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**Exploring the Nature and Function
of Religious Beliefs in Psychosis:
A Case Study Approach**

A thesis submitted in fulfilment
of the requirements for the Degree of
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at the
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ABSTRACT

This study investigated the potential developmental, maintaining, or protective role of religious beliefs in the presentation of psychotic symptoms. It examined the ways in which individuals with psychosis might use religion to interpret and apply meaning to their experiences. The research was based upon the constructivist paradigm which attempted to understand individual perceptions of reality. A qualitative approach was used such that five male participants took part in individual semi-structured interviews on two separate occasions. These participants explored with the researcher their understanding of religious experience, psychotic experience, and the interactions between the two. A thematic analysis approach was used to analyze and organize the data, while a case study approach was used to present the stories of participants. Similarities across participants were grouped together to form themes, and these provided the basis for discussion.

Key factors identified by participants as important in terms of conceptualizing religious experiences included developmental pathways, elements of faith, and meaning of faith. Similarly, factors important in the conceptualization of psychotic experiences included causative attributions, features of experience, and outcomes of experience. The associations between religion and schizophrenia were categorized into three general themes, which included religion in the content of symptoms, religion as a meaning system, and religion as a coping strategy. Together it was concluded that religion generally functioned as a constructive framework when used to understand experiences of psychosis. Overall, findings suggest that religion can certainly act as a protective factor and increase resistance to distress typically associated with unexplainable experiences, such as the positive symptoms of psychosis.

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CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

The Problem

Only within the last ten years have psychological constructs of religion been thoroughly studied (Marks, 2006), despite the fact that religious beliefs had been identified as integral in the lives of many individuals experiencing mental health difficulties (Breakey, 2001; W. K. Mohr, 2006).

While there are now an increasing number of studies which attempt identify relationships between religion and mental health, these have most generally focused on religious beliefs and practices as coping strategies (Hood, Spilka, Hunsberger, & Gorsuch, 1996). Moreover, there are still apparently few investigations which elucidate the specific mechanisms through which religion facilitates this relationship (Marks, 2006). Religious research in general has appeared to focus primarily on theoretical propositions; few empirical studies have been conducted which define the nature of religious constructs. Where these studies have been developed, they have by and large explored religion only as it relates to the most typical mental health illnesses, such as the mood and anxiety disorders (Kirov, Kemp, Kirov, & David, 1998).

Individuals experiencing psychosis have, as a population, been described as highly religious (S. Mohr, Brandt, Borrás, Gillieron, & Huguelet, 2006). Moreover, these individuals can often experience religious-themed symptoms in both hallucinations and delusions (W. K. Mohr, 2006). Religious attributions to causal mechanisms have been reported to ensure that the interpretations of these events are personally relevant and meaningful (Miller & McCormack, 2006). The perceived role that religion plays as a developmental, maintaining, or protective factor for those who experience psychosis however, has been surprisingly under-researched.

Overview

The following chapter presents a rationale for undertaking the current research. It begins with a discussion regarding how I, the researcher, came to develop an interest in the topics of religion and mental health. While not having any experiences with these two matters personally, it was important to consider the pathway through which I developed a passion about people's experiences in these areas, as it places me in the research process as an active, yet reasonably

objective participant. A discussion on the development of religious beliefs follows, and outlines the way in which people come to understand faith and meaning in life. The existing research on empirical and theoretical relationships between religion and mental health is then described and used to demonstrate the gaps in this literature. One such area that remains to be explored includes the processes through which religion plays a developmental, maintaining, and/or protective role in a specific mental health disorder (Marks, 2006). As such, the discussion then turns to an examination of the historical and current context of schizophrenia. Models relating to aetiology and consequential treatment regimes are then discussed in reference to the current research position.

Personal Statement

My passion regarding mental health issues developed as a result of the environmental and social context in which I grew up. I spent the first 20 years of my life in a small and relatively rural area in Canada. Given the size of the town, it was common to recognize, if not know personally, just about every face that you encountered. I noticed from a very early age that there were several individuals, whom I later came to understand had various mental health issues, living in this town. At this young age, I felt that there was something “different” about these people. However, I also noted the intrinsic benevolence and vulnerability in which they presented themselves. They did not display any less kindness or consideration than any other individual that I had met. I was curious as to why I thought these people were “different” and what may have made them this way. While I did not know it at the time, this represented my first, but very significant, encounter with the concept of mental health.

Both my parents were medical practitioners; my father a doctor, my mother a nurse. I have clear memories from my adolescence of family dinners (which occurred every night) being unintentionally monopolized by adult conversation regarding “patients” that my parents had seen throughout their days at work. While listening to these stories, I came to understand that while my parents knew a great deal about presenting symptoms, appropriate pharmacological regimes, and probable prognoses, a humanistic element was missing from the equation. Moreover, it became apparent that, within the context in which they worked, assessment and treatment was based primarily on physical or disease models, and to a great extent neglected psychological

aspects. Due to the encouragement of both my parents, I was challenged to explore alternative concepts of wellness, and discovered that I had a keen interest in how individual perceptions of psychological problems developed. Thankfully, my family valued the concept of “challenging what you think you know” and welcomed the opportunity to consider how previous individual experiences may impact upon current states of health and wellness.

When I was old enough to start working, I, not surprisingly, found a job working as a secretary in a medical practice. During my ten years at this office, the medical model of health became even more apparent as patients moved in and out of the office in fifteen minute intervals. Luckily this particular office was filled with some of the most considerate, compassionate, and enquiring people that I have known to date. Through discussions with these individuals, I was able to further appreciate how psychological constructs influence the presentation of mental health disorders such as depression, anxiety, and psychosis. While I acknowledge that I still maintain a belief that there is a place for the medical model of health, I now prescribe to what I see as a more holistic and comprehensive approach to well-being.

My interest in religious beliefs comes more from a selfish point of “wanting to know.” I was not brought up in a religious family. I was however, brought up to value understanding personal limitations to knowledge, and the importance of resolving such disparities. Moreover, as a student passionate about clinical psychology, I have been taught to acknowledge the areas in which I know little, and endeavour to find ways in which I can fill these gaps. I viewed the following research as an opportunity to address not only some of the limitations in my own knowledge, but also the general psychological knowledge about the subjective experiences of those people with psychosis.

Religion and Mental Health

Religion has persisted as a stable and continuous component of essentially all social structures that exist around the world. While the specifics of any given belief system may vary, the objective of religion remains the same; it provides meaning and purpose in life for individuals who question the unknown (Marks, 2006). For some, religion provides a framework for moral obligations and responsibilities, the consequences of which extend far beyond the immediate

social structure and into the afterlife. For others, religion provides an opportunity for life after death and acts to reduce distress about an unknown and uncertain future. Alternatively, religion may simply be used to give hope for the future, or even just to maintain a social support network (Breakey, 2001; Paloutzian, 1996). Religion can therefore be conceptualized as a common, but varied, element of civilization. It exists both within a social and individual context and carries significant meaning for individuals who practice a faith.

Definitions and Concepts

Literature indicates considerable variability regarding religious terminology, especially when these terms are used for research-related purposes. Whitehouse and Hollings note that to date, ‘there is no agreed upon definition of religion or spirituality’ (2008, p. 478). The inconsistency in definitions, and consequently concepts, has led to the terms being used interchangeably, suggesting that the two are similar in defining characteristics. However, the substitution of the seemingly simple expressions obscures the notion that distinct levels of religious faith, spirituality, and practice exist. Although slight in linguistic differentiation, these words indicate specific behaviours associated with the given beliefs, which are comparably different for individuals practicing at the two discrete levels. It is therefore important to clarify the specific characteristics that define the practices associated with these two terms. The New Zealand Oxford Dictionary offers the following definitions:

Religion:

1. The belief in a superhuman controlling power, especially in a personal God or gods entitled to obedience and worship. 2. The expression of this worship. 3. A particular system of faith and worship. 4. Life under monastic vows. 5. A thing that one is devoted to (Deverson, 2005, p. 949).

Spirituality:

1. Of or concerning the spirit as opposed to matter. 2. Concerned with sacred or religious things; holy; divine; inspired. 3. Refined, sensitive; not concerned with the material. 4. Concerned with the soul or spirit etc., not with external reality (Deverson, 2005, p. 1087).

According to clinical literature, spirituality generally refers to individual beliefs in a power greater than that of human existence (Corrigan, McCorkle, Schell, & Kidder, 2003; W. K. Mohr, 2006; Steger & Frazier, 2005). Such beliefs may address, but are not restricted to, questions regarding religious deities and life’s greater meaning (Huguelet, Mohr, Borrás, Gillieron, & Brandt, 2006). Additionally, spirituality does not necessitate practical applications of belief; individuals who profess to be spiritual may not actively exercise these beliefs within the greater

social community. Alternatively, religion is best defined as the practical externalization of spirituality (Corrigan, et al., 2003; W. K. Mohr, 2006; Steger & Frazier, 2005). This involves habitual practices that recognize particular beliefs, values, codes of conduct, and rituals which are necessarily conducted in a community setting with individuals who share these same beliefs (W. K. Mohr, 2006). It is worthy to note that while these two terms are certainly different in regards to behavioural occurrences, the two are not mutually exclusive (Whitehouse & Hollings, 2008); religious activity undoubtedly requires a spiritual devotion. For the purposes of the present study, spirituality is understood to occur under the umbrella of religion and religious practice, and will therefore be referred to as such unless otherwise differentiated.

Although not specifically related to religious terminology, the consideration of the concept of atheism demonstrates the importance of religion in the broader social structure. By definition, an atheist is a person who does not believe in God (Deverson, 2005). The general assumption follows that without a belief in a divine or superior being there can be no faith in religion at even its most basic level. While the term does indeed denote a lack of personal religious faith, it is still a religious term. Arguably, there can be no atheism without the concept of religion. In order to define oneself as an atheist, one has to recognize religion as a legitimate social construct. In doing this, the individual is acknowledging that there are indeed differing levels of religiosity; to choose to belong at the bottom of this continuum or spectrum is simply choosing the level at which the individual is most comfortable. This concept is discussed to help demonstrate the significance and prevalence of religion in society. Religion has become so entwined in the social system that even someone who does not have faith in a God will often define themselves in relation to the concept of religion. Religion therefore, can be viewed as an entrenched value system, through which a majority of individuals guide personal behaviour.

While understanding the definitions associated with the study of religion is important, these do not in themselves provide a description of the nature of religious belief. In an attempt to address this issue, Palourtzian (1996) has taken a dimensional approach that focuses on the thoughts, feelings, and actions which are associated with this phenomenon. Here, the broader concept of religious commitment is sub-categorized into five elements, which include religious belief (ideological dimension), religious practice, (ritualistic dimension), religious feeling (experiential

dimension), religious knowledge (intellectual dimension), and religious effects (consequential dimension). Similarly, Hood, Spilka, Hunsberger, and Gorsuch (1996) also indicated the value of a multidimensional framework. These authors however, referenced the work of Verbit (as cited in Hood, et al., 1996) and included within each sub-category the concept of variability in terms of content, frequency, intensity, and centrality. Table 1 details the components of the aforementioned models. Paloutzian (1996) argues that this dimensional approach more readily serves empirical studies which attempt to understand the nature or function of religious beliefs. Moreover, using these models allow the researcher to identify how individual facets may be acting in combination to strengthen or weaken levels of religiosity. Thus, the frameworks proposed by these authors are used throughout the following work as a basis from which to understand the nature of religion.

Religious Development from a Psychological Perspective

Developmental Pathways

The psychology of religion recognizes religion as “a generalized, abstract orientation through which people see the world” (Paloutzian, 1996, p. 13). This approach attempts to address the nature of faith and spirituality through an analysis of these correlates as they exist in relationship to the individual and within the greater social community. The analysis involves a thorough investigation of the interrelating variables that ultimately interact to develop into an individualized religious belief system. Appropriately then, it is within this literature that one would find information regarding developmental theory as it pertains to the socialization processes that lead to internalized religious beliefs. These theories explain, from a psychosocial perspective, how and why individuals develop faith and spirituality. It is important to understand these relationships as they highlight how social and environmental factors play a role in belief development.

Before entering into a discussion on religious development it is important to first note that while religious socialization processes can begin very early in life;

There can be no meaningful religion in young children, if ... referring to a fully developed (mature or internalized) type of religious life. In order to have a “more developed” type of religious life, the individual must first be psychologically more developed. However, children are religious in some sense. Religion, like other facets of life, is developing from an early stage (Paloutzian, 1996, p. 84)

TABLE 1.1: Multidimensional Models of Religious Commitment

Model and Components	Descriptions
<u>Verbit (as cited in Hood et al.)</u>	
<ul style="list-style-type: none"> ▪ Ritual ▪ Doctrine ▪ Emotion ▪ Knowledge ▪ Ethics ▪ Community 	<ul style="list-style-type: none"> Private and/or public ceremonial behaviour Affirmations about the relationship of the individual to the ultimate The presence of feelings (awe, love, fear, etc.) Intellectual familiarity with sacred writing and principles Rules for the guidance of interpersonal behaviour, connoting right/wrong, good/bad
Above components vary along the following dimensions:	Involvement in a faithful community, psychologically, socially, and/or physically
<ul style="list-style-type: none"> ▪ Content ▪ Frequency ▪ Intensity ▪ Centrality 	<ul style="list-style-type: none"> The essential nature of the component (eg. specific rituals, knowledge, principles, etc) How often the content elements are encountered or are acted upon Degree of commitment Importance or salience
<u>Paloutzian</u>	
<ul style="list-style-type: none"> ▪ Religious Belief ▪ Religious Practice ▪ Religious Feeling ▪ Religious Knowledge ▪ Religious Effects 	<ul style="list-style-type: none"> <i>Ideological Dimension</i> Refers to what is believed as part of a religion, how strongly the belief is held, the bases for the intellectual assent, and how salient that belief is in the person's life <i>Ritualistic Dimension</i> Refers to the set of behaviours that are expected of a person who declares belief in a certain religion. The emphasis is not on the effect the religion may have on the 'non-religious' aspects of the person's daily life, but on the specific acts that are part of the religion itself <i>Experiential Dimension</i> Concerned with the inner mental and emotional world of the individual <i>Intellectual Dimension</i> Refers to the information one has about one's faith, as compared to belief in the faith <i>Consequential Dimension</i> Refers to behaviour, but not behaviour that is a formal part of religious practice itself.

(Hood, et al., 1996, p. 9; Paloutzian, 1996, pp. 14-20)

It is argued that during the early stages of development, environmental and social supports allow the child to develop a sense of religion; the individual cognitive capacities however, lack to the extent that the internalization of religious beliefs does not occur. Here, the child models his or her own individual behaviour after significant others who socially endorse religious rituals such as prayer and church attendance. The meaning behind such behaviours however, continues to remain absent in the mind of the child (Paloutzian, 1996). Literature notes that perhaps one of the most important and influential factors at this point of religious development is that of religious nurturance, which is most prominently seen through the interactions of child and parent (Koenig, 1998). The reward for appropriately performed religious activities is positive regard from the given authority figure, with the additional relational consequence of increased social

attachment. At the individual level, the child has developed ‘extrinsic religiousness’ (Steger & Frazier, 2005) in that there is a superficial understanding of religion as it relates to material needs and desires for which there is no other means of attainment (Paloutzian, 1996). The literature would therefore suggest that young children do not initially observe and practice religion in the same way as adults. Accordingly, research in this area has proposed that religious beliefs not only develop progressively, but do so in much the same way that that cognitive and physical abilities develop; through socialization processes that allow the child to examine and expand upon previously held competencies and ideas.

Several models that address issues regarding religious development have been proposed, including those by Allport, Piaget, Kohlberg, Elkind, Fowler and Oser (Hood, et al., 1996; Paloutzian, 1996). While the content and perspectives of these theories differ slightly, the format of the models remains the same. All based upon the stage theory of development, these theories propose that development occurs through a series of successfully completed and sequentially ordered stages. While noted to be specifically related to religious development, these models seem to be extensions of the Piagetian model of cognitive development, in which the child moves through a series of stages to develop increasingly enhanced cognitive abilities (Hood, et al., 1996; Paloutzian, 1996). As such, models relating to religious development tend to correspond with and parallel models of cognitive development suggesting that religious internalization can and will only occur with the appropriately enhanced cognitive abilities. To further this claim, empirical research has been conducted that validates the claim that the development of religious beliefs occurs in ways consistent with these stage models (Paloutzian, 1996).

The consideration of religion as a developmental process highlights the fact that it is not something that merely “happens” to an individual (Paloutzian, 1996). Instead, much like many other psychological variables religious beliefs can be either positively or negatively influenced by expanding cognitive capacities and social environments. Thus, understanding these processes helps the reader comprehend the way in which initial beliefs develop, as well as some of the potential mechanisms through which these beliefs continue to remain functional (social impacts).

Explanations of Religious Behaviour

While the theories proposed above have attempted to address the process through which people develop religious beliefs, these do not explain why people continue to maintain such convictions. Literature notes that theories in this area focus on two main approaches; namely the defensive/protective tradition, and the growth/realization tradition (Hood, et al., 1996). In the defensive/protective tradition, religion is understood to be a result of people's need for meaning and control. A psychological equivalent of the biological concept of homeostasis, in which action occurs as a result of inadequacies in other areas, is proposed. Here, it is assumed that fear results when individuals are unable to make sense of experiences or maintain control in situations. Hood, Spilka, Hunsberger, and Gorsuch note that

It is not surprising that humans struggle to make the ambiguous clear, the doubtful certain, and the indeterminable sure. People search for ways to make sense out of life, to give them a feeling of control, to make the future predictable, and especially to insure a positive outcome. Religion offers such possibilities through scripture, theologies, prayer, liturgy, and ceremony (1996, p. 18).

Thus, from a psychological perspective, dissonance between needs and fulfilment motivates the individual to engage in religious beliefs and activities. The reduction of fear, anxiety, and the feeling of helplessness then reinforces the positive benefits and outcomes associated with religious commitment.

Alternatively, the growth/realization tradition suggests that "people attempt to utilize their capacities to their fullest, and to grow and improve at every opportunity, rather than simply to solve problems (Hood, et al., 1996, p. 19). This self-actualization occurs during "peak experiences" in which emotional and intellectual enlightenment is the result. Here, religion facilitates the creation of meaning, which is identified as an innate drive.

Religion in Research: Empirical Relationships

Literature suggests that there is comparatively little empirical information that discusses religion as it relates to clinical and psychological phenomena. The following sections outline the trends and explanations for the small number of already established relationships between religion and correlates of mental health.

Perceived Incompatibility between Religion and Medical or Psychological Services

The medical model of well-being, both from a psychological and physiological perspective, has generally refrained from addressing religion in both assessment and treatment of patients (Blass, 2001; Hartog & Gow, 2005; Huguelet, et al., 2006). There are several reasons that have been proposed that may account for this phenomenon.

Clients who are strongly religious have been reported to be less likely to seek out medical and pharmacological treatment (Miller & McCormack, 2006). The specific reasons for this are unclear, but studies suggest that the religious community may still hold several stereotyped beliefs regarding doctors and psychotherapists (Hartog & Gow, 2005) that may influence the probability of presenting to this particular population.

The literature notes that for those individuals who do seek medical or clinical assistance, there is an increased tendency to seek specifically religious counselling services over secular options that offer the same support opportunities (Hartog & Gow, 2005; Whitehouse & Hollings, 2008). It follows that religious individuals are also likely to seek treatment by someone who ascribes to the same religious denomination (Whitehouse & Hollings, 2008). For example, Protestant Christian denominations are often conceived of as occurring along a continuum that ranges from Fundamentalism to Liberalism. Where a Fundamentalist would view mental health issues as a consequence of sin and would therefore suggest confession as a means of treatment, a Liberalist would argue that mental health is an entity unto itself, and should therefore be treated primarily through psychological and pharmacological means (Hartog & Gow, 2005). It is not surprising that faith healers, rather than medical practitioners, are the primary sources of health management for this particular population. Unfortunately, the range and diversity of practicing faiths makes it exceptionally difficult to determine an appropriate framework to use as a general approach in the assessment of religious clients (Blass, 2001); this therefore remains one of the greatest obstacles for clinicians when working with a client who has strong religious convictions.

Additional studies have proposed that medical and clinical practitioners are less likely to be religious themselves (Kirov, et al., 1998) and therefore do not understand the capacity of religion, nor the importance of the relationship to personal well-being (Huguelet, et al., 2006). This noted

lack of the religiously inclined in the medical profession has been especially observed in North American and British practitioners (Blass, 2001; Marks, 2006). Historically, clinicians have been characterized as lacking religious education and pathologizing the religious aspects of client functioning (Huguelet, et al., 2006).

Alternatively, a small number of studies have suggested that individuals with mental health problems are less likely to be religious compared to the general population and that treatment consequently reflects this phenomenon. In a study which attempted to address the issue of importance of religion and spirituality, Mohr, Brandt, Borrás, Gillieron, and Huguelet found that “patients consider spirituality to be more important in their everyday lives than does the general population, but they participate in community religious activities less often” (2006, p. 1957). This finding would suggest some common misperceptions regarding individuals with mental illness who practice a religious faith. It is not necessarily true that this population is less religious than the general population, but rather that faith is practiced in different ways, and often outside of the community. The most noted reason for this occurrence relates to reports of individuals with mental health issues who feel stigmatized by the community (Huguelet, et al., 2006), and who therefore prefer to practice individually.

In a different study these same authors proposed, tested, and confirmed three hypotheses: “[1] religion is more important for patients who have chronic psychotic illness and [2] less important for clinicians than in the general population and [3] that patients’ religious practices and spirituality are underestimated and neglected by clinicians” (Huguelet, et al., 2006, p. 367). It was found that clinicians were less likely to be religious compared to the general population. Analysis of the information provided also demonstrated the importance of religion for individuals with chronic psychotic illness, especially when used as a coping strategy.

Despite the slightly varied directionality in explanations, the literature clearly demarcates a lack of religious acknowledgment in the assessment and treatment of clients with mental health difficulties. An additional reason for this may in fact be the lack of psychologically-informed religious research (Marks, 2006) and educational opportunities for professionals in this area . Bowman argues that, “in planning a curriculum to train mental health professionals, logic dictates

giving emphasis to (a) topics that concern the majority of patients treated by the professional and (b) topics about which the clinician is relatively uniformed” (Bowman, 1998, p. 367). The author further states that religion certainly meets these two criteria and must be integrated into psychological evaluations. Before doing this however, foundational information, such as the nature of religious beliefs in relation to mental health issues, must be considered and understood (Bowman, 1998). The relationships between these two variables are therefore discussed in the following section.

Religion and Psychological Well-Being

Up until the early 1970’s there was little if any empirical reference to religion in the literature on mental health disorders (Marks, 2006). Almost thirty years later, three very influential documents were published by Pargament, (1997), Koenig (1998), and Koenig, McCullough and Larson (2001) (as cited in Marks, 2006). These reviewed and analyzed all available literature discussing the association between religion and mental health (Koenig, 1998; Koenig, McCullough, & Larson, 2001). Interestingly, these documents stressed that although studies differed in samples, designs, methodologies, and measures, there remained a consistency of findings that suggested a positive association between religious involvement and psychological well-being (Levin & Chatters, 1998). Moreover, this consistency seemed to indicate a relationship of relative strength given that positive results were reported in diverse populations across a variety of cultures and faiths. While most research in this area has been conducted in the United States, Europe, or Israel, and therefore focuses on the Christian and Jewish faiths predominantly (Koenig, et al., 2001), there has been recent attempts to incorporate other world religions which have included Muslim, Hindu, Buddhist, and other such specific religious perspectives (Koenig, 1998).

General religious involvement has been cited in several studies as contributing to beneficial effects in psychological outcome such as increased personal well-being and quality of life (Corrigan, et al., 2003; Koenig, et al., 2001; W. K. Mohr, 2006; Steger & Frazier, 2005). Mediating variables such as increases in both pro-social values and effective cognitive schema (W. K. Mohr, 2006), as well as decreases in stress, anxiety, and depressive symptoms (Corrigan, et al., 2003; S. Mohr, et al., 2006) also point to the positive role of religion. Explanations have

most generally focused on the role that religion plays in the development of positive coping mechanisms and strategies which are applied while experiencing symptoms of mental health (Corrigan, et al., 2003; Huguelet, et al., 2006; Miller & McCormack, 2006). In a systematic review of religious coping, Harrison, Koenig, Hays, Eme-Akwari, and Paragament reported that:

Religious coping is expressed in the cognitive construction of the triggering event, in the ends sought, and in the methods used to reach these ends. Religious coping may be involved in the conservation or transformation of ends. Thus, religious coping methods are multi-dimensional. They belie stereotypic views of religion as simply a defence or a passive form of coping. [...] They span the range from active to passive, problem-focused to emotion-focused, positive to negative, and cognitive-behavioural to interpersonal and spiritual (2001, p. 86)

Table 1.2 illustrates the range of religious coping strategies identified in this article, as outlined by type and description. Others studies document religion as an essential underlying feature for individual insight into meaning in life (Marks, 2006). In a study which attempted to identify mediating variables between religiousness and psychological health, Steger and Frazier defined meaning in life as “feelings regarding the self-perceived significance of one’s life” (2005, p. 575). The authors concluded that the relationship between religious beliefs and reported improvements in life satisfaction, self-esteem, and optimism were all mediated through perceived meaning in life. Moreover, it was found specifically that religious activities increased well-being through meaning in life, thus suggesting that meaning can develop even over brief periods of time (Steger & Frazier, 2005). Finally, in a review of the literature, religion was credited for improving hope and optimism about the future in as many as eighty percent of all the studies conducted in this area (Marks, 2006).

At a more societal level, religion has been credited with providing “guidelines for interpersonal behaviour, leading to reduced aggression and improved social relationships” (S. Mohr, et al., 2006, p. 1954). The most general assumption regarding this relationship is that religious practices can improve mental health, which in turn leads to increased longevity (Marks, 2006). In this instance, it is not only the relationship between religion and mental health that is claimed to be positive, but also the relationship between religion and overall physical and psychological well-being. A thorough analysis of the literature found that “taken together, the studies reviewed suggest that religious involvement exhibits both preventative and therapeutic effects on mental health outcomes” (Levin & Chatters, 1998, p. 36).

TABLE 1.2: Illustrative Methods of Religious Coping

Type	Definition
Benevolent	Redefining the stressor as benevolent and potentially beneficial
Punishing God reappraisal	Redefining the stressor as a punishment from God for the individual sins
Demonic reappraisal	Redefining the stressor as the work of the devil
Reappraisal of God's powers	Redefining God's powers to influence the stressful situation
Collaborative religious coping	Seeking control through a partnership with God in problem solving
Deferring religious coping	Passively waiting for God to control the situation
Self-directing religious coping	Seeking control through individual initiative rather than relying on God
Seeking spiritual support	Searching for comfort and reassurance through God's love and care
Religious focus	Engaging in religious activities to shift the focus from the stressor
Religious purification	Searching for spiritual cleansing through religious action
Spiritual connection	Seeking a sense of connectedness with forces that transcend the individual
Spiritual discontent	Expressions of confusion, alienation, and dissatisfaction with God
Seeking support from clergy/members	Searching for comfort and reassurance through the love and care of others
Religious helping	Attempting to provide spiritual support and comfort to others
Interpersonal religious discontent	Expressing confusion and dissatisfaction with the clergy or members
Religious forgiving	Looking to religion for help in letting go of anger, hurt, and fear of others
Religious conversion	Looking to religion for a radical change in life

(Harrison, et al., 2001, p. 87)

Religiously Themed Symptoms versus Religious Experiences

Religious content has been indicated as possible in much of the literature regarding positive symptomology. Mohr, Brandt, Borrás, Gillieron, and Huguelet noted that “spirituality and religiousness have been shown to be highly prevalent among patients with schizophrenia” (S. Mohr, et al., 2006, p. 1952). Similarly Mohr and Huguelet (2004) found that individuals involved in religious practices were more likely to experience religious-themed symptoms. Several other authors have supported this finding (Appelbaum, Robbins, & Roth, 1999; Corrigan, et al., 2003; Drinnan & Lavender, 2006; Fuller-Torrey, 2006; Huguelet, et al., 2006; W. K. Mohr, 2006). In terms of specific content, religiously-themed delusions have most generally been categorized into three groups, which include persecutory, grandiose, and related to belittlement (S. Mohr & Huguelet, 2004).

Miller and McCormack (2006) conducted a study on faith and religious symptoms in first-episode psychosis and found that symptoms could be categorized into two groups; namely, clearly religious delusions (beliefs that fell outside the cultural norm of the individual) and delusions with religious content (beliefs that fell within the cultural norm of the individual). Both delusions and hallucinations of a religious nature were noted to have highly personal meaning, and occasionally served as protective factors in the conceptualization of both the illness and the

concept of self. The authors concluded by stating that while pharmacological treatment may decrease the presence of religious-themed symptoms, the faith which often influences the content of these symptoms will continue to prevail, and must therefore be addressed in psychological assessment and treatment (Miller & McCormack, 2006).

In a comprehensive review of the literature in this area, Mohr and Huguelet (2004) identified several issues in the conceptualization of religious beliefs and religious delusions. First, it was noted that the prevalence of religious-themed delusions and hallucinations was dependent to some extent on population and cultural variables. Moreover, religious beliefs and religious delusions were generally not considered mutually exclusive experiences, but rather supposed to exist together on a continuum of normality (S. Mohr & Huguelet, 2004). The authors thus proposed that:

Religious delusions may be differentiated from religious beliefs on the basis of three criteria: 1) the patient's self-description of the experience is recognizable as a form of delusion, 2) other recognizable symptoms of mental illness are present in other areas of the individual's life (ie. delusions, hallucinations, mood or thought disorder), and 3) the lifestyle, behaviour and direction of the personal goals of the individual after the event or after the religious experience are consistent with the history of a mental disorder rather than with a personally enriching life experience (S. Mohr & Huguelet, 2004, p. 371).

In addition, Mohr and Huguelet identified that theories related to altered states of consciousness may also help in differentiating between these two experiences. Here, the authors suggested that:

Psychotic and spiritual experiences would be characterized by a qualitatively different type of consciousness – a transliminal state – as compared to an ordinary experience. The difference lies in the capacity of the subject to turn back to reality after the mystical experience, which doesn't occur in psychosis (S. Mohr & Huguelet, 2004, p. 371)

Despite these potentially theoretically sound concepts, Jackson and Fulford (1997) found that distinctions between spiritual experiences and positive symptoms associated with psychopathology could not be made reliably on the basis of form, content, relationships with other symptoms or pathological causes, or descriptive criteria such as those provided in the “medical model” of health. Instead, distinctions are made based on the way in which the person experiencing the phenomena generates meaning from previously-established values and beliefs (Jackson & Fulford, 1997).

Given the above, an understanding of different spiritual experiences is considered clinically valuable, so as to ensure that such experiences are not pathologized to the detriment of the

individual. Donovan (1998, as cited in Eeles, Lowe, & Wellman, 2003) identified four types of religious experience, which included mystical, paranormal, charismatic, and regenerative. The defining characteristics of these experiences have been outlined in Table 1.3. Interestingly, the authors of this article note that while these experiences are, by definition, religious in nature, many individuals who do not prescribe to a faith can describe personal experiences that would fit into one or many of these categories. However, as previously noted, the interpretations of these experiences are typically based upon previously-developed concepts, and as such, these individuals are less likely to make religious attributions in terms of causal mechanisms (Eeles, et al., 2003).

Negative Influences on Functioning

It is important to note that while the majority of studies indicate religion as having beneficial effects on mental health, there are other reports that would argue instances of negative influence. Mohr, Brandt, Borrás, Gillieron, and Huguelet (2006) conducted a study which investigated the positive and negative roles of religion for patients suffering from psychosis. The authors noted that for those individuals seeking a form of religious healing, the absence of an immediate cure may lead to more despair, a finding that has been replicated in several other studies (Harrison, et al., 2001). In this instance, the individual loses not only a means of effectively addressing illness, but also the actual faith that was viewed as being potentially responsible for fixing the health crisis.

The study also cited individual rejection and loss of social support by religious communities as occurring when individual psychotic symptomology appeared (S. Mohr, et al., 2006). This in turn had the effect of limiting the participants to a more individualized and isolated routine of religious practice. This trend has also been reported in other literature (Fuller-Torrey, 2006) suggesting that stigmatization of individuals with mental health disorders is still a problem. Alternatively, some studies have found that too much support from specific religious communities, such as fundamentalist groups, might encourage individual symptoms, making treatment of the disorder very difficult (Fuller-Torrey, 2006).

TABLE 1.3: Types of Spiritual Experiences

Types of Spiritual Experiences	Characteristics
Mystical	Individuals experience periods of heightened awareness, a sense of oneness and of existence beyond the physical world and attach a sense of profound importance to these feelings
Paranormal	Include such things as psychic or out of body experiences, which tend to conflict with the Western scientific understanding of the world
Charismatic	Sometimes interpreted as manifestations of a spirit or divinity working within an individual. One example of this would be the experience of speaking in tongues
Regenerative	Bring a new way of being to an individual through religious enlightenment or conversion

(Donovan, 1998 as cited in Eeles, et al., 2003, p. 197)

Religious beliefs have also been cited as contributing to the negative reframing of events such that the individual views all distressing occurrences as caused by demons, devils, or God's punishments (Harrison, et al., 2001; Marks, 2006). Interestingly, results from the study by Mohr, Brandt, Borrás, Gillieron, and Huguelet (2006) have shown that, even with negative restructuring, the association between religion and mental health issues can be positive in psychological terms. This study found that even when religion provided a framework for negative connotations to be used as a source of meaning for illness, these associations "foster[ed] an acceptance of the illness or a mobilization of religious resources to cope with the symptoms" (S. Mohr, et al., 2006, p. 1954). Although the causal attributions are specifically negative in content, the direction of symptomology explanation remains positive, and the individual is able to use religion as a constructive coping mechanism. One might therefore conclude that it is not necessarily religion itself that has the potential for negative influence, but rather how the principles of the specific religious faith are perceived and applied to the given situation.

Religion in Research: Theoretical Suppositions

Given the above empirical evidence, the determination of the specific mediating factors that shape the relationship between religion and mental health would be the next logical step in the incorporation of religion into the psychosocial model of health. Theoretical suppositions have been proposed that would suggest the association between religion and psychopathology can be conceptualized in several ways, which would include the following:

- (1) People with disturbances become religious as a coping mechanism,
- (2) Religion induces pathology in initially healthy people,
- (3) Certain forms of religiosity are associated with health, while other forms are associated with pathology,
- (4) Religiosity and pathology or maladjustment are unrelated (Paloutzian, 1996, pp. 248-249).

Research has tended to focus on only the first of these four, very broad, propositions. Other, more specified, relationships have also been proposed. The following examples implicitly delineate why a relationship between religion and mental health might exist:

- (1) Religion may be an expression of mental disorder,
- (2) Institutionalized faith can be a socializing and suppressing force, helping (or forcing) people to cope with their difficulties and therefore to function as contributing members of society,
- (3) Religion can serve as a haven, a protective agency for some disturbed people,
- (4) Spiritual commitment and involvement may perform therapeutic roles in alleviating mental distress, and
- (5) Religion can be a stressor, a source of problems; in a sense it can be hazardous to one's mental health (Hood, et al., 1996, p. 408).

It is noted that in the above specified expressions of the relationship between religion and mental health, relationships (2), (3), and (4) most generally fit into the category of 'religion as a coping strategy,' outlining again the specific and collective focus of empirical research in this area. Relationships (1) and (5) however, represent the negative associations in which religion is regarded as an expression of, or causative factor in, mental illness.

Sociological explanations of this relationship tend to focus on concepts such as social cohesiveness in religious groups, theological contexts of meaning, and the discouragement of behavioural risk factors. Alternatively, psychological explanations have focused more on the role of individual cognitive perceptions, such as internal locus of control, and faith in God (Levin & Chatters, 1998). Levin and Chatters applied these two theories, along with behavioural and biological explanations, to produce a model in which "religious dimensions [were] linked to better mental health outcomes via several mediating pathways" (Levin & Chatters, 1998, p. 40). Here, religious faith was seen to range from subjective religious attitudes to active participation in community prayers and rituals. Accordingly, each differing degree of religious belief was thought to correspond with particular mediating factors that may be responsible for improvements or advances in psychological well-being. For example, religious commitment (subjective religious attitudes) was thought to be effective in reducing risky health-related behaviour, such as smoking, alcohol consumption, drug use, and poor diet, which consequently lowered risk of mental illness, while concurrently enhancing physical health. Alternatively, attendance to organized religious institutions was thought to increase well-being by providing meaningful social relationships, while religious worship was assumed to influence positive emotional

responses such as hope, forgiveness, empowerment, contentment, and love. Finally, religious faith in general was theorized to increase optimism and hopefulness, which helped maintain a more general positive mental attitude (Levin & Chatters, 1998).

Similarly, Koenig (2002) identified four reasons for an association between religion and mental health. The first of these reasons suggests that religious beliefs provide a framework from which a positive worldview could be developed, given an understanding that circumstances do not occur as a result of random chance. Instead, both positive and negative events can be viewed as providing purpose and direction in life, consequently giving these experiences meaning. Secondly, religious experiences may evoke positive emotions, which in turn counteract daily stressors. Thirdly, religion practices build ‘social capital’ which facilitates and promotes family, marital, and community bonds from which support is gained. In addition, religious beliefs also stipulate care for others, such that individual characteristics of kindness, generosity, forgiveness, and altruism are developed. Finally, religious institutions may act as agents of social control which determine and regulate the specific behaviours which are deemed to be acceptable or unacceptable.

Methodological failings

Despite the fact that religion is noted to have effects on several aspects of mental health, it is not being used in therapy or treatment-based programmes (Bowman, 1998). The most likely reason for this is the simple fact that studies in this area have only been conducted within the last thirty years (Marks, 2006); this has not given the research community enough time to fully and extensively evaluate the specifics of the relationship between these two variables. While several studies have conducted an overall analysis (Blass, 2001; Corrigan, et al., 2003; Harrison, et al., 2001; Hartog & Gow, 2005; Huguelet, et al., 2006; Koenig, 1998; Koenig, et al., 2001; S. Mohr, et al., 2006; W. K. Mohr, 2006; Steger & Frazier, 2005), the precise nature of the relationship, and the reason why this relationship exists, have yet to be determined (Levin & Chatters, 1998).

Additionally, there remain not only gaps in the literature, but also several issues with research procedures. While literature would seem to indicate a strong positive relationship between religion and mental health;

Published work on religion and health has been criticized on methodological grounds. Researchers have failed to control for confounding variables and other covariates, as well as to control for multiple comparisons using multiple statistical procedures (W. K. Mohr, 2006, p. 177).

Moreover, the nature of the research in this area is such that the variables are often defined subjectively and with the discretion of the researcher; a variable such as ‘meaning in life’ is likely to be defined differently across studies. Consequentially, the correlates of religion are both hard to qualify and hard to quantify. Finally, many of the variables that have been used as measures (such as self-esteem, meaning in life, and optimism) are almost always treated as trait variables (Steger & Frazier, 2005), such that all measures are assumed to be reliably stable over time. However, this is not always the case; one’s level of optimism about the future will likely be higher on a day when personal goals have been met, than on a day when a simple daily activity or goal has not been achieved.

Schizophrenia

While there seems to be an abundance of information on the topic of schizophrenia, there is still ambiguity pertaining to definitional issues due to the many contradictions that are present within the literature. Historically, reports on diagnostic criteria and epidemiological information have remained reasonably consistent throughout the literature, suggesting a relatively sound understanding of clinical presentation; however, recent research has questioned the validity of some of these reports. Moreover, no absolute and definitive theories regarding aetiology have been confirmed. The following sections summarize literature which relates to the historical and developmental context of schizophrenia, the epidemiological statistics and clinical presentation, and the current research pertaining to theories of aetiology. Through this discussion, it will be demonstrated that while research and literature continue to contribute to the already established wealth of information in this area, the contradictory content of such research has limited the understanding of this particular disorder.

Historical and Developmental Context

The concept of schizophrenia as a distinct disorder was first developed by Emil Kraepelin (Sadock & Sadock, 2003). Other influential theorists, such as Eugen Bleuler and Kurt Schneider, specified details related to the specifics and criteria of diagnosis. The developmental history

underlines how the conception of schizophrenia contributed to the current perception of the disorder as one which characteristically lacks clarity. It is therefore important to understand this history, as it sets the scene for the way in which schizophrenia is understood to present in a clinical setting.

In an early attempt to distinguish similarly presenting disorders, Kraepelin differentiated between two forms of mental illness (Tsuang, Stone, & Faraone, 2000). The first was termed *dementia praecox* and was a literal translation that described what Kraepelin believed to be the two defining characteristics of the disorder; namely ‘being out of one’s mind’, and ‘precocious onset’ (Kruger, 2000). He saw this particular form of psychosis as progressive and deteriorating, given that approximately only four percent of his patients returned to pre-morbid functioning (Kruger, 2000; Sadock & Sadock, 2003). Alternatively, manic-depressive psychosis was characterized by periods in which the individual was able to return to levels of normal performance (Tsuang, et al., 2000). According to Kraepelin, it was poor prognosis that differentiated dementia praecox from manic-depressive psychosis.

In 1911, Bleuler furthered the concept of psychosis as a degenerative disease when he coined the term *schizophrenia* to depict the disjunction between cognitive, emotional, and behaviour processes and expressions (Adityanjee, Aderibigbe, Theodoridis, & Wieweg, 1999; Kruger, 2000). Bleuler included in his theoretical conception of disease four fundamental symptoms, commonly known as the “four A’s;” ambivalence, disturbance of association, disturbance of affect, and autism, which was understood to present as a detachment from reality (Regan, 2008; Sadock & Sadock, 2003; Tsuang, et al., 2000). Bleuler’s approach was largely theoretical, which contrasted with Kraepelin’s more empirical observations; however Bleuler’s reconceptualization was important for three reasons:

First, his reformulation of dementia praecox as “the group of schizophrenias” foreshadowed the contemporary view that schizophrenia is a heterogeneous group of disorders with similar clinical presentations. Second, Bleuler included defects in affect as a core feature of the disorder. Third, his view of schizophrenia allowed for the possibility for recovery (Tsuang, et al., 2000, p. 1042).

Many individuals since Bleuler have attempted to delineate the nosology of schizophrenia, and have thus contributed to the current diagnostic criteria outlined in the *Diagnostic and Statistical*

Manual of Mental Disorders [DSM-IV-TR] (American Psychiatric Association [APA], 2000). For example, Meyer saw schizophrenia as a reaction to significant life stressors, while Sullivan emphasized social isolation as a main causative factor in the development of the disorder. Langfeldt classified individuals with psychotic symptoms into two groups, differentiating those with schizophrenia from those with “schizophrenia-like” symptoms, thus creating the concept of a continuum of psychotic disorders (Sadock & Sadock, 2003). Kurt Schneider developed a list of first-rank and second-rank symptoms which included the presence of voices, delusional perceptions, and thought insertion and withdrawal. Schneider stressed that these symptoms were not to be rigidly applied or used as etiological markers, but were instead more useful as diagnostic tools (Regan, 2008; Sadock & Sadock, 2003). Finally, Jaspers played an important role in understanding schizophrenic symptoms from a psychological perspective in which the subjective experiences of clients were considered essential in understanding the constructed meaning of delusions and hallucinations (Sadock & Sadock, 2003).

Considering the historical development of schizophrenia, it is no surprise that the current DSM-IV-TR has conceptualized schizophrenia as a disease, from which there is very little chance of recovery (Adityanjee, et al., 1999; Kruger, 2000). However, as outlined in further detail below, schizophrenia can be differentiated from the other psychosis disorders on the basis of severity and duration of symptoms alone (Kruger, 2000). Considering this, several authors have now begun to suggest that perhaps a more beneficial taxonomic model would include a continuum of psychoses, upon which schizophrenia may represent the most extreme of these cases (Kringlen, 1994; Kruger, 2000; Stip & Letourneau, 2009; Tsuang, et al., 2000). Such a model would have important implications in terms of assessment, diagnosis, and treatment.

Definitions of Schizophrenia and Other Psychotic Disorders

As indicated above, the definition of schizophrenia as a distinct diagnostic category has been altered quite significantly over the decades. However, the emphasis on psychotic symptoms as a necessary component of the disorder continues to remain consistent (Sadock & Sadock, 2003). Interestingly, the presentation of psychotic symptoms alone does not specifically differentiate schizophrenia from other DSM-IV-TR diagnoses. It is not surprising then that schizophrenia presents similarly compared to other psychotic disorders. In order to understand which

characteristics of schizophrenia define it as a distinct diagnostic category, the differences between this disorder and other psychotic disorders must be outlined. Table 1.4 reviews the diagnostic criteria for schizophrenia according to the DSM-IV-TR, while Table 1.5 differentiates between the specific types. Table 1.6 lists and briefly describes the other forms of psychosis identified in the same manual. The consideration of the information presented in these three tables outlines the heterogeneity of clinical presentation.

Schizophrenia is classified in the DSM-IV-TR as belonging to a group of conditions which fall under the title “*Schizophrenia and Other Psychotic Conditions*” (APA, 2000). Of interest is the fact that schizophrenia has been individually noted, potentially indicating some specific differentiation between this diagnostic classification and the remaining eight other psychotic conditions included in this section of the manual. Allusions to the content, severity, and duration of illness have been recognized in the DSM-IV-TR as probable grounds to preclude schizophrenia from what are typically characterized as the less invasive forms of psychosis. It is likely however, that this differentiation is the result of the historical development of the disorder in which the concept of schizophrenia had always been separated from other mental illnesses. The disorders which comprise the remainder of the DSM-IV-TR diagnostic category include; Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder due to a General Medical Condition, Substance-Induced Psychotic Disorder, and Psychotic Disorder Not Otherwise Specified (APA, 2000). The DSM-IV-TR also notes psychotic features associated with several other conditions which include Dementia, Post-Traumatic Stress Disorder, and a number of conditions which fall under the diagnostic categories of Substance-Related Disorders and Mood Disorders (APA, 2000). The presence of conditions which are not included in the psychotic disorders but which nonetheless maintain psychotic components adds to the difficulty and confusion in differential diagnoses.

Schizophrenia can be diagnosed when positive symptoms and/or negative symptoms are present (Criterion A of Table 1.4), and when other psychotic, mood, and pervasive developmental disorders have been excluded as possible diagnoses (Criterion D, E, F). In this definition,

TABLE 1.4: DSM-IV-TR Diagnostic Criteria for Schizophrenia

-
- A. *Characteristic Symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated);
1. Delusions
 2. Hallucinations
 3. Disorganized speech (eg. frequent derailment or incoherence)
 4. Grossly disorganized or catatonic behaviour
 5. Negative symptoms (eg. affective flattening, alogia, or avolition)
- Note:** Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.
- B. *Social/Occupational Dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
- C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (eg. odd beliefs, unusual perceptual experiences).
- D. *Schizoaffective and mood disorder exclusion:* Schizoaffective disorder and mood disorder with psychotic features have been ruled out because either (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
- E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (eg. a drug of abuse, a medication) or a general medical condition.
- F. *Relationship to a pervasive developmental disorder:* If there is a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).
- Classification of a longitudinal course* (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):
- Episodic with inter-episode residual symptoms** (Episodes are defined by the re-emergence of prominent psychotic symptoms); also *specify* if: **With prominent negative symptoms**
 - Episodic with no inter-episode residual symptoms
 - Continuous** (Prominent psychotic symptoms are present throughout the period of observation); also *specify* if:
 - With prominent negative symptoms**
 - Single episode in partial remission:** also *specify* if: **With prominent negative symptoms**
 - Single episode in full remission**
 - Other or unspecified pattern**
-

(APA, 2000)

positive symptoms would include those socially-deemed 'bizarre' behaviours such as hallucinations, delusions, and other active evidence of thought disorder (Regan, 2008).

Alternatively, negative symptoms are characterized by a deficits in behavioural, emotional, and cognitive expressions, such as apathy, blunted affect, emotional withdrawal, poor rapport, and a lack of spontaneity (Regan, 2008). In addition, a diagnosis of schizophrenia would require that there be a continuous disturbance present for at least six months and that at least one of these months would include the presence of active-phase symptoms (Criterion A symptoms) (APA, 2000). Finally, there must be social and/or occupational dysfunction for a significant proportion of time during the illness.

TABLE 1.5: DSM-IV-TR Subtypes of Schizophrenia

Subtypes	Characteristics
Paranoid Type	A type of schizophrenia in which the following criteria are met: A. Preoccupation with one or more delusions or frequent auditory hallucinations. B. None of the following is prominent: disorganized speech, disorganized or catatonic behaviour, or flat or inappropriate affect.
Disorganized Type	A type of schizophrenia in which the following criteria are met: A. All of the following are prominent: disorganized speech, disorganized behaviour, flat or inappropriate affect. B. The criteria are not met for catatonic type.
Catatonic Type	A type of schizophrenia in which the clinical picture is dominated by at least two of the following: 1. Motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor 2. Excessive motor activity (that is apparently purposeless and not influenced by external stimuli) 3. Extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism 4. Peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), stereotyped movements, prominent mannerisms, or prominent grimacing 5. Echolalia or echopraxia.
Undifferentiated Type	A type of schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the paranoid, disorganized or catatonic type.
Residual Type	A type of schizophrenia in which the following criteria are met: A. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behaviour. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for schizophrenia, present in an attenuated form (eg. odd beliefs, unusual perceptual experiences)

(APA, 2000)

There are significant limitations to the presented diagnostic criteria. For example, the DSM-IV-TR uses different definitions of the term *psychotic* depending on the diagnosis that is to be given.

As such:

The specific constellation of symptoms to which the term refers varies to some extent across the diagnostic categories. In Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder, the term *psychotic* refers to delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behaviour. In Psychotic Disorder Due to a General Medical Condition, and in Substance-Induced Psychotic Disorder, *psychotic* refers to delusions or only those hallucinations that are not accompanied by insight. Finally, in Delusional Disorder and Shared Psychotic Disorder, *psychotic* is equivalent to delusional. (APA, 2000, p. 297)

Thus, the most defining feature of these disorders has yet to be delineated consistently within the very document that uses the characteristic as a diagnostic criterion. While historically psychosis has been defined as a set of symptoms, it has recently been questioned whether or not these symptoms specifically differentiate the disorder.

TABLE 1.6: Other Psychotic Disorders by Definition and Characteristics

Types	DSM-IV-TR Definitions and Characteristics
Schizophreniform Disorder	<ul style="list-style-type: none"> A. Criteria A, D, and E of schizophrenia are met B. An episode of the disorder (including prodromal, active, and residual phases) lasts at least 1 month but less than 6 months (when the diagnosis must be made without waiting for recovery, it should be qualified as 'provisional')
Schizoaffective Disorder	<ul style="list-style-type: none"> A. An uninterrupted period of illness during which, at some time, there is either a major depressive episode, a manic episode, or a mixed episode concurrent with symptoms that meet criterion A for schizophrenia B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness D. The disturbance is not due to the direct physiological effects of a substance (eg. a drug of abuse, a medication) or a general medical condition
Delusional Disorder	<ul style="list-style-type: none"> A. Non-bizarre delusions (ie. involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration B. Criterion A for schizophrenia has never been met. NOTE: tactile and olfactory hallucinations may be present in delusional disorder if they are related to the delusional theme C. Apart from the impact of the delusions(s) or its ramifications, functioning is not markedly impaired and behaviour is not obviously bizarre D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods E. The disturbance is not due to the direct physiological effects of a substance (eg. a drug of abuse, a medication) or a general medical condition
Brief Psychotic Disorder	<ul style="list-style-type: none"> A. Presence of one (or more) of the following symptoms: delusions, hallucinations, disorganized speech (eg frequent derailment or incoherence), grossly disorganized or catatonic behaviour B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to pre-morbid functioning C. The disturbance is not better accounted for by a mood disorder with psychotic features, schizoaffective disorder, or schizophrenia and is not due to the direct physiological effects of a substance (eg. a drug of abuse, a medication) or a general medical condition
Shared Psychotic Disorder	<ul style="list-style-type: none"> A. A delusion develops in an individual in the context of a close relation with another person(s), who has an already-established delusion B. The delusion is similar in content to that of the person who already has the established delusion C. The disturbance is not better accounted for by another psychotic disorder (eg. schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance (eg. a drug of abuse, a medication) or a general medical condition
Psychotic Disorder due to a General Medical Condition	<ul style="list-style-type: none"> A. Prominent hallucinations or delusions B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition C. The disturbance is not better accounted for by another mental disorder D. The disturbance does not occur exclusively during the course of a delirium
Substance-Induced Psychotic Disorder	<ul style="list-style-type: none"> A. Prominent hallucinations or delusions. NOTE: Do not include hallucinations if the person has insight that they are substance induced B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2): <ul style="list-style-type: none"> 1. The symptoms in Criterion A developed during, or within a month of, Substance Intoxication or Withdrawal 2. Medication use is etiologically related to the disturbance C. The disturbance is not better accounted for by a Psychotic Disorder that is not substance induced D. The disturbance does not occur exclusively during the course of delirium
Psychotic Disorder Not Otherwise Specified	This category includes psychotic symptomatology (ie. delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour) about which there is inadequate information to make a specific diagnosis or about which there is contradictory information, or disorders with psychotic symptoms that do not meet the criteria for any specific psychotic disorder

(APA, 2000)

Epidemiology and Clinical Presentation

Schizophrenia most commonly develops during late adolescence between the ages of 18 and 25 (APA, 2000), however the age of onset can vary. Diagnosis is often not given until after a critical incident from which the individual required hospitalization; as schizophrenia is generally insidious in its developmental nature however, there may be signs of symptoms much earlier (Carr, 2006). These prodromal symptoms may include markedly peculiar behaviour, abnormal affect, unusual speech, bizarre ideas, and strange perceptual experiences (Sadock & Sadock, 2003). Unfortunately, these symptoms are often only recognized in retrospect, and are generally attributed to other social and environmental factors during the initial period of development (APA, 2000). Some individuals will display Schizoid or Schizotypal personalities, characterized as quiet, passive, and introverted, with some adolescent potentially showing a sudden onset of obsessive-compulsive behaviour. Onset of schizophrenia before the age of ten or after the age of 60 is rare; approximately 90 percent of individuals in treatment are between the ages of 15 and 55 years (Sadock & Sadock, 2003).

Historically, literature has noted that prevalence and incidence rates for schizophrenia were consistently and equally reported throughout the adult world at approximately one percent and 0.5 to five percent respectively (Sadock & Sadock, 2003)(APA, 2000); recently however, research has been conducted that would appear to contradict these reports (Goldner, Hsu, Waraich, & Somers, 2002; McGrath, 2005; Saha, Chant, Wilham, & McGrath, 2006). In a paper lecture by McGrath, it was stressed that researchers must not continue to adhere to the epidemiological 'myths of schizophrenia' which assert that, 1) schizophrenia is an egalitarian disorder and 2) schizophrenia is an exceptional disorder (McGrath, 2005, p. 6). The author notes that there is now ample evidence to support the supposition that schizophrenia varies in incidence. In a systematic review of the literature, Goldner, Hsu, Waraich, and Somers (2002) found that both prevalence and incidence rates maintained considerable variability throughout the world. Geographical variability has been reliably cited, with rates higher in urban and industrialized areas or nations (APA, 2000). Recently it was found that both the incidence and prevalence rates were elevated at higher latitudes; it was noted however, that this particular variable was related to influencing factors such as genetic background, biometeorological variables, age structure of populations, and socio-economic factors (Saha, et al., 2006). Migrants,

as well as specific ethnic and/or cultural groups have also been reported to be more likely to develop the disorder (McGrath, 2005), with low rates reported in Asian nations, as well as New Zealand and the Netherlands. Again, these findings may be related to mediating geographical and sociological factors, such as deprivation, minority status, socioeconomic conditions, stigma, and underreporting (Goldner, et al., 2002).

Variability also exists between the sexes. While schizophrenia has been reported equally in the adult population in both men and women, the two sexes differ in developmental factors such as age of onset and course of illness (Carr, 2006; Sadock & Sadock, 2003). Men typically have an earlier inception compared to women with peak age of onset occurring between the ages of 10-25 for men, and 25-35 for women (APA, 2000) (Sadock & Sadock, 2003). In addition, women also display a bimodal age distribution, with a second peak occurring in middle age. Some research has proposed that men are more likely to develop and be impaired by negative symptoms compared to women (Sadock & Sadock, 2003). This finding however, may be influenced by the fact that men are generally less likely to seek assistance for symptoms related to emotional regulation, such as flat affect and depression, and are thus more likely to receive treatment only when the symptoms have become severely debilitating. Women have been reported to have an overall better outcome or prognosis (APA, 2000), but this again, may be due to the differential patterns of assistance-seeking behaviour that exists between the sexes.

Aetiology and Current Treatment Regimes

Literature on aetiology clearly identifies that individuals with schizophrenia will display heterogeneity in both cause and clinical presentation, and that treatment responses will also consequently vary (Sadock & Sadock, 2003). Therefore, in considering a potential treatment regime for a client, it would be beneficial to have a comprehensive understanding of the aetiological models. Three main theories have been used in attempts to identify causal mechanisms in the development of schizophrenia, and these include the stress-diathesis model, neurobiological and genetic explanations, and psychosocial explanations. Within each of these categories are the more specific theoretical models which individually propose to account for different causal variables and mechanisms. Given that it is not within the scope of this review to

explain in detail these various sub-theories, the reader is referred Carr (2006) for a descriptive review.

Historically, treatment for schizophrenia has typically focused on pharmacotherapy given a biological basis of aetiology (Regan, 2008). While medication has proven to decrease both positive and negative symptoms (Chan & Leung, 2002), the classic persecutory nature of schizophrenia has predicted high relapse rates as medication is often either never started or discontinued (Gaudiano, 2005; Sadock & Sadock, 2003). Once off the medication, individuals typically fall back into psychosis and problem thoughts and behaviour re-occur (Tarrier, 2005). Further research has shown that even when on medication, up to 60 percent of individuals continue to experience positive symptoms (Chan & Leung, 2002; Gaudiano, 2005; Zimmerman, Favrod, Trieu, & Pomini, 2005). Additional problems become apparent when one considers how pharmacological treatments for schizophrenia typically aim only to decrease psychotic symptoms, with almost no consideration regarding the common co-morbid illnesses such as depression, anxiety, and social impairments (Chan & Leung, 2002; Gaudiano, 2005; Wykes, et al., 2005). Treatment in this area has consequently turned to clinical-based therapy programmes which serve to augment the standard pharmacological regime with a psychological approach to treatment.

Cognitive and cognitive-behavioural programmes aim to manage individual concepts and beliefs surrounding issues associated with the experience of psychosis (Morrison, Renton, Dunn, Williams, & Bentall, 2004). Andrew, Gray, and Snowden (2008) have reported that core cognitive schemata that are related to an individual's past and current life experiences determine whether or not the symptoms of psychosis are interpreted as positive or negative. Instead of targeting symptomology therefore, a cognitive-behavioural approach would attempt to target the belief systems that conceptualize the symptoms (Zimmerman, et al., 2005). Some of the techniques used to achieve this goal include; acceptance and commitment therapy, rational emotive behaviour therapy, reattribution, belief medication, ration thinking strategies, relaxation and anxiety management, social skills training, coping strategies, problem solving, distraction, and cognitive restructuring (Chan & Leung, 2002; Ellis, 2003; Gaudiano, 2005). Furthering the idea that cognitive-behaviour therapy is a treatment programme aimed at improving quality of life (Tarrier, 2005), several papers have also reported that use of family and community interventions

in which those who are close to the distressed individual are educated and prepared for the possible effects of the disorder (Chan & Leung, 2002; Gaudiano, 2005). Other reports have indicated that group therapy may also be affective when applying CBT strategies, given the propensity to enhance social skills (Wykes, et al., 2005).

Considering the contradictory nature of the above information, it becomes apparent that understanding schizophrenia from a diagnostic point of view serves little purpose for those individuals who are most affected by the disorder. Instead, it appears that it would be valuable to understand the *experiences* of those with the disorder in an attempt to further develop psychological assessment and treatment programs that treat the distress.

Understanding Relationships between Religion and Schizophrenia

As demonstrated, literature has evidenced relationships between religion and mental health. The majority of research in this area however, focuses only on the most frequently presented mental health issues, such as the mood or anxiety disorders (Kirov, et al., 1998; S. Mohr, et al., 2006). It is not surprising that this research has been able to concentrate on the intricacies of the many relationships that exist between religion and these forms of psychopathology. The role of religiousness as it relates to depression has been thoroughly assessed; conclusions have been drawn in the full range of this particular subject area and include statements regarding protective effects, symptomology, coping styles, and recovery. Literature on the relationship between religion and mental health issues relating to the more atypical disorders however, such as psychosis, remains quite limited (Kirov, et al., 1998).

In considering the relationships between religion and mental health, Marks noted that researchers must now explore “what types and expressions of faith facilitate and denigrate mental health, as well as how and why they seem to do so” (2006, p. 140). Given that ‘mental health’ is such a broad discipline, this is a rather large appeal. It is therefore intuitive to start this task by looking at how and why religion might play a developmental, maintaining, or protective role in a specific mental health disorder.

As demonstrated, schizophrenia has typically been characterized as a disorder in which there is an abundance of epidemiological and aetiological information, and yet very little is actually known about individual experiences. While most literature points to physiological and biological root causes (Carr, 2006; Fuller-Torrey, 2006; Sadock & Sadock, 2003), there is now strong evidence which supports the assumption that psychosocial elements are equally important in the manifestation of first symptoms and psychotic episodes (Bentall, 2003; Cantor-Graae, 2007; Drinnan & Lavender, 2006; Fuller-Torrey, 2006; S. Mohr, et al., 2006; Read, Goodman, Morrison, Ross, & Aderhold, 2004). This is particularly obvious when one considers how expressions of positive symptoms and other abnormal thoughts and behaviours can often be explained given the “context of a person’s life, [the] circumstances and culture, and [the individual’s] attempts to find meaning in their experiences” (Drinnan & Lavender, 2006, p. 318). The specific nature of this thought content has been considered a cognitive expression of previous social experiences such as traumatic episodes (Read & Argyle, 1999). It would appear appropriate then to study the relationships between schizophrenia and religion from a psychosocial and cognitive-behavioural perspective.

In a qualitative study conducted by Drinnan and Lavender (2006), the authors explored the role of previous experiences in the content of delusions. Participants were asked to discuss social background as well as personal experiences of both religious beliefs and delusions. Given the current researcher’s interest in the role of early social experiences, the following study has attempted to replicate the work of the aforementioned authors, with slight alterations in methodological procedure and participant characteristics. The reasons for these changes are provided in the following chapter.

CHAPTER TWO

METHODOLOGY

This chapter discusses the theoretical orientation of the researcher, as well as the specific methods used to both collect and analyse the data. Ethical considerations, the role of the researcher, and the demographics and characteristics of the participants are all reviewed. Materials developed for the purpose of this study have been discussed. Finally the quality and rigor of the current study is reflected upon.

Constructivist Paradigms and Qualitative Research

Ontological and Epistemological Foundations

In research, ontological and epistemological assumptions outline the philosophical worldview of the author. Simply, *ontology* refers to the way in which reality is viewed, while *epistemology* refers to the way in which knowledge is obtained (Yardley & Marks, 2004). While these two concepts are differentiated in the literature, they are linked to the extent that one will typically guide the other (Rosen, 1996). Moreover, these perspectives both inform the way in which material is gathered and analyzed, and influence the conclusions that are drawn from the data.

Ontological assumptions can be understood as occurring along a continuum. At one end of the spectrum are the philosophical perspectives of realism and positivism. Both these perspectives have strong connections with theory characteristic of the Modernist movement and Enlightenment period of psychology in which ‘truth’ and ‘legitimate knowledge’ were thought to be discovered and accumulated through a process of logical reasoning (Bracken & Thomas, 2006; Gavin, 2008; Neimeyer, 1995; Rice & Ezzy, 1999). Within the theoretical framework of these two positions, it was assumed that an objective physical reality existed and could be measured through quantified, precise, and value-free observations (Barker, Pistrang, & Elliot, 2002; Yardley & Marks, 2004). Accordingly, these perspectives were demonstrated epistemologically through the classic scientific design in which independent variables were controlled, dependent variables were manipulated, and cause-and-effect conclusions were drawn (Willig, 2008; Yardley & Marks, 2004). Advocates for this perspective argued that, “scientific attention should be restricted to observable facts; ‘inferred constructs,’ such as beliefs or motives

have no place in science” (Barker, et al., 2002, p. 55). While researcher and participant biases were acknowledged to exist, these were minimised to ensure that subjective perceptions of reality did not conflict with the objective observation of data (Yardley & Marks, 2004).

While appropriate for quantitative research, the perspectives borne from Modernist theory did not allow for the consideration of psychological constructs of experience, such as feelings, values, and subjectively ascribed meanings for events (Barker, et al., 2002). Moreover, critics of the realist and positivist approaches argued that attempting to eliminate a subjective reality from research was impossible (Yardley & Marks, 2004) and that attempts to do so would result in “a sterile and trivial discipline alienated from human experience” (Barker, et al., 2002, p. 56). Post-modern theory and ontological relativism responded to these limitations, and sought to highlight how facts and values were intertwined, thus ultimately emphasizing a world in which individual interpretations were diverse, and relationships were varied and complex (Rice & Ezzy, 1999; Willig, 2008). The corollary of this perspective was the supposition that absolute and total knowledge was unattainable (Gavin, 2008) as no one theory or framework was able to account for all experiences (Bracken & Thomas, 2006).

To this end, the former definitions of ‘truth’ and ‘reality’ as objectively knowable were reconstructed such that multiple pathways were possible, and subjective and experiential knowledge was validated (Bracken & Thomas, 2006; Neimeyer, 1995). From this relativist ontology, the nature of reality was viewed as influenced by social, cultural, and historical norms and structures (Neimeyer, 1995); as a result, studied constructs were not static, but instead changed and developed over time and in relation to an individual’s experiences. Language was considered an essential tool in the process of understanding such experiences, as it both developed from and represented the social structure within which the individual existed (Neimeyer, 1995). As such, qualitative inquiry is best suited for research conducted from this perspective.

Constructivism

Constructivism is a philosophical viewpoint that is commonly located within a relativist ontology. Much like many other perspectives, the constructivist paradigm is varied within itself

and offers several slightly different approaches (Rosen, 1996). For the basis of the current study, the constructivist approach attempts to understand individual interpretations of ‘knowledge’ as it develops within the social context (Patton, 2002). Given the relativist ontology, it is assumed that there are multiple constructions of reality, which have been both socially and experientially developed. Knowledge is constantly evolving and becoming more sophisticated as new information is provided; it is assumed to be authenticated when there is consensus among those individuals within society who are deemed competent to interpret the substance of the constructions (Boyatzis, 1998; Guba & Lincoln, 2004).

The Current Study

The following outlines the work upon which the current study is based, and details the reasons for the chosen methodology.

Pilot Findings and Expected Outcomes

The current study followed the work of Drinnan and Lavender (2006) outlined in “Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions.” The authors note that “as with normal beliefs, delusions have been conceptualized as forming over time and in response to experience” and that “there [was] some evidence to demonstrate that family beliefs and attitudes correlate with religious delusions” (Drinnan & Lavender, 2006, p. 319). The purpose of the research therefore was to focus on;

- How participants’ early experiences and religious backgrounds influence the development of religious delusions
- How participants’ religious beliefs influence their interpretation of any unusual experiences they may have [and]
- How experiencing mental health difficulties affected participants’ religious beliefs (Drinnan & Lavender, 2006, p. 319).

The authors recruited a total of seven individuals from two mental health agencies. These participants had been diagnosed as delusional and maintained a level of religiosity. All individuals who were experiencing active psychotic symptoms at the time of recruitment were excluded from the study. The methodology was qualitative in nature; a semi-structured interview was used to gather information and the grounded theory approach was used for data analysis.

The results of the study included several hypotheses which were extrapolated from the themed data. It was noted that early experiences did in fact influence the content of psychotic delusions, especially when related to religious and family themes. The authors also considered the relationship between religion and mental health and concluded that there was strong evidence to suggest that religion was generally beneficial for those individuals suffering from delusions or other forms of psychosis. In particular, religion provided a framework that enabled the participant to cope with the unusual beliefs and stigma associated with the illness (Drinnan & Lavender, 2006).

The current study remained the same in procedure with only slight alterations in the method; there were several reasons for these modifications, and these are discussed below.

Limitations of Grounded Theory

The study by Drinnan and Lavender utilized the grounded theory approach for assessment and data analysis. It is assumed that through the use of this approach, “it is possible to study the meaning of events of people [given] the assumption that meanings must be shared and this sharing is accomplished via a common language and socialization” (Backman & Kyngas, 1999, p. 147). While indicated as an empirically validated method in the literature (Strauss & Corbin, 1998), grounded theory has also demonstrated limitations (Charmaz, 2000) and has been criticised on the basis of the difficulty encountered by individuals conducting research for the first time (Backman & Kyngas, 1999), as in the case of the author for the current study.

One of the biggest challenges the novice researcher faces is the development of sound and valid practices when conducting research. The major obstacle when using grounded theory is simply the pedantic nature of the method; there are too many painstakingly minute details that must be considered (Backman & Kyngas, 1999). For an individual with no experience with qualitative research, the consideration of these details can often be overwhelming. In addition, the grounded theory approach typically does not follow the traditional research process whereby a research problem is identified, data is collected and analyzed, and results and conclusions are described. Instead, the compilation, examination, and construction of data and theory often occur

simultaneously, obscuring the steps involved in the research process as a whole (Backman & Kyngäs, 1999).

Another concern with the grounded theory approach relates to the concept of having a clear research question. According to Backman and Kyngäs, “the researcher is not able to know beforehand what the essential matters are and the research question may even change during data collection” (1999, p. 149). Such blurred processes make it difficult for the novice researcher to maintain and develop comprehensible research concepts throughout the study. In addition, grounded theory dictates that data collection precede literature review; this ensures that no assumptions exist regarding the relationships being studied (Strauss & Corbin, 1998). However, as a first-time interviewer, it is important to have pre-existing knowledge about the given phenomenon to use as a guide for the dialogue between researcher and participant.

Thematic Analysis

Given the limitations and challenges of the grounded theory approach, a methodology which involved a less structured and pedantic approach was viewed as more appropriate for the novice researcher and current study. Thematic analysis has been identified in the literature as a relatively straight-forward approach, “which does not require the same detailed theoretical and technical knowledge” (Braun & Clarke, 2006, p. 94) that other approaches might require. In addition, several authors (Attride-Stirling, 2001; Boyatzis, 1998; Braun & Clarke, 2006; Roulston, 2001) indicate that thematic analysis is an implicit process often used within other qualitative paradigms as a basis for the initial examination of data. Considered this way, one could argue that thematic analysis provides the groundwork for the development of those core skills which are utilized in any qualitative data analysis, and as such, helps to establish reliable and sound practices in research. In support of this position, Braun and Clarke argue that:

Thematic analysis should be seen as a foundational method for qualitative research. It is the first qualitative method of analysis that researchers should learn, as it provides core skills that will be useful for conducting many other forms of qualitative analysis (Braun & Clarke, 2006, p. 78).

The authors further state that, much like grounded theory and content, discourse, and narrative analysis techniques, thematic analysis can and should be considered a methodological approach in and of itself. The strengths of thematic analysis are discussed in reference to this postulation.

For example, it is noted that thematic analysis does not appear to be based specifically upon any pre-existing theoretical framework (Attride-Stirling, 2001), and as such can be used across the range of ontological and epistemological perspectives (Boyatzis, 1998), from realism to relativism or constructivism. This allows for flexibility in how the approach is used within the research.

Thematic Analysis in Research: The Stages of Process

The analysis of the current study was based on the work of Braun and Clarke (2006) and Attride-Stirling (2001), who both argue that a thematic analysis of participant data can be conducted in six steps. The authors also note however, that analysis is not a linear process, and as such, the researcher will often circulate and return back to previous stages to ensure that a complete and comprehensive analysis is achieved. The purpose of the current study did not allow for a detailed description of the individual stages; however Table 2.1 is offered from the work of Braun and Clarke (2006) as a succinct description.

In accordance with similar work done by Boyatzis, codes are defined as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (1998, p. 63). Braun and Clarke (2006) indicate that these codes differ from the themes of the study which are generally broader and more interpretively and theoretically enhanced. Thematic networks begin to develop when basic themes are extracted from the text, after several codes from across the data set are noted to have commonalities (Attride-Stirling, 2001). Analysis of the basic themes often arranges more abstract principle assumptions into organizing themes, which are then further analyzed into the concluding concept or global theme (Attride-Stirling, 2001). It is this global or over-arching theme which is used as the presenting argument for the final description of the research.

In following the work of the above-named authors, the current analysis began with the process of transcribing the interviews. The researcher then read the transcripts while simultaneously listening to the recorded discussion, and making notes on the inflection of speech. The transcripts were re-read and any seemingly relevant and interesting aspects of conversation were

TABLE 2.1: Phases and Processes of Thematic Analyses

Phase	Description of the Process
1. Familiarizing with data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back to the analysis to the research question and literature, producing a scholarly report of the analysis

(Braun & Clarke, 2006, p. 87)

underlined and highlighted. In a third review of the data, these underlined segments were coded, by describing the essence of the conversational content. In an attempt to organize the codes, these were taken from the transcripts and replicated on individual pieces of paper, such that these segments could be separated and organized into broader themes. This was done for each interview conducted, such that themes were identified first within an individual interview, then within each participant’s story, and finally across all the data provided. Once the codes had been organized into basic themes, these were then labelled and further conceptualized into broader organizational themes. The development of preliminary diagrammatical thematic networks (Attride-Stirling, 2001) was especially useful during this stage, and Appendix D is offered to highlight the relationships identified from the abstraction of codes. Case studies (presented in Chapter Three of this work) of the individual interpretations of experiences were created, and additionally reinforced the relationships between religion and psychosis at the individual level. Moreover, in supplementing these cases with the thematic networks, the global or over-arching themes within the whole data set were identified, and these ultimately provided the basis for the final thematic network, as demonstrated in Appendix E. While the initial networks displayed few relationships between the organizing themes, the continuous re-visitation to the data clearly demarcated not only relationships, but also a developmental pathway which facilitated the interaction between religion and psychotic experiences.

Ethical Guidelines and Considerations

The current research was approved by the ethics committee at the University of Waikato. All individuals took part on a voluntary basis and were advised of their rights as participants. Any processes associated with the research were discussed, and questions were addressed before any written consent was gathered. All interviews and communications were completely confidential, and pseudonyms were used in reporting the data.

The nature of qualitative research specifies that all information acquired through the investigation process belongs primarily to the participant (Beresford, 2006). There is a fundamental assumption when conducting such research that the approach will not work without the personal stories of the individuals whom choose to partake in the process. As such, it is imperative that these stories be used appropriately and safely, and that they are then returned to the owner after the research analysis is completed. For the current study all participant records, including the audio and paper transcripts, were either returned or destroyed as per the request of the participant. Any records that were to be destroyed were first held for three months; a time allotted so that the participant may change his/her mind as to the placement of the documentation. Individuals who chose this option were advised of this stipulation.

An additional ethical consideration in the current research was the issue of power imbalance between the participants and the researcher as a result of differences in mental health status, race and education level. Given the stigma that can sometimes be associated with mental illness, it was important that the participants understood that their stories would be used appropriately and their identities would remain confidential. The participants were identified as the 'experts' in the field of their own personal experiences with religion and mental health, and it was consistently stressed that there were no right or wrong answers to any of the questions posed during the interview.

Finally, the issue of informed consent was also considered for the current study. The nature of qualitative study may often seem slightly informal to the participant, given the assumption that interviews are generally more conversational in nature. Research has reported that participants in qualitative studies are less likely to differentiate between times when the researcher is actively

conducting the study compared to informally maintaining conversation (Shaw, 2003). It is in this context however that the participant may unwittingly disclose information not intended for research purposes. For the current study, only that information which was recorded on audio-tape was considered data and this stipulation was clearly discussed with potential participants.

The Researcher

An important consideration in qualitative research relates to the role of the researcher when constructing the meanings of participant experiences. In some studies (Lammers, 2002), the researcher is able to partake in the interviewing process as an individual whom has had similar personal experiences. In other circumstances, the role of the researcher is simply to listen and attempt to understand the experiences of participants in a relatively objective manner. However, even in this case, the researcher helps to construct the meanings by interpreting the information based upon previous experiences. For constructivist research, it is assumed that the researcher must take the role of active participant, as the constructions of ‘findings’ are developed and understood within the context of the interviewing process. For the current study, the researcher acknowledged personal perspectives which likely contributed to the development of specific themes from the participant content; however, the researcher was not an active participant in the sense that the experiences which were discussed were shared.

Participants

Criterion for selection

All individuals partaking in the interview process were required to meet the criteria of the study which included a diagnosis of schizophrenia and a history of a religious faith before and during diagnosis. Much like Drinnan and Lavender, the study relied on self-report for these two variables as the “research focused on individuals’ perceptions and beliefs rather than trying to quantify religiosity” (2006, p. 320) and/or schizophrenia. The stipulation that there be a diagnosis of schizophrenia specifically (compared to other psychotic disorders) was based on the diagnostic criteria set out in the DSM-IV-TR (APA, 2000) which states that symptoms must be present for at least six months. This specification was created to ensure that participants would have experienced a period of psychosis during which time recurring patterns of interpretation could be identified by both the researcher and the participant. Throughout the remaining text

however, these experiences are most generally understood as occurring within the broader concept of psychosis. Unlike the previous study, the current work did not specify delusions as the focal point of the research, but instead focused more broadly on the positive symptoms of psychosis. Similarly, no one specific religious denomination was chosen as an area of concentration.

Additionally, by subjective reports, the participants were to have stabilized and were not to be currently experiencing any active symptoms of schizophrenia. This supplementary caveat was established to ensure that information retrieved during the interview with the participant was accurate and introspective. The study required that each participant had acquired a level of insight into disorder, and was willing to explore possible relationships between past and present events.

Recruitment and Interviewing Process

Participants were initially recruited from mental health agencies in Hamilton and Auckland, New Zealand. A brief verbal presentation, which introduced the researcher and the research, was made to individuals who accessed these services, and was overviewed and called to order by the individual in charge of the facility. Advertisements (Appendix A) which outlined the basic process of the study were also posted at these agencies. Individuals who expressed a verbal interest in the study were given a preliminary letter (Appendix B) from the researcher, which further detailed participant and researcher roles, and allowed the researcher to retrieve contact information from the prospective participant. If the participant's interest was maintained, then a one-on-one meeting was arranged either by telephone or email communication or through face-to-face contact. During this meeting, the researcher ensured that all the study criteria were met, and that all questions and/or concerns were addressed. A Participant Information Package (Appendix C) was provided to the participants at this meeting, which included a letter of introduction, a copy of the interview schedule, and the consent forms for both the first and second interview. Having explained the research and the research process in detail, a meeting for the first interview was then arranged at a time and place convenient for the participant. Upon completion of the first interview, the audio-tapes were transcribed verbatim and the transcript was then given back to the participant so that any amendments could be made, as suggested by

Forbat and Henderson (2005). While all participants made alterations in the grammatical presentation of the data, none requested amendments to the content. The researcher used the revised copy of the transcript as a basis for the development of the second interview questions. The participant was contacted again through their chosen form of communication, to set a date and time for the second interview; the process of transcription and consequent modification remained the same as the first interview.

While the majority of the participant engagement came from the process of meeting individuals from mental health agencies, recruitment also occurred through a word-of-mouth process whereby individuals who were networked with agencies knew of someone who was interested in the study. In these situations, the participants were required to make first-contact, after the study had been explained to them through the networked individual or agency. This contact usually occurred by phone or through email such that the researcher could outline the information that was typically presented in the Letter of Introduction. From here, the one-on-one meeting was arranged at the convenience of the participant, and the recruitment and interviewing process remained the same as above.

Demographics of Participants

Table 2.2 outlines the demographics of the individuals who took part in the study. Two additional participants (both female) took part in the research, but for different reasons were unable to complete the second interview; as such these stories have been excluded from the analysis. The fact that all participants who completed the study were male was coincidental; however, this finding is important to the extent that the drawn conclusions will only be representative of male perspectives. In addition, with the exception of Mark, who identified with both Tongan and Pākehā ancestry, all participants identified as Pākehā with no further ethnic specification. The results may therefore reflect those opinions based solely upon Western-European cultural norms and experiences. Finally, the identification of religious orientation was taken verbatim from the participant. While the participants were questioned regarding what it meant to belong to the particular faith, the differentiation between the faiths was not explicitly discussed, nor explored by the researcher. In this way, the identification of religious orientation,

TABLE 2.2: Participant Demographics

Name	Age	Gender	Identified Ethnicity	Identified Religious Orientation
Paul	37	Male	Pākehā	Christian
David	34	Male	Pākehā	Baptist Church
Richard	57	Male	Pākehā	Catholic
Mark	41	Male	Tongan/Pākehā	Roman Catholic
James	35	Male	Pākehā	Catholic

and consequently the experiences associated with that orientation, was purely subjective on behalf of the participant.

Settings

The choice of environment for the initial meeting and consequent interviews were chosen by the participant. In accordance with the work of Elwood and Martin (2000), it was thought by the researcher that allowing the participant to choose the location of the interview may empower the individual and promote a more equitable relationship. Three of the five interviews were conducted at the participant’s home; the other two individuals chose to meet at a mental health agency.

The length of the interviews varied. The participants were advised that the initial interview would likely not be shorter than one full hour, but also that they could take as much time as they felt was necessary. Given that the second interview was based upon the information provided in the first, these also varied in length. Overall, the shortest interview took approximately one hour, while the longest interview took approximately two and a half hours. On average, interviews lasted approximately 90 minutes. All participants were also offered the opportunity to invite along a support person to all meetings and interviews; this option however, was not exercised by any of the participants.

Materials

Participant Information Package

The Participant Information Package was developed as an educational resource for the participants; it provided insight into the process of the research and outlined the researcher’s interests and goals for the study. The package included an introductory letter which summarized

the study procedure and the role of the participant. This letter also outlined the procedures that were taken to ensure confidentiality and safe practice, and provided resources for participants to use should ethical concerns arise. A copy of the interview schedule was also included in this package for the participant to review before consenting to the interview itself. This was done to ensure that the participant was familiar and comfortable with the subject matter of the interview. Copies of the consent forms for both the first and second interviews were also included in the package.

Interview Schedule

Research-related information from the participants was gathered through an open-ended and semi-structured interview format. The interview schedule was developed primarily from the existing set of questions used in the study conducted by Drinnan and Lavender (2006). The schedule was modified slightly so as to suit the abilities of the novice researcher. According to Wilkinson, Joffe, and Yardley (2004), semi-structured interviews contain five to eight broad questions with additional questions used only as probes in cases where elaboration is difficult. However, given the limited experience of the researcher in conducting interviews, a more detailed interview schedule was developed. Supplementary and exploratory questions were pre-determined and were based upon the broader subject matter. The interview covered four main areas;

1. Background Information
 - Demographic information and current circumstances
2. Family Background
 - Childhood, adolescence, and young adulthood
 - Considering how family background impacted on religious beliefs and how this changed over time
3. Developing Unusual Beliefs
 - Experiences, events, and beliefs around the time when the participant encountered psychological difficulties and received treatment from mental health services
4. Recovery
 - Concerned with how religion featured in the participants' beliefs and lives during the recovery process

(Drinnan & Lavender, 2006, pp. 320-321).

A copy of the interview schedule was included in the Participant Information Package, as outlined above. While the interview was semi-structured, in that all participants covered the aforementioned subject matter, it was mostly guided by the perceptions and experiences which the particular participant believed to be important to the issue at hand. In this way, the discussion

was founded upon a peer-based relationship in which the participant was educating the researcher about personal experiences with religion and schizophrenia (Roulston, 2001). The style of enquiry was informed by constructivist theory which required that interviewing questions were open-ended (Creswell, 2007). This ensured that the researcher obtained the most thorough understanding possible of the participant's construction of meaningful events (Wilkinson, et al., 2004).

Recording and Storing Data

The interviews were audio-taped with the permission of the participant. The audio-tapes were then transcribed verbatim and coded following thematic analysis techniques, as outlined by Braun and Clarke (2006). All information on participants was kept in individual folders and locked in a secure cabinet. Access to this information was only granted to the researcher, the thesis advisors, and the participant to whom the information belonged. After the completion of the study, all information was either returned or destroyed, as per the wishes of the participant.

Quality and Rigor of Study

The term *rigor* refers to the validity and reliability of a study (Rice & Ezzy, 1999). Authors studying qualitative work in general and constructivist approaches specifically have noted that determining rigor of such studies can be particularly difficult (Seale, 2000), given that rigor as a concept, was originally developed and applied to quantitative work, and as such maintained criteria different from qualitative research (Patton, 2002; Rice & Ezzy, 1999). Lincoln and Guba (2000) argue that *trustworthiness* and *authenticity* are two concepts which feature in the development of a credible qualitative study. According to the authors, trustworthiness involves aspects of credibility, transferability, confirmability and dependability, each of which parallel the positivist concepts of internal validity, external validity, reliability, and objectivity respectively (Patton, 2002). Alternatively, authenticity involves fairness, as well as ontological, educative, catalytic, and tactical authenticity (Lincoln & Guba, 2000).

While slightly different from the criteria proposed by Lincoln and Guba (2000), the guidelines suggested by Elliot, Fischer, and Rennie (1999) were thought more pertinent to the current study, as these identified considerations in specific relation to a case study approach of analysis. These

authors have suggested that owning one's perspective, situating the sample, grounding in examples, providing credibility checks, coherence, accomplishing general versus specific research tasks, and resonating with readers are guidelines which are especially pertinent to qualitative studies.

In owning one's perspective, the researcher is required to identify the specific theoretical orientation as well as personal expectations in relation to the research (Elliot, et al., 1999). Individual history and personal biases were identified to the reader in both the introduction and methodological section of this study. Moreover, in conducting the research the author explicitly discussed with participants personal perspectives and experiences in terms of religion, psychosis, and the interactions between the two. Theoretical orientation was also noted at different levels as the author placed herself within the qualitative research process as a proponent of the constructivist paradigm. Further, participants were advised that the researcher was an individual with a clinical background who understood religion from a psychological perspective and psychosis from a cognitive-behavioural model.

The second guideline proposed by the authors involves situating the sample, which requires the author to describe in as many ways possible the life circumstances, demographics, and experiences of the participants, such that the reader is advised upon the range of individuals to which the conclusions may be applicable (Elliot, et al., 1999). Given the complexity of both religion and psychosis as individual variables, let alone the extremely multifaceted nature of the relationship between these two, a case study approach to analysis was considered the best fit for the current study. Here, the author was able to specifically identify and discuss at length the experiences, interpretations, and outcomes of events as these occurred sequentially for the participants, despite the fact that these experiences were often discussed concurrently. In addition, basic demographic information, which places each individual participant in terms of gender, age, ethnicity, and religious orientation, was provided.

In grounding in examples, the author uses the available data to support statements regarding the nature of the studied phenomenon (Elliot, et al., 1999). One of the main goals of the current research was to determine the nature and function of religious beliefs; the case study approach

allowed the author to present rich, but simply descriptive accounts for a small number of individuals, while conducting and presenting the analysis of broader themes in a different section of the study. Excerpts taken directly from the transcripts were left embedded within the context of the discussion, and were used as much as practically possible. Where this wasn't possible, specific descriptive words were used instead. This approach also addressed both the coherence of the study, and the specific research tasks. In the former of these guidelines, the goal is to provide a framework, while also elucidating the nuances of participant experiences (Elliot, et al., 1999). The use of a case study approach also provides a systematic and comprehensive presentation of data, which provides the basis for the eventual proposed framework (Elliot, et al., 1999).

Providing credibility checks requires researchers to check with participants, where relevant, the credibility of categories, themes, or accounts (Elliot, et al., 1999). For the current study, the researcher transcribed both interviews and allowed participants to make amendments where necessary. Moreover, where the initial interview was conducted to identify the influencing factors in the experiences of religion and psychosis, the second interview was conducted for the purpose of clarifying understanding on the behalf of the researcher. Here, concepts discussed from the first interview were more fully explored and delineated by the participant.

Finally, through the use of an extensive literature review, the empirical studies and theoretical suppositions which have been linked to similar subject matter have been explained in an attempt to develop an appreciation for the relationships presented (Elliot, et al., 1999).

CHAPTER THREE

CASE STUDIES

Introduction

The following case studies outline participant characteristics and social histories, as well as their perceptions about experiences with religion and psychosis. While the author endeavoured to create the most comprehensive outline of each participant's story, the quantity of information gathered was enormously extensive; as such, the information provided is that which relates only to the research question regarding the relationships between religion and psychosis. Each case study is presented in a similar manner, with the main topic headings based upon both the subject areas covered within the interviews, and the most commonly occurring themes from the data. A brief description regarding individual presentation is given first, followed by any relevant social and developmental history. The information provided in this section relates to those factors the participants identified as influencing both current religious beliefs and the development of psychotic symptoms. These histories are presented so the reader is better able to comprehend the explanatory model used by participants in understanding personal experiences. A discussion on the nature of religious beliefs is then presented, followed by an examination of the nature and experiences associated with psychosis. Any interactions, as identified by participants, between religion and psychosis are then considered. The main headings of "Understanding Religion," "Understanding Psychosis," and "Understanding Relationships" are titled as such to emphasize the subjective nature of the current study. While general themes were recognized across these cases, each individual had a very unique perspective on the nature of religious beliefs and experiences of psychosis; the subtopics within each case thus reflect the participant's focus. For example, in considering the nature of religion, most cases covered early experiences and general religious concepts; however where there appeared to be a focus by a participant on one particular topic, space was given to exploring this issue in greater detail, irrespective of whether or not this was common to other cases. This same consideration applied to the discussion related to psychosis. There has been little analysis conducted in this section of the research. The aim of the following chapter is only to provide the reader with a comprehensive account of each participant's personal understanding of the concept of religion and the experiences of psychosis. A thorough examination of the themes is conducted in the following discussion section.

PARTICIPANT #1 – PAUL

Presentation

Paul was a 37-year-old male who identified as New Zealand European. He was very well spoken and had obviously put a lot of thought into his current situation as he demonstrated very perceptive and descriptive responses. He was relaxed during the interview sessions, and spoke candidly about his experiences.

Understanding Religion

Development of Religious Beliefs

Paul identified with the Christian faith and reported that, with the exception of his grandmother, he was the only one in his family to maintain any form of spirituality. He stated he developed his beliefs early with an awareness of God by the age of three, and the commencement of religious practices such that he was “pray[ing] in [his] own quiet way when [he] was quite young.” Paul’s first religious memory involved reading “poetic writing” from the bible with his grandmother. While he noted that his grandmother likely had a strong influence on the development of his religious beliefs, Paul also stated that the process was very much an individual one, as he felt an internal motivation to develop his faith early.

Initially, Paul stated that his faith was “more spiritual in nature than being Christian.” While he ascribed to some religious concepts (a belief in God) and traditions (reading the bible), he stated he did not go to church and therefore he only had a very superficial relationship with God that lacked any personal connection. Paul also reported that he deviated slightly from his faith when he was in high school; however he always had “that compass pointing north that [he] had to follow, that [he] had to get back on track with.” Paul reported that it was not until he was in his twenties that he started to consistently and actively participate in a religious community. At this time, Paul had made a very conscious and deliberate decision to change his method of worship. While Paul reported that the way in which he practiced his faith had changed, he thought that his overall religious beliefs had not altered, but instead developed progressively and would continue to do so in an ongoing process.

Religious Concepts

Paul described his faith as “authentic,” stating that it was stronger than just a belief in God; it involved actually “knowing” that He existed.

God’s big enough to handle that doubt because most of us, we can’t see God; He’s not in the room as such, He’s invisibly sitting there right where you are, but because of experiences we’ve had, where some of us have had sort of spiritual experiences, we still have something a bit more tangible to put our faith on. But it’s still got to be, when it falls down to it, it’s got to be always about the faith. Just believing and really, an authentic faith is probably almost getting to the stage of knowing that God is there, not just faith, but actually knowing.

Paul reported that he had always had an intuitive awareness of God and His presence, and thought that His love was similar to a parent’s love, but more intense and unconditional. While he perceived God as an individual much like a father, he also noted that God was an “over-flowing entity” that could not be contained in one being; instead He existed in the three ethereal forms of the Father, the Son, and the Holy Spirit. For Paul, these three beings, while separate, had developed a “communal nature” based on the process of communication. Therefore, Paul understood that God appreciated and desired communication from His people, and would always be receptive to Paul’s willingness to “share [his] heart about little things and big things.” Paul stated that he thought God offered His love and His approval and would watch over him and monitor his behaviour; when off the track, Paul believed that God did not punish, but rather gently guided him in the right direction such that he would “do things a bit better and do things the right way.”

For Paul religion meant having a personal and intimate connection with God. He reported that it was through the development and practice of his beliefs that he was able to become more “Christ-like” and thus establish such a relationship. While an ability to model his behaviour after God was generally perceived as a factor which would strengthen the relationship, it was the act of “giving [his] heart to the Lord” specifically that enabled him to develop the initial bond. According to Paul, this involved saying a prayer that equated to making a statement or declaration of his faith. Paul had reported that he had always felt open to God, and therefore compelled to give his heart to Him when he was mature enough to manage this relationship. Other religious practices, such as prayer, church attendance, and reading and following the moral lessons in the bible, served to further progress this relationship. In addition however, these practices also had positive outcomes for Paul specifically. For example, he reported that prayer

functioned as a “natural” form of communication with God such that he felt completely secure with his disclosures and confident that there would be no judgement passed.

The ability to develop a relationship with God was dependent to some extent on his adherence to the rules set out in the bible. The bible gave him “graphic insight into the nature of God” and allowed him to practice a “vibrant faith.” He modelled his behaviour after that of Jesus and God, and also attempted to maintain many of the same personality traits and characteristics. Paul briefly spoke about his experiences of “sin” and the fulfilment that came from obedience.

Just knowing that sin is very enjoyable as I found out; it’s great fun, it’s a lot of fun, you know, it’s great. But it doesn’t really fulfil. For me, the only times that I’d found I’d been fulfilled is when I’d been obedient. It’s quite a sort of catch-22 because most people think that to have your own way is, that’s kind of freedom, that’s liberty. But to me, freedom and liberty come from obedience. And not in a harsh, disciplinary sort of way, but just more of a wholesome sort of feeling of approval that really comes from being on the straight and narrow as much as you can.

While Paul had experienced “sin” he obtained no satisfaction from these acts, and thus believed following the moral code of his faith to be more gratifying. He was able to apply the code to his everyday practices, and again used this to maintain his relationship with God.

Understanding Psychosis

General Background and Presentation

Paul had his first psychotic break shortly after his 21st birthday, during the winter. He had been working in a small, rural town, and was staying in an old cottage with his uncle. His job required long days of intensive and “demanding” physical labour and Paul reported that the “poor” living conditions made it especially difficult to recuperate from his work. Thus, according to Paul, both environmental and physical factors specifically contributed to the development of this first “breakdown.” However, Paul also noted that there was a spiritual element to the experience:

It was just not that much of a healthy environment spiritually and something happened to me over there. I don’t know whether it was, just what the spiritual origin of it was, but I actually thought that my uncle was possessed and tried to cast the evil spirit out of him without really having any authority to do so. Or even knowing what I was doing. As it turned out, I don’t think that he really had any more demonic possession than any number of us do. I mean, because of the nature of man, we’ve all got that, that element of brokenness in us, and that was probably just what I was seeing. But my eyes were open spiritually, and could see in other people that were round about that they seemed to have what appeared to me to be demonic spirits, and others seemed to have ... light in their eyes and it looked to be not spiritually possessed. Whatever happened, whether it was from God or from the opposition, it was a spiritual turning point in my life and it was my first breakdown. So it was that whole, mixed up sort of confused state that I was in.

Paul referred to this episode as his “first breakdown” which appeared to indicate that he understood the experience as related to mental health issues. The fact that he was hospitalized, diagnosed as having schizophrenia, and medicated shortly after this incident likely reinforced the conceptualization of the experience as one of psychosis. However, in his explanation, Paul also reported that it was “a spiritual turning point” for him. Moreover, Paul believed that his ability to see spirits in the eyes of the people around him was a skill bestowed from some ethereal figure, be that God or “the opposition.” While he spoke about this incident in relation to his first psychotic breakdown, he also reported that he maintained the capacity to see into a person’s eyes, even when not actively psychotic.

It is a spiritual gift, and it’s called discernment. With a Christian, every Christian should really have the ability to go and identify people who have spiritual entities that are inside them. Just, um, it’s hard to describe, but just something about the eyes are really the window to the soul, and you’ve probably heard that expression before, and you can see, looking into people’s eyes that, um, almost benevolence looking back at you of an entity which is a representation of Satan in people. It’s just, it’s just sort of known that that presence is there, and you can’t really give it characteristics and say, ‘*the eyes look this way, the eyes look that way,*’ it’s just sort of an impression.

While his first psychotic episode appeared to be very heavily influenced by religious themes, Paul reported that other instances of psychosis did not maintain the same type of content. For example, Paul stated that he would often see “dark shadows” and “shadowy figures” which would make him feel uneasy and paranoid. At other times he would think there was a significant value to regular, every-day objects, which would otherwise have no personal meaning for him. More generally, he would experience “off-beat” thoughts or feelings. While Paul stated that these psychotic episodes would “occur at random,” he also noted that he was more likely to develop symptoms when he was “overloaded with stress,” tired, using alcohol excessively, or off his medication. He further reported that he would often deny his faith and “leave God” when he was mentally unhealthy. As he had experienced many acute episodes previously, Paul reported that he had developed an ability to identify the precursors and triggers and re-establish his wellness routine before these were exacerbated further.

Outcomes

Paul spoke relatively briefly about the outcomes of psychosis. One significant drawback for Paul had been the effects of the medication he had been prescribed. He noted that he often didn’t have energy or motivation to partake in his general everyday activities. This was especially pertinent

to his religious practices. He reported that his spirituality suffered given that he struggled to pray, “read the word,” and go to church. However, overall Paul had a very constructive and affirmative perception of his illness.

I don't regret having had schizophrenia because it's opened my door and eyes to a whole different realm and a whole different way of seeing the world that if I hadn't had the experience, I would never know. And there's been a lot of positives to take away with it; there's been some negatives, some harder moments too, but there's also been a whole heck of a lot of good that's come about as a result of being more in tune with myself, and in some ways the people around me as well. Yeah, I can see that there's been a lot of benefits. And I'd actually, something that I've come to realize too, is that if I'd had a choice between being healed or being whole and not having an illness, I'm not sure that I would put my hand up for not having an illness. ... I think that it's because I sort of embrace it as a friend almost. And there would be part of me that wouldn't be here and I just wouldn't feel the same if I didn't have it. But then, it's kind of, it's hard to really know because it's been such a long time since I really hadn't had an illness. But really, who I am hasn't changed whether I have an illness or not. That's the most important factor I think is that, it's not, it doesn't define who I am. It's an element of who I am, but it's not the deciding factor. It's kind of like, I kind of use the image of a big circle and a little circle, and the big circle being me, and the little circle being the illness. Some people have it the other way around, and that's not healthy. So it's a little bit, part of me, it's not the whole dimension.

Paul had experienced episodes of psychosis for an extended period of time, and it was clear that he had embraced his illness as part of his identity. He reported that he did not let it define him, but instead understood that it could bring many benefits.

Understanding Relationships

Paul did not believe that his religious beliefs in any way caused the development of psychotic symptoms. While he viewed the two as distinct, and was able to differentiate between religious and psychotic experiences, he maintained that these were also hard to separate.

With a psychotic experience, I guess it's, I mean for me, Jesus and the spiritual realm is very real whereas a psychotic experience isn't. It's kind of, it's something that my brain has malfunctioned and cooked up; the chemistry has gone wrong and it's just twisted and taken it out of norm. So it's kind of unhealthy, kind of an experience or perception. Whereas spirituality to me is very authentic, it's very real, and it's just an awareness to another world or another realm.

For Paul, religion had featured in his life from the time that he was very young and he reported that it was an integral part of his life. He noted that he had always had an awareness of the spiritual realm, which he stated he perceived as real and tangible. Paul understood the religious content in his symptoms as evidence that “the lines were open to the spiritual realm in a way that isn't healthy for us humans to really see.” Accordingly, he reported that his psychotic symptoms were tangential spiritual occurrences, which allowed him an opportunity to view religious entities

not otherwise capable of being viewed. While Paul did not perceive these experiences as particularly “normal” or “healthy,” he noted that they were, for him, a link to the spiritual realm.

While there were indicators of religious themes in some symptoms, Paul also had experiences which maintained no form of religious content. However, he used religious concepts and terminology in his attempts to understand seemingly inexplicable events or behaviours. For example, Paul considered the possibility that the devil may have been responsible for an episode in which he was slightly psychotic and accidentally caused himself physical harm. Alternatively, he questioned the role of God in regards to the whole development of his illness, considering that He wished to use Paul’s personal experiences for the betterment of others.

I think part of the reason why I’m here on earth is the use of the experience that God’s given me in mental health to reach out to people that are in mental health. Encourage them, support them, and hopefully show them a bit of love along the way, and just express how much God is passionate about them.

Paul reflected on the experience of psychosis in general, and stated that at times he felt this was similar to that which Jesus must have experienced while he was nailed to the cross. He further noted that if Jesus could suffer and consequently die on the cross only to be re-born, then so too could Paul die to his old nature and become something better. Finally, Paul stated he thoughts of psychosis as a test of strength and character from God.

Through suffering of any kind is how God would perfect our character. And that whole testing that helps to bring out the good qualities. It helps to do work with patients, and just, um, the whole long suffering approach, and sometimes, through suffering we can be refined and shaped and moulded more into the mission God has for us.

Paul viewed his religious beliefs as so integral to his life that he stated he “would not be here” if it weren’t for his relationship with God and that he thought that life would be meaningless without a faith. Paul also spoke about how he would often “leave God” just before he would become mentally unhealthy, and discussed how he saw this behaviour as pre-emptive of psychotic episodes; he thus reported that religion had also been fundamental in his recovery. It was clear that Paul understood his faith as essential for maintaining wellness. He reported that even when he turned his back on God, God was still there to support him, encouraging him to come back to his faith. Generally, Paul stated that religion had enriched the quality of his life.

DAVID – PARTICIPANT #2

Presentation

David was a 34-year-old male who identified as Pākehā. He spoke clearly during the interviews, but appeared to demonstrate a relatively simple and uncomplicated appreciation of both his religious beliefs and psychotic experiences. He kept his answers brief, with only a sentence or two used to explain his thoughts. Often David appeared to misunderstand or get confused by questions; he appeared to answer genuinely, but his responses were frequently vague and occasionally contradictory to previous statements or unrelated to the question which had been posed.

Relevant Social and Developmental History

David was brought up within a large family which included his married parents, a female fraternal twin, two additional sisters, and a brother. David also spoke very briefly about his grandmother whom, along with his mother. Unfortunately, David had suffered great losses, with the death of his mother approximately seven years prior to the interview, and the death of one of his sisters due to a medical condition. In addition, David indicated that at some point within the last year, he had lost both his grandmother from old age, and his twin sister to blood poisoning. He reported significant distress regarding these losses.

Understanding Religion

Development of Religious Beliefs

David's grandmother, mother, and siblings were all practicing Catholics. With the exception of his father, who did not have a religious faith, David's whole family would attend church together. The fact that his father would not come on these outings made David feel "sad" and "terrible." The concept of family was very important to David, and he indicated that he thought going to church as a cohesive group would strengthen family bonds. While most of David's family had practiced a faith, he noted that the majority of his religious education came from a pastor at the Baptist Church whom he went to live with at the age of 19. David reported that he was able to "share how [he was] going and all that" with the pastor, which he thought was beneficial.

Given that David regularly attended church with his family when he was younger, he stated that this was the time in his life when his religious beliefs were the strongest. As he entered adulthood however, David reported that while his faith did not alter, the extent to which he actively participated in religious practices such as prayer, reading the bible, and attending church, did vary. In general, he said this departure from his religious routine was due to lack of time; however he noted specifically a deviation from his faith when he became ill, due to lack of motivation. David reported that he currently was not practicing his faith as much as he would have liked, and desired to spend more time at church.

Religious Concepts

David found it difficult to identify exactly what his faith meant to him personally, as he reported that he initially went to church only for “something to do.” He was however, able to discuss what specific practices occurred within the Baptist Church, and the meaning behind those practices.

(Interviewer) What beliefs and what practices take place within the [Baptist Church]?

(David) Um, the pastor preaches a lot and he prays a lot.

(Interviewer) What sort of things does he pray about or preach about?

(David) About our lives.

(Interviewer) Yep, anything specific about your lives?

(David) Ah, we've got to get on to it he reckons.

(Interviewer) Okay, what sort of things do you think he means by that?

(David) Get our lives together.

(Interviewer) Yeah, what do you think ‘getting your lives together’ involves?

(David) Being on to it.

(Interviewer) What does ‘being on to it’ mean?

(David) Ahhh, being on to it so that we can be a church family.

David reported that listening to the sermon helped him learn moral lessons, while prayer was used to request assistance either for himself, or for others he knew in need; other activities included singing hymns and reading the bible. For David, participating in these activities was an expression of love for God and the people around him; it was also through this expression of love that he was able to receive God’s love in return. In addition the practice of giving his heart to the Lord was very valuable to David.

(Interviewer) You mentioned that you gave your heart to the Lord. Why is that important to you?

(David) Because without the Lord, you wouldn't be here.

To give his heart meant that David would “give everything to the Lord” which included his life. While it was a simple statement or declaration of his faith, it also involved continuing to maintain

his religious practices. In addition, this practice was used to cement the relationship he had established with God. David reported that making this declaration made him “feel good” and ultimately offered him support.

David spoke briefly about his ideas related to the characteristics and functions of the religious entities, such as God and the devil. He clearly differentiated between the two, on the basis that “God [came] from heaven and the devil [came] from hell;” David indicated he believed in the dichotomy of good and evil in that “God [was] truth, the devil [was] no good.” He reported that both entities would try to tell individuals what to do and how to behave; however, God was responsible for positive attributes and behaviours, while the devil was responsible for all things negative, especially “wrong” thoughts. David stated that the devil was always present and would influence behaviour in a negative way if individuals were not conscious of his existence.

Unlike the devil, David viewed God as a father figure in that He would watch over people and respond to individual prayer.

(Interviewer) You mentioned that you thought God was awesome. What makes him so awesome?

(David) Cause he watches over us.

(Interviewer) What else does God do?

(David) Um (*Long pause*). He watches us to see what we’re doing.

(Interviewer) What happens when He likes what you’re doing?

(David) (*Long pause*). He talks to us.

(Interviewer) What happens when He doesn’t like what you’re doing?

(David) He tells us.

(Interviewer) Okay. And how would He tell you?

(David) Cause you hear His voice.

(Interviewer) Yeah, and what does He sound like?

(David) Awesome.

David stated that God allowed him to make mistakes; however David also reported that God would also guide him gently in the right direction with verbal directives should David continue to follow the “wrong path.” David did not believe that God provided people with material objects; instead he reported that He offered His love, support, and guidance when it was needed.

Speaking in Tongues

On several occasions, David discussed and examined his understanding of “speaking in tongues.” The following excerpts were taken from an extended conversation regarding this phenomenon,

and are used specifically as they most clearly illustrate David's perceptions about the causes and effects of this particular experience.

(Interviewer) When did [speaking in tongues] start happening for you?

(David) Um. When I got to church. But I haven't got that now.

(Interviewer) No. Why did it go away?

(David) I don't know. Because I haven't been praying.

(Interviewer) Where do you think the ability to speak in tongues came from?

(David) From God. Yeah.

(Interviewer) And how did other people respond to it?

(David) When they're worshipping God, they get it.

(Interviewer) Does everyone get it?

(David) Yeah. I don't know. But yeah, they do. Basically, they all get it.

(Interviewer) Is there something that people do to ensure they are able to speak in tongues?

(David) They just pray and it comes on.

(Interviewer) How did you feel when you were speaking in tongues?

(David) I felt good.

(Interviewer) Yeah. And how did you feel afterwards?

(David) I feel terrible cause I lost it again.

David indicated that for him, the ability to speak in tongues was specifically related to a religious experience, as it occurred both within the context of a religious environment, and was controlled to a certain extent by religious practices, such as prayer and worship. Moreover, David reported that speaking in tongues was obviously a valued skill to him as it made him feel "good" when he was able to use this form of communication, and "terrible" when he no longer had the same ability. David noted that it was God who had allowed both himself and others to experience this phenomenon. There was no evidence to suggest that David's experience of "speaking in tongues" was understood in terms of a symptom of psychosis. Moreover, his descriptions indicated that he viewed this phenomenon positively, with no associated distress. While clinically these experiences could be defined as delusions or hallucinations, the fact that David did not define them as such or experience any distress as a result negated the purpose of a clinical conception.

Understanding Psychosis

General Background and Presentation

It was unclear the exact time that David first began developing symptoms of psychosis as he noted only that it was "years ago." Moreover, David was unable to identify specifically what was going on in his life at that time stating that "[he] was just getting on with life, but [he] got sick."

David did identify that he had been living with his wife and two children, but was eventually admitted to “respite” care, and consequently moved away from his family after he had become ill.

David found it difficult to recollect the time that he had initially started to develop symptoms; however he reported that his main symptom involved hearing multiple male voices telling him to harm and kill himself. David stated he was able to differentiate these voices from his regular thoughts as “they came on in [his] head” and because he would “hear [them] all the time.” He noted the voices had caused him significant distress as he found it difficult to ignore the directives. David further indicated the content was always negative and always made him feel bad. Because of this, David stated he believed the voices had come from the devil, despite the fact that there was no religious content in the actual symptoms. He reported none of the voices had ever come from God, but also stated that he was able to hear God speaking to him at different times; he did not know how he was able to differentiate between these two however. To cope with the voices, David would “tell them to go away,” and while this would work occasionally, most often he would continue to experience the symptoms. David had not heard the voices “for a while” as he had been prescribed medication which decreased his positive symptoms; he stated that he felt “good” about this outcome. While he did not note any other symptoms which may have influenced his diagnosis, he reported that he thought his “life was going nowhere” at the time, and suggested that this was both an indicator of illness and a potential trigger to the development of symptoms.

Outcomes

Despite the fact that David did not speak about his experiences in hospital or with the medical profession in general, he reported that he felt “bad” when he received his diagnosis as he “changed a lot with [his] schizophrenia.” David indicated that these were alterations related to his core identity, personality, and behavioural expressions. However, David also specifically noted that it was the diagnosis itself that made him feel this way given his belief that “there’s a lot of work to do with schizophrenia.” He noted that pharmacological regimes and psychiatrist appointments engaged a lot of his free time, and required more responsibility than he was initially willing to provide. In addition, David believed there to be a lot of “bad things” associated with

the diagnosis, given common misconceptions about psychosis within the broader social community.

Understanding Relationships

David used his religious background in a variety of ways to help him both understand and cope with his symptoms of psychosis. He discussed here what he specifically saw as the relationship between religion and mental health:

(Interviewer) Do you see any link between religion and the symptoms of schizophrenia?

(David) Yep.

(Interviewer) Yeah? What link do you see?

(David) Um, people looking after me and all that.

(Interviewer) Do you think that there's a link between religion and schizophrenia specifically?

(David) Yeah.

(Interviewer) What link would you say exists there?

(David) Link?

(Interviewer) How are they connected?

(David) They are connected with God.

Considering his previous statements in which David viewed the devil as responsible for his symptoms, it appeared that he also saw God as responsible to some extent for the existence of mental health issues. However, David also reported that God provided him with specific attributes and coping mechanisms such as his positive attitude. More generally, religion provided support in the form of a supportive community, such that these individuals would watch over David and pray for him to get better. The following excerpts were chosen to demonstrate the way in which David's faith helped him cope with his experiences of psychosis.

(Interviewer) Why do you think [God] helps you?

(David) Because, if you didn't have God, you'd have no one.

(Interviewer) You mentioned that the church helped you quite a bit. In what ways did it help you?

(David) They look after us.

(Interviewer) How did they look after you?

(David) They watch over us.

(Interviewer) What would you say you get out of religion?

(David) Good things.

(Interviewer) Good things like what?

(David) Um, people helping me to recover.

It was clear from David's responses that he believed religion to be a positive and beneficial aspect to his life, as it allowed him to connect with a community which assisted in his recovery,

and thus affected his mental health positively. Religion meant “good things” to David; he reported that his faith altered internal mood states and ultimately made him feel “happy.”

RICHARD – PARTICIPANT #3

Presentation

Richard was a 57-year-old Pākehā male. He was articulate and refined in his dialogue, and he spoke about his experiences with highly detailed descriptions and perceptive explanations. He appeared eager to discuss both his religious beliefs and his knowledge and understanding of psychosis. Richard very rarely required prompting; he had many examples to support his statements, indicating that he had thought about his situation at length. He discussed his experiences with both abstract and concrete explanations, and evidenced good insight.

Relevant Social and Developmental History

Richard discussed only briefly his family and the relationships therein. Both of his parents had been deceased for several years, but he generally spoke about them, his sisters, and his childhood fondly. Richard also made reference however to several memories in which his mother was described as controlling and critical, and further stated that he was always weary of his father and his tendency to become emotionally enraged. Richard reported that alcoholism was common in his family and that his parents were more interested in “socializing around alcohol” than spending time with the children. Neither of his parents had been personally interested in religion, but Richard stated that he felt supported in his religious activities and beliefs throughout his childhood and into his adulthood.

Richard had been working within mental health services as a support worker for thirteen years prior to the current study. He had a great deal of knowledge about mental illnesses, which he reported he had learned from his own experiences, but also the experiences of others. In addition, Richard had gone back to university to supplement his extensive practical knowledge with a theoretical education.

Understanding Religion

Development of Religious Beliefs

Richard stated that he had always felt that there was an aspect of him that was spiritual as from a very early age he wanted to become involved in religious practices.. At the time, these practices

included going to church, participating in the boy scouts, and trying to “do good things.” Richard stated that he had been christened in and attended an Anglican Church for the first 14 or 15 years of his life. However, he reported that it was at this age that he deviated from his religious practices after he “started drinking and getting into mischief and all that sort of rubbish that goes on with teenage boys.” While Richard noted that he still maintained a spiritual connection, he stated he felt that the Anglican Church was not facilitating this, and thus was not the right fit for him religiously.

In his mid-twenties, Richard met Margaret, who would later become his wife. Margaret had come from a large Catholic family and was very involved in the Catholic Church. Richard reported becoming very close with Margaret’s family, and stated that he found himself being positively influenced by their religious beliefs.

It was very attractive looking at her and her family’s connection to the Catholic Church. They had a long history of Catholicism in her family. And while it was a dysfunctional family, it was also a very beautiful family. They were very harmless people. As much as [her father] may have been a social drinker, as a family, I really liked them a lot. They had a family like, where we didn’t.

Richard reported that part of his motivation to attend the Catholic Church was related to his perception that religious and family tradition had been maintained within Margaret’s family members as a result of spending time together. This family tradition was contrasted with Richard’s perception of his own family, in which individual bonds were not strongly developed.

Religious Concepts

Richard reported that he experienced both emotional and social benefits as a result of practicing his faith.

I always used to come home [from church] feeling good; feeling wholesome and clean and pure and there was joy in life and life was good, and being around the people and hearing the stories; there was a sense of connection to community. There was a connection to God.

Richard’s positive emotional response to these experiences appeared to be mediated by the social relationships he was able to form with both God and the individuals within the religious community. Richard noted that one of the greatest things that he was able to get out of his spirituality was a sense of service to others, both human and ethereal. Achieving a relationship with God was paramount and Richard reported that many of his religious practices, such as attending mass, prayer, confession, reading scripture, and saying a daily rosary, facilitated this

goal. For example, Richard noted that the scripture was both “divinely inspired” and a reflection of God. It provided a “manual for living” and acted as the basis for a moral code. Richard stated that the adherence to this moral code gave his life meaning and meant that he would continue to act in a “Godly” manner and consequently provided opportunity to be viewed positively by God himself. The remaining practices were noted to reinforce this moral code which was encapsulated in the concept of living a “Christian life;” or living like God was always watching and modelling behaviour after that of Jesus.

While Richard viewed God as a “lovely, warm father” who supported His followers, Richard also noted that should you “do bad,” God would “deal to you so that you learn[ed] your lesson.” Richard reported that he believed in the reality of heaven and hell, but thought that the devil was no where near as powerful as God, despite the fact that he was part of the religious dichotomy. Richard further stated that, unlike many other religious individuals, he did not see the devil as responsible for behaviours or decisions that had a negative outcome; instead Richard noted that people had to take responsibility for their own actions to obtain forgiveness. If an individual did not seek penance however, then Richard reported that he believed this person would likely be banished to hell, and have to spend eternity with the devil.

Understanding Psychosis

General Background and Presentation

Richard had his first psychotic break at the age of 30, while he was located away from home and working on an on-shore oil rig. He reported that approximately mid-afternoon, he was in the workmen’s residence, and he began to have thoughts that the other workers were going to make attempts to kill him. Richard stated that several hours after the onset of these thoughts, he went to the kitchen and retrieved a large knife to ensure his safety. He further reported that by this stage he had started hearing voices, which were both threatening him and telling him to kill himself, and was experiencing visions, which depicted his decomposed dead body. Richard noted that the intensity of these experiences was such that he was unable to sleep, and was becoming more and more distressed. He stated he went to a neighbouring cabin and asked his co-worker if he had a bible, which he then took back to his room. Richard reported that he was able to distract himself from the voices by reading his favourite passages, and thus he continued

to do so until he fell asleep at four o'clock in the morning. According to Richard, after only two hours of sleep, he awoke to his work alarm, and immediately began to hear voices again. He reported that he was told that he was the devil, and that he had no other option but to kill himself. Richard stated that he believed the voices and thus took the knife he had retrieved the previous night, and stabbed himself in the chest. Luckily, Richard was found by a co-worker and was hospitalized; he reported he received a diagnosis of schizophrenia shortly after this experience, and was given medication to control the positive symptoms.

Richard noted several significant factors which contributed to his first breakdown. Shortly prior to the event, he stated he had moved to a new country to work on the oil rig. The country was drastically different culturally, and was unfamiliar to Richard. The job involved intense labour, and Richard reported that he was under a great amount of pressure to learn new skills. In addition he was required to work two straight weeks of twelve hour days. Richard reported he then had two weeks off during which he socialized with individuals who were using drugs and alcohol excessively. Richard noted that he participated in excessive drinking, and also used a small quantity of marijuana. He stated that even this small amount of drug use was “poison on [his] mind” as it brought out his already present self-consciousness and exacerbated it, such that Richard felt paranoid, insecure, and uncomfortable. Richard also reported that he had perfectionistic standards, which only increased the perceived pressure to achieve.

In addition, Richard reported that he had an emotionally traumatic experience shortly after he had arrived in this new country. He reported that, while out on a work errand, he neglected to help an incredibly poor woman and her child. He felt a great sense of guilt and regret regarding the way he treated these individuals and indicated that these feelings were related to the fact that his behaviour did not align with his self-concept and values. When he eventually became ill, Richard assumed that the voices were telling him that he was the devil because of his actions in this circumstance. Given his religious beliefs regarding the devil, Richard thought that he had no other option but to attempt to commit suicide.

Symptoms and Symbolism

Despite the fact that Richard had been medicated, he reported that he continued to experience symptoms of psychosis; many of which maintained religious content. He noted he would experience both delusions, where he thought that he was either Jesus or the devil, and hallucinations, during which he would either see large religious symbols in front of him, or he would hear voices. He stated he understood these episodes as the result of his mind thinking in extremes, such that he viewed himself as either all good or all bad. Richard reportedly attributed this thought pattern to his early experiences from which his parents had instilled little confidence in him; thus Richard noted he thought his low self-worth was an influencing factor in the presentation of his symptoms. Richard also reported that many of his real life experiences would often be woven into the content of his psychotic symptoms.

[There were examples] of my voices taking me somewhere I didn't want to go. And it was an example of clear, illogical, psychotic, chaotic thinking. I think it's a good example how when you're in a psychotic state, the voices or whatever, tries to weave real things into a new reality for you. It sometimes takes things and jumbles them up and represents them, and tries to get you to believe it, and in your psychotic state you do because it's so believable. But then you think later, *'well, that's just pure madness.'*

Richard reported that, despite the fact that he would often get “caught up” in the “madness of psychosis” he could also identify (with hindsight) that elements from his daily life would affect the content of his symptoms. Richard also spoke about experiences in which he would “beat the voices” by using his faith. He stated that reading scripture, or saying a prayer would often distract him from the voices.

Outcomes

Richard reported several negative consequences of his illness; one of which being the invasive and traumatic nature of the disorder, as noted here:

I'd actually taken myself prisoner, because waking up with schizophrenia, you feel dead in the morning; you just feel that you're on another planet, that's part of the illness. It's probably the culmination of the medication and the illness.

Richard noted clearly his experience of the distressing and at times very debilitating nature of schizophrenia; he noted that the loss of his wife, job, and home had all been a consequence of psychosis. In addition to the symptoms and social consequences, Richard reported that he also had to cope with side effects of the medication. While pharmacotherapy initially helped to reduce the positive symptoms, Richard stated he began to lose his stamina, energy, and

motivation to get well. He discussed in clear detail the specific effects medication was having on his quality of life:

I knew that the medication was turning me into a zombie. I couldn't get in touch with my feelings; I was just like a wooden face; non-emotional, non-reactive. It dealt with the positive symptoms, but not the negative symptoms and it just turned me into a nobody.

Reportedly, the depressive mood that Richard felt led him to self-medicate with alcohol and cigarettes, two substances that he readily acknowledged were predisposing factors in his presentation of symptoms. He reported that it was only after he made the decision himself to cut his dosage in half that he was able to “get in touch with [his] emotions” and give up both alcohol and cigarettes. Richard noted however, that this also made him vulnerable to relapses into psychosis; an equally significant consequence, as he stated how easy it was for him to get caught up in his delusions and hallucinations.

Richard also discussed his initial perceptions of his illness in terms of negative thoughts and emotions he felt when he was around others.

I hated being mentally ill; in the sense that I was embarrassed and ashamed of it. And one of the things that I took great pride in doing, it was part of the blow-out thing on my part, to totally blow people out. The first sentence they say, you'd introduce yourself and say, *'I'm Richard.'* And they would ask, *'What do you do?'* And I'd say, *'Oh, I'm a schizophrenic.'* And for many years, for the first or second sentence when I met someone new, that's what I'd tell them, and they'd move away and I'd think, *'Oh, good job. You're not worth knowing anyway.'* And it was sort of like, it's hard to explain, but it was sort of like saying, *'well, you don't want me, so I'm going to make you piss off. Before you piss off and leave me, I'm going to make you piss off by telling you I'm a schizophrenic.'* And there's sort of a shame, embarrassment, and a real sense of rejection, so *'I'm going to get in and I'm going to reject you before you reject me.'*

Interestingly, Richard reported that it was his own perception of the illness that compelled him to “reject” others, despite the fact that many of these individuals had not displayed any stigmatized beliefs about psychosis. He noted it was his assumption, based on his own previously developed perceptions of illness, that other people wouldn't want to have anything to do with him.

Despite the numerous drawbacks of the disorder, Richard indicated that he had also very successfully been able to find advantages to his situation, which appeared to help him cope to some extent with the disadvantages. He reported that his experience of schizophrenia had taught him empathy and love for others, especially those who also experienced a form of “disability.” He stated he saw his illness as an opportunity to learn more about himself, and then to teach what he had learned to others.

Understanding Relationships

There was evidence throughout discussions with Richard that he would reconceptualize his symptoms in terms of religious experiences and expressions from God. For example, Richard spoke about his perception of psychosis as a “divine lesson” which had been used by God so that Richard could learn more about himself; he could then take this knowledge and help teach others. Richard also noted that his experience with psychosis was a spiritual test in which both he and his family and friends were examined. Richard stated that he felt that struggling through these experiences made him stronger and a better person.

Richard indicated that he would also often use his faith as a coping strategy to deal with the voices. He noted on several occasions, for example, that he would “call on scripture” and the voices would go away. He reported that he also used religious practices such as prayer, confession, and saying a rosary every day, to “beat” the voices and cope with other symptoms. Finally, when significantly distressed, Richard noted he would use the support of both his priest and the religious community to reduce tensions and concerns.

Given that Richard used his religious beliefs to both reconceptualize and cope with his illness it was not surprising that there was a lot of overlap between his religious experiences and his psychotic experiences; however, for Richard, the difference between these two was decidedly clear. He reported that the voices that were associated with his illness were always commands and very intrusive in nature. Alternatively, for Richard, the voice of God was a much more “natural process” and came in the form of prompts or “leading feelings.” Moreover, Richard stated he thought that his psychotic experiences maintained no meaning for others, and would often lack any element of insight, while a religious experience had meaning for others, and had positive connotations. While he indicated these experiences were separate, he also reported that they would often occur at the same time.

It was clear that there were many relationships between religion and mental health for Richard. He reported that to some extent he believed his symptoms had come from God, but he also stated that he believed his psychosis had allowed him to experience religion in a way that many others

would not. He used religion as a way to reconceptualize his symptoms and understand his illness, and he used the religious community to help him cope.

PARTICIPANT #4 – MARK

Presentation

Mark was a 41-year-old male who identified as part Pākehā, part Tongan. He had a comprehensive understanding of his faith and was able to articulate his beliefs with excellent clarity and full descriptions. Mark had a tremendous amount to say regarding his experiences related to religion and psychosis. He rarely deviated from the topic, and was able to speak about quite abstract and conceptual themes while at the same time remaining focused on the questions posed to him.

Relevant Social and Developmental Information

Mark reported that at the age of 16 he dropped out of school and started drinking and taking drugs. He stated that while he was no longer in the education system, he continued to remain unemployed. Mark noted that during this time he had developed strong friendships which he valued; however he also noted that he never really felt that he was a part of the group. Mark indicated that he developed a relationship with a woman that involved sexual interaction that he was unready for emotionally; moreover, he reported that this caused him immediate distress and had long term detrimental effects on his mental health. Reportedly, Mark then had his “own kind of crash” and after speaking to the doctor, was given a diagnosis of depression. He indicated that it was suggested that he start on medication; however, Mark stated he did not desire a course of pharmacotherapy, and opted to spend more time with his peers, as per the suggestion of his General Practitioner. He noted later that this course of treatment never worked for him, and he continued to suffer from depression.

At the time of the interview, Mark had been attending university courses to work toward his BA, and indicated that he was highly motivated to continue to learn in such an environment.

Moreover, Mark noted that education was an important aspect in the process of his recovery, and he desired to continue his education so as to maintain wellness.

Understanding Religion

Religious Concepts

There were many religious practices and concepts that Mark identified as important to his faith. He spoke relatively briefly about symbolic figures, but demonstrated a sophisticated understanding about the roles and purposes of these individuals. In his discussion about God, Mark clearly delineated the essential characteristics and nature of an individual whom he saw as virtuous and faithful.

My sense of God is that He is just like a father and so, like a father, He lets us fall, He lets us make mistakes, but He's always there to listen. However, if we do continue to spend our life sinning and doing things that bring Him into disrepute, and bring everyone in the church into disrepute, then basically we ruin our souls and just basically make a real hash of our lives. And if we're not sorry about that, they He'll have no option but to cast us out of the spiritual house because He's a holy being, so He demands that we are holy to be in His presence.

For Mark, the symbolic figures as entities which served a function in enforcing religious guidelines and values; he reported that God's role, for example, was to support and guide in terms of moral behaviours and spiritual beliefs. Mark also noted that these figures also had defined characteristics which separated them from one another. For example, while God was an entity that existed beyond human sight, Jesus was an individual who, despite his influential characteristics, was much like any other.

Mark reported that he actively participated in a number of religious practices which included prayer, sermons (or the Homily), communion, and confession. He noted that all of these practices had positive connotations for him, which were either associated with memories from his youth, or related to his current morals and ideologies. For example, Mark reported that his experiences of the Homily were calming, inspiring, and informative in that he was able to sit back and enjoy the sermon, while at the same time allow his mind to be "opened up and expanded" upon. The practice of confession was also identified as an integral and valued aspect of Mark's faith; he noted the advantages of this process:

Whenever you confess your sins to a priest, he's not actually allowed to tell anybody what your sins are; he's got to keep that quiet between him and God and offer [it] up to God and ask for forgiveness. So, it's very good, it's very good; I mean, being able to have your sins forgiven is very important because it's very easy to carry stuff, baggage, with you throughout life.

Mark appeared to use confession as a way to acknowledge and take responsibility for behaviour he perceived to be negative or immoral. The pattern of disclosure was likely strengthened with the knowledge that only the priest and God would hear his declarations. The verbal recognition

of what Mark referred to as “his sins” allowed him to off-load concerns that he may have otherwise continued to carry.

There was evidence in the discussions with Mark that suggested he would often use the moral guidelines derived from his religious beliefs in his approach to everyday living. Mark stated he saw religion as the “[moral] glue in society” that held people together and ensured that people did not revert back to more “basic” and “savage” ways. For Mark, religious traditions and values developed over time and helped teach practical and concrete lessons which could then be applied to everyday life. At a more individual level, Mark reported that he used religion to guide his decisions, and based these on whether or not his behaviour, or any possible outcome of that behaviour, would harm his soul.

General Coping Strategy

It appeared that religion functioned as a coping strategy for Mark in a variety of ways. He noted that his faith had a direct relationship to his overall well-being. Mark stated he would often thank God for positive outcomes as well as character traits which helped him get through tough times. Such traits appeared to have included courage, patience, and consideration for others.

In addition, there was a strong theme in Mark’s discussions which related to the importance of stability in his faith. Mark first noted that his faith could be traced back 2000 years; the ongoing and unfaltering tradition of the Catholic institution meant to Mark that there had been clear and reasonable religious guidelines established which were trusted to be both functional and effective. Mark also noted that the support he found through his faith and religious practices was more stable than any other relationship he had encountered.

What I actually think now is that really holding on to your faith is the only precious thing you have in life. Even more precious than human relationships. Human beings can always let you down, but God won’t, and in His wisdom, He’s looking after billions of people every day at the same time. So we’re not going to get exactly what we pray for, but He’s still the best bet for humanity.

Mark reported that he greatly valued the relationship he had with God as it provided him with a sense of consistency more so than any other relationship. Mark further stated that he felt that God was the only one who truly knew him, as He was always watching and aware of Mark’s thoughts and behaviours.

Finally, Mark noted that there were advantages related to the social community he encountered and became a part of when he attended church.

There's the fact that I can meet people of God, people in the church who I don't necessarily share an origin with, you know, we're not of the same race or we're not of the same school or we're not of the same career, but yet we can still meet as human beings, and it's not dependent on whether we have a big wallet or a small wallet, you know? We can just go in there and chat and be part of something, something bigger than ourselves.

There appeared to be something comforting to Mark about the concept that his religion would accept everyone and take all kinds without judgement. He reported that within the religious community he was able to feel that he belonged with a group of people who, no matter how diverse, were coming together to share in an experience that was meaningful.

Understanding Psychosis

General Background and Presentation

Mark indicated that he understood the aetiology of schizophrenia from a multi-factorial model which included biological/physiological, cultural, spiritual, and social influences. He also appeared to have clear ideas about the triggers of his illness in terms of this model. Mark reported that the symptoms he was experiencing were not a direct result of schizophrenia; instead he offered descriptions of events that normalized his experiences. Explanations therefore, focused on the consequences of early experiences, a head injury, peer influences, and personality characteristics that determined the way in which Mark coped with these events and situations.

Mark discussed his understanding of a “split personality” in relation to psychosis and noted how he related this to the relationship dynamics in his family.

You always hear that popular conception of the split personality, and although that's changed nowadays, to a degree that's correct, because for me when I was growing up, I was trying to find my own identity as a person and all this sort of thing. But my mom and dad were very distant from one another. They were apart in the way they thought and the way they did things. So, you know, that makes sense that they split up after a while, as is the usual nowadays. But for me, I was trying to find my own identity, and I really wasn't close to my mother or my father, and I was sort of splitting off in two ways.

For Mark, his “split personality” had developed from difficulties he had encountered as a result of the differences in his parent's beliefs, cultural and religious heritages, socioeconomic backgrounds, and personality traits. Mark stated he thought this family “conflict” hindered the

development of a secure self-concept or identity, and left him feeling confused and unsure about his relationships with others; for Mark a consequence of this insecurity was suspiciousness and paranoia. In addition, Mark indicated that the consequences of traumatic sexual encounters in his childhood also impacted the development of symptoms.

It's like cutting the leaves off the trees; denuding them of their self-respect and of developing normal sexual relationships as they get older. So what happened in my family was that I basically covered it. I'd always felt that if I went drinking with a lot of guys they'd pick up on it, and that would happen. I'd become very paranoid in public and very nervous.

Mark indicated that he felt his paranoia was justified given his fear that others would find out about a perceived shameful encounter about which he felt a great deal of guilt. While his initial concerns seemed to focus on the perception of his peers, Mark stated that he eventually became more and more convinced that everyone around him, including his neighbours and the individuals at the church, knew his secrets and had suspicions that he was a bad person. The content of these beliefs included an element of persecution, in that Mark thought the police or others were watching him, despite the fact that he had done nothing wrong. Interestingly, Mark also reported that he experienced suspicions about individuals around him, thinking, for example, that his neighbour had killed his wife. Mark associated this form of what he referred to as “disorder thinking” to his paranoia, and thus applied the same explanation of causal factors. He additionally noted that he would “take paranoia on board” when he was around his wife or peers who also had suspicious thoughts. Mark offered no explanation as to why the direction of the paranoia had changed from thoughts of his own persecution, to his persecution of others. Mark readily acknowledged evidence against his thought however and, when his neighbour’s wife came home from work, was able to realize he had made the wrong assumption and drawn the wrong conclusion.

Mark spoke very briefly about an experience in which he heard voices while he was in hospital.

When I get [to the hospital] I sit in the booth where they have the interview and then I come out into the ward and I'm hearing voices everywhere saying this, that, and the other. And I'm thinking, *'well, everybody knows my darkest secret now.'* And I've only done this because I said to the Lord, *'Lord, if I'm going to suffer for my sins, let me suffer here on earth.'*

Again, Mark appeared to use paranoia as the basis for understanding his experience. It was unclear as to whether or not the “voices” Mark heard could be clinically understood as hallucinations given the context. It was more likely that Mark heard people talking, and assumed that they were talking about him; a symptom which would have been reflective of a paranoid or

persecutory delusion. Mark however, had reported that he had previously requested the Lord let him suffer on earth, instead of after death, for his sins. He reported that his symptoms were likely the result of this request, and that it was God's way of punishing him for the perceived wrong deeds.

Mark also demonstrated a very interesting conception of another aspect of his presentation as he explained what would clinically be understood as hallucinations in the following way:

I gave up on my art, but what I found out was that the whole part of me that was visual had no outlet to it. So my brain could still see things visually, but I wasn't drawing them. [...] But I've always had a fairly photographic memory, so I mean, that doesn't really mean anything to anybody unless you can actually exercise it. So I spent however long not doing any art, not drawing, and as such, yeah, I was maybe having a visual thing happening.

The "visual" occurrences Mark was experiencing were not understood in terms of symptoms of schizophrenia, but instead had been reconceptualized; by perceiving these experiences as expressions of his natural artistic talents, he was able to normalize and understand in a personally relevant way what could potentially be very distressing symptoms of psychosis.

Outcomes

Mark reported that he had not initially believed that he had schizophrenia, but instead thought that he had continued to suffer only from depression. While he was eventually advised by doctors on the new diagnosis, Mark stated that no one had bothered to explain to him exactly what "schizophrenia" meant, and thus he remained confused regarding the status of his mental illness.

There's lots of little theories that get developed that may or may not be totally true. And it wasn't until I [had several negative experiences] that I was given a diagnosis. But I don't know, they didn't tell me at the time, I don't remember anybody telling me anything about that. It wasn't until I got back [home] they started talking to the doctors about schizophrenia. But my thought had been that depression was that going down, down, down to the depths of despair, and that schizophrenia was like having mixed messages about how you should behave and so your behaviour becomes erratic because you don't know what to do. So one minute you think this is the right thing, and then you think, 'no, that can't be it, it must be this, no, no no...' you see? And for somebody observing that kind of behaviour they're going to say, 'oh, that guy's crazy, he doesn't know what he wants to do, he's got a split personality or something like that.' And that's my summation.

It appeared that Mark pulled understanding from his previously established concept of psychosis in which people were described as having a "split personality;" it appeared that it was from this concept that Mark began to understand his illness as deriving primarily from his early

experiences, thus normalizing what would have otherwise been described as psychotic symptoms, and alleviating any associated distress. Therefore, understanding his diagnosis in terms of an outcome of life experiences appeared to help Mark in accepting his illness.

Interestingly, it appeared that the way in which Mark pulled knowledge from his previous understanding of psychosis also maintained the concept that schizophrenia was very much a stigmatized disorder, and impacted on the extent to which Mark disclosed information regarding his illness. He indicated that he was concerned regarding public perception, stating that there was a lack of understanding and a lot of fear and stigma associated with psychosis. While Mark stated his family accepted his diagnosis right away, he reported that he was aware of others who had been told that the illness was “all in [the] mind and all [there was] to do was go and get a job and be normal like everybody else.” Mark also noted he thought that there were few outlets for social support, which made the experience of psychosis especially difficult. While he reportedly desired to express his thoughts, feelings, and “energies,” the lack of interest and consideration from others resulted in Mark’s withdrawal from social practices. It was here that Mark was able to use religion as a supplemental means to help him cope.

Mark reported that he had achieved “recovery” through the process of finding meaning in his life; he identified gardening, education, art, and most importantly religion, as particular elements that provided this meaning. These activities reportedly acted like ski poles; Mark stated he could continue to function effectively if he was stabilized with continued personal support. While Mark acknowledged the role of medication in his recovery, he reported that this form of treatment addressed only the presentation of his symptoms. For Mark, medication merely provided the means to achieve the clarity needed to understand and resolve the other underlying issues which had caused the development of the disorder in the first place. To resolve these, Mark stated he relied on his religious beliefs, “God’s grace,” and the support from his religious community.

Understanding Relationships

While Mark did not have religious themes in the symptoms of schizophrenia, he continued to use religion to understand his experiences. He spoke about how he used religious concepts as coping

strategies, and the religious community as a support system. Mark understood some of the causal mechanisms for the disorder as related to perceived sins, and the consequences of suffering on earth. Furthermore, he reported that his illness had pushed him to really acknowledge and use his faith.

PARTICIPANT #5 – JAMES

Presentation

James was a 35-year-old male of Pākehā descent. He took his time in answering the questions posed to him, which appeared to be a process of reflection as opposed to misunderstanding or confusion. However, James would also deviate from the interview topic quite regularly, and often gave answers which were apparently unrelated to the question posed. In addition, James' responses were somewhat jumbled and at times illogical in that the subject matter would often jump from one theme to another seemingly unrelated one. At other times however he demonstrated good insight.

Relevant Social and Developmental History

James described his childhood as extreme in nature in that he and his siblings were either harshly disciplined, or given high praise. As such, his relationship with his parents was reported to vary from good to bad. He stated that he always felt “confused” in his childhood, and thought that his parents “brought [him] up to be a basket-case.” James had the perception that his childhood was unstructured and at times unpredictable. He understood his current situation as the result of these early experiences, believing these to have had negative effects on his behaviour and general social functioning.

Understanding Religion

Development of Religious Beliefs

James recalled his first religious experience as attending church with his family, which was an activity that occurred every Sunday. He noted however, that he did not have an internalized belief in God in his youth, but instead thought it was the principles of religion which were important to learn and understand.

We were brought up when we went to church every Sunday, went to confession. It was more a matter of course than believing that there's a God. But when you're talking about religion, people will say, you know, 'do you believe in God?' And so I guess it's the principles of religion that we were brought up with.

While the majority of his religious education occurred in the church, James also attended a religious school. As such, along with learning about how to treat others, James also learned

about the Ten Commandments, which appeared to act as a basis for his moral code, and the importance of forgiveness, which was later used indirectly as a coping strategy for mental health difficulties. His experience as an altar boy also facilitated the development of a coping strategy, as it was honourable to have been given such a role within the church community; with this honour bestowed upon him, James was able to increase the sense of belonging, and use the social support in times of need.

Religious Concepts

James spoke very clearly regarding his beliefs about the religious entities, such as God, Jesus, and the devil. He depicted God as an “all-powerful” being, who was not contained to a single person or body, but was instead an entity which was present everywhere. God was also seen as a father figure, who punished individuals for wrong deeds, but was equally likely to grant requests when needed, if these requests were made through prayer. Alternatively, James viewed Jesus as a person who had taken real human form, but remained influential, with all the makings of a leader. While James stated that he had not thought too much about the devil, he noted that “that’s where you go when you don’t go to heaven.” Despite the different characteristics of these religious entities, it appeared that they all served a unique function in enforcing religious law.

The church initially appeared to be the main location in which James actively practiced his faith. He described being in church as a very “formal” experience; however he also implied that it was generally a positive one for him.

I don’t think it’s like being belittled, but you’re there to serve. Yeah, there to serve a purpose. But they tell you what you are to sing, they tell you what you are to read, they tell you what you need to say, they tell you what you need to do. It’s very military style. You don’t ask questions.

It appeared that there was meaning and value in the concept of ‘serving a purpose.’ For James, this related not only to serving a purpose within the church and the community worshipping therein, but also at the broader level of spiritual worship in which his religious activities attended to one or more of God’s needs and requirements. In addition to helping achieve this endeavour, the church also served as a place in which James was able to gain time for himself so that he was able to reflect upon his own needs and desires; for James, the church was where he went to “find answers.”

I guess it's like being in a different world. When you go to church and it's just you, you're not having to, not having to talk to anyone in the church. It's just you and it's time to be yourself. It feels like there's no one around you. You're focused on what you want, and what you need.

James found that he was able to relax and find some sense of what could be described as inner peace. It was obvious that he felt completely comfortable and accepted; he felt loved and love for others. The access to a community of individuals who provided social support was a particular advantage for James as this was generally used as a coping strategy in difficult times. In addition, because James had good memories from his experiences in church as a youth, the location continued to provoke positive thoughts and feelings which still maintained meaning for him.

In addition, there were several customs that James identified as important in practicing his faith; these included attending and listening to sermons, singing hymns, and going to confession. However, the most common practice, and the one which appeared to continue to hold the most value and meaning over time, was prayer. Additionally, out of all the practices mentioned, prayer was the only one which was maintained outside of the church setting. It may be for this reason that this particular custom remained stable even after James had discontinued attending the church.

James appeared to have a very unique perception of the function of prayer. He noted, for example, that he did not expect change to occur as a result of his requests.

Cause when I would have been praying, I would have been praying that these things would happen, but not that there's someone that would divine intervention or just, I must have, when I was little, I must have thought there was a God, but we wouldn't really pray [to Him], there was just a sense that, like everything, everything around me, would make changes or would happen. But I never really thought of God as a single person.

Although prayer was specifically noted to be a religious practice, and was done so as a means to an end, James did not believe any change would be the direct result of God's will or action. Instead, it was likely that change would occur naturally on its own, or as the result of other triggers within his environment, social network, or other contexts which may have impacted on James at the time. Interestingly, James did appear to use prayer in times of need as a coping strategy. For example, he noted that he was not currently praying because he thought his life was "balanced" and therefore he did not need to pray for anything to change. While prayer was still

considered to be an important aspect of his faith, it was only used when James was feeling “down” or when he thought that there was something missing from his life.

As a result of his faith, James had internalized a set of rules which served as moral guidelines. He noted that religious stories with moral undertones about being good and treating others with respect had been taught to him by his Catholic teachers from a very early age. He reported that it was religion that prevented him from hurting himself and others both physically and verbally when he became upset (especially after he became unwell). The Ten Commandments were especially important to James, and he attempted to follow these as best he was able, as he believed that he would go to hell should he break any of these rules. In addition, showing respect and kindness to others, and always being as honest and truthful as possible were particularly significant, as James valued these behaviours and wished to be shown the same considerations.

Loss of Faith

Despite the fact that James participated in religious activities, he reported that he never internalized a belief in God as there were too many types and variations of religious faith for a single entity such as God to exist. Instead, James considered his faith “a matter of course.” It remained however, an important element in his coping mechanisms, and he would use both the social community for support and the values for decision making when he encountered difficulties throughout his adult life. However, James reported that he did not receive any help from the church, despite numerous requests, when he began to struggle with his mental health. He noted that until that point he had looked up to the church and the priests, and felt abandoned when he did not receive the support he desired. He consequently lost his respect for the whole religious institution, and made a conscious decision to stop attending church, and looked for help elsewhere.

Understanding Psychosis

Hospitalization and Diagnosis

For James, the process of acknowledging his illness started when he was admitted to hospital. Before this, he had been “crying” and “getting pretty down;” however, James attributed these feelings to difficulties in his relationship with his wife rather than to any of the symptoms he may

have been suffering in the prodromal phase of what was later to be diagnosed as schizophrenia. James recognized several key issues regarding his illness when he spoke about his first experience of being taken to the hospital.

They came around to my house and my GP came around, and they said, ‘do you want some help?’ And I said, ‘yep.’ But they had the police there; I think that they were going to take me anyway. So they took me to [the hospital] and I went on medication probably straight away. But they didn’t diagnose me for quite a while.

It was obvious that James had several people concerned about him prior to his being admitted to the hospital. He indicated that there was some concern regarding harm to self or others, and the fact that James was immediately medicated upon arrival at the hospital seemed to support the idea that there was some urgency in getting him admitted. Despite all this, and despite the fact that James thought that he did indeed need some help, he still did not perceive any of his behaviour as unusual or out of character prior to this event. Moreover, he stated that while he had been confused at the time, he knew that he did not want to go anywhere with monitored care, but instead wished to stay at home.

Upon admission, James was highly medicated; as a result he stated that he could not remember the length of his stay in hospital. James was able to note however, that while he wanted to leave, he was not allowed to go, and this left him feeling “hopeless,” “helpless,” and “abandoned” as he thought that no one was giving him help. This may have been perpetuated by the fact that James believed the staff struggled to find a diagnosis, as there was an extended period of time before this occurred, despite the fact that he had numerous tests conducted. Moreover, James believed that it was the stay in the hospital that affectively created the opportunity for the development of symptoms.

I always maintained that I was not unwell. But by the time they were finished with me, of course I was unwell.

In addition, James reported that his experience at the hospital was like being “crucified.” Much like Jesus when He was on the cross, James thought he “wasn’t of any use” and was consequently “made an example of” by the individuals he saw as responsible for his being admitted.

Interestingly, James appeared to have based his concepts of “wellness” and “sickness” on the context in which he found himself. For example, he spoke about his belief that he wasn’t ill:

Like, if I was sick, I’d have to stay in hospital until I got well. So I thought that I wasn’t sick, so that I could just keep continuing doing what I was doing. But they had different ideas.

It appeared that James believed that as long as he could maintain a lifestyle outside of the hospital, he would remain healthy. Once he was admitted, he was cued by what would likely have been previously developed ideas about the function of a hospital, and had to concede the possibility that he was sick. Whereas some individuals might have thoughts related to the possibility of ill-health before seeking help, it appeared that James acknowledged his mental illness status only after he was within a context that would generally suggest the presence of a mental health issue.

For the majority of the discussion, James indicated that his experiences with the hospital had been relatively negative; however James also stated that he felt the right thing was done, given the limited resources that were available to him at the time. Moreover, while the medication that had been prescribed appeared to have initially obscured cognitive clarity, James reported that it also helped him get better, and was thus beneficial in the long term.

Symptoms and Triggers

James reported that when he became unwell, he would suffer from paranoid thoughts that other people were out to harass or hurt him. The reasons for this interfering were, according to James, related to his spiritual and religious beliefs and the fact that he was a “non-productive participant in life.” Interestingly, James stated that he thought being idle in life was one of the main triggers to his developing these symptoms. In addition, he noted that being alone would also lead to paranoid experiences. The effects of this paranoia had led James to feel “helpless,” “abandoned,” and “isolated” as he had lost his closest confidant (his wife), and consequently no longer felt safe with other people. It is possible that the isolation that James experienced as a result of his illness cyclically perpetuated his paranoid experiences, given that he identified isolation as one of the triggers to ill health. Other variables that were identified as maintaining factors included the negative relationship that James had with his neighbour, and the fact that James currently believed his paranoia to be justified and legitimate. Interestingly, when asked what paranoia meant to him, James gave the following definition:

Paranoia. It's believing that someone is going to harm you, when actually they want the best for you. It's misplaced.

Despite the fact that James was able to acknowledge the “misplaced” beliefs, he still maintained that a lot of the incidents of harassment against him had occurred. Furthermore, it appeared that James held on to his paranoid thoughts to some extent, believing that it made him more careful and aware of the potential to be harmed by people or situations (such as being hit by a car).

James also reported that he would occasionally receive “messages” from organizations. While he acknowledged that this was likely just advertising, he also stated that he thought these messages had come from particular individuals and were sent specifically for him. The content of these messages was often positive, and helped James in making decisions about his lifestyle, such as taking an educational or employment opportunity. James did not however, conceptualize these experiences as delusions, and noted that he had never experienced such a symptom. He also stated that he had never experienced a hallucination.

Outcomes

James very briefly spoke about his recovery. He stated that he came to understand schizophrenia as a “disease,” a concept which indicated to James that it was a serious illness that he must live with on a daily basis. While James had conceded that this “disease” was just another part of him, he also stated that he “would rather have a heart attack and die than have [schizophrenia].” His recovery had been ongoing, with relapses in both symptomology and hospitalization. In addition, James had experienced the negative affects of stigma associated with mental illness from some of those whom he thought he was closest. He thus attributed the loss of several significant relationships to his diagnosis.

Understanding Relationships

James did not believe that there was a specific relationship between religion and psychosis, and differentiated between the two experiences.

A psychotic belief would be something that’s unobtainable; something that can’t be accomplished. A religious belief would be just something that you’ve been told.

It was clear that James understood religious experiences in much the same way that he understood his own faith; specifically as “just something that [he’d] been told.” It did not appear that James had ever experienced hearing the voice of God or seeing religious entities; however

this may be reflective of the degree and content of his religious beliefs. Alternatively, James defined a psychotic experience as something “unobtainable,” indicating that it was not necessarily a perceptual anomaly, but rather something that was simply unrealistic and inaccessible.

James did not report having any symptoms of psychosis which had religious content or themes. However, James did very often use religious terminology in explaining his understanding of psychosis. He paralleled his experiences in the hospital to those of Jesus, noting that he had been “crucified.” In addition, he spoke about psychosis as a “wake up call” from the “powers that be,” indicating that his symptoms were a cue to get his life together. Finally, there were clear indicators that James had initially used religion as a coping strategy. He reported that religion gave him a “good lifestyle” and “inner peace.” Because of his faith, James knew that mistakes would happen, but that he would always be given another chance if he repented. He perceived psychosis as one such “mistake” and thought that religion would allow him an avenue to attempt to get better. James additionally reported that he couldn’t look after himself without religion. Moreover, despite the fact that James noted the perceived loss of support from his religious community after the development of his mental illness, he reported that he currently wished to become involved again, as his overall view of religion was still generally positive.

CHAPTER FOUR

GENERAL ANALYSIS AND DISCUSSION

Introduction

Despite the fact that the participants interviewed for this study had varied histories, experiences, and presentations of symptoms, there remained commonalities in the conceptual understanding of both religion and psychosis. Interactions between these two variables were noted for all participants. Generally, this interaction appeared to occur as a result of positively-viewed early experiences associated with religious beliefs and practices, and the negative outcomes associated with psychosis. A diagrammatical presentation of the proposed relationships is outlined in Appendix E. Early experiences were viewed to impact upon the development of both religious beliefs and psychotic symptomology; however, these appeared to do so in different ways and through different mechanisms. The specific content of these early events helped participants understand and give meaning to the associated experiences of religion and psychosis. While religion generally served as a framework from which to understand life, it appeared to be particularly useful for participants when the negative outcomes of psychosis were identified; here participants appeared to actively engage previously developed religious beliefs, practices, and attitudes to help cope with and make sense of these events.

The following analysis and discussion summarizes the participant conceptualization of the variables, and proposes possible mechanisms which facilitated the relationships between religion and psychosis. The developmental pathway of religion is first considered, along with a brief discussion on the specific elements which function to maintain current beliefs. The perceived potential causes of psychosis are then briefly discussed in an attempt to illustrate the participant's understanding of disorder. The subjective experience of psychosis is considered, and the negative outcomes identified by participants are discussed. Finally, the way in which religion and psychosis were identified to interact is outlined. Literature relevant to these matters is also considered, and where gaps in the literature remain, possible directions for future research are identified.

Understanding the Nature and Function of Religion

Developmental Pathways

The development of religious beliefs in children and adolescents has been linked to the Piagetian stage model as well as social learning and attachment theories. Thus, the development of an internalized faith is seen to be a result of the interactions between family relationships, individual cognitive development, social context, and the passing of time (Paloutzian, 1996). These theoretical constructs are relevant to the current study to the extent that they inform an appreciation of the specific factors which both facilitate the initial development of religious practices and continue to maintain current beliefs.

Considered together, the findings from the current study appear to support the developmental process proposed in the literature. Taking from both social learning and attachment theory, family relationships are noted to be a necessary factor in the initial stages of religious development, during which time the child essentially imitates and models those practices in which the parents partake (Paloutzian, 1996). With rewards of reinforcement, the child becomes more likely to repeat these behaviours in the future. David, Mark and James all reported that they had been brought up within religious families, and had been influenced in their religious development by the attachment figures from within these relationships. Alternatively, both Paul and Richard reported that, for them, the development of religious beliefs as an individual and internal process. Interestingly however, both these participants also identified at least one individual with whom they had a significant relationship which consequently helped foster the development of an internalized faith; for Paul it was his grandmother, whom he was very close with when he was younger, and for Richard, it was Margaret, the woman who later became his wife. Given there is very little literature relating to religious development in general (Paloutzian, 1996), it was not surprising to find that there was no information relating to the effects of significant relationships other than those of attachment figures on the development of faith. It is proposed that this is an area that would benefit from future research to determine if the factors suggested in attachment theory are generalized to broader social relationships. If these are not, it would be beneficial to understand what factors specifically facilitate the development of religious beliefs.

Literature also notes that the young individual's beliefs are initially very simplistic as the cognitive capacity to understand abstract concepts is generally absent until the age of twelve (Hood, et al., 1996). Language and emotion are essential components of understanding at this stage; however as words have not yet been associated with the necessary repertoire of experiences to allow for a comprehensive structure of meaning, perceptions remain concrete in nature (Paloutzian, 1996). The general principles, practices, and non-physical entities associated with religion are therefore initially limited to literal representations and habitual, rather than meaningful, behavioural patterns. Participants also identified this pattern in their own experiences, reporting that early beliefs were one-dimensional and often unsophisticated.

(Richard): As a youngster, [my beliefs were] very simplistic. [...] Good people go to heaven. Bad people go to hell. Simple as that.

(James): We were brought up when we went to church every Sunday, went to confession. It was more a matter of course than believing that there's a God.

Finally, social context has been reported to either help or hinder the continued development of religious faith, as the individual begins to explore the greater social community (Paloutzian, 1996). With the commencement of school comes curiosity regarding the experiences of others. The exposure to a variety of belief systems that differ from his or her own, coupled with continued cognitive development during adolescence, promotes challenges to the religious teachings from childhood. Thus, it is not uncommon for individuals at this age to deviate from religious practices (Hood, et al., 1996; Paloutzian, 1996). Of the five participants from the study, Paul, Richard, and Mark all reported deviating from their religious beliefs for a short period of time during adolescence. The desire to participate in new experiences and the influence of peers with different religious backgrounds were both cited as reasons for this departure for all three participants.

(Richard): Young boys are young boys; they get into trouble and do stupid things like drinking alcohol and getting in a car, and being around girls. I was never extroverted, I was introverted. But mixing with boys who were surfing boys and good looking, and the whole distraction of a teenage thing was a total distraction from having anything to do with religion or anything like it.

(Paul): I remember being in high school and thinking to myself that I wanted to continue with this religion thing, but I thought that it was something that you got when you got older. And I sort of panned it all out; I was going to make this decision when I got older and I was going to live life up until then, and just go off the rails and have fun. And to a certain extent I did I guess. [...] I guess a lot of it had to do with youth. Just peer pressure; wanting to do what my brothers were doing and what my friends were doing, and just wanting to rebel a bit I suppose.

Given the aim of the current study was to explore the nature as well as the function of religious beliefs, it was considered important to understand the developmental pathways through which these beliefs were cultivated. As reported by Paloutzian (1996), the religious commitment of an adult has been related to the extent to which religious beliefs were practiced in childhood and adolescence. As noted previously, the consideration of religion as a developmental process highlights the fact that it is not something that merely “happens” to an individual. Instead, much like many other psychological variables, religious beliefs can be either positively or negatively influenced by expanding cognitive capacities and social environments.

Personal Conceptualization of Religion

While variation in social history and denomination existed across the participants, there were clear defining features regarding the concept and purpose of religion. Despite the enormous amount of data available, general themes became apparent. The information provided could have been broken down into elemental categories; however, the entities, practices, values, and emotional outcomes associated with religion were interwoven so extensively that they have been considered together. Each component of religion appeared to serve a function; however together these elements strengthened the broader concept of religious commitment. While the current study explored the nature of religious belief, it was thought more important to understand the function of these beliefs, as reported by the participants. The following section therefore only briefly reports on the elements which contribute to a broader conception of faith; the exploration of subjective experience is considered in much more detail. Overall, findings suggested that the aforementioned concepts appeared to provide the basis for the framework which facilitated explanatory models.

Features

Paloutzian (1996) reported that when conducting an analysis of a phenomenon such as religion, it is often beneficial to start by describing what the phenomenon is in terms of thoughts, feelings, and actions. Both Hood, Spilka, Hunsberger and Gorsuch (1996) and Paloutzian (1996) have provided models for this purpose. The data from the current work found that participants did in fact use a dimensional approach when discussing religious commitment. Particular areas which were covered included beliefs (particularly those related to religious entities), practices, values,

and to some extent, emotional impact. However, the way in which these areas were discussed may have been influenced by the direction of the researcher, and this was certainly a limitation of the study (and as such, will be discussed in further detail in the following chapter).

All the participants identified God as the central ethereal entity or symbolic figure of their faith. Individually, the participants described Him as “warm,” “lovely,” “all-powerful,” “awesome,” and “holy;” however, across participants, His defining and most significant characteristics were demonstrated in the way He was portrayed as a “father.” All the participants reported believing that God “watched over” people and both guided and monitored morally-related cognitions and behaviours. His love was viewed to be unconditional, irrespective of whether or not individual behaviour was negative or positive. Paul and James specifically identified that He was an “overflowing entity” and could thus be present in different places simultaneously through different forms of being, such as the Father, the Son, and the Holy Spirit. The participants also all identified Jesus as an essential religious entity; in contrast to God however, they spoke of Him as a real person, despite His influential characteristics and otherwise similar nature. Only David and Richard discussed the defining features of the devil, and these discussions remained quite limited and concrete. While David perceived the devil to be responsible for negative and immoral thoughts and behaviours, Richard reported that while he believed a dichotomy of good and evil existed, the devil was not as strong as God, and therefore had little affect on individual behaviour.

The religious practices most commonly identified throughout discussions with participants included prayer, reading scripture (the bible), and listening to sermons (also referred to as the Homily or mass); additional activities which were also integrated into religious practice involved confession, communion, singing hymns, and saying a daily rosary. Both Paul and David spoke about the ritual of “giving [their] heart to the Lord.” Despite the fact that both participants indicated that this was a single act or declaration, it appeared that it signified a change in the strength and frequency of religious beliefs and practices respectively. Paul described what the experience was like for him:

Even before I went to that meeting, I had already decided before we even got in the car that I was going to give my heart to the Lord that night. Just because I had the openness to do that. And it was something I had seen reflected in different people around the community that had an act of vibrant faith and that was something that I wanted for myself. [...] It was definitely, definitely a sort of a, a hallmark if you like. A definite point of, well, a change of direction, change of course.

All participants indicated that religion provided a moral code or “manual for living” (Richard). Values associated with religion included those often cited in the Ten Commandments or in scripture, such as “do unto your neighbour as you would have them do unto you,” “honour your mother and father,” “do not be a false witness,” “do not murder,” “do not steal,” and “do not covet.” All participants identified that the moral guidelines provided by religion served to function at an individual level, supporting research in this area that cites increased individual prosocial values as an outcome of religious beliefs (W. K. Mohr, 2006). In addition, Mark also reported that he saw religion as the “moral glue in society” that ensured that people did not revert to “basic” and “savage” ways, thus lending support to the concept that religion also functions at a societal level to reinforce interpersonal behaviour and social relationships (S. Mohr, et al., 2006).

Function

While the above elements of religion were discussed separately by participants, it was clear that these interacted and produced a cohesive and comprehensive concept of religion. In general, participants identified that the motivation behind participation in religious practices and values was related to achieving and maintaining a relationship with God. David and James discussed how participating in religious practices was a behavioural expression of love for both God and the members within the religious community. These practices also served to promote positive interpersonal relationships with others, which was viewed as important within religious values.

Paul described the concept of developing a relationship with God in the following way:

[It's] trying to be as close as you can to resembling the maker or the creator. And trying to be transformed into His likeness; to be transformed and to grow and develop and mature. And it may not mean that you do the same sort of miraculous stuff that He did, but the personality and the characteristics, the character and integrity that you want, and all that sort of good stuff is there.

It appeared that participants viewed the symbolic figures as character representations of acceptable cognitive, emotional, and behavioural expressions. Both God and Jesus were viewed as exemplary entities, and participants identified wanting to model their own behaviour upon that of these individuals. In this way, the concept of religious entities seemingly facilitated the development of a framework for acceptable personal behaviour. Moreover, these symbolic figures served to enforce religious guidelines and morals. All participants noted the possibility of repercussions and consequences from God and the devil should behavioural expressions not meet the expectations of these entities. Not surprisingly, the ways in which these enforcing figures

would facilitate change was very different. It was generally found that God would “guide” behaviour, which was drastically different to the devil who would impose negative consequences and outcomes upon the individual.

Moreover, it appeared that it was through this relationship with God that individuals were able to derive a sense of service to others, both human and ethereal. This would appear to support the assumption that increased meaning in life, defined as subjective feelings of significance, can be an outcome of religious belief (Steger & Frazier, 2005). Moreover, the nature of this relationship supported individuals in disclosing and repenting for perceived wrong-doings without judgement; for participants, this likely facilitated a sense of security as well as self-control and responsibility for individual behaviour. As identified by Hood, Spilka, Hunsberger and Gorsuch (1996), the defensive/protective theory of religious beliefs assumes that religion provides a sense of mastery over personal needs of meaning and control. The findings from the current research therefore, appear to support this proposition.

Overall, it appeared that religion served to function as an orienting framework from which individuals could approach social and interpersonal relationships as well as difficult and seemingly unanswerable questions and situations.

Understanding Experiences of Psychosis

Perceived Causes of Psychosis

There were several common experiences that were identified and recognized by participants as predisposing factors or precursors to illness. These were generally grouped into two categories, which included internal attributes and external attributes. While it was important to consider these issues, the following discussion remains relatively brief, given that the objective of the study was not to understand participant concepts of aetiology, but rather to understand how the current experiences of psychosis were being conceptualized.

Internal Attributes

Of the five participants, three clearly attributed internal variables to their experiences of psychosis. Paul and Richard discussed shy personality styles apparent from early childhood and youth in relation to their illness.

(Richard) And as I said, I was a late developer; reserved, awkward, shy, immature. All those things. The triggers.

Both participants specifically identified introverted personality styles, as opposed to the more extroverted type, in their explanatory model of the development of psychosis. Interestingly, these traits were viewed to have changed over time and as a result of experiencing psychotic symptoms, such that both Richard and Paul saw themselves as more extroverted after experiencing their first major psychotic break. In addition, while Mark did not specifically identify that he had been shy as a child, he did speak about personality changes after the onset of his illness.

(Paul) But I was very introverted as a child and very quiet, very withdrawn, and I would hardly talk to anyone about anything. And that included my parents, even to some extent close friends, that I had one or two of, my old friends, I wouldn't really talk about my feelings with anyone or even my brothers; this is what it seems to me looking back anyway. And, certainly my school reports would back that up. A lot of them said that I was shy and didn't ask questions and so forth. And so at the point at my first breakdown, that all changed. I underwent quite a transformation.

(Mark) I'm a little bit more outgoing, and a little bit more happy to be so. [...] Part of it's a growing up type of thing, part of it is becoming more normal, part of it is being accepted by others.

Interestingly, while Paul and Richard identified these specific personality traits in their discussions, it did not appear that they necessarily saw these factors as directly responsible in the development of psychosis. Instead, personality characteristics appeared to be influential for these participants to the extent that they impacted upon the way in which these individuals approached the world. Alternatively, for Mark, there appeared to be clear mechanisms which facilitated individual change, and while some of these were related to experiencing symptoms of psychosis, others were related to external factors such as the passage of time, or the perceptions of others.

In addition, both Richard and Mark reported feelings of guilt over perceived wrong-doings as related to symptom presentation. For example, Richard discussed his experience of hearing the voice of the devil in the following way:

And one of the things that completely blew me away, and completely stuffed me up for a long time afterwards, that voice that I heard when I became unwell that said, '*you are the devil so do the world a favour and kill yourself.*' I really thought that was true because I had gone to a caterpillar warehouse and I stepped over this woman and a child; they were just lying in the dust. And they were absolutely in the most shocking state in an industrial part of town where there were no houses. And women over there are treated really despicably. I stepped over them, I went and got the part, and came down, stepped over them, and thought nothing of it. And when I became unwell, it just haunted me and haunted me that I could do that. I had a huge amount of money on me at the time; I just didn't do anything. I couldn't believe that I could be so callous, that I was capable of doing that.

Alternatively, Mark associated his paranoia with guilt regarding a family secret and a perceived shameful encounter of a sexual nature. His fear that others would find out about this event was thus understood as the basis for his paranoid beliefs. These results support findings that previously experienced personally traumatic events may result in negative emotional states that can influence the content of symptomology (Andrew, et al., 2008; Read & Argyle, 1999; Read, et al., 2004). This alternatively has implications for psychological treatment. This finding highlights how conducting an analysis of client perceptions of content in symptomology may elucidate previous traumatic experiences that may be causing the client distress (Read & Argyle, 1999). Moreover, it provides evidence for the application of the cognitive-behavioural model of psychosis in which the interpretation of symptoms is influenced with core cognitive schemata developed from previous social experiences. The use of cognitive-behavioural techniques would therefore be appropriate in attempting to target dysfunctional beliefs and behaviours surrounding the trauma experience (Andrew, et al., 2008).

Another factor that was considered to be an internal attribution included perceptions about the self; Mark, for example, reported thinking that there was something wrong with him from the time he was young. Mark also noted that he felt he lacked a sense of identity, which often meant that he would feel uncomfortable around others, and would thus retreat both socially and emotionally.

External Attributes

While internal attributions focused primarily on distressing experiences and consequential negative emotional states, the participants identified a range of external factors that were perceived to be causally linked to the development of symptoms. Factors which were indicated by more than one participant are included in the following list: increased stressors prior to the

onset of symptoms, drug and alcohol consumption, unemployment and financial difficulties or changes in employment, and loss of a stable social network (prior to the development of disorder). The identification of several psychosocial variables aligns with the research in this area that suggests a number of predisposing variables or triggering factors may influence the presentation of symptoms (Sadock & Sadock, 2003). One implication of this finding might relate to educational endeavours which would attempt to inform those who have been identified as at risk for developing psychosis on the potential predisposing factors.

Overall, it appeared that all participants attributed a multi-factorial causal model to the development of psychosis, which is supported in the clinical literature on this topic (Sadock & Sadock, 2003). Mark summed up this belief very clearly:

I wonder myself if really there's just one illness, or maybe it's just more complex, because the brain is complex and if there's different pathways that are being forged through the brain for people to think along a certain track, or there's certain chemicals that are being discharged in the brain that are altering its biochemistry so it's no functioning at the so-called normal mode, or whether there are cultural factors that are sort of throw-backs to the past when such a person could be accepted because they would have said, '*oh, he's listening to the spirits, so we better not harm him*' or '*we better not disturb him because he's hearing what the spirits are saying to him.*' There's all these different things that are unknowables at this time.

Features of Psychosis

Much like religious beliefs, there was heterogeneity in the presentation of schizophrenic symptoms. While some participants identified several episodes in which positive symptoms were present, others denied ever having such clinically-defined experiences. In addition, for some there appeared to be variance in the content and themes both within and between psychotic episodes, while others appeared to have experienced one main symptom, which was associated with a particular belief. The consequences and outcomes of psychosis were also discussed by all participants, and these were most generally identified as negative in nature.

With the exception of David, all participants reported experiencing delusions; of these individuals, Paul, Mark, and James noted that this type of symptom most commonly presented in the form of paranoid beliefs, a finding that supports the notion that paranoia is one of the most common symptoms of psychosis (Bentall, 2003). In addition, David, Richard, and Mark discussed hallucinatory experiences in which they heard voices. Only Paul and Richard

experienced symptoms with strong religious content and themes; however all individuals used religious terminology in the description of their psychotic episodes.

Despite the above information, the process of identifying the common features of psychosis was very difficult for this population, as the focus was on the subjective experiences associated with psychosis; thus it was not surprising that reports of symptoms varied to a great extent. Moreover, while the majority of the participants acknowledged episodes of psychosis, these were often reframed, and the symptoms were either normalized and explained in terms of everyday experiences, or defined as an experience which was primarily religious in nature. While seemingly clinically relevant, the presentation of symptoms was not always perceived as such by the participant, and therefore difficult to define in categorical terms. An example of this was David's discussion about his ability to "speak in tongues" or Mark's description of his mind in a "visual mode."

(Mark) I wasn't hearing voices, and I wasn't seeing things. But my mind was in a visual mode, and I was seeing certain things that other people wouldn't see. ... I gave up on my art, but what I found out was that the whole part of me that was visual had not outlet to it. ... But I've always had a fairly photographic memory, so I mean, that doesn't really mean anything to anybody unless you can actually exercise it. So I spent however long not doing any art, not drawing, and as such, yeah, I maybe had a visual thing happening.

It was also found that many of the participants did not have a clear concept of schizophrenia in terms of general presentation and symptom description, which may also have contributed to the difficulty in identifying specifically clinical symptoms. Mark and James both discussed their experiences of being diagnosed:

(Mark) It wasn't until I [had several negative experiences] that I was given a diagnosis. But I don't know, they didn't tell me at the time, I don't remember anybody telling me anything about that. It wasn't until I got back [home] they started talking to the doctors about schizophrenia.

[...]

And somebody said, I think the doctor said, '*oh, your diagnosis is schizophrenia.*' But I had to really look up in the books and find out what that meant. Nobody told me what that meant.

(James) Tell you what, the bit that's got me now to tell how ill I am: I looked it up in the dictionary and it's got, '*is a disease.*' [...] Schizophrenia. So I'm thinking now, "*oh man, this is serious; this is something serious.*"

For these individuals as well as the others, it appeared that information regarding their illness was not clearly delineated during the diagnosis process. This seems particularly concerning given that the outcomes of schizophrenia can be dangerously debilitating and have severe impacts upon cognitive functioning (Regan, 2008).

Outcomes of Psychosis

Participants identified several outcomes of their experiences of psychosis, which existed at both individual and social levels. Richard discussed how the very nature of psychosis was traumatic in that it was debilitating and invasive, and negative emotional states would often occur. David further supported this account as he noted that changes in core identity, personality, and behavioural expressions caused him significant distress. The detrimental side effects of medication were noted to affect all participants, and this additionally contributed to the motivational and emotional difficulties. Finally, Richard, David and Mark all identified the perceived stigmatization of the disorder as a particular struggle in terms of disclosing information and coping strategies.

Relationships and Interactions between Religion and Psychosis

For all participants, religious beliefs had developed prior to the onset of psychosis. While some participants were able to identify experiences in their youth that may have influenced the later development of schizophrenia, not one participant identified religion as a possible causative factor for this illness. Instead, relationships were positive in nature and generally helped the participants understand and cope with the disorder. The associations between religion and schizophrenia were categorized into three general groups, which included religion in the content and themes of symptoms, religion as a meaning system, and religion as a coping strategy.

Content

Literature and research on the content of psychotic symptomology has found that themes related to traumatic early experiences are often present (Andrew, et al., 2008; Read & Argyle, 1999). Initially, the very nature of the symptoms of psychosis was considered to be traumatic and distressing; recently however, the application of the cognitive-behavioural model to experiences of psychosis has suggested that whether or not the symptoms are perceived as negative or positive depends on the beliefs and emotions associated with the experience (Andrew, et al., 2008). Further, these responses are generally related to both past and present events and interpersonal relationships (Andrew, et al., 2008). The consequences of these theoretical models and empirical research have implications for the way in which psychosocial variables are considered for assessment and treatment. Generally, research has focused on traumatic events

only, and neglected other psychosocial variables which may serve as protective factors in the perception of symptoms. Thus, the religious content of symptoms was considered important to explore in the current study to determine if any such relationships existed.

Presence of Religious Themes

Despite the criteria for selection, only two of the participants in the current study discussed experiencing religious-themed symptoms; this outcome was a direct result of difficulties encountered in recruiting participants, and is further discussed in the limitations section which follows. In addition, given the small sample size, it was difficult to determine if early experiences of religion influenced the content of current schizophrenic symptomology. While both Paul and Richard identified strong aspects of religious symbolism in the content of their symptoms, it could not be stated with any degree of certainty that these were the direct result of religious experiences from childhood and youth. Indeed, there was no specific evidence that supported the idea that the content of religious experiences would be replicated in the psychopathology of the participants, as it often is for individuals with traumatic early experiences such as sexual or physical abuse (Andrew, et al., 2008; Read & Argyle, 1999). Wilson (1998) notes that religion has little to no aetiological significance in the development of psychotic symptoms. However, this belief is based upon the assumption that schizophrenia is essentially biologically determined. Alternatively, other authors, such as Bentall (2003), discuss the effects of psychological constructs such as emotion, and indicate that positive symptoms are likely to worsen when individuals are emotionally stressed. Taking these findings into consideration, one could interpret the results of the current study as an outcome of religious experiences from childhood and youth generally being viewed positively, and thus having little impact upon emotional states present in symptoms.

Given that research on the content of psychotic symptoms has generally focused on traumatic and negative experiences, it would be beneficial for future research to address how positively ascribed experiences contribute to the content presentation. Moreover, as the current study could not definitively identify that religious experiences were influencing the content of the symptomology, it would be advantageous to conduct future research to address this issue. Such a study might involve using a quantitative approach in which samples of religious and non-

religious individuals reported religiously-themed content. If early religious experiences did impact the content of symptomology, then it would be expected that those individuals who had a religious history would express higher levels of religiously-themed symptoms compared to controls.

Despite the above, there was evidence to suggest that religious experiences had generally affected the way in which both Paul and Richard conceptualized the content of their symptoms. Paul reported that at the time of his first breakdown, he saw an “evil spirit” in the eyes of his uncle, and had since maintained the ability to see other spirits the eyes of those around him. Alternatively, Richard had experienced delusions in which he believed he was either Jesus or the devil, and hallucinations in which he had heard religious voices or had seen large, colourful religious symbols in front of him. Both participants attributed the causal mechanisms of these experiences to religious entities or concepts, as described here by Paul:

It is a spiritual gift, and it's called discernment. With a Christian, every Christian should really have the ability to go and identify people who have spiritual entities that are inside them. Just, um, it's hard to describe, but just something about the eyes are really the window to the soul, and you've probably heard that expression before, and you can see, looking into people's eyes that, um, almost benevolence looking back at you of an entity which is a representation of Satan in people. It's just, it's sort of known that the presence is there, and you can't really give it characteristics and say, '*the eyes look this way, the eyes look that way,*' it's just sort of an impression.

Interestingly, both Paul and Richard also identified that while they were actively psychotic for the duration of these experiences, the experience itself was understood as one that was religious in nature.

(Paul) A lot of distorted reality really, and just sort of going off on a tangent. I guess the lines were open to the spiritual realm in a way that isn't healthy for us humans to really see.

(Richard) I'm psychotic, probably mildly at this stage, a little bit better than I was earlier in the night. [...] I swear that this is the truth; you don't have to believe it because you're not a Christian and you won't understand it. A warm hand came out of nowhere, and I don't know where it was from, who's hand it was, but a warm hand came out and was placed just on the side of my face. There was no one else in the room. I've had a number of experiences like that.

Neither Paul nor Richard was able to identify specifically what aspects of these seemingly “mixed” experiences resulted from schizophrenic symptoms. Instead, both individuals perceived the experience of psychosis as an alternate pathway to religious encounters with entities that would have otherwise been imperceptible, as discussed here by Paul:

I actually think that a better, another way of putting it too, it's the brain chemistry going awry, but it's also having an awareness, a perception of the spiritual realm, and having your eyes open to things that you probably shouldn't have your eyes open to. Stuff going on, and just kind of seeing more than what I was probably every designed to see.

This finding aligns with the work of Drinnan and Lavender (2006) which demonstrated that individuals with religious beliefs and psychotic symptoms use both a model of illness as well as religious attributions in an mutually inclusive way to understand their personal experiences of psychosis. An alternative theoretical position suggests that religious attunement, such as that demonstrated by the experiences and explanatory models of Paul and Richard, may provide an evolutionary advantage of schizophrenia (Rogers & Paloutzian, 2006). The authors provide the following argument:

Individuals with schizophrenia may have a unique ability to tap into a possible spiritual realm and to experience the divine via hallucination, delusion, and anomalous perceptual experiences in a way that may have contributed to its endurance. [...] Therefore, the boundaries between the human and the divine may be significantly more blurred for those with schizophrenia, perhaps in a way that provided a historical advantage (Rogers & Paloutzian, 2006, pp. 173-174).

Paul gave the following account of his conceptualization of experience:

I actually think that a better, another way of putting it too, it's the brain chemistry going awry, but it's also having an awareness, a perception of the spiritual realm, and having your eyes open to things that you probably shouldn't have your eyes open to. Stuff going on, and just kind of seeing more than what I was probably every designed to see.

Interestingly, this model of religious attunement clearly identifies the presence of both spiritual and clinical elements in schizophrenia, thus reiterating the approach suggested by Drinnan and Lavender (2006) in which religious and illness explanations can be used concurrently.

It is worthy to note that while Paul and Richard were the only two participants to experience religious-themed symptoms, they were also the only two to discuss how religion can be taken to extremes when experienced by individuals with psychosis.

(Paul) I guess, well, everything was kind of just distorted and I just wasn't thinking clearly. I was, perhaps when I was reading the bible I was looking for specific versus and perhaps even taking them a bit out of context the ones that I did find.

(Richard) Things can really go wrong in religion, and [some of my experiences] are clear examples. So I'm really aware of it, and that's why I think that it's really important for people like me to have a really moderate viewpoint.

This finding may be supportive of the theoretical work of Fuller-Torrey (2006) and Paloutzian (1996) who both suggested that religious practices may impact upon the mental health of some

individuals. As noted previously, Richard had reported that he was aware of the impact of daily occurrences on the content of his symptoms. It may be that the process of actively engaging in religious practices on a regular basis increases the relevance and salience of this matter. In such a case, it could be hypothesized that the consistency and intensity of faith would increase the probability that religious themes would be present in psychotic content. If this were the case, it would also be more likely that themes would present in both negative and positive contexts. However, future research would be required to determine the mechanisms through which religion acts as a beneficial or detrimental factor.

In considering the process of identifying the presence of religious content in schizophrenic symptoms, special attention and reflection was given to David's case. David reported an ability to "speak in tongues" which, when considered outside of the religious context, may have presented as similar to symptoms associated with psychosis (Fuller-Torrey, 2006). However, David clearly identified that this ability was perceived to be religious in nature, given that it occurred within a religious context, and was controlled to a certain degree by specific religious practices. David's ability to speak in tongues very clearly fits the "charismatic" classification outlined in Donovan's categorization of spiritual experiences (as cited in Eeles, et al., 2003). This would appear to provide support for David's conception that his experience was religious in nature and not a symptom of psychosis. As previously stated, Jackson and Fulford (1997) reported that psychotic phenomena can regularly occur within a religious context, and not be considered symptoms of a more general mental illness. The authors further found that distinctions between spiritual experiences and positive symptoms associated with psychopathology could not be made reliably on the basis of form, content, relationships with other symptoms or pathological causes, or descriptive criteria such as those provided in the "medical model" of health. Instead, distinctions are made based on the way in which the person experiencing the phenomena generates meaning from previously-established values and beliefs (Jackson & Fulford, 1997). Thus, the subjective understanding of the ability to speak in tongues was made in reference to David's religious beliefs, and consequently perceived as spiritual in nature. Given this appreciation of perception, it would have been erroneous to attempt to understand these episodes as related to the clinical presentation of schizophrenic symptoms.

Absence of Religious Themes

The remaining three participants (David, Mark, and James) did not report experiencing any specific religious themes in their symptoms. However, the absence of this type of content was not viewed as evidence that religion did not affect these individual's perceptions of their presentation. On the contrary, it was found that all three participants used religion to understand their symptoms, and in many cases compared the cognitive, emotional, and behavioural outcomes of schizophrenia to those which may have been experienced by religious entities. This provided the basis for the concept of religion as a general meaning system which provided a way of interpreting and normalizing what would otherwise be considered psychotic events.

Religion as a Meaning System for Making Sense of Psychosis

Participant reports substantiated the conception of schizophrenia as an invasive, chronic, and debilitating illness, which affects social, occupational, familial, and cognitive functioning (Regan, 2008). It was clear from the responses, that experiencing and managing such an illness was often challenging, distressing, and generally arduous. The process of dealing with both the positive symptoms and negative consequences of schizophrenia relied on each participant's ability to develop a personally relevant and meaningful understanding of the illness (Bentall, 2003; Geekie, 2004; May, 2004). According to Rogers and Paloutzian, a meaning system can be understood as "a cognitive structure that allows for abstraction, generalization, and representation of a relationship or relatedness between two entities" (2006, p. 163). The authors posit that such a meaning system is more actively engaged during stressful periods of an individual's life. When disturbing or concerning information is present, appraisals are made which determine whether or not the information is consistent or inconsistent with the underlying model. While congruent information is incorporated and thus strengthens the model, incongruent information evokes reappraisal and reconstruction. Thus, discrepant information can be rejected or it can be retained and used to modify the underlying and global meaning system. Furthermore, new meaning is constantly developing as the pre-existing model interacts with new information (Rogers & Paloutzian, 2006). Religion can be observed to provide such a system given that it includes:

A global meaning system that serves as an overarching umbrella subsuming beliefs about the divine-human relationship, global goals and values, and a subjective sense of meaningfulness – a sense that, at the end of it all, there is continuity and the self and community are included in it. This system enables individuals to evaluate everyday events, such as whether a behaviour is consistent with one's beliefs, if a communication or event can be attributed to God, or if an

event that follows a prayer constitutes God's divine answer (Rogers & Paloutzian, 2006, p. 163).

There was evidence to suggest that this theoretical supposition was applicable to the current study, as all participants appeared to use their religious beliefs in explaining and understanding their symptoms, although notably in slightly different ways and to various extents. David, Mark, and James, evidenced this meaning system through the identification of religious concepts and terminology, which were used to describe and explain personal experiences. For example, both David and Mark used religious beliefs to identify the causes of psychosis.

(Interviewer) Where do you think [the voices] came from?

(David) From the devil.

(Mark) And when I get [to the hospital] I sit in the booth where they have the interview and then I come out into the ward and I'm hearing voices everywhere saying this, that, and the other. And I'm thinking, *'well, everybody knows my deepest, darkest secret now.'* And I've only done this because I said to the Lord, *'Lord, if I'm going to suffer for my sins, let me suffer here on earth.'* It wasn't just bringing myself into disgrace; it was bringing my family, people at church, my flatmates, everybody that I was bringing deep into disgrace as well. Especially with all the news that goes about the Catholic Church. Which is not a good look for anybody in my case. It was like an exposure, and strangely enough, it's only been since I've gone through that that I've been able to grow as a person.

While David understood the voices he was experiencing as the direct result of the devil's work, Mark perceived his symptoms as the result of God granting him a personal request. Interestingly, despite the differences in directionality, it appeared that when these participants used a religious attribution to explain the symptoms, the experience was given meaning, and consequently alleviated the distress associated with the more debilitating understanding of psychosis as an illness or disease. Thus, it was found that even though religion sometimes provided a negative connotation for the explanation of symptoms (such as in David's case where these were understood to be caused by the devil), it remained beneficial in psychological outcomes. This finding aligns with the work of Mohr, Brandt, Borrás, Gillieron, and Huguelet (2006) where it was reported that such associations helped participants accept illness, or contributed to the mobilization of religious resources, such as individual coping strategies and social support. Additionally, this finding may also provide support for Koenig's (2002) theoretical model in which religion serves as a framework that helps individuals conceptualize events as not occurring at random. The defensive/protective explanation of religious belief (Hood, et al., 1996) also appears to be supported from this research. This model proposes that given the presence of negative emotional states, such as anxiety and fear (evident in the above participant descriptions

regarding the outcomes of psychosis), an individual will use religion to regain frameworks of meaning and a sense of control.

Despite the fact that James did not attribute religious factors to the causal explanations of his psychotic experiences, he evidenced a religious framework by discussing these episodes in reference to religious terminology:

(Interviewer) Did religion ever feature in any of the symptoms that you were having?

(James) Yep. Like, I felt that I was crucified. [...] I felt that I was made an example of. Or, just my, I wasn't useful anymore. I wasn't of any use. [...] I felt helpless. When I was, yeah, just feeling helpless. There's nothing you can do, it's the end of the road, why was I there? What did I do to get locked up? Nothing. So that's why, like Jesus got crucified and he didn't do anything.

It is assumed here that an individual would be unlikely to use religious terminology, if religious belief were not a part of the individual's world concept. It would appear to follow that the presence of religious beliefs would thus serve as a framework to understand experiences, irrespective of whether or not causal explanations were religious in nature. This however is a hypothesis that would require further testing. Alternatively, as described above, both Paul and Richard reconceptualized experiences in terms of the concept of religious attunement (Rogers & Paloutzian, 2006).

A finding that was not intentionally sought out, but was evident nonetheless, was the relationship between the strength of religious beliefs and the extent to which these beliefs were used to understand experiences of psychosis. While all of the participants noted a religious background, there were certainly degrees of religiosity noted even within the five participants. Paul, Richard, and Mark all displayed relatively robust religious beliefs, practices, and knowledge, and, when compared to the other two participants, were better able to clearly delineate the aspects of faith that had impacted upon their understanding of psychosis. Moreover, these three participants all reported that their religious beliefs had continued to develop and intensify through the experiences of psychosis and the process of recovery. Alternatively, for David (who went to church for "something to do") and James (who had lessened his religious practices as a result of not receiving support from the church), the data to suggest that religion was used as an explanatory model was less evident. Considering participant presentations, confounding variables such as personality traits and cognitive deficits may have also impacted upon this

relationship. Future research which controlled for such variables would be beneficial therefore, as the relationship between the strength of a given belief and the probability of using this belief as an explanatory framework would likely have implications for the use of cognitive-behavioural models in the treatment of psychosis.

An additional area that also remained unclear was the extent to which the participants used religious beliefs consciously versus unconsciously in the understanding of psychotic symptoms. If considering the overall experience of psychosis, it could be assumed that religion was used unconsciously, given that it served to facilitate casual explanations and provided personally relevant meaning to individual experiences. In this case therefore, religion would act as the underlying meaning system, which, in addition to understanding psychosis, would more often serve the broader function of understanding life (Rogers & Paloutzian, 2006). Alternatively, the negative outcomes of psychosis more likely required a conscious decision to use religion, as it was typically these that required the use of an active coping strategy. Harrison, Koenig, Hays, Eme-Akwari, and Paragament (2001) note that despite the prevalence of religious coping, there are very few empirical studies which identify the antecedents to this strategy. Again, future research that endeavoured to identify the specific mechanisms through which people come to use religious beliefs or practices would be beneficial. Such research could influence the development of strategies that would help clients experiencing psychosis cultivate active and conscious strategies which could then be used to alleviate distress associated with symptoms.

Coping Strategy

It was obvious that all five participants used religion as a coping strategy to deal with the symptoms and outcomes of psychosis that caused them distress. Moreover, there appeared to be a variety of ways in which religion was able to facilitate this endeavour. Paul discussed his perception of the benefits of religious beliefs:

I'm not religious because I have a mental health illness, and it's not the other way around either. I think it's just one of those things that Christians aren't immune to. And it's certainly a coping strategy and I'm not even afraid to use the term 'crutch,' but it's certainly more than that too.

Similarly, Mark acknowledged the support that he was able to gain from his faith:

That's my safety factor. Like someone on a plane has a parachute, or someone on the sea has a lifejacket, you know? So I feel that I can believe in the church, I can have faith in what the church teaches, and I do become part of a religious community.

It appeared that the very nature of religion provided support for these individuals. Moreover, religion provided access to a community of individuals who shared the same values, and were willing to offer social support. The nature of the relationship with God, as reported by all participants, likely furthered the idea that support could be gained through the church. Furthermore, as noted previously, Steger and Frazier (2005) have reported that the active participation in religious activities serves to increase perceived meaning in life, which subsequently facilitates improvements in subjective well being. Although this variable was not directly assessed for the current study, it did appear that the involvement in religious practices positively impacted upon the participants.

For Richard, religion was also used as a distraction technique. Here, Richard reported that participating in prayer or reading scripture would often result in his positive symptoms abating. It was unclear the specific mechanisms which allowed for this phenomenon, and, again, future research would be required to identify to what extent distraction serves to alleviate the symptoms. However, the results of such research would likely have implications for the way in which such symptoms may be treated. If an individual was able to control the extent to which positive symptoms impacted upon daily functioning, (ie. used distraction techniques to cope with active symptoms), then this could mean that the use of pharmacological techniques, which have been noted to have negative side effects, would be less necessary. In addition, Richard also noted that he would often use scripture to "beat the voices." To this end, he would find an excerpt that would contradict the content of the voices; for example, reading scripture that specifically identified suicide as immoral.

While not specifically religious in nature, Richard also discussed how he would use his personality traits as a basis for a coping strategy.

Luckily I've been blessed with insight all the way through. And I've also been blessed with a reflective personality. And that has sort of helped me. And I've spent hours and hours mulling over things as to why this happened, and why that happened, and eventually it has given me the ability to say, '*well, that's crap and that's good.*'

[...]

I would just go to the shop and get what I wanted; don't talk to anyone, just get what you want, come home, just keep away from people in case I said something just a bit silly. So I had a

really good handle on that and others would say that I'm a bit of a loner and a quieter sort of a person and more reserved and on the introverted level more than on the extroverted level, so I'm able to cope with that easier probably than an extroverted person. But all the way through, I had made a pact with myself that I wasn't going to get into trouble.

Again, the concept of personality traits appeared to impact the way in which Richard understood and made sense of his illness. Despite the fact that he earlier identified these introverted traits as potential predisposing factors in the development of psychosis, he used these same characteristics as a basis for a coping strategy. Richard thus appeared to assign neither a negative nor a positive connotation to this aspect of self, but merely acknowledged and accepted that his experiences of psychosis were a part of his identity.

Summary

The findings from the current study replicate much of the work that has already been done in regards to the relationships between religion and mental health. The use of religious beliefs and practices as a coping strategy has been well documented in previous empirical studies.

However, as previously stated, most of the work in this area has focused on the more common and typical mood and anxiety disorders (Kirov, et al., 1998; S. Mohr, et al., 2006), with little specific focus on disorders such as psychosis. Interestingly, religious themes in delusions and hallucinations have been reported and extensively covered in both the theoretical and empirical information in this area. The mechanisms which facilitate these relationships have not been well studied, and the current research attempted to address this issue through a qualitative analysis of religious beliefs in those individuals diagnosed as schizophrenic. A diagrammatical model which attempted to account for the interactions found in the current study between religion and psychosis was provided; however, there is still a large amount of work to do in this area to specifically identify and delineate the ways in which these relationships develop.

It was important to understand the way in which both religious beliefs and psychotic symptoms developed, as this provided a basis from which to understand the meaning systems applied to these experiences by the participants. It was found that across participants, religious beliefs developed in a similar pattern, which depended on individual cognitive development, family relationships, social context, and the passage of time. Alternatively, participants varied in the extent to which early indicators of psychosis were identified. Factors which were mentioned by

at least two participants were considered potentially significant, and discussed further; these included internal attributes (personality traits and emotional responses), external attributes (alcohol/drug use and stress), and social context (family dynamics). While some individuals were more inclined to focus specifically on one of two of these factors in their explanations, it was clear that all participants applied a multi-factorial model of causal development.

Although not the particular aim of the study, the participant data certainly supported the supposition that religious faith serves as a coping strategy for some individuals. In relation to psychosis, it was found that individuals will evoke previously developed meaning systems in an attempt to understand their experiences. In much the same way that religion generally serves to provide meaning in life, it also provided meaning for the experiences of psychosis. It appeared then, that one of the mechanisms through which religion facilitated an adaptive coping strategy was found within the very nature of religious beliefs. Already functioning as a framework from which to understand seemingly unanswerable questions (such as the meaning of life or the existential experiences of death), religion could be readily applied to the difficult-to-understand experiences associated with psychosis, such as delusions and hallucinations. Moreover, the institutionalized nature of religion provided participants with a ready-made social support network to serve as an additional coping strategy. While it could not be determined the extent to which these participants consciously or unconsciously applied their religious beliefs to their understanding of psychosis, it was clear that religion, for all participants, was a very integral aspect of their lives.

CHAPTER FIVE

FINAL CONSIDERATIONS AND CONCLUSIONS

Implications

The findings from the current study have several implications in terms of clinical practice. Perhaps most importantly, it has been found that relationships between religion and mental health do in fact exist. Moreover, these are generally positive in nature (Whitehouse & Hollings, 2008), and therefore have beneficial affects on those who belong to both populations. While research in this area has improved over the last thirty years, there remains an extensive amount of knowledge to be found in relation to the specific mechanisms which facilitate or denigrate these relationships (Marks, 2006).

The finding that religious experiences had affected the way in which participants conceptualized the content of their experiences may have implications for prognosis variables. Considering the theoretical assumptions of the cognitive-behavioural model of psychosis, it could be assumed that a positive appraisal would cause less distress, and therefore have fewer negative implications for general daily functioning. It is proposed that the consequential reduction of symptom distress that often leads to social, occupational, and familial impairments would suggest a better overall prognosis. However, future research would need to be conducted in this area to determine whether or not religious conceptualization does in fact generally decrease distress.

There has been recent interest in the value which individuals with psychosis attach to positive symptoms such as delusions and hallucinations, especially when these beliefs or sensory perceptions are held with great conviction and with seemingly little emotional and cognitive distress (Bentall, 2003). For some, these experiences may become integrated into identity concepts (Drinnan & Lavender, 2006), or even provide a social support network (in the case of auditory hallucinations). Here, one must question the consequences of taking these experiences from the individual through the use of medication. This is especially important if no alternative support network is provided as a replacement for the positive symptoms. Thus, one of the implications of the findings from the current work relates to the importance of discussing with individuals the interpretation and value of the symptoms that are experienced (Read & Argyle,

1999). Moreover, Harrison, Koenig, Hays, Eme-Akwari, and Pargament (2001) have reported that simply asking the client about religious perspectives allows the clinician to understand how the client gives meaning to experiences, and reinforces religious coping strategies.

Finally, the growing body of research in this area has suggested that religion is being used more and more as a basis from which to understand mental illness. However, there is still little interaction between clergy members and psychologists. If religion is to be employed in psychological assessment and treatment, then continued research in this area would benefit from improvements in this relationship.

Limitations

There were several limitations of the current study which ranged from theoretical and methodological drawbacks to practical restrictions of research. While perhaps not the most crucial limitation, the personal views and characteristics of the author certainly affected the study adversely in several different ways. At the commencement of the research, despite the five years of previous university study, no field work research had been conducted, and only very minimal face-to-face work with individuals with mental health disorders had been experienced. Moreover, although extremely passionate about the topic, the author had no personal experiences with either religion or psychosis. In hindsight, it would be reasonable to say that the author entered the study with a great deal of naivety regarding the complex and multifaceted nature of not only the variables in isolation, but also the way in which religion and psychosis interacted. Furthermore, the extensive theoretical and empirical literature on these topics was often overwhelming, and developing a comprehensive understanding of how the variables related to each other at a social and individual level was difficult.

It was this naivety, coupled with other factors, which led to another important limitation of the study; namely the difficulty in recruiting participants to help conduct the research. Networking opportunities with mental health agencies was a particularly difficult process. Several agencies, as well as numerous medical practitioners, were contacted in regards to the research. Here there appeared to be a level of professional gate-keeping in that many of the employees of these agencies were interested in the research, but were unable to allow individual contact with the

service users. This may have been the result of personal characteristics of the researcher, given that she was female, relatively young, and relatively inexperienced. However, this phenomenon was noted to have interesting implications. Through discussions with employees at the agencies, it was reported that one of the main goals of the research was to give a voice to individuals who had experienced psychosis. It was certainly appreciated that staff were attempting to protect a population which is typically viewed as quite vulnerable. However, preventing the researcher from speaking to individuals who might qualify for the study (without first approaching these very people regarding potential interest) was considered in some respects to in fact take this voice away. The participants who did engage in the research process all reported that it was a beneficial experience, and for some, it even facilitated further insight into their experiences. Attempts to recruit participants may have yielded better results had the author previously established a relationship with the agencies through which the passion, consideration, commitment, and responsibility to the topics being studied could have been observed.

The very nature of the topics and context of the relationship with the author likely influenced the extent to which participants were willing to disclose information. Despite the fact that the author had met with the individuals prior to the interviews to answer questions and discuss personal views on the topics, it was likely that there was still a level of hesitation on the part of the participants, given the still-prevalent stigma associated with psychosis. Moreover, religious beliefs are often extremely personal and, as noted by participants, hard to describe. Given that the author had disclosed a history in clinical psychology, and a lack of a personal religious faith, the participants may have been uncertain and cautious about the nature of the researcher's interest and prerogatives in conducting such research.

At the time of the interviews, the author had few developed interviewing skills. There were several instances in which opportunity was not taken to probe further for details regarding a given phenomenon. The quality of the data was therefore less than optimal. While the practical skills of interviewing certainly developed to a certain degree over the course of the research, even the last interview conducted lacked the thoroughness and attention to detail which was likely required to fully understand such complex and convoluted issues as the relationships between religion and psychosis. While themes from the data could be identified, the extent to which these

could be comprehensively analyzed was likely restricted. Moreover, the generalization of the results to other populations would be difficult. This is not to say that the results of the current study are meaningless; the fact that themes were identified at all may in fact speak to the strength of the relationships between these variables. However, it would have been beneficial for the study should the author have had previous interviewing experiences.

The interview structure itself also acted as a limitation to some extent, given that it was very thorough and precise in the content areas to be explored. While the development of such an interview schedule was initially used to quell the author's concern regarding omitting necessary information during the interviews themselves, it became restricting in the extent that it controlled the particular topics which were explored. If the schedule had been more general, then the participants may have felt unrestricted in what they could speak about. For example, as noted in the discussion, it was found that all participants discussed religious entities, practices, and values. However, the extent to which each of these elements was important to the individual was unidentified, because these areas were all introduced specifically by the researcher. Perhaps a more reliable approach would have allowed participants to identify on their own the particular elements of religious belief and psychotic experience that were relevant.

In a study of a similar nature, participants were individuals who had previously engaged in psychological work with the author (Geekie, 2004); an approach that is beneficial for several reasons. The fact that the researcher was simultaneously a practicing psychologist would seemingly suggest a previously established level of experience and knowledge in relation to theoretical models of psychosis as well as practical applications of clinical training (such as interviewing skills). Moreover, as a practicing clinician, the author is able to develop a relationship with the participant over several sessions; rapport is thus established, and this consequently can facilitate feelings of security and trust. This would likely affect the extent to which participants felt comfortable disclosing information of a personal nature, such as traumatic childhood experiences. With such information, the researcher would have a more comprehensive understanding of the development of explanatory models. Moreover, working within first-episode psychiatric services allows easy accessibility (Drinnan & Lavender, 2006; Geekie, 2004)

to a population of individuals with psychosis who may be interested in the research topic, thus increasing the probability that participants would present with diverse demographic backgrounds.

In terms of methodology, limitations have been noted in reference to both the theoretical background, and approach to analysis. A main criticism of the constructivist approach comes out of the core theoretical assumption which postulates that individuals construct different views of reality based on personal experience. Here it is noted that while the researcher can attempt to understand individual perceptions, it is assumed that it is impossible to uncover all versions of reality, and therefore those represented in the research are no more than a select few of the total representations available (Seale, 2000). This assumption brings into question the reliability of such research, as the conclusions which are drawn would appear to be based upon only a limited selection of all possible conclusions. Certainly, the sample of participants for the current study was small and arguably not representative of all individuals experiencing psychosis. As previously noted, all participants were male, all identified with a form of Christianity, and four of the five identified as Pākehā. Although each participant story was unique, it cannot be assumed that these stories span the complete range of experiences. Moreover, differences in results may have been found if the demographic composition had been different. For example, listening to the experiences of women with psychosis and religious beliefs may potentially show different types of symptom explanation or different styles of coping. Future research would benefit from addressing these issues.

In terms of analysis procedures, Boyatzis (1998) has argued that thematic analysis is best considered a process to be used alongside qualitative approaches rather than a methodology that stands alone as a research technique, given a lack of guidelines which would ensure uniformity and consistency across studies. While the current research was based upon the work of both Braun and Clarke (2006) and Attride-Stirling (2001), who both explicitly delineate each stage in the process, there were few other instructive or educational articles to be found that provided a basis for thematic analysis as a unitary research method. In addition, the current study used a solely descriptive or interpretive approach to data analysis. While validated in the literature as an acceptable approach unto itself, it is worthy to acknowledge that the descriptive approach does not require the use of scoring or scaling of themes. Often, it is this numeric representation of the

identified content that is used to examine the consistency of researcher judgments regarding the value of a chosen theme (Boyatzis, 1998).

Given the research was qualitative in nature it was not surprisingly that it relied solely upon the subjective reports of the participants. However, while the majority of the data obtained was rich, some of the participants would deviate from the topic at hand, and discuss clinically relevant, but empirically unrelated topics and issues. Moreover, the ability to identify and describe clearly the subjective emotional and cognitive processes that were experienced during episodes of psychosis was apparently difficult for this population. Both these issues may have been reflective of the cognitive impairments associated with schizophrenia (Sadock & Sadock, 2003); however these were a limitation to the research to the extent that the nature of the subjective reports may have influenced the quality and reliability of the reporting. For example, while David identified that his ability to speak in tongues was understood in terms of a religious experience, it may have been beneficial to understand how significant others may have perceived these events. These experiences would more likely be conceptualized as symptoms of psychosis had others not perceived them as religious in nature. Alternatively, if the experience was understood by others as primarily religious, this might provide evidence of social influences on the development of a particular orienting framework. To this end, it may have been beneficial to acquire third party information from family members or doctors and client files. This would contribute to a more comprehensive understanding of individual presentation, which would consequently give more value to the explanatory models applied by the participants.

The length of the research also likely impacted upon the results. Due to many unforeseen circumstances, the above research took approximately three years to complete. The duration of time between the initial interview and the eventual analysis and report writing was considerable, and there was a period in which the researcher was simply re-familiarizing with the data. In doing this, the author reviewed both the audiotapes and transcripts. However, as Forbat and Henderson (2005) note, as a concrete document, transcripts tend to reify participant accounts of experiences. Given that the first interview was conducted within the first year of research, it is possible that this individual's perceptions or framework (as well as those of the other participants) had shifted over time. It would have been beneficial therefore to revisit the concepts

discussed in the transcript with participants prior to the commencement of analysis (Forbat & Henderson, 2005). Moreover, given that review consisted of only the audiotapes and transcripts, it was likely that many of the personal nuances of conversation had been lost over time. To this end, it would have been beneficial to have kept a researcher journal (Strauss & Corbin, 1998) which reflected upon the interview process in terms of emotional and behavioural responses that did not have the opportunity to be revealed within the transcripts.

Future Research

Further to those mentioned in the discussion, implication, and limitations sections, there were additional questions raised with the previous research which would benefit from being answered in future empirical studies.

Although not specifically related to the research results, the constructivist concept that knowledge is authenticated when there is consensus among individuals deemed competent to interpret the constructions (Boyatzis, 1998; Lincoln & Guba, 2000) has implications for future research. As noted in the methodology, the current research was based upon similar work conducted by Drinnan and Lavender (2006). The author of the current study found there was a slightly different focus within the participant data and thus derived different themes and interpretations of experience. Given the qualitative nature of both the current study and the work of Drinnan and Lavender (2006), it would be beneficial for future research to control for the identified limitations of the current study while concurrently attempting to replicate this work. Any results that were found to exist across studies could consequently be identified as reliable, and potentially studied further in quantitative research.

Despite the fact that there are an increasing number of empirical studies which identify the relationship between religion and mental health, there are still apparently few investigations which elucidate the specific mechanisms through which religion facilitates this relationship. This is confounded by the difficulties in establishing sound and reliable definitions in general religious terminology (Whitehouse & Hollings, 2008). Furthermore, religious research has appeared to focus primarily on theoretical propositions, and has few empirical studies to define its nature.

Therefore, it would be beneficial at this time to conduct empirical studies which attempt to either construct or use a previously-defined operational definition of both religion and spirituality.

An additional question that was raised concerned the necessary historical development of religious beliefs. Despite the fact that all participants in the current study had developed religious beliefs prior to the onset of illness, it would be difficult to assume that this was a crucial occurrence for the use of religion as a meaning system. It would be interesting to determine if the strength of the religious beliefs impacted at all upon the extent to which this framework is used to understand experiences of psychosis. One could assume that with less engagement in religious practices and beliefs, an individual would be less likely to use this as a platform from which to understand illness. Moreover, it would be interesting to determine how individuals without a religious framework interpret religious-themed symptoms, or if it is likely that individuals who have not been brought up with a faith would even have such symptoms.

Moreover, the extent to which the individual applied religious coping strategies consciously versus unconsciously would also be important to study, as this would have implications for the use of this strategy in treatment. For example, if it were found that people consciously applied religious principles in attempts to cope, then this could be used to help individuals who were not coping develop strategies based upon the principles of their faith.

A final question related to the process of treatment for psychosis in individuals with religious beliefs. It would be interesting to determine if people with religious beliefs were more or less likely to be on medication. Given the results of the current study, it could be assumed that cognitive-behavioural interventions which promoted the use of individual religious beliefs as coping strategies might provide enough support for individuals with psychosis that daily functioning remained at a reasonable level. If this were the case, it would be expected that individuals with a religious faith would be less likely to be on medication.

Final Conclusions

This thesis explored the nature and function of religious beliefs in psychosis. The overall findings suggested that individuals will often use explanatory models developed from pre-

existing frameworks to conceptualize and understand personal experiences. By definition, psychosis often involves symptoms which are disorganized and lack meaning, thus creating uncertainty and fear in those who have such experiences. Religion, alternatively, by its very nature, provides a way to interpret seemingly unanswerable questions, such as the meaning of life and the purpose of existence. It was therefore not surprising to find out that, when faced with unusual perceptual occurrences, the participants from the current study applied a personally relevant religious framework to understand individual experiences. Although there were limitations to the current work, the findings presented above contribute to the psychological literature relating to two variables that have historically been considered challenging to conceptualize and study.

REFERENCES

- Adityanjee, Aderibigbe, Y. A., Theodoridis, D., & Wieweg, W. V. (1999). Dementia praecox to schizophrenia: The first 100 years. *Psychiatry and Clinical Neurosciences*, *53*, 437-448.
- Andrew, E. M., Gray, N. S., & Snowden, R. J. (2008). The relationship between trauma and beliefs about hearing voices: A study of psychiatric and non-psychiatric voice hearers. *Psychological Medicine*, *38*, 1409-1417.
- Appelbaum, P. S., Robbins, P. C., & Roth, L. H. (1999). Dimensional approach to delusions: Comparison across types and diagnoses. *American Journal of Psychiatry*, *156*(12), 1938-1943.
- Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research*, *1*(3), 385-405.
- Backman, K., & Kyngas, H. A. (1999). Challenges of the grounded theory approach to a novice researcher. *Nursing and Health Sciences*, *1*, 147-153.
- Barker, C., Pistrang, N., & Elliot, R. (2002). *Research methods in clinical psychology: An introduction for students and practitioners* (2nd ed.). West Sussex, England: John Wiley & Sons, Ltd.
- Bentall, R. P. (2003). *Madness explained: Psychosis and human natures*. London, England: Allen Lane.
- Beresford, P. (2006). A service-user perspective on evidence. In M. Slade & S. Priebe (Eds.), *Choosing methods in mental health research: Mental health research from theory to practice* (pp. 223-230). New York: Routledge.
- Blass, D. M. (2001). A conceptual framework for the interaction between psychiatry and religion. *International Review of Psychiatry*, *13*, 79-85.
- Bowman, E. S. (1998). Integrating religion into the education of mental health professionals. In H. G. Koenig (Ed.), *Handbook of religion and mental health* (pp. 367-378). San Diego, California: Academic Press.
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. California: Sage Publications, Ltd. .
- Bracken, P., & Thomas, P. (2006). Postmodern mental health services. In M. Slade & S. Priebe (Eds.), *Choosing methods in mental health research: Mental health research from theory to practice* (pp. 231-238). New York: Routledge.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101.
- Breakey, W. R. (2001). Psychiatry, spirituality and religion. *International Review of Psychiatry*, *13*, 61-66.
- Cantor-Graae, E. (2007). The contribution of social factors to the development of schizophrenia: A review of recent findings. *Canadian Journal of Psychiatry*, *52*(5), 277-286.
- Carr, A. (2006). *The handbook of child and adolescent clinical psychology: A contextual approach* (2nd ed.). New York, NY: Routledge.
- Chan, S. W.-C., & Leung, J. K.-Y. (2002). Cognitive behavioural therapy for clients with schizophrenia: Implications for mental health nursing practice. *Journal of Clinical Nursing*, *11*, 214-224.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). California: Sage Publications, Inc.

- Corrigan, P., McCorkle, B., Schell, B., & Kidder, K. (2003). Religion and spirituality in the lives of people with serious mental illness. *Community Mental Health Journal*, 39(6), 487-499.
- Creswell, J. W. (2007). *Qualitative inquiry and reserach design: Choosing among five approaches* (2nd ed.). California: Sage Publications, Ltd.
- Deverson, T. (Ed.) (2005) *The New Zealand pocket Oxford dictionary* (3rd ed.). Melbourne, Australia: Oxford University Press.
- Drinnan, A., & Lavender, T. (2006). Deconstructing delusions: A qualitative study examining the relationship between religious beliefs and religious delusions. *Mental Health, Religion and Culture*, 9(4), 317-331.
- Eeles, J., Lowe, T., & Wellman, N. (2003). Spirituality or psychosis? An exploration of the criteria that nurses use to evaluate spiritual-type experiences reported by patients. *International Journal of Nursing Studies*, 40, 197-206.
- Elliot, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publications of qualitative research studies in psychology and related fields. *The British Journal of Clinical Psychology*, 38(3), 215.
- Ellis, A. (2003). Cognitive restructuring of the disputing of irrational beliefs. In W. O'Donohue, J. E. Fisher & S. Hayes (Eds.), *Cognitive behaviour therapy: Applying empirically supported techniques in your practice* (pp. 79-83). New Jersey: John Wiley & Sons, Inc.
- Elwood, S. A., & Martin, D. G. (2000). "Placing" interviews: Location and scales of power in qualitative research. *Professional Geographer*, 52(4), 649-657.
- Forbat, L., & Henderson, J. (2005). Theoretical and practice reflection on sharing transcripts with participants. *Qualitative Health Research*, 15(8), 1114-1128.
- Fuller-Torrey, E. (2006). *Surviving schizophrenia: A manual for familes, patients, and providers* (5th ed.). New York, NY: Harper Collins Publishers.
- Gaudiano, B. A. (2005). Cognitive behaviour therapies for psychotic disorders: Current empirical status and future directions. *Clinical Psychology: Science and Practice*, 12(1), 33-50.
- Gavin, H. (2008). *Understanding research methods and statistics in psychology*. London: Sage Publications, Ltd.
- Geekie, J. (2004). Listening to the voices we hear: Clients' understandings of psychotic experiences. In J. Read, L. R. Mosher & R. P. Bentall (Eds.), *Models of madness: Psychological, social, and biological approaches to schizophrenia* (pp. 147-160). New York, NY: Brunner-Routledge.
- Goldner, E. M., Hsu, L., Waraich, P., & Somers, J. M. (2002). Prevalence and incidence studies of schizophrenic disorders: A systematic review of the literature. *Canadian Journal of Psychiatry*, 47, 833-843.
- Guba, E. G., & Lincoln, Y. S. (2004). Competing paradigms in qualitative research. In S. N. Hesse-Biber & P. Leavy (Eds.), *Approaches to qualitative research: A reader on theory and practice*. New York: Oxford University Press.
- Harrison, M. O., Koenig, H. G., Hays, J. C., Eme-Akwari, A. G., & Pargament, K. I. (2001). The epidemiology of religious coping: A review of recent literature. *International Review of Psychiatry*, 13(86-93).
- Hartog, K., & Gow, K. M. (2005). Religious attributions pertaining to the causes and cures of mental illness. *Mental Health, Religion and Culture*, 8(4), 263-276.
- Hood, R. W., Spilka, B., Hunsberger, B., & Gorsuch, R. (1996). *The psychology of religion: An empirical approach* (2nd ed.). New York, NY: The Guilford Press.

- Huguelet, P., Mohr, S., Borrás, L., Gillieron, C., & Brandt, P. Y. (2006). Spirituality and religious practices among outpatients with schizophrenia and their clinicians. *Psychiatric Services, 57*(3), 366-372.
- Jackson, M., & Fulford, K. W. M. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry, and Psychology, 4*(1), 41-65.
- Kirov, G., Kemp, R., Kirov, K., & David, A. S. (1998). Religious faith after psychotic illness. *Psychopathology, 31*(5), 234-245.
- Koenig, H. G. (1998). *Handbook of religion and mental health*. San Diego, California: Academic Press.
- Koenig, H. G. (2002). Religion and medicine: Religion, mental health, and related behaviours. *International Journal of Psychiatry in Medicine, 31*(1), 97-109.
- Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. New York, NY: Oxford University Press.
- Kringlen, E. (1994). Is the concept of schizophrenia useful from an aetiological point of view? A selective review of findings and paradoxes. *Acta Psychiatrica Scandinavica, 90*(384), 17-25.
- Kruger, A. (2000). Schizophrenia: Recovery and hope. *Psychiatric Rehabilitation Journal, 24*(1), 29-37.
- Lammers, M. (2002). *Women's experience of emotional abuse in intimate relationships: A qualitative study*. University of Waikato, Hamilton, New Zealand.
- Levin, J. S., & Chatters, L. M. (1998). Research on religion and mental health: An overview of empirical findings and theoretical issues. In H. G. Koenig (Ed.), *Handbook of religion and mental health*. San Diego, California: Academic Press.
- Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 163-188). California: Sage Publications, Inc.
- Marks, L. D. (2006). Mental health, religious belief, and "the terrifying question". *Journal of Child and Family Studies, 15*(2), 135-141.
- May, R. (2004). Making sense of psychotic experience and working towards recovery. In J. F. M. Gleeson & P. D. McGorry (Eds.), *Psychological interventions in early psychosis: A treatment handbook* (pp. 245-260). West Sussex, England: John Wiley & Sons, Ltd.
- McGrath, J. J. (2005). Myths and plain truths about schizophrenia epidemiology: The NAPE lecture 2004. *Acta Psychiatrica Scandinavica, 111*, 4-11.
- Miller, R., & McCormack, J. (2006). Faith and religious delusions in first-episode schizophrenia. *Social Work in Mental Health, 4*(4), 37-50.
- Mohr, S., Brandt, P. Y., Borrás, L., Gillieron, C., & Huguelet, P. (2006). Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. *The American Journal of Psychiatry, 163*(11), 1952-1959.
- Mohr, S., & Huguelet, P. (2004). The relationship between schizophrenia and religion and its implications for care. *Swiss Medicine Weekly, 134*, 369-376.
- Mohr, W. K. (2006). Spiritual issues in psychiatric care. *Perspectives in Psychiatric Care, 42*(3), 174-183.
- Morrison, A. P., Renton, J. C., Dunn, H., Williams, S., & Bentall, R. P. (2004). *Cognitive therapy for psychosis: A formulation-based approach*. New York, NY: Brunner-Routledge.
- Neimeyer, R. A. (1995). Constructivist psychotherapies: Features, foundations, and future directions. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 11-38). Washington, DC: American Psychological Association.

- Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Needham Heights, Massachusetts: Allyn & Bacon.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, California: Sage Publications, Inc.
- Read, J., & Argyle, N. (1999). Hallucinations, delusions, and thought disorder among adult psychiatric inpatients with a history of child abuse. *Psychiatric Services, 50*(11), 1467-1472.
- Read, J., Goodman, L., Morrison, A. P., Ross, C. A., & Aderhold, V. (2004). Childhood trauma, loss and stress. In J. Read, L. R. Mosher & R. P. Bentall (Eds.), *Models of madness: Psychological, social, and biological approaches to schizophrenia* (pp. 223-252). New York, NY: Brunner-Routledge.
- Regan, S. P. (2008). Schizophrenia: Understanding a split mind. In S. F. Davis & W. Buskist (Eds.), *21st century psychology: A reference handbook* (Vol. 2). Thousand Oaks, California: SAGE Publications, Ltd.
- Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Victoria, Australia: Oxford University Press.
- Rogers, S. A., & Paloutzian, R. F. (2006). Schizophrenia, neurology, and religion: What can psychosis teach us about the evolutionary role of religion? In P. McNamara (Ed.), *Where God and science meet: How brain and evolutionary studies alter our understanding of religion* (Vol. 3, pp. 161-185). Westport, Connecticut: Praeger.
- Rosen, H. (1996). Meaning-making narratives: Foundations for constructivist and social constructivist psychotherapies. In H. Rosen & K. T. Kuehlwein (Eds.), *Constructing realities: Meaning-making perspectives for psychotherapists* (pp. 3-54). San Francisco, CA: Jossey-Bass, Inc.
- Roulston, K. (2001). Data analysis and 'theorizing as ideology'. *Qualitative Research, 1*(3), 279-302.
- Sadock, B. J., & Sadock, V. A. (2003). *Synopsis of psychiatry: Behavioural sciences/clinical psychiatry*. Philadelphia, PA: Lippincott Williams & Wilkins.
- Saha, S., Chant, D. C., Wham, J. L., & McGrath, J. J. (2006). The incidence and prevalence of schizophrenia varies with latitude. *Acta Psychiatrica Scandinavica, 114*, 36-39.
- Seale, C. (2000). *The quality of qualitative research: Introducing qualitative methods*. London: Sage Publications, Ltd.
- Shaw, I. F. (2003). Ethics in qualitative research and evaluation. *Journal of Social Work, 3*(1), 9-29.
- Steger, M. F., & Frazier, P. (2005). Meaning in life: One link in the chain from religiousness to well-being. *Journal of Counseling Psychology, 52*(4), 574-582.
- Stip, E., & Letourneau, G. (2009). Psychotic symptoms as a continuum between normality and pathology. *Canadian Journal of Psychiatry, 54*(3), 140-151.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and practices for developing grounded theory*. Thousand Oaks: Sage Publications.
- Tarrier, N. (2005). Cognitive behaviour therapy for schizophrenia: A review of development, evidence, and implementation. *Psychotherapy and Psychosomatics, 74*(3), 136-144.
- Tsuang, M. T., Stone, W. S., & Faraone, S. V. (2000). Toward reformulating the diagnosis of schizophrenia. *The American Journal of Psychiatry, 157*(7), 1041-1050.
- Whitehouse, M., & Hollings, R. (2008). Psychology and religion. In S. F. Davis & W. Buskist (Eds.), *21st century psychology: A reference handbook*. Thousand Oaks, California: SAGE Publications, Ltd.

- Wilkinson, S., Joffe, H., & Yardley, L. (2004). Qualitative data collection: Interviews and focus groups. In D. F. Marks & L. Yardley (Eds.), *Research methods for clinical and health psychology* (pp. 39-55). London: Sage Publications.
- Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). New York, NY: McGraw-Hill Education.
- Wilson, W. P. (1998). Religion and psychoses. In H. G. Koenig (Ed.), *Handbook of religion and mental health* (pp. 161-174). San Diego, California: Academic Press.
- Wykes, T., Hayward, P., Thomas, N., Green, N., Surguladze, S., Fannon, D., et al. (2005). What are the effects of group cognitive behaviour therapy for voices? A randomised control trial. *Schizophrenia Research*, 77(201-210).
- Yardley, L., & Marks, D. F. (2004). Introduction to research methods in clinical and health psychology. In D. F. Marks & L. Yardley (Eds.), *Research methods for clinical and health psychology* (pp. 1-20). London: Sage Publications, Ltd.
- Zimmerman, G., Favrod, J., Trieu, V. H., & Pomini, V. (2005). The effect of cognitive behavioural treatment on the positive symptoms of schizophrenia spectrum disorders: A meta-analysis. *Schizophrenia Research*, 77, 1-9.

**APPENDIX A
ADVERTISEMENT**

University of Waikato
Psychology Department
PARTICIPANT RECRUITMENT

RESEARCH TITLE: The Role of Religion in Schizophrenic Symptoms

RESEARCHER: Megan Lenny

SUPERVISOR: Dr. Jo Thakker and Cate Curtis

**LEARNING ABOUT SCHIZOPHRENIA AND RELIGION:
WHAT ARE THE RELATIONSHIPS?**

What is this study about?

This is a research project that I am conducting to extend the knowledge about schizophrenia and religion and spirituality. I am intending to look at the relationships between these two topics to better understand how they relate to each other. Specifically, I want to explore how past religious experiences are affecting schizophrenic symptoms.

What is required of the participants?

Participants will be required to attend two discussions with myself that will take approximately one hour each. In these discussions, we will go over subject matter that relates to past religious/spiritual histories. We will also discuss how these religious/spiritual histories may have played a developmental role in the content of religious-themed symptoms.

Who is eligible?

Individuals who wish to participate in this study must have a diagnosis of schizophrenia. Moreover, they must have a history of religious/spiritual involvement; it would be beneficial if there was a history of religiously-themed symptoms.

Who do I get in contact with?

If you are interested in the study and would like more information, please do not hesitate to get in contact with me personally.

There are two phone numbers that you can reach me at;

Home: 07-843-5352

Mobile: 021-2300-511

**FOR ALL THOSE INDIVIDUALS WHO TAKE PART IN THE INTERVIEW,
THERE WILL BE COUPONS AVAILABLE FOR BOTH PAK'N'SAVE AND THE
WAREHOUSE.**

**APPENDIX B
LETTER OF INTRODUCTION**

Megan Lenny
Phone: (07) 856-5289 (Home)
021-2300-511 (Mobile)

Dear

This letter is to let you know about some research that I will be conducting as a post-graduate student of psychology at the University of Waikato. It is my hope that you may find this information interesting, and that you may wish to consider participation in this project. If, at any time, you wish to discuss the details with me in person, please do not hesitate to get in contact with me so that we can arrange an appropriate time.

I have had a great interest in mental health since the beginning of my studies five years ago. The project that I have mentioned above is the result of this particular interest. I intend to look at the relationship between past and current religious experiences and how these experiences manifest and play a role in schizophrenic symptoms. It is my hope that I can learn from your experiences and that I may, in turn, impart some of this knowledge to others so that mental health is better understood by the community.

At this point, I am asking individuals to consider helping me out by allowing me to hear their story. I would like to be able to get in contact with you personally, within the next two weeks. At this time, if you agree to consider the project further, we could discuss details and I could answer any questions you might have.

This would be followed up with written information regarding the details of the study as well as consent forms. Please be assured that all contact is strictly confidential and that I am bound to the ethical code of the University of Waikato concerning research.

Please also be advised that there is absolutely no obligation to participate, or even to talk with me. I would appreciate it if you could please fill out the slip attached to the bottom of this letter. If I do not hear back from you, I shall assume that you do not wish to partake in the study. Otherwise, I will phone you or get in contact with you through the mental health agency within a couple of weeks. Thank you for considering this issue.

Sincerely,

Megan Lenny
.....

I, _____, **wish/do not wish** to have further information about the research project proposed by Megan Lenny.

I am willing to be contacted at _____ (phone number or name of Mental Health Agency).

The best time(s) to phone me would be (please offer three times) _____

Signed _____ **Date** _____

APPENDIX C PARTICIPANT INFORMATION PACKAGE

University of Waikato
Psychology Department

INFORMATION FOR PROSPECTIVE PARTICIPANTS

RESEARCH TITLE: The Role of Religion in Schizophrenic Symptoms

RESEARCHER: Megan Lenny

SUPERVISOR: Dr. Jo Thakker and Dr. Cate Curtis

About Me

I was born and raised in a small town in Canada. I completed my first degree at the University of Western Ontario before moving to New Zealand to further my study and complete my Honours year in psychology at the University of Waikato. I have stayed here to work towards the completion of my Master's of Social Sciences. I hope to continue studies here in New Zealand, with plans to enrol in the Clinical Psychology Programme in the interest of working in the mental health field.

The Project

The small town in which I grew up was very much a safe-haven for several individuals with various mental health problems. Fortunately, through numerous avenues I was able to gain some exposure to these unique individuals. This, consequently, gave me some awareness and comprehension about mental illness. Furthermore, I took an early interest in mental health in my studies, and this interest has continued throughout. I believe that mental health, as well as corresponding mental health issues, are often misrepresented and misunderstood by the public. It is my desire to gain knowledge not only for myself, but also to hopefully pass on this knowledge to reduce some of the ignorance in this area. I am interested in knowing how past experiences manifest in current schizophrenic symptoms.

Your Part

Your participation would include a discussion between the two of us (with a mental health worker or care taker present if you wish), which would focus on the relationship between religion and schizophrenia. I would be looking for information from both past experiences and present situations. The conversation would be semi-structured, in that there would be a brief outline that will guide the discussion (see following page), but the main focus would be on your personal story. This conversation would probably last approximately one hour. It would be audio-taped and then transcribed. The manuscript would then be sent to you for any revision or alterations that you may wish to make.

Any and all conversation or material related to this project would be treated with absolute confidentiality, as per the ethical code of the University of Waikato. Files will be made for each participant, but will be locked in a secure cabinet. Anonymity will be preserved through the use of pseudonyms. Furthermore, you would have the right to withdraw from the project at any time if you are unhappy with any of the material, or if you have concerns regarding the way the material is being handled. Having noted this, it is possible that, while no personal information will be reported, demographic information may be utilized in the study write up.

Ethical Disclosure

The proposal for this study has been approved by the Ethics Committee of Human Research for the Psychology Department, University of Waikato. The proposal has outlined the research topic, the reasons for conducting this research, and the method I will use to carry out this project.

I undertake to use the information that you give me for the sole purpose of completing my Masters of Social Sciences Degree at the University of Waikato. Only with your consent, will I use this information for the purpose of publishing an article in a professional journal.

Signed: _____ Date: _____

If you wish to contact me about any part of this project, please do not hesitate to get in contact with me personally.

Megan Lenny
Phone: 07-843-5352 (Home)
021-230-0511 (Mobile)

Should you wish to contact my supervisor, her name and contact information is as follows:

Dr. Jo Thakker
Department of Psychology
The University of Waikato
Gate 1, Knighton Road
Private Bag 3105
Hamilton 3240
Phone: 07-838-4466, ext. 6809
Email: jthakker@waikato.ac.nz

If you have any concerns regarding ethical matters for this research, or wish to contact someone who is not personally involved in the study, please contact the convenor of the Research and Ethics Committee:

Dr. Robert Isler
Phone: 07-838-4466, ext. 8401
Email: r.isler@waikato.ac.nz

University of Waikato
Psychology Department
SYNOPSIS OF INTERVIEW SCHEDULE

Please bear in mind that this is only an outline of the interview schedule. As I plan on having an open discussion, I will base the conversation on these questions and areas of interest, but will be more interested in how you personally perceive your experiences. The discussion will consist of six brief segments, as outlined below, but will flow more like a conversation. If you feel that any of these particular areas of interest or questions are inappropriate, do not hesitate to refuse to answer, with no explanation required.

1. Introduction

- Conditions of consent form to be reviewed.
- Reminder that all participants have the right to refuse to answer any questions, or end the discussion at any point, without explanation.

I'm interested in discussing with you what you believe the role of religion to be in your life, both before and during diagnosis of mental illness. I am specifically interested in the role that religion has had in the experiences of unusual beliefs or delusions. I will begin by asking some particular questions, and I will use these questions as a guide for the discussion. However, I am particularly interested in your personal experiences, and as such, will allow you to tell as much or as little of your story as you please. In this way, you will also guide this discussion by your experiences. Do you have any questions? Would you like to continue?

2. Background Information

It would be helpful for me at this point, to first start by asking you some questions regarding background information about you.

Areas to be covered:

- Living situation
- Occupation
- Ethnic background
- Age
- Religious orientation (What does this mean to the individual-practices, beliefs?)

3. Early Years

Now I'd like to start the open discussion segment of this conversation by asking you some questions about your early and late childhood. These questions will centre on the role that religion played during this time of development.

Areas to be covered:

- What did your religious orientation teach?
- What were your earliest experiences of religion?

- What were your first specific religious beliefs?
- What were your ideas about God, Jesus, the devil, etc (any other religious entity)?
- What were your parent's beliefs about religion?
- Were the religious teachings or lessons ever questioned?
- Was religion ever a source of conflict or disagreement in the family?
- Did religious experiences as a child ever involve elements of extremism? Fundamentalism? Eg. speaking in tongues, religiously sanctioned delusions/hallucinations
- Where were religious beliefs generally practiced? Eg. church environment, family setting, individually at home?
- What level of devotion was there to the religious community?
- How did religion feature in school lessons or other education facilities?
- To what extent were your friends religious?
- How did religious beliefs change with getting older, and through adolescence?

4. Being Diagnosed as Schizophrenic and Suffering from the Corresponding Symptoms

I would like to now move on to the time when you first began to develop the symptoms of schizophrenia and/or the unusual beliefs and delusions. I would like it if we could start by you telling me what was going on in your life at this time?

Areas to be covered:

- What was the trigger to becoming ill?
- Can you describe any delusions/symptoms you were having?
- Where would your delusions/symptoms usually occur?
- How often did these symptoms occur?
- How did the content of the delusions change over time?
- To what extent would you say the delusions were a response to social/environmental cues?
- How did you feel when you experienced the delusions/symptoms?
- How did you interpret these symptoms at the time that they were occurring?
- When was diagnosis given? At what age?
- How did you feel about receiving a diagnosis?
- How did family/friends respond to any changes?

- What were your religious beliefs at this time?
- How did religion feature in these experiences?
- Where do you think these religious ideas came from?
- Prior to developing these unusual beliefs, how did the religious thoughts, ideas, beliefs change (eg. in content, frequency, pre-occupation, emotions associated with these ideas)?
- How comfortable were you in discussing your religious beliefs?
- To what extent would you say your religious beliefs were respected?
- How did family, friends, staff, and professionals respond to your religious beliefs and ideas?
- What happened to your religious beliefs while you were ill?

5. Recovery

Finally, I would like to discuss with you the importance of religion at the time that the unusual beliefs or delusions stopped being a problem.

Areas to be covered:

- To what extent did your religious beliefs change when the delusions were lessening?
- How involved were you in religious worship then?
- What are your religious beliefs now?
- How does religion feature in your life now? Eg. Strong vs. weak influence, etc.
- To what extent do people accept your beliefs as normal?
- What would you say you get out of religion?
- How do you think religion has affected your mental health?
- How do you think religion influenced your recovery?
- Looking back, what sense do you make of the link between religion and the symptoms you had?

6. Debriefing

Thank you very much for allowing me to discuss with you your personal experiences with schizophrenia, delusions, and religion. I would now finally like to ask you if you might want to reflect on the experience of taking part in this discussion.

Areas to be covered:

- How have you found the experience of being asked about your story?
- Is there anything that you would like to be retracted from the record of this discussion?
- Do you have any questions?

If any (more) questions or issues arise, please do not hesitate to get in contact with me personally by phone. When the findings have been completed, a summary will be sent to you to allow for any additional input.

University of Waikato
Psychology Department
CONSENT FORM

RESEARCH TITLE: The Role of Religion in Schizophrenic Symptoms

RESEARCHER: Megan Lenny

SUPERVISOR: Dr. Jo Thakker

I understand that I need not feel any pressure to participate in this project.

I have read the information about this project and have had the opportunity to ask any questions.

I understand that any information I give will be treated as confidential.

I understand that the researcher and I will meet for a semi-structured conversation about the issues raised in the information package. A set of focus questions, which I received previously, will provide a basis for the discussion.

I understand that I have the right to refuse to answer any questions at any point during the conversation.

I understand that I may withdraw from this project at any time, and that I may do so without having to provide reason for my withdrawal.

I understand that, while no personal information will be reported, demographic information may be utilized in the study write up, even if I drop out of this research project.

I understand and give permission for the conversation to be audio-taped and later transcribed and coded.

I understand that the transcribed conversation may be reviewed by a graduate student to ensure that coding remains as objective as possible. I understand that if this occurs, a statement of commitment to confidentiality will be signed and no personal information other than the transcript itself will be revealed.

I understand that I will have the opportunity to read through the transcript of the audio-taped conversation and to ask for anything I have said to be withdrawn or altered. I will discuss with Megan the most appropriate way for material to be exchanged between us.

I understand that Megan may use my information anonymously for publication of an article in a professional journal and will check with me if information not in the thesis is to be used.

I understand that if I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee (Dr. Robert Isler; phone: 838-4466 ext. 8401; email: r.isler@waikato.ac.nz)

I consent to participate in this research.

Signed: _____ Name: _____

Date: _____ Phone No: _____

University of Waikato
Psychology Department
CONSENT TO SECOND INTERVIEW

RESEARCH TITLE: The Role of Religion in Schizophrenic Symptoms

RESEARCHER: Megan Lenny

SUPERVISORS: Dr. Jo Thakker & Dr. Cate Curtis

I _____ give my consent for a second interview to take place should this be necessary.

I understand that I have the right to refuse to answer any questions at any point during the conversation.

I understand that I may withdraw from this project at any time, and that I may do so without having to provide reason for my withdrawal.

I understand and give permission for the conversation to be audio-taped and later transcribed and coded.

I understand that all information will be anonymised and treated as confidential.

I understand that I will have the opportunity to read through the transcript of the audio-taped conversation and to ask for anything I have said to be withdrawn or altered. I will discuss with Megan the most appropriate way for material to be exchanged between us.

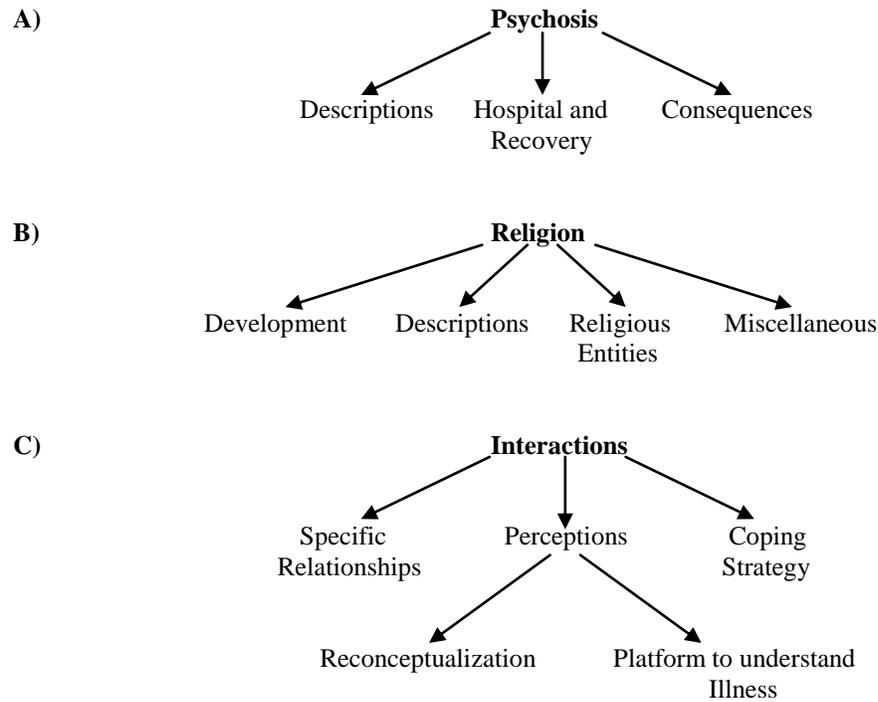
I understand that all other rights that were afforded to me for the initial interview still stand for the second interview.

Signed: _____

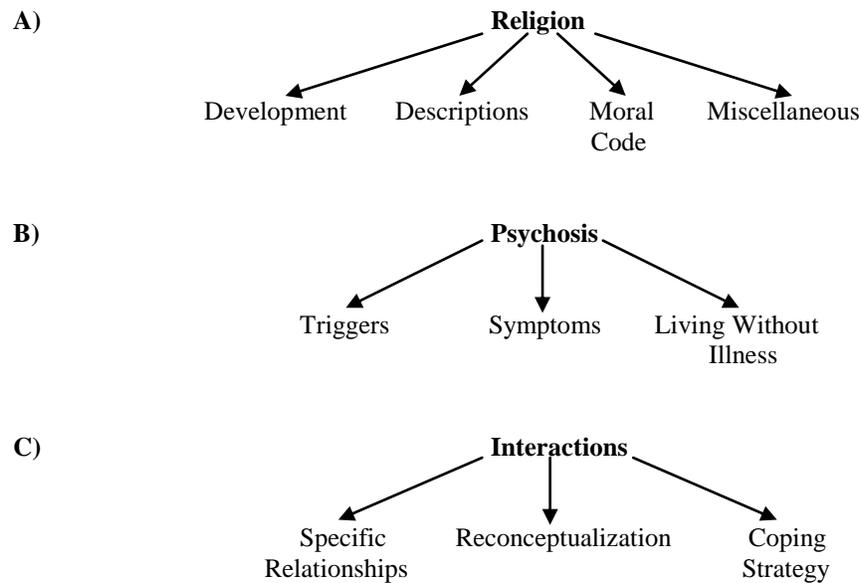
Date: _____ Phone No: _____

APPENDIX D INITIAL THEMATIC NETWORK DIAGRAMS

Participant #1 – Paul
First Interview

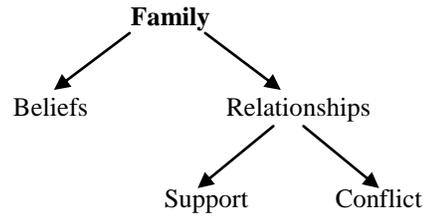


Second Interview

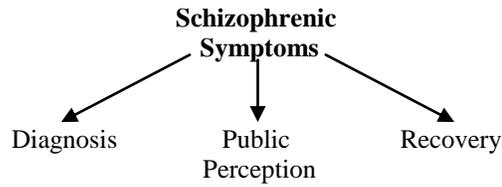


Participant # 2 – David
First Interview

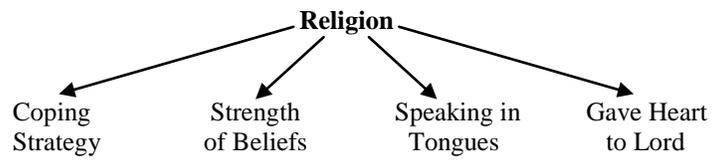
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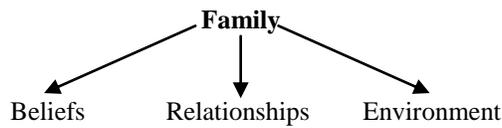


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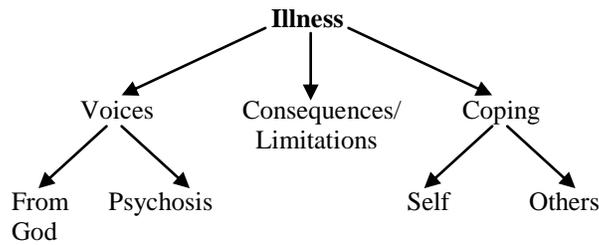


Second Interview

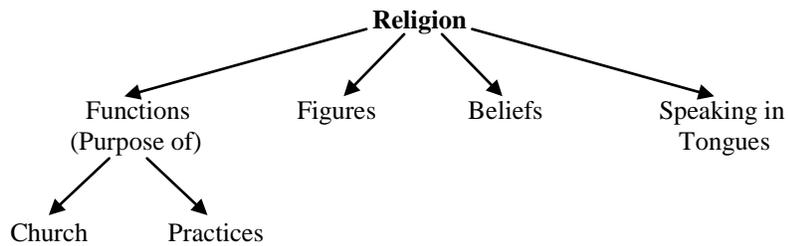
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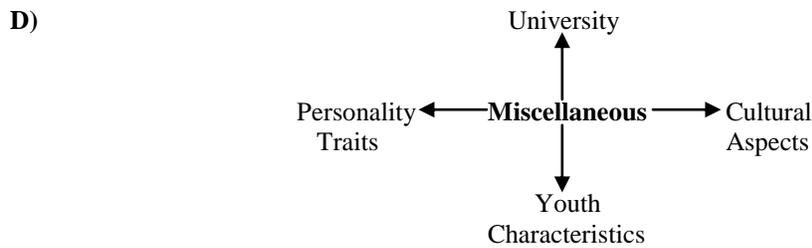
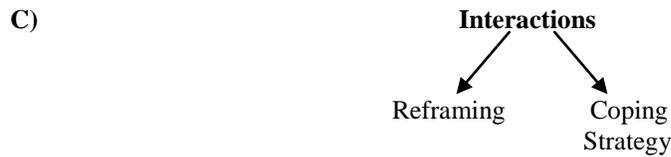
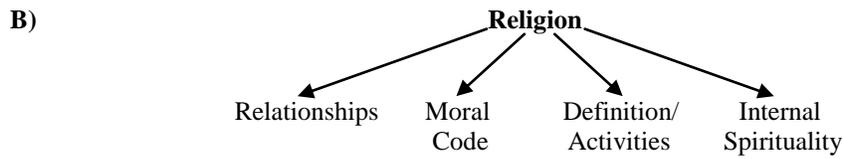
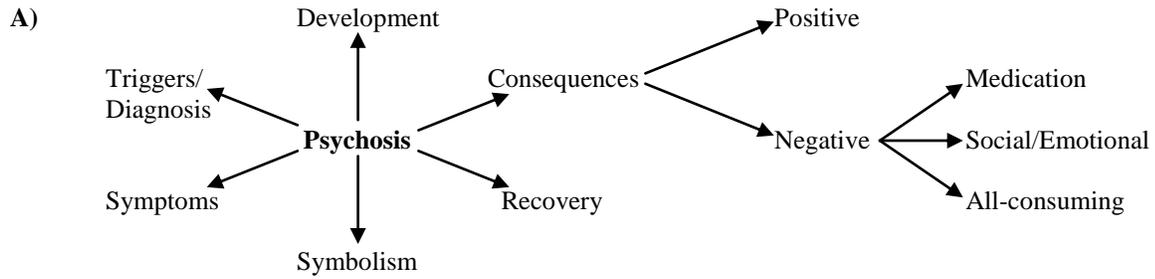
B)



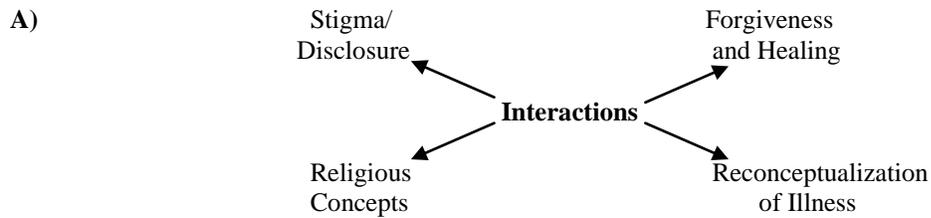
C)



Participant #3 – Richard
First Interview

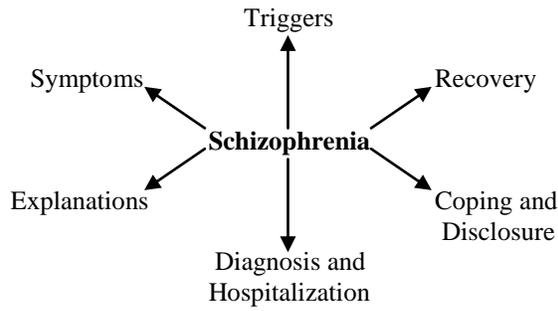


Second Interview

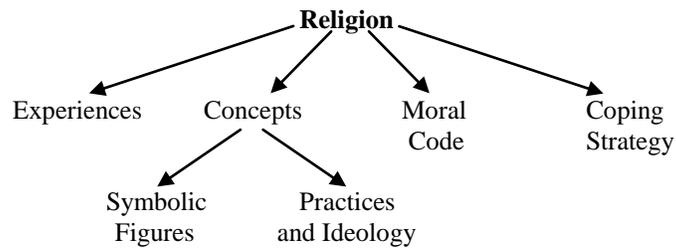


Participant #4 – Mark
First Interview

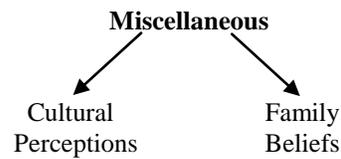
A)



B)

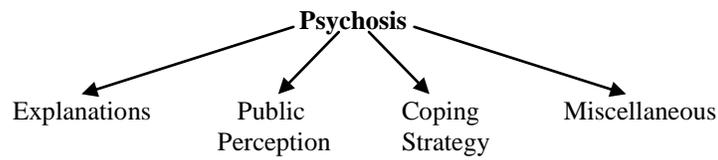


C)

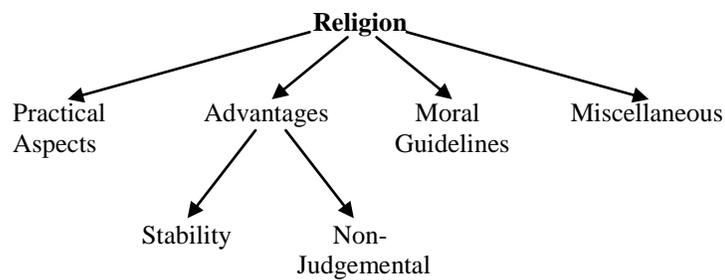


Second Interview

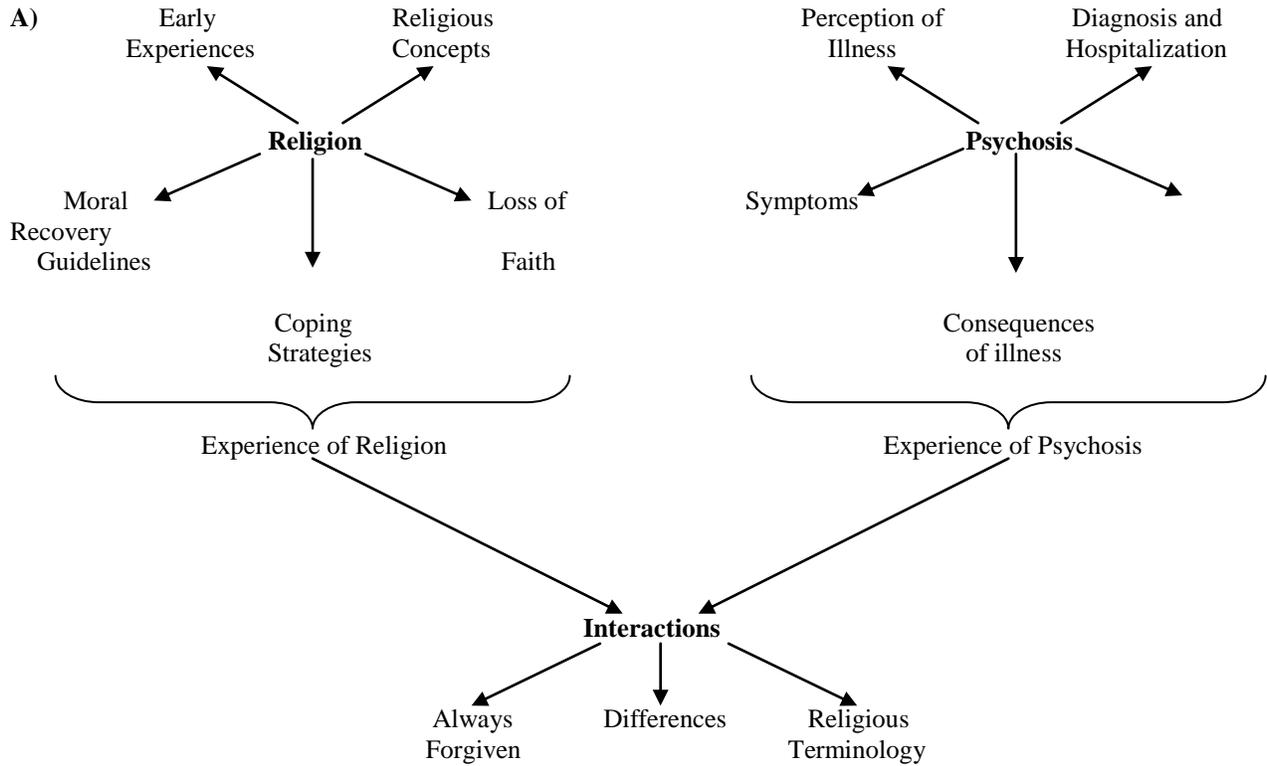
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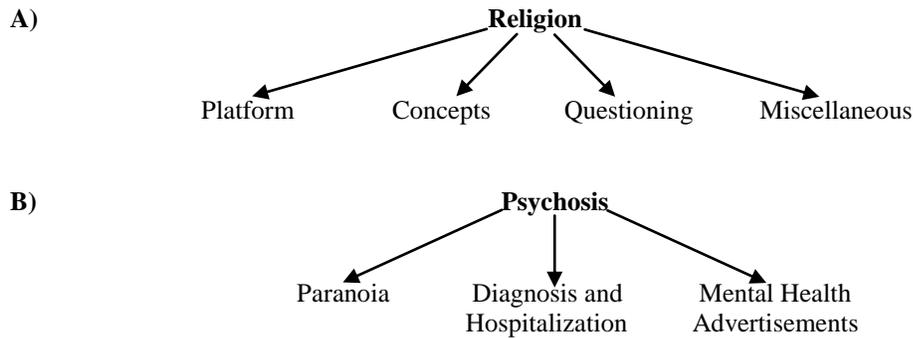
B)



Participant #5 – James
First Interview



Second Interview



APPENDIX E
FINAL THEMATIC NETWORK DIAGRAM

