.”

3.2.7. “Part 7: Life After Death”

“I felt like, / to an extent, / I'd failed.”

Within the 'Enlightenment' storyline a return to 'normality' is a failure, an unfulfilled duty to be transformed. 'Enlightenment' as a construct is not discredited, but further work on the self is necessary.

Spoon positions against possible 'consensual reality' interpretations of his experience:

“It was interesting that throughout my experience / I didn't hallucinate anything, / it was all a question of my brain / putting a different interpretation on my experience.”

Once again the notion of layers of 'reality' is deployed. PLE is situated in an arena of multiple viable interpretations. Spoon, as self-observer is beyond the psychiatric gaze, he claims the authority to interpret his experience.

“The thing about psychosis / is that it is absolutely real / to the person experiencing it, / at no time did I consider that I was having delusions / and should present myself to someone in authority / and ask for help.”

This is the first time 'psychosis' is deployed, and understandably significant positioning is apparent. Spoon positions himself as knowledgeable about the moral order of 'consensual reality' in relation to PLE, but insist on the 'reality' of his direct experience. So doing, he rejects the compulsion to present to the 'authority' (implicitly referring services back to their disciplinary role).

3.2.8. “Part 8: Back Down the Rabbit Hole”

Spoon recognises that he still has “character flaws” and further self-transformation is required. He deploys the practices of thinking and writing about his experience to achieve this, thereby taking up the duties of his new moral order:

“The two months following this first experience / where *[sic]* spent feverishly thinking / and writing [...]

I took a number of long walks / with some very long trains of thought / - attempting to start everything / from first principles.”

The duty appears not so much to know one's self, but to re-position one's self through a onerous transformation of knowledge. Prior knowledge based on 'consensual reality' is spoilt. Taking up Spoon's 'Enlightenment' storyline entails an imperative to reinterpret everything from “first principles”. The self is transformed by reworking the world around it.

“I had the insight / that there wasn't really any part of my mind that I could call "Me", / it was all just process.

But I think / this insight was very much intellectual in nature, / I understood that there was "no-self" - / or thought I did, / but there wasn't an experience of no self.”

Changes in intellectual understandings are insufficient, ultimate authority has been located at the level of “experience” and self-transformation can only be achieved there. Eventually his practices are successful in as much as Spoon is “tipped [...] back into unreality”, which paradoxically enabled a “fuller experience of reality”. He experienced himself as “artificial intelligence”, as growing “bigger

and bigger”, and as having “Alzheimer's”. Again PLE provides a window to 'realities' inaccessible to his prior-self:

“I felt as if I was slipping between realities / where any array of possibilities might be played out.”

Spoon's wife and mother became concerned about his behaviour. These interactions are treated as second hand accounts, as once again actor and observer are separated, e.g., ““John isn't here”, / I apparently told her”. This same abstraction is amplified in relation to his 'interaction' with MH services, which are barely mentioned, and positioned as almost impossibly removed:

“Some local medical service / delivered two anonymous pills through the door / - tranquillisers.”

3.2.9. “Part 9: Hospital Bound”

“I was taken to hospital / in a police car / by a couple of officers / who clearly thought that psychosis and psychopathy were synonyms / and were looking forward to giving me a good kick-in / if I exhibited any anomalous behaviour.”

Spoon elaborates on the moral order of 'consensual reality' – particularly on a normalising gaze which compels him to hide “anomalous behaviour”. Although this tactical silencing suggests competence, he also describes being lost in 'unreality' at this time. Perhaps reflecting this, he describes little from his week on the ward. Staff are positioned as distant disciplinarians. This description of psychiatric force firmly positions Spoon as a 'survivor':

“I found myself pinned down to the bed / by four orderlies / with my

trousers around my knees / and a hypodermic needle in my arse.”

The only reference to other 'patients' positions them as active co-conspirators, potentially conscious at the 'Enlightenment' level of 'reality'. They spent time together “making endless cups of tea, / [and] speaking in conspiratorial tones”.

Spoon describes being “finally allowed out”, but no further follow up or treatment. An extremely limited engagement with psychiatric 'realities' seems to function to protect his 'Enlightenment' 'reality' from medical scrutiny.

3.2.10. “Part 10: Consensual Reality”

“So now it's been exactly two years / since that initial Enlightenment experience.

I feel like I've been able to integrate it somewhat.”

Integration of Spoon's PLE into a meaningful narrative is an obligation, as it was for Sarah. For Spoon, 'Enlightenment' is now a concrete step towards transformation. While he does not explicitly claim that he is 'Enlightened', elsewhere on the site he makes it clear that he considers himself radically altered by these experiences.

Spoon leaves open an ambiguity which seems central to the operation of the spiritual narrative in relation to 'consensual reality':

“...any experience will leave the experiencer with the choice / as to what they take from that experience.

Is it spiritually significant, / or is it all just being generated by my subconscious / in a psychotic interlude?

I hope the answer is that it's both."

3.3. Philip's 'Garbage'

Philip describes a childhood filled with night horrors and inner suffering. As an adult he became involved with various spiritual and 'new age' traditions. He "crossed the threshold of Enlightenment", or as he now prefers, gained "fundamental clarity" in 1997. Isolated, and troubled by aggressive PLE, he was "incarcerated" in psychiatric hospitals twice in 2004, and found more benefit from two further hospitalisation in 2006. He describes functioning perfectly since this time, and defends stringently against the idea that he is, or has been, 'mentally ill'. He now also rejects 'spirituality' itself, offering his own "clear mindedness" as a mystical replacement. Philip's website (www.clarityofbeing.org) advocates his own brand of "Self-Actualization", and offers a vast collection of his writings. The narrative selected (retrieved January, 2014) relates to his first hospitalisation.

This narrative differs from the previous two in that it is frequently updated, and constantly evolving. Throughout the text Philip inserts footnotes and revisions, which demonstrate an active process of re-storying. A great deal of 'identity work' is done through multiple re-tellings so that the final 'self' presented by the narrative is not the 'self' as character in the storyline, but the 'self' as reflective narrator.

This long text has been divided into four parts, made up of 65 strophes, stretching the limits of Gee's (1991) framework.

3.3.1. "Part 1: What Led Up To This?"

"In the beginning of 2004 / the attacks started with a vengeance, / and that was a desperately trying time for me [...].

The attacking and tormenting 'entities', / which I had no idea at that time / were actually just illusory phenomena / caused by the garbage, / were pretty consistently my only 'company'.

My 'guidance' / (really the garbage, / though I did not realize that at the time) / was getting more and more pushy [...].”

The rhetorical function of this part is to introduce a construct Philip calls “the garbage”, and to use this to reframe experiences he previously understood as “spiritual”. The text represents the active re-working of self-narrative, from a disavowed “spiritual” understanding, in which Philip was channelling “guidance” from his “higher self”, to a self for which this same PLE is attributed to “garbage interference”. Each reference to “the garbage” links through to the site glossary, which explains that this is his preferred term for an external “Dark force”:

“A troublesome non-physical influence / that interferes, directly or indirectly, / with every single person”.

This is elaborated later, within the text, when Philip steps back from attributing consciousness to “the garbage”:

“[...] if you can really talk / of a quasi-autonomous / complex of rogue programming / in thought energy / (a bit akin to a computer virus) / having an intent or plan [...].”

Philip describes how “channelling” messages from what he then understood to be “higher non-physical beings” in 2003, opened him up to an “apparently long-set-up 'campaign' by the garbage” with the aim of weakening his “subtle or non-physical aspects sufficiently for it to be able to take [him] over and make [him] one of its puppets”.

Philip describes how “the garbage” deployed “serious and reckless trickery”:

“the emphasis was on giving me lots of convoluted 'story' / [...] / including alleged / (but actually fictitious) / past lives of mine / and a purported major destiny of mine / for the whole human race”

Buying into this storyline led to:

“disruption of my life / and also causing friends / and acquaintances / to start to back off / and see me as 'getting a bit loopy'.”

Philip (like Sarah and Spoon) positions his prior-self as in need of transformation: Whilst he understood his PLE as 'spiritual' he was being misled by 'the garbage', although he was continually struggling to make sense of PLE. He is 'Enlightened' and, therefore, open to experience, but detached from it. This open-minded stance is central to the selves Philip and Spoon deploy – positioning themselves in proximity to a 'truth' that can only remain a mystery; there will be no final answers, only right modes of inquiry. Claiming that the garbage took advantage of his temporarily “weakly grounded” state he presents a prior-self that was rational, but overwhelmed by largely situational factors (e.g., isolation):

“This did not represent / some stupid belief / that I had taken on, / but was simply the best assumption / that I could make at that time / on the basis of available evidence.

I still actually had an open mind about everything / - but it would have been plain stupid of me / to be so 'open minded' / that I simply did not engage at all / with my very real experiences / and operate on the basis of the best working assumptions / that I could in the circumstances.”

This positioning allows him to disavow prior-beliefs, and to defend his fundamental rationality – he was misled by “illusory phenomena”, which are storied into the 'garbage' narrative as external to the self, and ultimately to be overcome.

It is through his articulation of a 'self as narrator' that we learn how Philip currently conceptualises his experience, and constitutes himself as a subject. By reinterpreting his PLE in light of a developing “working model” (i.e., chiefly caused by 'the garbage'), he is able to re-story and re-position himself. His transformed self has a special relationship with 'the garbage': he was targeted by it from an early age; has seen its workings; and thus is no longer as susceptible as others. Throughout the text, we learn that 'the garbage' operates between “What is” (roughly 'reality') and perception. Direct experience can no longer be trusted, and must be subjected to truth-testing through regimented self-exploration (“inner inquiry”). Philip is compelled to review and re-story his experience, or else be misled. As self-actualized-narrator, Philip claims authority over 'truth'.

'The garbage' is metaphorical, the clearest description of an unknowable force, which Philip is attempting to describe in his 'Working Model'. Its metaphorical nature does not limit its efficacy. Drawing on the construct Philip is able to re-story what, through a psychiatric lens, may have been read as 'grandiose delusional beliefs', as not only external to the self, and 'real', but also meaningful in facilitating a deeper understanding of 'reality'. Although in this story PLE is not straightforwardly meaningful (as it was for Sarah and Spoon), it can be rendered meaningful through 'inner inquiry', allowing Philip a unique insight into the operations of 'What Is'. This leaves Philip in a position to benefit mankind, upon whom 'the garbage' still operates.

Like 'Kundalini', and 'Enlightenment', 'the garbage' is a universal force. Lack of insight into its operations leaves us susceptible, hence Philip positions his audience as probably under the influence of 'the garbage'; undermining the authority of our experience, and the credibility of traditional authorities (scientific

and religious), which are likewise corrupted. Philip can determine what is valid in others' experience, while they themselves have no way of making this distinction (without following his program of "self-actualisation").

Following five sleepless nights, Philip came to believe he was cursed, would die as his guts liquefied, and fall into a "succession of hells". This was sufficiently frightening that he sought help from a "healer" acquaintance, his neighbour and "two women" at a church – this communication was controlled:

"I deliberately used language / that would mean something to them."

His neighbour, "a bit worried", contacted NHS Direct. As a result "two very nice policemen called at [his] door", and Philip, happy not to die alone in his flat, allowed himself to be escorted to hospital. It is only once he was transferred from A&E to the Psychiatric Unit that Philip became alarmed:

"NO! Not there!" I exclaimed at once / - a bit shocked, actually, /
because it had not crossed my mind that what was happening to me /
would get interpreted as a psychiatric issue / - 'mental illness', of all
things!"

3.3.2 "Part 2: Enter My Prison"

Philip describes his first days on the ward. The rhetorical function seems to be to demonstrate the rationality of his current 'garbage' narrative.

At first, his storyline self, still convinced of the "curse", finds relief in having found a venue for "a peaceful death". He then experiences a terrifying descent into hell, followed by troubling ideas about having been replaced in the outside world by a doppelgänger. Ongoing development of the 'self-as-narrator' through re-storying

is evident: from a 'spiritual' telling, to one rooted in 'the garbage'. 'The garbage' storyline incorporates all PLEs, in fact, all experience. 'Spiritual' experience is 'real', but implanted by a malignant force. Being 'real' the experience is retained as meaningful for the self, if not beneficial. It is by facilitating the transformation of 'truth' (i.e., by revealing the operations of 'the garbage'), that PLE contributes to the transformation of self:

“As I well understand in retrospect / from my much greater clarity now, / some years later, / what was really going on was that, / with me still having a fair degree of ungroundedness of a particular part of my awareness at that time, / the garbage was constantly / and mostly covertly / feeding into my mindspace 'pseudo-thought' messages”

The susceptibility of the prior-self to such covert interference might represent a threat to identity, and to Philip's credibility as narrator. Repositioning himself as strong enough to defy 'the garbage' addresses this:

“I think actually the garbage / was failing quite magnificently in that trick, / because I am sure its real aim was to get [the belief that I would die] established sufficiently deeply in my system / that it would [...] potentially fatally, / bring about a sort of 'subtle energy' feedback loop of self destruction / though believing that I actually was then rapidly disintegrating [...].

Yet in practice, my consistent open-mindedness / and also my consistency in progressively grounding my awareness / while I was there in the hospital, / prevented any such thing from happening.”

On his first morning on the ward Philip felt well enough to return home, but found his status as a voluntary 'patient' in question:

“I was kept in / - and my following my 'guidance' / to seek to escape /
just led to my being stopped each time / and clearly being regarded as
some sort of unstable miscreant”

Repeated attempts to escape the ward led to Philip being “hustled off to the so-called Extra Care Area, where difficult characters [...] could be restrained as necessary”. The following night, still in “seclusion” Philip received “directions from his guidance” to allow himself to be teleported out of the hospital:

“However, several apparent attempts failed to work / and I was
directed / to put up a big show of agitation / to get out, / so that I would
be sedated, / and then, when I was sedated, / it would all work.

So, having some degree of acting ability [...] / I acted my part / and
duly got sedated / by the ward doctor.”

Philip's act of “agitation” is purposive within ‘the spiritual/garbage’ storyline, but is received, as intended, within the psychiatric frame as sign of 'pathology'. As a result Philip is sectioned:

“However, just being myself / and visibly well / was one thing, / but I
had already set the machinery of the Establishment in motion.

When I came out of the isolation room / and met my guards (nurses) / I
had a piece of paper given to me / explaining that I was now put under
the provisions / of the infamous Section 2”

The MH system as “Establishment” is positioned as inflexible, misguided and oblivious to the fact that Philip is “visibly well”. Within 'the garbage' storyline nurses are essentially supportive, but blind to the true nature of 'reality'. He attributes their supportiveness to his own natural openness and friendliness,

which had won them over. Where nurses did not comply with this friendly expectation, they were being “constrained by a rotten system”.

His positioning with regards to the ward psychiatrist is complex. At the time he believed him to be an “angel incarnation”, rejecting this 'spiritual' understanding later, he reworks this into 'the garbage' storyline, reversing the diagnostic gaze:

“Basically, / according to my more recently developed working model, / he would have been either a no-soul incarnation / (as I am) / [...] thus potentially would have had unusually deep awareness.

My much more recent inner inquiry results / are suggestive that what was causing him to have such a lack of awareness / superficially / was a spirit attachment [...] / used as a means for the garbage to control him.

Without a doubt, / if he had not had that 'entity' issue, / he would never have had anything to do with psychiatry.”

3.3.3. “Part 3: The Patients”

The rhetorical function here appears to be to discredit “misguided psychiatry”, and to offer in its place his own method for “clearing emotional issues”. In the first strophes of this part Philip develops a description of the 'patients' en masse. Pre-positioning himself for this task by taking up another label:

“As far as I was concerned, / I myself was not a patient / but simply a prisoner.”

In differentiating 'patient' from 'prisoner', Philip distinguishes himself from the 'patient' body. He used the term 'prisoner' on the ward, which led to people

feeling uncomfortable:

“Not that I wanted to create disharmony as such, / but in this place to speak your truth / meant inevitably a certain degree of 'rocking the boat'.

If other people had previously been prepared to risk 'rocking the boat' / in order to speak their truth / I need not have been in this situation in the hospital now.”

Within 'the garbage' storyline the act of rejecting the 'patient' label is invested with significance; it becomes part of a larger resistance against an oppressive system, which unwittingly facilitates the operations of 'the garbage'. Philip is a lone maverick, standing up for 'truth'.

Under the influence of psychiatry the 'patients' believed “there was little about them / that was even worth their lifting their heads about”. Philip juxtaposes this with his own stance, “even then [...] / standing my full height / in body / and mind”. He positions the 'patients' as passive, docile bodies, unthinkingly awaiting 'cure', and buying into 'the garbage' delusions of the medical staff:

“none had any idea of what *really* getting better entailed, / and none appeared to have any coherent notion / of any positive direction for their lives.

Seeing that all the indications / were that the doctors had no idea either, / it was evidently a case of the blind leading the blind.”

Philip elaborates on his relationship with one 'patient' in particular, who he then saw as a “powerful being of light”, however, he continues to position himself as the only one who really sees 'what is'. The “lack of rapport” Philip experienced

with most of the other 'patients' is located in the 'unenlightened' other. He denies the validity of any "mental illness", dismissing labels like "Depression" and "Schizophrenia", instead suggesting that these are manifestations of different kinds of "garbage interference", and better responded to with his own "self-actualizing" techniques, developed from and verified by direct experience.

3.3.4. "Part 4: We Want To Keep You Under Observation"

The rhetorical function of this final part might be universalising the benefits of self-actualisation. Towards this end Philip continues his critique of psychiatry. Like Spoon, Philip draws on literature, referencing Kafka to position the psychiatric institution as a "labyrinthine, / depersonalized / bureaucracy".

Philip thickens his description of the doctors, who are "bemused by" his "rapid recovery" and left without a proper frame of reference for understanding the process. As a result, Philip is a source of fear and embarrassment to them. At times this fear leads the psychiatrists to "primitive and petty" behaviour, such as deliberately delaying ward rounds:

"so it appears / that the doctors' behaviour / was a deliberate snub for me.

I suppose it was the way / they routinely treated anyone / who really spoke up for themselves / and did not 'toe the Party line'."

Through the following strophes Philip describes his frustration at his experience of ward rounds: including cancellations, delays and unreasonable questioning. After nearly two weeks Philip is allowed a home visit, with follow-ups, before returning to the ward for a final meeting, diagnosis, and his official discharge. Philip describes the reception of his "special qualities" (e.g., spiritual guidance, having a higher purpose) in a ward round setting:

“it was clear that, / to these men of limited outlook, / my receiving guidance / was none other than 'hearing voices' / and thus, in their eyes, / to be seen as a psychiatric disorder.

For them, the expression 'hearing voices' / was like a Pavlovian trigger.

I got the strong impression / that their minds were loaded with a small / and unedifying repertoire / of such trigger expressions / that rang the "DISORDER!" bell for them.”

Philip rejects the psychiatric frame by reducing it to the absurd. Equating diagnosis to a reflex action (effectively deploying psychological 'truth' against psychiatric 'truth') positions the psychiatrists as unthinking and reactionary. This is problematised when Philip as narrator disavows his 'guidance' as the work of the 'garbage'; he is clear though that the psychiatrists were still making a “woefully inaccurate assumption / that [hearing voices] is just malfunction of the mind or brain / and that there is nothing external / actually communicating with the person”. Like Spoon and Sarah, Philip's PLE remains external to the self.

In what is becoming a complex truth-game Philip reverses the gaze as he tells us that the suggestion that his PLE was “hearing voices” allowed:

“my first really strong nudge / towards beginning to understand / the universality of interferences from the garbage, / so that I could before long / start to use my own experiences / for the benefit of mental healthcare generally / on a global basis / - as I am now doing, / largely through this website.”

The universal and external nature of PLE storied as 'garbage interference' provides Philip with something of value to offer on “a global basis”. He expands this beyond mental health, suggesting that “virtually all unbidden sexual desires”

that people experience are caused by 'the garbage' steering them away from "love" and towards "self gratification". Elevating 'the garbage' in this way, Philip is able to position himself as a potential prophetic leader. His struggle is not through madness, but out of basic insanity – we can all learn from his path. He has something significant to share with the world. Tragically, the world is unable to hear it.

The doctors' final response to Philip's "special qualities" is a diagnosis of "Mild Schizotype". Storyline Philip positions himself alongside "Jesus and all our healers and spiritual teachers", whom, from this "limited outlook" would require "hospitalization and treatment / to bring them down to a blinding mediocrity / of some supposed normality". Reviewing this as narrator, through the lens of 'the garbage', Philip expands his reach still further, all these spiritual teachers were in fact, "under covert control from the garbage" and "the way forward for every one of them would be through the sort of healing / self actualization methodology that I present".

In the final strophes, Philip introduces a "distinct air of something akin to sadness" about his doctors, as they had:

"some inner sense, / probably not really formulated in their minds, /
that I was not only beyond their reach / but also that I had something
precious / that they felt was barred to them".

This serves as an example of the universal value of PLE as transformative experience. The doctors are trapped by "blocked awareness" in a mediocre 'reality', with "no idea of what real happiness was like". Philip's 'reality' is precious and barred to them, not because it is physically unavailable, but because it is repressed by fear, or social obligations.

In summarising, he re-stories his own experience, with a new sense of agency. In the re-telling his PLE episode began when he "initiated the positive changes"

which:

“meant stepping outside my limits / as perceived at that time, / the prospect of facing disapproval / from some quarters / and losing certain friends / could feel intimidating and scary, / but this became outweighed / as I gave proper consideration / to where I could be pointing”.

Finally, Philip, transformed by knowledge of 'the garbage', is able to step back from negative ways of relating to others:

“I am beginning / to draw in people / who are truly like-minded / and LOVE me / - and that love is mutual.”

This brings us to Philip's final message. If we can step beyond our own “limited outlooks”, and open up to “What Is”:

“We discover / more and more / that it is as though the world, / the Universe, / the entirety of 'What Is', / has been ever so patiently waiting all along / for us to make each step / and gently encourage us forward to the next one [...] / thus maximizing the abundance and variety of our life experience.”

4. FURTHER ANALYSIS

4.1. A Foucauldian Hermeneutic of Suspicion

We cannot have a “view from nowhere” (Ricouer, 1981). Here, I take an explicitly Foucauldian position to 're-viewing' my initial analysis. I will draw primarily upon Foucault's discussion of 'counter-conduct' in relation to the Christian Pastorate (Foucault, 2006a), as I have identified certain correspondences with the 'resistances' evident in the current accounts. The narratives could be read as 'counter-conducts' not only of psychiatry, but of a particular form of neo-liberal governmentality.

For Foucault, resistance entails a self-constitution based upon critique (Thompson, 2003). Critique offers opportunities for self-creativity within a restricted field of possible action. The three narratives, as critiques or problematisations, can be seen as acts “of voluntary inservitude, of reflective indocility” within this field of possible action; the essential function of which is “desubjectification” (Foucault, 1996:386). Such a critique “consists in seeing on what type of assumptions, of familiar notions, of established, unexamined ways of thinking the accepted practices are based” (Foucault, 2003a:172).

In the three narratives we witness a tactical reversal by which particular understandings of PLE are utilized against the structures of psychiatric power. Two modes of critique can be identified. The first addresses the dimorphism between psychiatrist and 'patient'. The accounts reverse the psychiatric gaze. This is a 'game of visibility' – the 'patient' moves from being seen, to seeing. Speaking on visibility, Foucault argues that power is most tolerable when masked. Removing the mask is one possible act of counter-conduct. The extent to which these accounts trouble the psychiatric mask varies; what is universally brought into question is a related 'mask', a material-realist conception of what can

be said to exist. The 'reality' of PLE makes visible the restricted world-view of psychiatry (most explicitly for Philip), and the limits of 'consensus reality' (for all three). Here, being 'imprisoned' in a mental hospital speaks to the madness of the system, not the madness of the narrator. In reversing the gaze, the narrators escape the subjectification of examination, and reject identities as 'mental patients'. They are then able to take up the position of observers, whose experiences allow insight, and the space for critique.

The second, interrelated, mode of critique could be called 'truth games'. Reversing the gaze problematises the absolute right of non-madness over madness; the psychiatrist's position as "master of madness"; and his privileged position with regards to the proximity to truth (Foucault, 2006a). Locating insanity within the psychiatrist, and the medical system, invokes a suspension of their power to determine 'reality' for the would-be-patient. The psychiatrist no longer functions as the conduit between the would-be-patient and the 'truth'. All three accounts take up the ancient discourse which associates madness with wisdom (Foucault, 1970); for the narrators, PLE provides immediate revelation, and direct access to 'truth'. Each of the accounts reverses the hierarchy of 'truth', demanding a dialogue in response to psychiatric monologue, and insisting that psychiatry and the 'realists' learn from their experience.

These accounts represent a "revolt of conduct" (Foucault, 2007:171), that is, 'counter-conduct' developed in response to "crises of governmentality". The accounts share crises' brought about by a refusal of authority, such as that outlined above. As each account responds to these crises, they can be read as idiosyncratic versions of spiritual 'counter-conduct'.

According to Foucault (1980:131) "we are subjected to the production of truth through power and we cannot exercise power except through the production of truth". The 'truths' produced by these 'counter-conduct' narratives share certain correspondences. Each draws on a 'bricolage' of 'New Age', 'spiritual' and psychological discourses (themselves bricolages of older technologies). Each

makes an appeal to what Foucault has called a “metaphysic of the infinite” (1970:316), a transcendent order of representation outside 'consensus reality'. The grand project of each appears to be giving birth to a new kind of human experience (although these 'projects' need not be achieved in order for the 'truths' to be productive). What must be achieved is a transformation of the self; there remains a need for salvation (although not from 'illness'), and a duty to conduct one's own conduct.

The narrators demonstrate ongoing concern for their own conduct. They have not freed themselves from power relations, but repositioned themselves within them, such that new possibilities for action become available. Consequently these 'counter-conduct' strategies function as a sort of internal-'pastorate', a different governmentality. This new governmentality is not equivalent to that which it replaces. It is a 'self' centred struggle. The privileged status of PLE, the immediacy of communication, to some extent escapes pastoral power, and allows a shift of authority towards personal experience. Because it is an exercise of self-on-self “the authority, presence, and gaze of someone else is, if not impossible, at least unnecessary” (Foucault, 2007:204). Authority over the self leads to a “reversed obedience which becomes egoistic self mastery” (ibid:207). In fact, because they draw on a bricolage of discourses, each narrator comes under the influence of multiple authorities, but no one formative authority. Thus, there are ongoing and significant obligations for our narrators, most evident in their disavowal of unenlightened modes of behaviour, thought and feeling. These 'counter-conducts' then, have their own privileged dogma, hierarchy, rituals, postures, and forms of social action and community. The psychiatrist-patient dimorphism is replaced by a dimorphism of 'enlightened' and 'unenlightened' individuals. These binaries are not equivalent, the new order is less determinate; enlightenment is a state rather than a trait and is theoretically universally accessible.

Foucault developed his notion of 'counter-conduct' into 'subjectivation' (Kelly, 2013) – the process of producing a mode of existence for one's self, which itself

can be a form of resistance. As Foucault (2006b:252) wrote, there is “No first or final point of resistance to political power other than in the relationship one has to oneself”. This is less reactive than 'reversal', as one acts autonomously in caring for oneself, within the confines of the possible field of action. As Kelly (2013:513) summarises, “the subject constitutes itself in different forms at different times through the use of varied practices, but always by distinguishing itself from the physical body that engages in those practices”. Our narrators' 'counter-conduct' actions represent 'techniques and practices of the self' – such as 'Inner Inquiry' or disavowing desire – through which they constitute themselves, in an active fashion, as something more than a physical body. Foucault stresses that these practices are not pure invention: “They are models he finds in his culture and are proposed, suggested, imposed upon him by his culture, his society, his social group” (1997:291). In response to ambiguous and disintegrated PLE, and a 'crisis of governmentality' the authors make attempts to know themselves and 'reality' anew, putting into practice new metaphysical conceptions of themselves by assembling a bricolage of the available discursive resources. In doing so, they avoid being 'malignantly positioned' by the mental health system (Sabat, 2003).

The bricolage, being diffuse in nature, having an absence of leaders, allows for a certain creativity regarding the subjectivity produced. The narrators take agency in selecting by whom they consent to be conducted – who will lead them and in what direction they will be led. Each narrator calls on and privileges certain texts (i.e., spiritual, academic, sci-fi, and literary) – a purposeful sampling of the ways humanity has understood itself. No one text is given ultimate authority, even 'spirituality' itself can be disavowed. Psychiatry backgrounds its texts, and locates authority in the psychiatrist who interprets the word. Here, the texts speak for themselves and have no need for authoritative relay, at least for the narrator. The abundance of potential texts allows for considerable flexibility in agency. The three narratives are united within this multiplicity only insofar as they are orientated by a conception of self-transformation.

Considerations of community and communication are vital for the narrators in

situating themselves acceptably within 'society', and thereby retaining this creativity. With regards to communication, they have not escaped the compulsion of confession, as communicating their PLE seems requisite to 'integration' and transformation. The ineffability of PLE therefore problematises their 'counter-conduct'. The narrators' responses to this problematisation draw on the unenlightened-enlightened dimorphism: communication failures are externalised, and transferred to the alternate 'unenlightened' node, who is subjectified as 'unable to see the truth'. Thus, the construction of an authoritative 'higher self' instantiates a certain isolation from devalued 'normal' people, at the same time that universality and connection are emphasised. A practice of silence develops, as the narrators refuse to speak in contexts in which they may be misunderstood. By selecting their audiences they are more likely to enjoy what Foucault, in another context altogether (1976:6), has called the "speaker's benefit", i.e., "to utter truths and promise bliss" is an appealing position to speak from. They take up the prophetic pose of the sage, who speaks for humanity: "outside of power and within the truth" (ibid:130); but only insofar as they speak in the appropriate context.

Connection to like-minded communities legitimise the accounts. Foucault identified the power implicit in mystical communities that made alternate readings of Christian scripture. In much the same way, spiritual communities, such as Sarah's White Eagle Lodge, offer counter-readings of 'reality' and 'mental illness'. By disqualifying the psychiatrist's role, these communities allow new subjectivities to emerge. They are connected by a mutual 'unreality', a failure of the modernist paradigm to account for their lived-experience, which allows them to co-construct a new 'reality'. While real-world relationships are clearly important to our narrators, the presence of these accounts online highlights the importance of virtual communities. Cyber-communities offer a place of inclusion, and a site for subversion; where counter-narratives can be shared. Online it is possible to enter into confrontation with the psychiatric discourse without having to subject the embodied self to scrutiny. Each of the narrators has found online a space for agonism, which opens up the possibility of new subjectivities, and allows

madness to emerge from its silence. Moreover, sharing their accounts publicly positions our narrators as modern sages, whose identity claims can be bolstered by supposed or real followers.

Finally, I will consider the consequences of this counter-conduct for the medical model of psychiatry, and neo-liberal governmentality more broadly. The unsuccessful exercise of psychiatric power reveals possible points of insubordination, which were points of 'escape' for the narrators. For instance, consider how, despite being sectioned, Philip would not be forced into the 'patient' role, rebranding himself a 'prisoner'. Psychiatry, with its prodigious surplus of disciplinary power, is shown to be vulnerable to the power of the 'patient', who, by refusing confession and psychiatric pastoral authority, can refuse to establish the psychiatrist as a doctor, and pull away the 'mask' by referring him back to his disciplinary role. Both Spoon and Philip explicitly use their 'incarcerations' to develop their critique, allowing them unique insights. By intensifying and extending its power, psychiatry was forced to reveal its limits. However, the narrators' practice of silence reduces their impact on the local psychiatric systems. By publishing their stories they may facilitate others in taking up such stances, hence, although the resistance is initially individual and private, it becomes serial and public, through resonance.

These narratives transgress the limits of authority. "Transgression forces the limit to recognize and acknowledge what it excludes, and hence "the world is forced to question itself" (Foucault, 1967:231). The accounts transgress, and to some extent trouble, the reason-unreason divide. However, for all three narrators, demonstrating adherence to other modes of 'normalisation', that are the bedrock of neo-liberal governmentality, is central to their avoiding the disciplinary arm of psychiatric power. Essentially, the accounts seek to bring PLE into the 'normal' fold by demonstrating the competence, rationality and lack of 'idleness' of the authors. Whilst there is an implicit critique of the modernist paradigm, this too is minimised by the compulsion to silence. Hence, these narratives are not a rejection of governmentality and neo-liberalism, per se, but of a local and

individualising, essentially pastoral, power over another's self. They represent a move to resist control of the self, not of the collective.

At times, then, these accounts go beyond reversals, which affirm a value for madness which has been repressed. By stressing their unique insights, and particularly the externality of PLE, and, therefore, its importance in relation to 'what is', they suggest we all must open ourselves up to 'unreality', in order to comprehend the 'real'. In universalising the value of their experience, they take up an argument that Foucault himself had made: that a new ethics is required; and that this requires tearing down dividing practices. They authors' argue their examples could open up a space for a new form of experience. They trace a path Foucault described as an "aesthetics of existence", in which each takes him/herself as "object of complex and difficult elaboration" and "makes of his body, his behaviour, his feelings and passions, his very existence, a work of art" (2003b: 50). These narratives, by attempting to universalise this message and, thereby, to take action upon the action of the audience, are themselves instantiations of power.

5. DISCUSSION

5.1. Purpose of the Thesis

I will now demonstrate how my analysis can be made to speak to my research questions.

5.1.1. How do individuals who have had spiritually transformative Psychotic-Like-Experiences (PLEs), story these experiences?

The three accounts were storied idiosyncratically, diverging with regards to tone, certainty, and apparent function; however, certain commonalities were apparent in their operations:

- ⤴ Describing a struggle for the meaning of PLE, in a context where lack of understanding prevailed.
- ⤴ Treating PLE as profoundly (if not directly), meaningful, and making effort to 'integrate' this experience into self-narrative.
- ⤴ 'Externalising' PLE, so that it 'existed' outside of the mind of the narrator.
- ⤴ 'Universalising' rather than 'normalising' PLE; so that it became a super-normal aspect of human experience.
- ⤴ Experiencing PLE as providing insights, and therefore a privileged relationship to 'truth' and right to define 'reality'.
- ⤴ Establishing credibility of their 'truths' through direct experience, rhetoric, authoritative texts, and counter-conduct communities.
- ⤴ Reconstructing 'reality' in light of the experience, and thereby, repositioning the self.
- ⤴ Transcending and discrediting the prior-self in relation to the newly emerged 'reality', and transformed 'self'; and maintaining a distinction between pre- and post-PLE self.
- ⤴ Personalising the experience, PLE related to previous experiences and

special qualities of the narrators, which contributed to thicker self-narratives.

- ⤴ Concealing PLE from those who 'lacked insight' into the meaningfulness of the experience.
- ⤴ Seeking opportunities to share PLE with those who offered support, or could be supported; connecting through a shared 'unreality'.

5.1.2. What kind of identities are created?

Each narrator presented a 'self' fundamentally transformed by PLE, brought closer to 'truth' by privileged experience. Identities were made powerful through the production of a dichotomy between the 'enlightened' (including the self) and the 'unenlightened' (including psychiatry and 'consensus reality'). This 'truth' entailed new duties and rights for the self, most particularly by demanding ongoing self-transformation as part of a journey towards a 'spiritual' ideal. This required ongoing, and onerous, 'spiritual' identity-work, which entailed rejection of incompatible aspects of the prior-self.

'Patient' identities were also rejected; instead the narrators constructed themselves as fundamentally misunderstood witnesses to a 'spiritual' truth. Reversing the psychiatric gaze located any 'delusion' within the 'unenlightened' Mental Health (MH) system. This reversal was problematised, and quietened, by the 'lack of insight' of 'unenlightened' others; and by the narrators' own distancing of their experiences from 'regressive psychosis'. Demonstrating this distance required the construction of productive, rational, competent and relatively docile selves.

On-going PLE can easily be incorporated, even welcomed, within these 'enlightened' self-narratives. Here, PLE does not entail a stigmatising, hope-dashing, return of 'illness' (McCann & Clarke, 2004), but rather, a confirmation of 'spiritual awakening'. As 'enlightened selves', the narrators have the potential to contribute meaningfully, not only to others with PLEs, but more broadly (because

of the universal quality of their experience), to a global 'spiritual awakening'.

5.1.3. Which narrative resources do they draw upon?

The narrators took a 'bricolage' approach, drawing selectively from the techniques and practices available within their local contexts. Given the identified similarities in their overall narrative structure, surprisingly little is shared between the accounts; although the narratives drawn upon appear to belong to the same family of ideas (mostly having their roots in 'Eastern' modes of thought, and privileging a 'unitive' rather than 'dualist' world-view).

Initially, each narrator made sense of their PLEs within explanatory frameworks which were immediately available, although ongoing 'spiritual identity work' meant exploring wider knowledges, which thickened these understandings. The narratives drawn upon were not new to the narrators, although the implications for self were significantly revised in light of their PLE. Multiple narratives were drawn upon such that none dominated; this allowed the narrators significant flexibility with regards the rights and duties they took up.

5.1.4. What does this afford them in relation to the medical model?

The analysis revealed some of the complexities of the politics of truth in MH. The stories were demonstrated to operate in relation to psychiatric power in a manner comparable to a historical 'mystical' 'counter-conduct' which developed in response to the dominant Christian pastorate (Foucault, 2006a). Essentially, by troubling a realist conception of 'reality', the narratives produced a position outside of the psychiatric discourse. By demonstrating competence they refused the psychiatrist his position as 'doctor' and his right to determine their 'reality'. In exercising this power the narrators produced new 'spiritual' 'truths'; accepting which necessitated ongoing work upon the self.

Each narrator developed and articulated a critique of psychiatry, but none

communicated openly with MH services in the 'real world' during their PLE. This selective communication seems to maintain the dichotomy between 'spiritual' PLE and 'regressive psychosis'. However, in making their accounts public they puncture the 'terministic screen' of the medical model. By demonstrating the value they found in reconceptualising their PLE as variously spiritual they provide narrative resources for others, thus, extending their resistance beyond the individual level; at the same time as strengthening their own identity projects.

5.2. Situating the Research in the Literature

This research is agonistic with much of the literature, which reifies 'psychosis', 'schizophrenia' and the 'medical model'. It is in line with research which is critical of this approach (e.g., Boyle, 2002), and which advocates for the utility of alternative explanatory models (e.g., Romme & Escher, 2000). The narratives I have identified, and my analysis, trouble the pessimistic medical narrative of 'psychosis'. These accounts support the notion of a 'psychosis-continuum' (BPS, 2000); and van Os et al.'s (2009) contention that most PLE “are transitory and disappear over time” (p.179). More specifically, they shed light on observations that many 'in recovery' from 'psychosis' consider themselves transformed by the experience (Tooth et al., 2003), and offer a way to understand this phenomenon.

The accounts share characteristics with the 'enlightenment' genre identified by Thornhill et al. (2004), but, under close analysis, appear more nuanced, and are not satisfactorily captured by this category, also containing aspects of Thornhill's 'endurance' and 'escape' genres. Furthermore, Thornhill and colleagues' focus on 'recovery' from 'psychosis' fails to capture the experiences described by my narrators; all of whom reject the medical notion of 'recovery'. The phases of transformative experience identified by Nixon et al. (2009), and the six categories of paradigm-shifting PLE identified by Williams (2012), can also be discerned in these accounts, suggesting that the same phenomenon is being explored. That these models offer little further insight into the experience described by the three

narrators demonstrates the limited utility of descriptive models, without accompanying in-depth analysis of how such constructs operate.

My findings are broadly in line with psychological models of PLE, which reframe 'psychosis' as a 'problem-solving' or 'paradigm-shifting' process (e.g., Perry, 1999; Jackson, 2010). In each of the self-narratives we see PLE arising in the context of an intolerable situation; the PLE destabilising a previously firmly held worldview; and a subsequent, fundamental re-conceptualisation of 'reality', which re-positions the individual in the social world, and in relation to authority structures, facilitating new modes of agency. The findings also support Williams' (2012) contention that it is the 'unitive' nature of PLE which encourages paradigm-shifting; as it appears to have been this 'unitive' quality that allowed the narrators to conclude that their experiences were universally significant.

Some literature suggests that a 'strong observing ego' (e.g., Jung, 1960; Clarke, 2010; Williams, 2012) distinguishes transformative experiences from 'psychosis' – the narrative lens offers a different interpretation. The accounts examined herein share a narrative structure in which PLE is meaningful, externalised, and universalised. Accepting that the narratives available to us shape our experience (Burr, 1995), one can appreciate that self-narratives sharing these characteristics might produce more 'transformative' outcomes than a medical understanding, i.e., by instilling hope, and offering a wider field of possible actions, by undoing stigma, and offering preferred subject positions. This research suggests that determining which factors facilitate this kind of narration may have greater clinical utility than searching for new intra-personal deficiencies, such as the 'weak ego'; and that the sub-cultural narrative context of the narrator may be important.

This is relevant to Lysaker and colleagues' (2010; 2012) work. Their research demonstrates the disruption of narrative in those who inhabit the 'patient' identity, but largely fails to attend to the co-construction of identity that happens in MH services, and argues instead for the importance of 'insight' into 'disorder'. The narrators demonstrate that transformation, or 'recovery', following PLE is

possible, separate from subscription to medical understandings; and further, that such a subscription may be problematic.

Finally my research speaks to two central questions within the critical literature: how do some people who have unusual experiences avoid becoming service users? (Boyle, 2006); and why has the psychiatric narrative persisted? (Bentall, 2009). A partial response to both is found in my analysis: the narrators avoided, or escaped, identities as service users through 'spiritual identity' work and carefully controlled communication, thereby avoiding contestation in the medical frame (a silence which allows the psychiatric narrative to 'persist'). In addition, and to varying extents, the narrators directly reified the psychiatric frame by 'othering' the 'regressive psychotic'.

5.3. Evaluation

The criteria used to critique quantitative research are not appropriate for qualitative methods (Yardley, 2000). For instance, my analysis is not representative; I employed a highly restricted sample chosen for their special attributes. Nor is it exactly replicable; I offer just one of many possible interpretations. In reviewing the 'quality' of this study I will refer to Yardley's (2000) characteristics of good qualitative research.

5.3.1. Sensitivity to context

To ensure sensitivity to the theoretical context of the study, I reviewed the literature in the introduction. Above I attempted to develop this theory by linking it to the specifics of my findings.

Although the significance of the data appearing online was considered, and only UK accounts selected, the socio-cultural context of the narrators is largely left unexplored. The narratives become somewhat disembodied, although this is

remedied to the extent that they describe their own context. However, the lack of attention to the socio-cultural context of the narrators remains a limitation. An advantage of this distanced approach to my data collection (asides from accessing unusual and interesting data), is that typical research concerns regarding the power imbalance between the researcher and the researched are avoided. However, this leaves the narrators in a totally passive role with regards to my interpretation, where an alternative methodology might have given them a more active position.

5.3.2. Commitment and Rigour

Commitment in this context is demonstrated by my prolonged engagement with the topic, as demonstrated by my introduction and by my immersion in a related but broader 'dataset' (as reflected in section 1.2.), for instance, my experiences with the Spiritual Crisis Network.

“Rigour refers to the resulting completeness of the data collection and analysis” (Yardley, 2000:221). The sample was small, hardly comprehensive; however, as I have previously argued (Section 2.4.1.1.), the three narratives, studied in-depth, provided all the material necessary to illustrate the narrative processes under investigation. Regarding analysis, the 'completeness' of my interpretation was bolstered by my inclusion of two distinct analytic levels, which could be considered a form of triangulation.

5.3.3. Transparency and Coherence

I have already argued for the coherence of my research questions, philosophical, methodological, and analytic approach (Chapter 2). I also sought to demonstrate transparency with regards to every aspect of my data collection, reading, and the analytic steps taken (See Chapter 2, and Appendix 7.5 and 7.6).

My moment of reflexive engagement (1.2.) represents another move towards

'transparency', wherein I considered how my own experiences may have influenced my interpretations. However, this attempt was necessarily partial, and could never be comprehensive. I have, therefore, been transparent in describing this as a single interpretation.

The most significant challenge to the 'coherence' of this thesis is the argument that the experiences of the narrators are fundamentally different from those of others who are diagnosed 'psychotic', as I have frequently drawn equivalences throughout. This argument can be countered: firstly, two of the three narrators were, temporarily, service users themselves, and received 'psychosis' related diagnoses, whilst the third was arguably qualified to 'self-diagnose', and did; and secondly, because, as I have demonstrated, the validity of a distinction between the two types of experience has been troubled (e.g., Jackson, 1997).

Ultimately, the reader is best placed to judge the transparency and coherence of my presentation.

5.3.4. Impact and Importance

Yardley (2000:223) argues that “the decisive criterion by which any piece of research must be judged is, arguably, its impact and utility.” It is to these factors that I finally turn.

5.4. Implications

5.4.1. For Research

I am in agreement with Radden (2012), who argues that the 'mentally ill' have suffered a systematic and damaging mis-recognition, for which the remedy lies in redefining 'madness'. In this process, the 'mad', rather than simply being heard,

must be accorded the status of 'credible knowers'. I would further argue that a full understanding of 'madness', means looking beyond the clinic, the ward, and the counter-movement, to those who experience PLE beyond the medical frame.

Radden suggests first-person accounts represent a useful point of departure for this broader project of redefinition. This thesis supports that suggestion, and further, has demonstrated the research utility of the vast dataset available online. That so much data is indexed allows for remarkable specificity in data collection, free from many of the usual complications of power. Further research on first person accounts, online or offline, might examine in more detail, or within different contexts, how the patient 'identity' is avoided. Arguably, more interesting is what kind of identities are created instead, that is, which narratives have sufficient illocutionary force to override the medical narrative, and under what circumstances?

Exploring a broadly 'spiritual' narrative of psychosis has demonstrated that PLE can coherently be conceptualised as 'spiritual' experience; that 'spiritual' narratives can make meaningful objects of study; and that this offers insight into processes generally understood as 'mental illness'. I follow Clarke (2010), in calling for a paradigm shift in the way we conceptualise and research 'psychosis', that recognises both the narrative restrictions of the medical model, and the 'spiritual' significance of PLE.

More specifically, my analysis suggests that more research is required into the role of the narrative environment in the development of 'psychosis', which might offer another perspective on research that internalises narrative deficiencies within the 'patient' (e.g., Lysaker, 2010); and which explores the practices and implications of the 'tactical silencing' of 'spiritual' accounts in MH services.

5.4.2. For Clinical Practice

What is needed more urgently than yet more research into PLE, is a better way to

respond. Only part of this response is the way PLE is received clinically, although this is the area in which Clinical Psychology may be able to exert greatest influence.

To begin with, we should not assume that all PLE brought to our clinical attention is experienced as distressing, and in need of remedy (Cromby & Harper, 2012). This means considering the context of referrals: 'who identifies PLE as a problem?'; 'how does the experiencer understand PLE?'; and 'how PLE is received in their local context?'. In some cases, the most appropriate response will be supporting the individual and their network to communicate PLE more effectively.

If we are resolved to work at the individual level, one option is to consider how Narrative therapy (White, 2007) might support the individual and their network in exploring the implications of the stories they tell about each other and those told about them by others, and to begin to author new and preferred stories. My analysis demonstrates that even PLE which was experienced as meaningless can be reintegrated into a transformative self-narrative when the appropriate structure become available. Narrative therapy, with its specific metaphors for externalising constructs, attending to personal meaning, and thickening preferred-narratives may support this reintegration. Holding in mind the operations of the accounts analysed above might facilitate clinicians working with individuals to scaffold more empowering self-narratives.

Beyond individual therapy, narrative theory encourages us to consider our own contribution to the narratives landscape. Modifying individual narratives may be insufficient if the wider culture is not accepting of these new understandings. The analysis revealed that MH services were experienced as distant, generally unhelpful, and threatening to newly emerging self-understanding (as well as liberty). A great deal of identity work is necessary to escape the negative identity implications of the medical model. Recent developments in MH approaches to 'psychosis', such as Community Treatment Orders, and Early Intervention in

Psychosis teams, threaten to push the medical narrative deeper into our collective narrative reservoir.

We must take the narrative implications of this pessimistic model seriously, and consider what changes are necessary. In particular, we must resist privileging our own world-view, and attributing lack of insight to those who do not share it. Within the 'spiritual' narrative, the world-view represented by the medical model (and consensus reality) is akin to a 'psychosis': being a suboptimal and distorted reality, which fails to recognise its own distortion. The 'spiritual' narrative creates a 'reality' which is no less 'real' than that promoted by the 'psy-complex', and is arguably a 'better' metaphor for the ineffable pre-narrative experience, being potentially implicated in improved outcomes. I join Chadwick (2010) in urging that we no longer ignore the 'spiritual' aspects of PLE, and instead create space for these understandings within services, thereby offering hope and meaning to 'patients'. This requires clinicians, and services, not only to be open to such experiences, but to find ways to articulate this openness, and to allow our clients to bring unusual experiences to us without fear of unwanted treatment or diagnosis (Hagen & Nixon, 2010). Furthermore, we should consider how MH services influence broader cultural narratives around madness, and seek remedy where our involvement limits the meaning-making opportunities of those we seek to serve.

If we accept that some PLE represent transformative or paradigm shifting processes, we also need to think about how these might be supported. Williams (2012) employs a butterfly chrysalis metaphor to argue that the transformative process necessarily entails a period of increased 'vulnerability' (as the old self is broken down, and before the new self is established). As a result, the process requires a supportive, or at least non-harmful, environment to resolve properly. My research suggests that a facilitative environment would offer alternative understandings while privileging none, a supportive community, and opportunities to narrate one's experience. 'Alternative' medication-free residential facilities, which offer such safe, supportive environments, and a meaningful narrative of

psychosis (as a process of renewal), have demonstrated good outcomes (e.g. Calton et al., 2008), but struggled to attract funding. The Open Dialogue approach (Seikkula et al., 2001) attempts to create the same conditions in a community/family context, and has replaced traditional psychiatric services in Western Lapland. These services now work with families and communities to develop a supportive network around the individual, and aim to privilege individual understandings, treating all understandings as valuable. In turn, this has transformed the psychiatric narrative in the region, and led to radical improvements in outcome (Seikkula et al., 2006). In fact, the Open Dialogue approach may have gone even further, and transformed the cultural reception of 'psychosis' in Western Lapland, since, over 30 years, a significant proportion of the population have participated in network meetings (which insist on the value of individual understandings), and been exposed to these alternative narratives (Seikkula, 2014).

Both approaches above have demonstrated efficacy, but also significant challenges in deployment and despite significant interest have failed to become widely-available. This itself may be related to the dominance of a medical understanding of 'psychosis' amongst those in a position to determine service provision, leading to an insistence on 'treatment' as a primary response, and, typically, a conflation of 'treatment' with 'antipsychotic' medication. Finding ways to challenge this narrative hegemony should be a clinical priority.

Finally, and perhaps most importantly, we must stop believing that these experiences belong to the clinical domain – a 'belief' my research has suggested may be highly problematic. Individuals experiencing PLE should not be denied access to the most empowering and meaningful understandings of their experiences. For 'spiritual' PLE in those who present to us as 'clients', this may involve working alongside, or referring to, 'non-traditional healers', for instance, yoga instructors or spiritualists. Beyond the client-clinician relationship we should recognise the value of 'peer support' networks, as they can represent 'counter-conduct' communities: validating culturally-marginalised discourses; providing

alternative readings of PLE; and reinstating hope and meaning. Examples in the UK include the Hearing Voices Network, and The Spiritual Crisis Network. Clinicians should look for opportunities to support, and be supported by, these organisations. Such groups are already working to change the narrative landscape of PLE, and may be better placed to achieve this than NHS clinicians.

'Peer support' also exists online, as do a plethora of narratives regarding the 'true' nature of PLE. This research has begun to examine the implications of this revolutionary narrative arena for the development of preferred and marginalised self-narratives. Certainly new subjectivities have been made possible, partially demonstrated by these accounts. However, I would argue that the broadest implications of our radically enhanced connectivity have yet to emerge; will be more readily apparent in the next generation; and should be closely attended to.

5.5. Conclusion

I have argued that the apparent dichotomy of PLE, between 'spiritual awakening' and 'regressive breakdown', should not be understood as the relation between two distinct phenomena, but as representing two extreme positions on a continuum of one kind of human experience. In addition, I argued that the position one takes up along this continuum is to some extent determined by how one comes to understand the experience, and how one integrates this into 'self-narrative'. Finally I have argued that this process of integration is itself influenced by the culturally-available narrative resources, and that, for some, MH services have a significant role in promoting or denying particular ways of knowing.

As MH practitioners we have a duty to attend to the discursive context we co-create with 'clients', 'service users' or 'patients'. In doing so we may be able to support these individuals in integrating what are oftentimes frightening experiences into narrative frameworks which offer hope, meaning, and a positive sense of self. By demonstrating that understanding can be found beyond the

medical narrative of PLE we may even start to loosen the modernist stranglehold on 'consensus reality', and to open up a space for the 'multiple voices' and 'multiple realities' which make up human experience.

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7. APPENDICES

7.1. Appendix 1: Glossary

Mysticism – Distinctive practices, discourses, texts, traditions, and experiences aimed at human transformation, or at achieving direct experience of the 'Divine', the 'Ultimate', or with 'Absolute Reality'. Also, a belief in 'higher' forms of 'reality', which are at once beyond perceptual apprehension, and directly accessible to subjective experience.

Psychotic-Like-Experience (PLE) – A term to describe a plethora of 'out of the ordinary' experience (OOE) that might meet the psychiatric criteria for 'psychotic experience', but may also be responded to, or understood, very differently, for instance, as 'spiritual' or 'mystical' experience. PLEs can include hearing voices, or seeing things, that others do not. I have used PLE, rather than OOE or any other term, because I am concerned here with the nexus of 'spiritual' and 'psychiatric' ways-of-knowing, and hoped to keep this in focus as I discuss experiences largely understood as 'spiritual'. I do not mean that these experiences would be better understood as 'psychosis', only that such an understanding is possible.

Psychosis – An ongoing 'condition' predominated by out-of-the-ordinary experiences that generally cause significant distress or disruption to the experiencer. Also a generic term for mental states in which the individual is judged by others to have lost touch with 'reality', because they have “experiences such as hearing voices other people do not hear, seeing or sensing things other people do not see or sense, holding unusual beliefs (delusions) or beliefs about the malevolent intention of others which seem unwarranted (paranoia)” (Thornhill et al., 2004:181). Often associated, or used synonymously with psychiatric diagnoses like 'Schizophrenia'.

Schizophrenia – A formal diagnosis within The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) Psychiatric classification system. A 'psychotic condition', characterised by positive symptoms such as 'delusions', 'hallucinations', and 'disorganized speech', but also 'negative symptoms', such as 'affective flattening'. DSM-V raised the symptom threshold, to be diagnosed one must now have at least two (rather than one) of these symptoms present over a period of one month or more, AND a significant social or occupational dysfunction (American Psychiatric Association, 2013)

Spirituality – Various defined, this term describes an inward and personal sense of the 'sacred' or 'divine'. For instance, “the feelings, thoughts, experiences and behaviours that arise from a search for the sacred” (Hill et al., 2000:66), or "a transcendent dimension within human experience [...] discovered in moments in which the individual questions the meaning of personal existence and attempts to place the self within a broader ontological context." (Shafranske & Gorsuch, 1984).

Religion – Describe organised human relationships with the 'sacred' or 'divine'. Refers to relations that have become 'canonical', meaning that they privilege particular writings, teachings, and structures, and view these as essential for their devotees.

7.2. Appendix 2: Literature Search Strategy

In a sense my literature review began when I read Paris Williams' (2012) 'Rethinking Madness', which led to the conception of this study. I was struck by the breadth of literature he was able to draw upon, the coherence of his central argument and the potential utility of his model. I was also struck by what appeared to be a central, but largely unattended to, role for narrative in understanding both why 'spiritual' understandings of psychosis seemed to lead to positive outcomes, and in explaining the apparent dimorphism between 'spiritual' and medical PLE.

I began my formal literature review by searching the EBSCO database in August 2013 and repeated these searches periodically until March 2014. All my searches employed the 'all databases' and 'all years available' parameters. 'Psychosis' returned 144,709 papers, and 'Schizophrenia' 177,122. I therefore selected more focussed search terms, reflecting the interest of this project, as listed:

Psychosis OR Schizophrenia AND Narrative

Psychosis OR Schizophrenia AND Narrative Psychology

Psychosis OR Schizophrenia AND Self narrative

Psychosis OR Schizophrenia AND Illness narrative

Psychosis OR Schizophrenia AND Recovery narrative

Psychosis OR Schizophrenia AND Mystic*

Psychosis OR Schizophrenia AND Spiritual*

Psychosis OR Schizophrenia AND Relig*

Psychosis OR Schizophrenia AND Explanatory model

Madness AND [search terms as above]

Hearing Voices AND [search terms as above]

Hallucinat* AND [search terms as above]

I extended these searches by repeating them on Web of Science and Google Scholar. Potentially relevant publications were identified by a review of titles. I then read the abstracts of the identified papers, before reading potentially relevant texts in full. I excluded results which had no clear relevance to this project. In addition, I attended carefully to the reference lists of identified publications, looked for papers that cited key papers, and took recommendations from individuals with personal and professional interests in the overlap between 'spiritual' and 'psychotic' phenomena.

Many more papers were read than are referenced in the final thesis. My introduction represents a narrative review of the literature, as it applies to my research questions. It is necessarily narrow; by focussing upon narrative as a heuristic for understanding PLEs, I have marginalised important areas for consideration (particularly the role of material and developmental factors), the reader must decide if this decision was well-grounded.

7.3. Appendix 3: Self-Narrative Search Strategy

Despite a the wealth of narratives online, identifying narratives that met all of my inclusion criteria (section 2.4.1) was a lengthy process. I used simple keyword searches using www.google.co.uk to identify relevant websites. For example:

'spiritual accounts of psychosis'	About 8,270,000 results
'spiritual accounts of psychosis UK'	About 1,370,000 results
'spiritual narratives of psychosis'	About 16,500,000 results
'spiritual narratives of psychosis UK'	About 13,300,000 results
'spiritual accounts of schizophrenia'	About 12,800,000 results
'spiritual accounts of schizophrenia UK'	About 1,300,000 results
'spiritual narratives of schizophrenia'	About 14,300,000 results
'spiritual narratives of schizophrenia UK'	About 11,500,000 results
'personal story psychosis spirituality'	About 4,050,000 results
'personal story psychosis spirituality UK'	About 17,700,000 results
'personal story schizophrenia spirituality '	About 4,240,000 results
'personal story schizophrenia spirituality UK'	About 16,300,000 results
'psychosis and spirituality'	About 713,000 results
'schizophrenia and spirituality'	About 1,390,000 results
'schizophrenia and enlightenment'	About 283,000 results
'psychosis and enlightenment'	About 169,000 results
'psychosis and kundalini'	About 47,200 results
'schizophrenia and kundalini'	About 1,380,000 results
'psychosis and shamanism'	About 45,600 results
'schizophrenia and shamanism'	About 72,300 results

Clearly, each search produced a large amount of data. To manage this I explored the first ten pages of each search (100 results), identifying relevant webpages. I then 'snowballed' this data identification by following hyperlinks within these pages. I searched manually within this corpus for first-person accounts which met my inclusion criteria. Often certain information (such as geographical location) was ambiguous, in which case the account was discarded. Once a suitable account was identified I contacted the author to request permission, if no reply was received the account was discarded. In this manner I identified the three accounts included in my analysis.

7.4. Appendix 4: Permissions from Authors and Web-masters

7.4.1. Sarah

Sarah's narrative was hosted on the Royal Collage of Psychiatry (RCP) website. I contacted the RCP in the first instance:

“Dear [RCP Staff member],

I am a Doctoral Clinical Psychology student. I am interested in including an article hosted on your site in a research project I am conducting at the University of East London. The article is a transcription of a talk given to the Spirituality SIG, and can be found here: <http://www.rcpsych.ac.uk/pdf/A%20personal%20experience%20of%20Kundalini%20%20Sarah%20Sourial%20EDITEDx.pdf>

Could I please be put in touch with someone who might be able to grant me permission to include the article in my analysis?

Thank you,

James Peddie

Trainee Clinical Psychologist

University of East London”

Initially, I received the following reply, to which I responded, declaring that I was not yet 'Dr. Peddie':

“Dear Dr Peddie

Thank you for your email and your interest in this article. The copyright of the article belongs to Sarah [deleted]. I’m afraid I am unable to give you her email address but I will forward your enquiry to the Chairman of the Spirituality SIG to pass on.

With kind regards,

[RCP Staff member]”

I was then contacted by Sarah directly:

"Dear Dr Peddie,

Thank you for asking permission to use my article as part of your analysis.

I am very happy for you to do so and I wish you all good wishes with your work.

Yours sincerely

Sarah"

To which I responded, once again clearing up the confusion about my 'doctor' status, and elaborating on the nature of my request:

"Dear Sarah,

Thank you so much for getting back to me. I found your account extremely interesting, not least because of its context - a presentation of a concept like Kundalini to a group of psychiatrists (albeit presumably relatively sympathetic given their attendance at the spirituality SIG). I would love to include it in my thesis.

I feel it's important to point out that I am not a doctor, psychiatric or otherwise. I think there must have been some crossed wires in my communication with [RCP staff member]. I am a trainee clinical psychologist in my final year of my doctoral training at the University of East London.

My thesis is looking at how experiences traditionally diagnosed and treated within a medical framework (i.e. as 'psychotic') are sometimes interpreted by the individual within a mystical/spiritual one, with potentially personally transformative results. In particular I'm looking at what narrative resources or discourses are drawn upon, what these 'do' for the individual (in terms of self-concept, opportunities for action etc), and what such implicit or explicit resistance says about the operations of the medical discourse itself. I intend to use extended quotes from your presentation, and include a complete summary of the narrative you present.

I hope that none of that has been sufficient to put you off, but please do get back to me one way or the other, I wouldn't feel comfortable

taking your consent under the pretence of being Dr Peddie! Of course if you have any questions please feel free to ask.

Yours sincerely,

James”

To which Sarah kindly responded with her consent:

“Dear James,

I am still very happy for you to use my paper as part of your thesis.

Having worked for many years as a psychiatric nurse, I am aware that for myself and clients I have nursed, meaning sometimes cannot be found within a medical perspective alone. In my case, until I found an explanation from the White Eagle Lodge that seemed to match my own experience exactly, I just felt abnormal in some way. Following my own experience I started to use a spiritual perspective as well as a medical one when assessing and treating clients. Now I would say 12 years later that it was the best thing that could have happened to me, that it was a very profound event giving me much meaning in my life and that I have developed a great deal further since then.

Yes presenting to psychiatrists is a challenge. Next year I will be doing the same in my own Trust which feels even more of a challenge.

Your work sounds very interesting and I would love to know more about it in the future if at all possible?

I wish you the very best of luck with it all.

Yours sincerely

Sarah”

7.4.2. Spoon

Spoon's narrative was presented on his own site, as a result he is both author and webmaster, and was relatively easy to contact, streamlining the process above. I contacted Spoon, explaining the nature of my research, and the way in which I hoped to make use of his narrative, as I did for Sarah above. To which

Spoon agreed:

"Hi James

The "I am the Spoon" website is already somewhat anonymised, so you're welcome to quote sections and reference the website directly as you see fit.

Please do send me a link to whatever you publish.

I'm also happy to discuss the content and my subsequent thoughts about it further.

Kind Regards,

[Spoon]"

7.4.3. Philip

Like Spoon, Philip's account appeared on his own website, once again simplifying the process. Philip responded:

"Hi there, James.

Actually, I don't see what you're asking as being something requiring my permission - though of course I much appreciate your courtesy in asking. Where I would tend to be a right old bugger of a dog-in-the-manger is where people ask me to give interviews or 'discuss my ideas' with them. As the people who ask such things virtually always have their own beliefs and preconceptions, they would all be a very frustrating waste of time to engage with, for beliefs and an open-minded objective approach do not mix - the beliefs inevitably seeking to mangle and discredit anything or anyone that seriously calls their belief based mindset into question.

So, of course, you're welcome to include contents of my website in your own review / analysis - though I do counsel that you do your best to heed the various cautions and caveats that I give in many places about the problems caused by people coming to the site with preconceived notions and failing to understand that what I present is a working model and not a claim of categorical / 'objective' truth or 'fact' that people are supposed to take on as a belief system, because, especially for all that is non-physical, nobody in all of 'Existence' can absolutely, objectively, know the truth of anything! I hope, too, that you

will take on board the amusing little homily that I give in the preamble of my Night Hells page (i.e., if you haven't already done so)! :-) I would also draw your attention to the following in case you haven't already seen it:

http://www.clarity-of-being.org/my-own-self-healing.htm#note_for_psychiatric_workers.

Actually I have a friendly if rather distanced, very open-minded view of the activities of people like you, because it's very like that figurative glass of water, which can be described as half full or half empty. I can see you as yet another 'Bad Boy', no doubt taking a very mangled version of my 'message' into the public or at least professional arena. Yet on the other hand I can see you as a real Good Guy, for anyone bringing in any ideas at all, even if still rather mangled, that challenge the horrendous and woeful status quo of the mental 'health' system and bring in more liberating notions can be seen as a necessary step towards people more widely gaining a more fully 'enlightened' and genuinely objective approach that recognises that consciousness itself, not any 'external' or 'physical' reality, is the basic nature of what we experience, and thus, as far as anyone can tell, of reality itself, so that the 'medical' approach to 'mental health' can then be seen to be nonsensical and be replaced by a proper evidence / experience based approach such as what I put forward.

I wish you every success in weakening the whole 'medical' mindset in mental healthcare!

Philip."

To which I responded, hoping to clarify various issues, particularly the 'text' of interest, and my intended presentation method:

"Hi Philip,

Thank you for getting back to me so quickly.

I appreciate your permission - while I'm particularly interested in your account because it is available in the public domain, permission satisfies the ethics board I am accountable to.

I'm trying to come to the material with as few conceptions as possible, and present whole narratives (as far as that's possible within word limits) - in this instance I would like to use your 'little brush with psychiatry' text . As for objective truths I'm take a relativist position, my

intention is to examine how the authors influence their own 'realities', and to what extent they liberate themselves from the MH system in doing so, also more broadly in what this says about that same system.

Thanks for the pointers to further material on the site, I've taken a good look around, but I'll revisit those sections.

Best wishes,

James”

To which Philip responded, briefly:

“Good on you, James! I wish you a great time on your project! :-)

Philip.”

7.5. Appendix 5: Worked Transcript

<p>KEY CONSTRUCTS: Medical/illness Spiritual/Kundalini Transforming Psychology</p>	<p>What is lost in transfer to text? What was the context for the talk? We know it was related to SIG. James Peddie 23/08/2013 16:10</p>
<p>STROPHE ONE. Abstract and pre-positioning</p> <p>STANZA 1. Abstract</p> <p>This talk is my personal account / of a brief psychotic episode / that seems to fit with the classical description / of a Kundalini spiritual awakening.</p> <p>After a long career as a psychiatric nurse, / I felt there was something different about my own experience / compared to most regressive psychotic states / I have witnessed in others, / and instead of leaving me ill and damaged / I feel transformed.</p> <p>As a result of this episode, / the changes in me / include a strong faith in God / and an expanded consciousness / that allows me to contact other dimensions / previously unavailable to me.</p> <p>On reflection / I would now say that it has improved my life / beyond all recognition.</p> <p>I am using Roberto Assagioli's (1993) / four critical stages of spiritual transformation / to structure the talk.</p>	<p>Expert by experience. Deployed early. Bolsters credibility w/ audience? James Peddie Today, 11:39 INTENT? Prepositioning - establishing character (difference) and competence (nurse). James Peddie 20/12/2013 15:00 Narrative draws upon elements of a quest' (Frank, 2012) 'enlightenment' (Thornhill et al., 2004) and 'revelation/purposeful suffering' narrative (Adame & Hornstein, 2006) James Peddie 20/12/2013 15:03 Further prepositioning as academic, carefully considered position. Audience positioned outside area of expertise. Model = conceptual buildingblock James Peddie 20/12/2013 15:05</p>
<p>STROPHE TWO. Crisis preceding spiritual awakening</p> <p>STANZA 2. A mid-life existential crisis, and leaving unhappiness and stress</p> <p>1. Crisis preceding the spiritual awakening</p> <p>Assagioli said / that in this stage there is often an existential crisis / where the person begins to ask about the meaning of life / and I would say this was the case for me.</p> <p>Despite experiencing an outwardly successful life in material terms, / I was desperately unhappy inside / and I sensed I was not living life in a way that was right for me.</p> <p>During this mid-life crisis, / I first left my unhappy marriage / and later my demanding and stressful job / in nurse education management.</p> <p>Now that my life was not so exacting or busy, / I found that some of my unresolved emotional issues / were able to surface and be addressed.</p>	<p>Appeal to outside academic authority, further positioning self as academic thinker James Peddie 20/12/2013 15:10 Asking questions, curiosity itself, initiates the process. SARAH as agent. Medical narrative dismissed. James Peddie 15/01/2014 19:57 Very briefly attended to, little sig to current narrative? Only serves to justify adherence to Assagioli's model? James Peddie 29/04/2014 13:13 Inevitability. Causal within the psychological frame. James Peddie 29/04/2014 13:14</p>
<p>STANZA 3. Unresolved grief surfaces, releasing my Kundalini awakening</p> <p>One major issue was an unresolved grief reaction / I experienced when my 27 year old partner died in a plane crash, / when I was 25 years old.</p> <p>As soon as I grieved for him / I experienced my Kundalini awakening.</p> <p>I was 42 years old / and I was not ill / or taking any medication at the time / and I do not have any personal or family history / to explain the crisis.</p> <p>PART TWO. Kundalini Awakens</p> <p>STROPHE THREE. My Crisis</p> <p>STANZA 4. An academic account of Kundalini awakenings</p> <p>2. Crisis of spiritual awakening</p>	<p>An appeal by narrative coherence. James Peddie 27/08/2013 17:41 Differentiation. Nurse expertise. Refusing undifferentiated, objectified position of patient. A search for a 'vacant' position free from pre-established rights and duty assignments. (Lee, Lessem, Moghaddam, 2008) James Peddie 20/12/2013 15:13 Having differentiated herself from 'mental patient', Sarah does work here to establish credibility of another category. Emphasising the positive qualities of Kundalini serves to further separate from the 'regressive' states. James Peddie 20/12/2013 15:21</p>
<p>This is one description of Kundalini awakening / by Lee Sannella (1989) / I found in Grof's book / on spiritual emergency:</p>	<p>We can read the anticipated familiarity of the audience here, with this author and his 'classic' text. We can also read the speakers familiarity with the transpersonal literature, but can't date this to pre or post episode. James Peddie 20/12/2013 15:19</p>

7.6. Appendix 6: Analytic Phases

I now offer, by way of an example, a brief summary of the outcome of the analytic phases as they were applied to Sarah's account. This is necessarily artificial, as it ignores the overlapping nature of the phases, and the interactions of the analysis of this narrative, with the analyses of Philip and Spoon's narratives.

A) *Phase 2: Identifying narratives, narrative tone, and rhetorical function*

'Master narrative' – Kundalini Awakening (Yogic/Transpersonal Psychology)

Additional narratives – Mid-life crisis (Psychological); Psychotic Episode (Psychiatric); Spiritual Development (Christian?)

Emotional tone – Varies: Generally upbeat/educative. Not angry, although somewhat defensive (many justifications). Occasionally heroic. Shifts in tone attended to in transcript.

Rhetorical function – Relatively consistent: to describe and define a misunderstood spiritual experience; to argue that this fits her 'reality' better than the alternative of 'regressive psychosis'. Also: educating; justifying; persuading. Responding to an anticipated medical counter-argument, but not wholly anti-medical.

B) *Phase 3: Identities and Identity work*

The 'self' that was being brought into being:

Positioned by self as – Spiritually awakened, more advanced towards a universal goal than most others; Educator; Expert-by-experience (Kundalini veteran); Expert-by-education (psychiatric nurse); Transformed from previously

emotionally broken prior-self (naïve and empty existence) from materially to spiritually 'well-off' (therefore, not 'ill'); Also, a victim of trauma and 'psychotic'.

Transformed self is competent/rational in consensus reality; Symptom free; Critical and inquiring mind; A researcher of spiritual wisdom; 'Virgin Mary'; In need of 'ongoing' spiritual identity-work. In contact with *something* else, personal proof, which cannot be shared. Privileged.

Positioned by others as – Largely avoids being positioned by others, or describing this, because of tactical silencing; 'a freak at times'; Validated by friend and counter-community.

C) *Phase 4: Thematic priorities and key constructs*

Key constructs and themes being deployed by Sarah (and what work they do):

Kundalini and Higher Self (universalising PLE, privileging PLE, externalising PLE; offering direct access to 'truth'; reconstructing 'reality'; producing dichotomy between 'enlightened' and 'unenlightened')

Regressive Psychosis (Demonstrating psychiatric understanding; differentiating PLE; rejecting patient identity; avoiding contestation with psychiatry)

Mid-life crisis / Unresolved grief (Personalising the experience; Providing narrative coherence; transcending and discrediting prior-self)

Communicating PLE (Demonstrating common 'misunderstandings'; emphasising importance of being understood; emphasising importance of spiritual experiences; demonstrating 'lack of insight' of 'rationalists'.

D) *Phase 5: Destabilizing the narrative*

Re-reading Sarah narrative from a Foucauldian perspective:

- ⤴ Sarah distancing her experiences from 'regressive psychosis' by constructing a productive, rational, competent and relatively docile self.
- ⤴ Sarah's Kundalini 'reality' could be described as a 'technology of the self'; demanding ongoing self-transformation as part of a journey towards her 'spiritual' ideal – entailing 'spiritual' identity-work, and the rejection of incompatible aspects of the prior-self. Authority over the self, facilitated by a bricolage approach to supporting authorities.
- ⤴ Sarah, in demonstrating various expertises, reverses the psychiatric gaze, and locates any 'delusion' within the 'unenlightened' Mental Health system. This is a 'truth-game' – who determines reality? Closeness of knowledge/power revealed.
- ⤴ Sarah's resistance is quietened, by her selective silence, a necessary tactic in the face of a normalising disciplinary power.
- ⤴ Communication is key though, a spiritual community supports Sarah's counter-reading of experience, and their 'truth' comes to shape her 'reality'.

7.7 Appendix 7: Change of Title



James Peddie
19 Mill Pond Close
Vauxhall
London SW8 4SN

19 February 2014

Student number: 1138195

Dear James

Notification of a Change of Thesis Title:

I am pleased to inform you that the School Research Degree Sub-Committee has approved the change of thesis title. Both the old and new thesis titles are set out below:

Old thesis title: Understanding Experience and Constructing Identity in 'Transformative' Accounts of 'Psychosis'. An FDA Study of First-Person Narratives.

New thesis title: Understanding Experience and Constructing Identity in 'Spirituality; Transformative Accounts of 'Psychosis': A Study of First-Person Narratives on the Internet.

Your registration period remains unchanged. Please contact me if you have any further queries with regards to this matter.

Yours sincerely,

A handwritten signature in black ink that reads 'James J. Walsh'.

Dr James J Walsh
School Research Degrees Leader
Direct line: 020 8223 4471
Email: j.j.walsh@uel.ac.uk

cc. Maria Castro