The Lure and Lore of Lunacy

The meaning of spiritual experiences during psychosis for recovery from bipolar disorder

Arjan Lelivelt

alelivelt@gmail.com

June 2017

Master's Thesis Spiritual Care; Faculty of Philosophy, Theology and Religious Studies, Radboud University, Nijmegen, The Netherlands

Advisor: Hans Schilderman, PhD

Hereby I, Arjan Lelivelt, declare and assure that I have composed the present thesis with the title "The Lure and Lore of Lunacy", independently, that I did not use any other sources or tools other than indicated and that I marked those parts of the text derived from the literal content or meaning of other Works – digital media included – by making them known as such by indicating their source(s).

Nijmegen, 16-06-2017

To Bonnie

"The conflict between empirical reality and this conception of the world as a meaningful totality, which is based on a religious postulate, produces the strongest tension in man's inner life as well as in his external relationship to the world. To be sure, this problem is by no means dealt with by prophecy alone."

Max Weber, "Economy and Society"

"But the Lord God called to the man, "Where are you?" He answered, "I heard you in the garden, and I was afraid because I was naked; so I hid."

Genesis 3: 9-10

Contents

Summary

Psychotic episodes are often characterized by spiritual or religious content. The current study empirically investigates what kinds of spiritual experiences people have during psychosis, what it means to them and if and in what way these experiences affect the process of recovery. Two semi-structured interviews with people diagnosed with Bipolar I disorder are reported in detail. It is concluded that the spiritual experiences were meaningful to the participants and reflected an already ongoing process of identity formation that in more or less direct ways influenced their process of recovery. Rather than viewing the contents of spiritual experiences during psychosis as mere symptoms that need to be recovered from, it may be helpful to consider whether they could actually provide starting points for recovery.

Foreword

The figure on the cover of this thesis is Tamiyo[1], who kept me company on my travels through the spiritual mind. She is a character in a card game that I like to play, called "Magic". Tamiyo is one of the so called "Planeswalkers" the game revolves around. Planeswalkers are mages, but *"... while most mages are bound to one plane, unaware of the true vastness of the Multiverse, Planeswalkers have a spark within them that sets them apart. This spark is only ignited through facing a great ordeal. However, once the spark ignites, the Planeswalker can travel between planes, journeying to new worlds and tapping into new spells, reaching unmatched heights of power."* Planeswalkers can manifest themselves in the game in multiple ways and Tamiyo manifests herself both as a Sage of the Moon, as well as a Field Researcher, with a special research interest in madness. Need I say more[2].

Writing this thesis has been quite a journey. Fortunately, I did not travel alone. Leaving aside my imaginary colleague Tamiyo, the one real-life companion that I would like to mention first and foremost is Bonnie. Thank you so much, Bonnie, for being there, giving me all the space I needed, for your faith, encouragement, kindness and patience. Thank you for providing this opportunity. Now it is your turn!

I would also like to thank the people who participated in my research, who have been so generous to share their life's stories with me. Due to unforeseen circumstances, only two of you ended up in this thesis. But all of your stories have been read and reread, again and again, and they permeate my thoughts on the topic of spirituality and recovery. I hope that one day I will be able to paint a more complete picture that includes all of your stories.

Thank you, Hans Schilderman, for many hours of light-hearted and good-spirited conversations. Yet we have not even begun to really address the cognitive aspects of spirituality, mysticism and consciousness, the boundaries of psychology and the beginnings of spiritual care. But who knows. I am ready to take another dive!

Finally, I would like to thank Bonnie. Again. Thank you so much. I love you.

[1] Image by Eric Deschamps

[2] Actually, I do need to say more. In the game of Magic, madness is an *ability* rather than a shortcoming. When a card with madness is discarded from your hand, it does not end up in your graveyard like other discarded cards, but it is temporarily exiled from the game. You may then put the card back into play, usually for a much lower cost than before its exile, giving you a pleasant advantage.

1. Introduction

> *"I was in a very difficult, emotionally turbulent passage, punctuated with periods of psychosis. The anguish of it seemed endless, and I had lost all sense of time. I remember pressing my body against the concrete wall in the corridor of the mental institution as wave upon wave of tormenting voices washed over me. It felt like I was in a hurricane. In the midst of it, I heard a voice that was different from the tormenting voices. This voice was deeply calm and steady. It was the voice of God, and God said, "You are the flyer of the kite." And then the voice was gone. Time passed and I kept repeating what I had heard, "I am the flyer of the kite." When I repeated this phrase, I had the image of a smaller me, standing deep down in the center of me. The smaller me held a ball of string attached to a kite. The kite flyer was looking up at the kite. To my surprise, the kite looked like me also. It whirled and snagged and dove and flung around in the wild winds. But all the while, the flyer of the kite held steady and still, looking up at the plunging and racing kite.*
>
> *"I am the flyer of the kite", I repeated again. And, slowly, I began to understand the lesson. "I have always thought I was just the kite. But God says I am the flyer of the kite. So, even though the kite may dive and hurl about in the winds of pain and psychosis, I remain on the ground, because I am the flyer of the kite. I remain. I will be here when the winds roar, and I will be here when the winds are calm. I am here today, and I will be here tomorrow. There is a tomorrow, because I am more than the kite. I am the flyer of the kite."*
>
> Pat Deegan, PhD[3]

The potential relationship between mental illness and spirituality has been noticed by many, both researchers as well as experiencers. For instance, at the start of the 20th century, William James wrote:

> *"Even more perhaps than other kinds of genius, religious leaders have been subject to abnormal psychical visitations. Invariably they have been creatures of exalted emotional sensibility. Often they have led a discordant inner life, and had melancholy during a part of their career. They have known no measure, been liable to obsessions and fixed ideas; and frequently they have fallen into trances, heard voices, seen visions, and presented all sorts of peculiarities which are ordinarily classed as pathological."*
>
> (James, 1982, p. 10)

Around the same time, psychiatrist Karl Jaspers wrote his "*Allgemeine Psychopathologie*". On the connection between schizophrenia, religiosity and culture, he remarked:

[3] Pat Deegan is one of the originators of the recovery movement in mental health. She was diagnosed with schizophrenia while in her teens, obtained her PhD in clinical psychology in 1984 from Duquesne university, and is currently an adjunct professor at Dartmouth College Medical School. The quote is taken from a blog she wrote on her website (Deegan, 2004)

> *"Die überall auf der Welt auftretenden Schilderungen von Reisen der Seele durch die Welten des Himmels und der Hölle erinnert an schizophrene Erfahrungen. […] Mythologische und abergläubische Vorstellungen muten gelegentlich so an, als ob sie gar nicht ohne Kenntnis dieser eigenartige Erlebnisformen der Dementia Praecox entstanden sein könnten"*
>
> (Jaspers, 1965, p. 611)

Although one can readily agree with the fact that there c*an be* a relationship between spirituality and mental illness, the nature of that relationship is not so straightforward, but depends on a person's condition, his circumstances and cultural surroundings. Furthermore, the interpretation of the relationship depends also on the belief system of the researcher or expert who is making a judgment of the person at hand. In the above quotation, James stresses the "ordinarily pathological" quality of the religious experiences. Jaspers does so as well, but grants that these experiences may be more than just craziness, as he tentatively states that they seem to have colored the way cultures typically imagine the realms of the spirit as well as the grand narratives people live by in these cultures.

Eugene Taylor (2005) speaks of "states of consciousness"[4] that do not necessarily reflect pathological states of mind. Taylor is an expert on the American counterculture that emerged in the sixties and seventies of the previous millennium, and with the increased usage of LSD and other psychotropic drugs in those days, altered states of consciousness, ordinarily labeled as pathological, became less extraordinary phenomena, and visions and voices that were up to this point only available to the "happy few" became a commodity (Taylor, 1999). Growing interest in Eastern religions and the practice of various forms of meditation also contributed to an increased familiarity with extraordinary mental states accompanying these practices (Tart, 1969).

In the wake of these developments, non-drug induced altered states of consciousness became viewed not as pathological, but even as desirable and healthy signs of spiritual awakening. One can think of the work of Stanislav Grof for instance, who, after abandoning his experimental therapeutic treatments with LSD, developed ways of inducing altered states of consciousness through what he termed "holotropic breathwork" (Grof, 1992).

In 1998, a new DSM-IV category termed "Religious or Spiritual Problem" was introduced, signifying the possibility of non-pathological problems of a spiritual or religious kind occurring alongside other problems or pathologies (American Psychiatric Association, 1994; Lukoff, Lu, & Turner, 1998). In recent years, several personal accounts have been published by "psychiatric survivors" of altered states of consciousness and some concerned professionals that challenge the traditional pathologizing medical model of extraordinary states of consciousness (Clarke, 2000, 2010; Chadwick, 2009; Lucas, 2011, 2016; Blackwell, 2011; Mottram, 2014; Razzaque, 2014).

The relationship between spirituality, altered states of consciousness and psychopathology is a complex one, and it is not the goal of this paper to sort this relationship out. For the purpose of the current research, we will simply acknowledge that, whatever their ontological status may be, both spiritual and pathological experiences, as well as altered states of consciousness, are in any case states of

[4] When speaking of *states* of consciousness, it should be noted that we do so merely by convenience. Consciousness is a dynamic process, an ever changing fluid stream, rather than a sequence of distinctly identifiable states.

consciousness. As such, we may ask what those states of consciousness mean to those who experience them, without classifying them beforehand in any objective way as spiritual or pathological.

In the light of recent developments in the mental health system towards a recovery based approach, the question of meaning has become increasingly important. Within the recovery paradigm, rather than focussing on curing some real or hypothesized mental illness, treatment is directed towards managing the consequences of the condition, finding meaning in it, and establishing a purposeful life given the (dis-)abilities resulting from the condition.

In recent years efforts have been made to develop measurement tools that aim to capture factors of recovery as quantifiable outcomes (e.g., Giffort, Schmook, Woody, Vollendorf & Gervain, 1995; Jones, Mulligan, Higginson, Dunn, & Morrison, 2013; Resnick, Fontana, Lehman & Rosenheck, 2004). Out of twenty-two potential instruments, Burgess, Pirkis, Coombs and Rosen (2011) identified four instruments that may be suitable for the Australian context. In the light of the current research, it is remarkable that out of these four candidates, only one explicitly touched upon religious or spiritual factors (Jerrell, Cousins, & Roberts, 2006). This is all the more remarkable considering that for psychiatric patients issues of religion and spirituality seem highly relevant: in a New Zealand survey, 78% of a group of people with bipolar disorder are reported to hold strong religious beliefs, and their beliefs determined the way they viewed their illness (Mitchell & Romans, 2003). Furthermore, spiritual and religious beliefs or problems may lie at the heart of a condition, or, on the contrary, may prove to be the cure to an illness, or influence the course of an illness in less direct ways. For instance, Jones et al. (2013) found a significant positive correlation between recovery and self-reported improved understanding of spiritual matters in bipolar patients.

Considering the importance that psychiatric patients attach to spirituality, and the potential influence spirituality may have on the recovery process, it is relevant to know what spirituality means to patients in relation to their condition, and if and how their spiritual beliefs and practices influence their recovery process. Some research has been done in this area, as summarized below (see section 3.2.). This research generally does not specifically focus on the content of spiritual experiences and its potential influence on recovery, but rather on the role that religion and spirituality in general play in coping with mental illness. It usually asks if and under what circumstances religion and spirituality may be conducive to the occurrence of mental illness, and whether or not mental illness influences the religious or spiritual outlook on life. While this is indeed highly relevant when addressing the role of religion and spirituality in recovery, the contents of the experiences themselves are often ignored, because they are generally viewed as mere symptoms of disease. Patients frequently report their reluctance to talk about them for fear of not being taken seriously, and if they do, psychiatrists and other professionals often do not know how to deal with the spiritual themes and questions that patients raise.

The purpose of the current research therefore is to explore the nature of the spiritual experiences during psychosis in order to establish their relevance (or irrelevance) for the process of recovery. The research questions are as follows:

1. What spiritual experiences do people have during psychosis?
2. What do these experiences mean to the experiencers?
3. In what way are these experiences relevant for the subsequent process of recovery?

Figure 1 shows a simple representation of the conceptual model underlying these research questions.

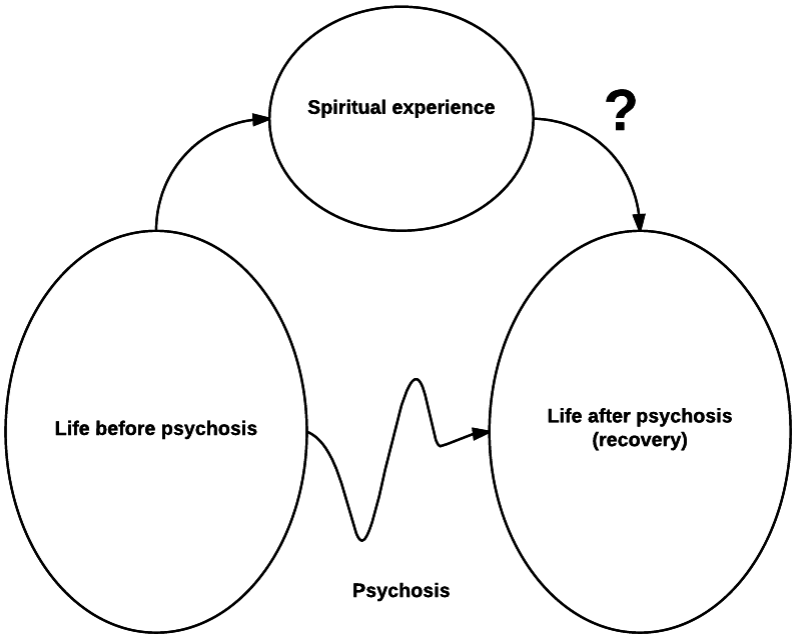

Figure 1. Simple conceptual model underlying the current research.

To answer these questions, we will start with a clarification of concepts and definitions pertaining to the domain of psychiatry and recovery (Chapter 2), and the domain of spirituality (Chapter 3). In the domain of spirituality, we will specifically focus on one theoretical perspective, namely Schilderman's Life Orientation Model (2017), that has provided the basis for structuring and analyzing five interviews with participants diagnosed with bipolar disorder, who report having had spiritual experiences during one or more of their psychoses. After clarifying the methods used to conduct the research (Chapter 4), the analyses of two of the interviews will be presented in detail (Chapter 5), and the relevance of the findings with respect to the process of recovery is discussed (Chapter 6).

2. Concepts and definitions: Psychiatry and recovery

Below, we will clarify the concepts of psychosis and bipolar disorder from a psychiatric perspective, and after that, briefly discuss mental health from the wider perspective of recovery.

2.1. Psychosis and bipolar disorder

Psychosis is usually thought of as an abnormal mental state that is in some way disconnected from reality[5]. The term "psychosis" is also used to denote a range of disorders, the so called "psychotic disorders".

According to DSM 5, key features of a psychotic disorder include the "positive symptoms" of delusions and hallucinations, disorganized thinking, disorganized motor behavior, and the "negative symptoms" such as lack of interest, monotonous speech, and diminished emotional expressiveness (American Psychiatric Association, 2013).

Psychosis may be caused by a variety of conditions or hypothesized underlying diseases, such as schizophrenia, bipolar disorder, schizoaffective disorder, schizotypal personality disorder, substance use or abuse, and childhood trauma .

More recently, it is acknowledged within psychiatry that psychotic experiences are rather common in the general population[6, 7] and these experiences are less and less viewed as symptoms of an underlying psychotic disorder like schizophrenia or bipolar disorder (Hanssen et al., 2003; Mohr & Claridge, 2015; van Os & Reininghaus, 2016). Risk factors for psychotic experiences include age, minority or migrant status, income, education, employment, marital status, alcohol use, cannabis use, stress, urbanicity and family history of mental illness (Linscott & van Os, 2013).

Bipolar disorder is characterized by disruptive mood swings, ranging from utter despair and depression at one end to euphoria and ecstasy at the other end. Bipolar disorder can be distinguished from unipolar depression by the occurrence of at least one manic or hypomanic episode.

---

[5] Although perhaps useful in a pragmatic sense, this is a rather simplistic definition ridden with complex philosophical problems. As Blom (2004) notes: *"Obviously, empirical research is virtually inconceivable without the assumption of a real world with real objects, but there is no compelling reason why this world and its objects should be understood in a realist sense and not in a transcendentalist sense. Moreover, we should keep in mind that it is our conceptual gaze which determines in large measure what we call reality. While this view is almost a platitude in philosophy, in general medicine and psychiatry it is not yet self-evident"* (p. 237).

[6] Based on an extensive systematic review and meta-analysis, Linscott and Van Os (2013) estimate the prevalence of psychotic experiences in the general population to be 7.2%. 80% of those never develop a psychotic disorder outcome.

[7] Within psychology, however, the notions of psychoticism and schizotypy as non-pathological personality traits have been around for quite a while, most notably in the work of Eysenck (1952; 1976) which was further developed by Claridge (1972; 1997).

Clinical symptoms of manic and depressive episodes have been described by Goodwin and Jamison (2007) in terms of mood, of cognition and perception, and of activity and behavior. Manic mood can be described as unusually self-confident, happy, exalted, elevated, euphoric, but also irritable and prone to sudden outbursts of rage. Manic thinking is flighty, associative, unfocused, quick, fragmented, and may become grandiose, delusional, and paranoid. Manic sensation and perception is often characterised by heightened acuity and increased though unstable attentiveness, and may become hallucinatory. Manic behavior is characterised by indefatigability, increased sexual or erotic excitability, aggressiveness, impulsiveness and excessiveness.

Depressive mood is characterised by bleakness, melancholy, despair and pessimism. Depressed cognitive functioning is slowed down, indecisive, confused, ruminative and morbid, and suicidal thoughts occur frequently. When depressed, activity is slowed down as well, sleeping patterns are disturbed, and volition is impaired. Suicide risk, both attempted and completed, is substantially higher than in the general population.

Both manic and depressed moods can be, but need not be, accompanied by psychotic episodes, though psychosis is more frequent in manic than in depressed states. Goodwin and Jamison (2007) estimate the prevalence of psychosis in bipolar disorder to be about 50%.

Two main types of bipolar disorder are distinguished[8], namely Bipolar Disorder Type I, which is characterised by the occurrence of at least one full blown manic episode (with or without psychotic features), and Bipolar Disorder Type II, which is characterised by the presence of so called hypomanic episodes. Hypomanic episodes are like manic episodes but they are by definition not accompanied by psychotic features such as delusions and hallucinations, and they do not severely impair daily functioning (American Psychiatric Association, 2013); they may in fact enhance daily functioning[9].

Rather than thinking of bipolar disorder, schizoaffective disorder and schizophrenia as three categorically different diseases, as was common up till DSM 4, DSM 5 nowadays acknowledges the dimensional character of the symptomatology (American Psychiatric Association, 2013). Figure 2 shows three hypothetical patients that would be classified as bipolar, schizoaffective and schizophrenic, respectively, and their scores on the five dimensions of mania, depression, psychosis, negative symptoms and cognitive impairment (van Os & Kapur, 2009). The move towards a dimensional approach to mental illness is highly relevant to the current research, because it potentially allows for religious and spiritual perspectives to be integrated in managing exceptional mental states in addition to treatments based on a classical biomedical perspective[10].

---

[8] Several other types of bipolar disorder are also distinguished, most notably the milder form of cyclothymia and substance induced bipolar disorder (American Psychiatric Association, 2013).

[9] *"For many individuals, indeed, hypomania by this definition is a positively attractive state to be in if it is not followed by depression or mania itself"* (Goodwin, 2002, p. 94).

[10] In his book on Anton Boisen, an American chaplain who suffered from schizophrenia, Arends (2014) elaborates on the relevance of the dimensional approach to mental illness and the possible role of spirituality: *"We conclude that a dimensional approach to psychotic disorders is sound because of the combination of genetic, neurological and biological information, and its recognition of the personal and cultural components of the subjective experience of disorders, including delusions. There is a risk of stigmatizing normal human behaviour* [because a dimensional approach does not clearly demarcate the normal from the pathological, AL]*, but it is outweighed by the advantage that certain psychiatric syndromes*

Treatment of bipolar disorder generally consists of pharmacotherapy combined with psychotherapeutic interventions. Pharmacotherapy usually consists of mood stabilizers, antipsychotics, and antidepressants. Psychotherapeutic interventions may include psychoeducation, cognitive behavioural therapy, family-focused treatment, and interpersonal and social rhythm therapy (National Institute for Health and Care Excellence, 2014)[11].

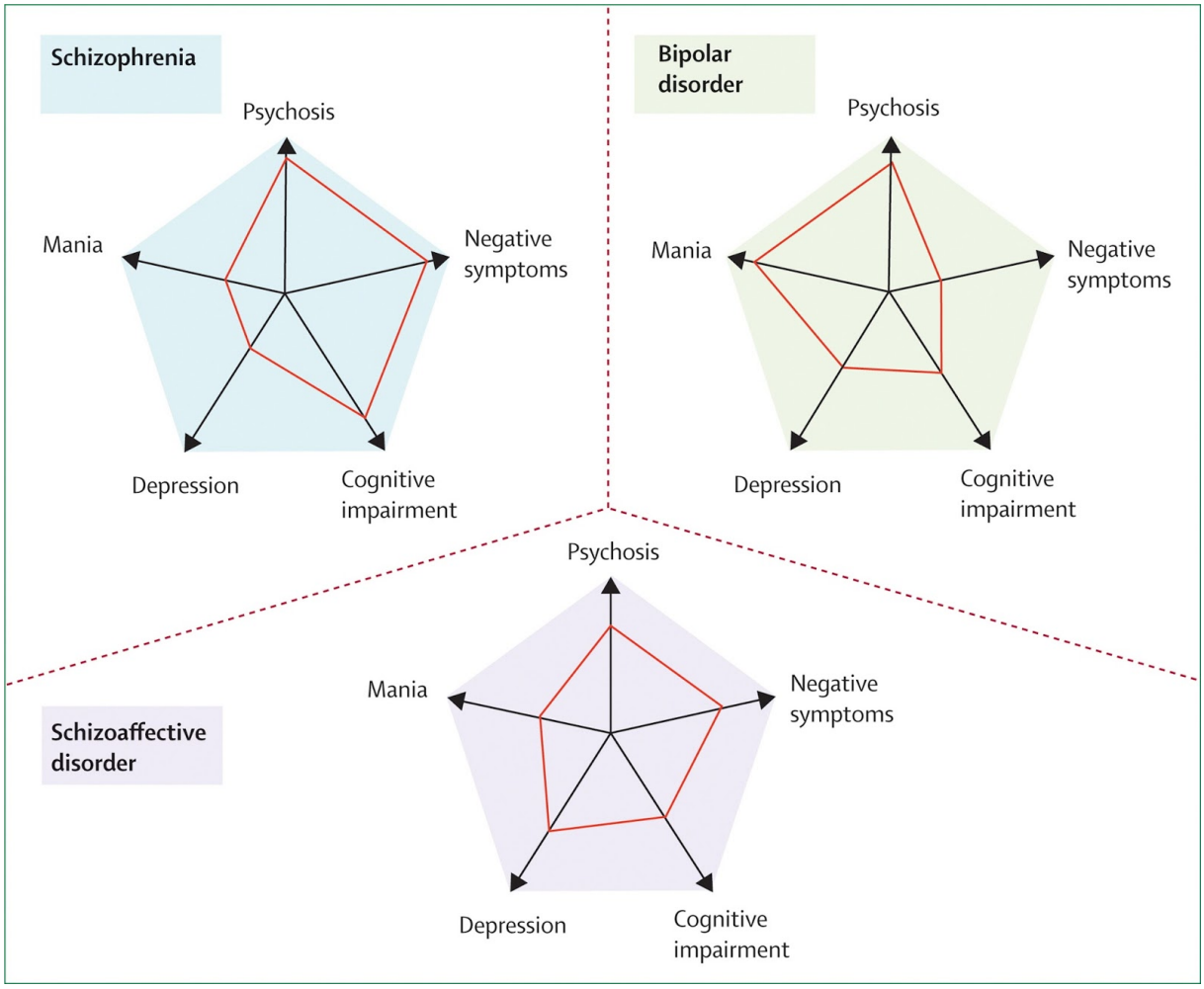

Figure 2. Schizophrenia, bipolar disorder and schizoaffective disorder depicted as expressions on a transdiagnostic psychosis spectrum. Reprinted from "Schizophrenia" by J. van Os and S. Kapur (2009), *The Lancet*, *374*, p. 637.

are seen as forms of human expression that need to be treated on the basis of the personal and cultural meaning assigned to them. That leaves scope for theological/spiritual interpretation" (p. 57).

[11] The Dutch guidelines (Nederlandse Vereniging voor Psychiatrie, 2015) closely follow the UK guidelines as stated by the National Institute for Health and Care Excellence (2014).

2.2. Recovery

The so called Recovery Paradigm in mental health was introduced by William Anthony (1993), as the guiding vision of mental health for the 1990's, although Anthony himself acknowledges that the concept originated in the writings of mental health clients themselves (e.g., Deegan, 1988). Anthony describes recovery as follows:

> *"Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals and skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with its limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."*
>
> (Anthony, 1993, p. 727)

Barton (1998) describes recovery as *"the consumer's effort to regain functional skills, social roles and self and further develop them to his or her highest potential"* (p. 177). It is the very process by which the outcomes of the medical model, the rehabilitation model and the community systems support (CSS) model are being reached. Said differently, recovery is the overarching process that is to be supported by the medical, rehabilitation and CSS models.

The medical model focuses on cure. Its goal is to cure the patient, and if complete cure can not be established, it tries to at least reduce symptoms and stabilize the condition of the patient. The rehabilitation model subsequently deals with impairments, disabilities, and dysfunctioning resulting from the illness. The CSS model, finally, specifies what services are needed within a community to provide adequate support to psychiatrically disabled people, with case management at its core.

Recovery can be thought of as not yet another model replacing or complementing the models just mentioned, but as the lived experience (Deegan, 1988) of the process of cure and rehabilitation through community support services that are tailored to the needs, values and circumstances of the individual client. Although the literature suggests many different meanings of the concept of recovery, including an idea, a movement, a method for change, a philosophy and a policy (Bonney & Stickley, 2008), for our purposes we adopt the meaning of lived experience of the process of rehabilitation as originally formulated by Deegan.

Deegan (1988) mentions several processes that are central to the spirit of recovery: *"... to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution"* (p. 11). The recovery process thus both requires and delivers participants who are active and responsible in their own rehabilitation process.

Deegan's description of the basics of the recovery process corresponds very well to the four domains of personal recovery identified by Slade (2009), namely hope, identity, meaning and personal responsibility. Hope entails an expectation of attaining personally valued goals in the future. Identity pertains to the discovery and development of a sense of uniqueness as well as connection to the rest of the world. Direct meaning can be found in the experience of illness itself, and indirect meaning can be attained by integrating the direct meaning into personal and social identity. Personal responsibility can

be enhanced by acquiring a constellation of values, emotions and behaviours that enable full engagement in life.

Over the years, a variety of initiatives, methods and programmes have been developed that intend to initiate, support and enhance recovery in mental health[12]. One of the most widely implemented is the Wellness Recovery Action Plan (WRAP), developed by Mary Ellen Copeland (Copeland, 2002). WRAP provides a well structured, practical approach to using tools and skills relevant for personal recovery in daily life and is put together by the recovering person him or herself. WRAP basically consists of six steps: 1) identify skills and tools that help to feel better or to stay well, 2) create a daily maintenance list, consisting of things to be done daily to stay well, 3) identify triggers that could cause a crisis, as well as adequate responses to those triggers, 4) identify early warning signs and appropriate responses, 5) list personal symptoms of breakdown and what should be done in case of emergency, and 6) write a crisis plan in case the recovering person is no longer capable of making decisions him or herself.

Whereas WRAP is a lean and pragmatic program focused to a large extent on identification and application of tools and skills to prevent or deal with crisis, other programs have been developed that have a broader scope, and that may include WRAP as one of its elements. One such program is "*Towards Recovery, Empowerment and Experiential expertise*" (TREE) developed in The Netherlands by psychiatric service users (Boevink, 2012). By now, TREE is a nation wide organisation, and is entirely run by experts by experience, who get paid for their work. A TREE team can be hired by institutions to set up recovery programs tailored to the needs and wishes of participants. A TREE program consists of several courses, but is built around a recovery self-help group, consisting of maximally eight persons, meeting for two hours every two weeks.

The meetings provide ample opportunity for participants to share the goings on in their daily lives, with a focus on strengths and possibilities without denying or ignoring aspects of suffering. Participants provide support and advice to each other, and by doing so learn that they themselves are a source of experiential knowledge for others. Minutes are taken at the end of every meeting to create some distance for reflection on the immediate experiences. Further down the road, participants are invited and trained to construct their own life stories, and to present them to fellow users outside of the group, requiring the story to be coherent and accessible to this new audience. Parts of the TREE program, including the self-help group, have been empirically evaluated in a randomised control trial and shown to have a small but significant positive impact on mental health confidence, care needs, self-reported symptoms and institutional residence (Boevink, Kroon, van Vugt, Delespaul, & van Os, 2016).

Although it seems straightforward to evaluate a recovery program with certain outcome measures such as mental health confidence and quality of life, it is less clear what exactly needs to be recovered when recovering, and what one is actually recovering from. In closing this section, it is perhaps good to spend a few words on these questions.

The word "recovery" suggests that something was lost and needs to be regained, yet when asked what was helpful to him in his recovery process, Christian Horvath, a member of the Austrian Society for Schizophrenia, answers: *"Not to aim for becoming once again the way you were before you became ill; people don't consider the fact that this period was precisely the time of their life when they became ill"* (Amering & Schmolke, 2009, p. 97). Barton, quoted above, mentions functional skills and social roles

[12] See Slade et al. (2014) for a brief discussion of ten empirically supported recovery enhancing interventions.

and self as elements to be regained, and Deegan, also quoted above, paradoxically mentions as a goal of recovery "*re-establishing a new and valued sense of self and purpose".* Suffice to say that it is altogether not clear what exactly needs to be retained or regained and what needs to be developed during recovery. Rather than trying to specify in advance what needs to be recovered, we may also ask in what respects people factually remain the same and in what respects people factually change when they recover. That is precisely what is done in the current research.

The question what precisely one recovers from is also somewhat less straightforward than one might think at first glance. We speak about "recovery from mental illness", but when reading for instance Boevink's "Stories of Recovery" (2006), or indeed her own intimate story of suffering child abuse, becoming psychotic and being hospitalized (Boevink, 2011), one cannot escape the conclusion that much that needs to be recovered from is the experiences people have suffered before the onset of "illness" on the one hand, and additional trauma and stigma that is inflicted upon people while being hospitalized on the other hand: *"After I broke down at the age of 20, I was in a psychiatric hospital for three years. During these years I prolonged the splitting: the violence I had been a victim of was never mentioned. My breakdown was said to be the consequence of my psychiatric disorder"* (Boevink & Corstens, 2011, p. 124).

Recovery processes are of a highly individual, and some would say "non-linear" nature (Amering, 2009), which adds to the overall intangible nature of the concept. It is however, widely agreed upon that the concept of recovery in any case includes the elements of hope, identity, direct and indirect meaning, and responsibility as outlined by Slade (2009), and corroberated empirically by Leamy, Bird, Le Boutillier, and Slade (2011).

3. Concepts and definitions: Spirituality and Life Orientation

Before elaborating on the role of spirituality and religion in mental health, it may be helpful to inquire a bit into the meaning of the terms religion and spirituality, and how they relate to one another. Although for all practical intents and purposes most of us have an intuitive sense of what those concepts mean, upon closer examination their meaning is less clear cut than we might think. Indeed, students of religion have heavily debated, and still do, what exactly constitutes the domain of religion, and what the role of spirituality is within and outside of religion. Clarifying both concepts may also aid in understanding the potential role of spirituality in mental illness as well as in recovery from mental illness.

3.1. Conceptualising spirituality

In order to get a better grasp of what the concept of religion means, it may be helpful to take a closer look at the various kinds of definitions of religion. Following Roberts and Yamane (2015), definitions of religion concern themselves either with what religion essentially *is* (substantive definitions), what religion *does* (functional definitions), or what religion *points to* (symbolic definitions). Substantive approaches to religion (Durkheim, Eliade) stress the distinction between sacred and profane dimensions of reality, and the idea that adherents of beliefs and practices related to this sacred dimension form a single moral body, namely a church. Functional definitions (Yinger, Bellah) stress the fact that religious systems provide practices and beliefs that help people in dealing with what is of ultimate concern to them. The symbolic interpretation of religion as developed by Geertz stresses the significatory aspect of religion: religions provide a worldview that points to a deeper truth that is outside of empirical verification, but that asserts the inherent meaningfulness of life.

These various perspectives are not mutually exclusive, but upon closer examination reveal certain shared elements: things that are of utmost concern to people, such as truth, tend to be sacred to them, and when these core values are shared deeply, communities (or “moral bodies”) arise, that subsequently instill and nourish those values in new members of the group. In short, religion deals with the communal aspects of making sense of what is of ultimate concern to human beings.

Spirituality can then be thought of as the subjective experience that accompanies dealing with whatever is of ultimate importance to human beings, either within the boundaries of an established religion, or outside of such a community. Many people nowadays consider themselves spiritual, but not religious, and usually this distinction then refers to the fact that people are looking for answers to what concerns them most by themselves, away from authoritarian, established traditions and institutions (Heelas & Woodhead, 2005). While spirituality and religion as modes of living are not mutually exclusive[13], it is for the current research important to point out that there often is a certain tension

[13] In fact, some authors raise the question why a strictly individual quest for meaning without an outside referent such as a church, a society or a divine power would be called “spiritual” at all, rather than, say, a way of personal transformation (Carrette & King, 2005).

between the two[14]. This tension between shared, communal value systems and worldviews on the one hand, and individual values and subjective realities on the other are indeed highly relevant for the person suffering from psychosis.

Though it is good to be aware of some of the definitional disputes that are going on when it comes to religion and spirituality, we have not beforehand restricted inclusion of participants on the basis of some criterion of what counts as a spiritual or religious experience. It is after all part of our research to explore what those experiences mean to our participants and their process of recovery. From that perspective it is more relevant to discover what turns out to be spiritual for them, and why they would call a particular experience spiritual.

3.2. Spirituality and bipolar disorder

As already indicated in the introduction by the quotes from Jaspers and James, mental illness and spirituality seem closely connected. In many non-western cultures shaman priests and faith healers exhibit behavior that to the western mind seems schizophrenic (Silverman, 1967)[15]. It has been suggested that the founders of the Judeo-Christian cultural tradition such as Abraham, Moses, Jesus, and Paul[16], suffered from a variety of psychiatric conditions (Murray, Cunningham, & Price, 2012), or alternatively, that by its systematic development of self-reflective consciousness Christianity actually was conducive to the emergence of schizophrenia (Littlewood & Dein, 2013)[17]. To some atheists, simply every form of religious belief is actually deluded (Dawkins, 2009; Freud, 2008).

The role that religion and spirituality may play in mental illness is multi-faceted. Certain religious beliefs and practices may be conducive to the development of mental disorders, e.g. causing depression by invoking extreme feelings of guilt and hopelessness, whereas other aspects of religion may prevent mental illness by providing a meaningful context to an otherwise perhaps unbearably meaningless existence and by providing a sense of community and social support. We may view the latter positive aspects of religion and spirituality as ways of coping with the problems of existence, of which coping with (mental) illness is a special case.

---

[14] *"Thus the key value for the mode of life-as* [religion, AL] *is conformity to external authority, whilst the key value for the mode of subjective-life* [spirituality, AL] *is authentic connection with the inner depths of one's unique self-in-relation. Each mode has its own satisfactions, but each finds only danger in the other, and there is deep incompatibility between them. Subjectivities threaten the life-as mode - emotions, for example, may easily disrupt the course of the life one ought to be living, and 'indulgence' of personal feelings makes the proper discharge of duty impossible. Conversely, life-as demands attack the integrity of subjective-life. This is because the latter is necessarily unique"* (Heelas & Woodhead, 2005, p. 4).

[15] However, Silverman's conjecture that shamans are in fact suffering from schizophrenia has been criticized by several authors (Handelman, 1968; Noll, 1983; Weakland, 1968)

[16] Paul writes about himself: *"I know a man in Christ who fourteen years ago was caught up to the third heaven. Whether it was in the body or out of the body I do not know—God knows. And I know that this man—whether in the body or apart from the body I do not know, but God knows— was caught up to paradise and heard inexpressible things, things that no one is permitted to tell."* 2 Corinthians, 12, 2-4

[17] Littlewood and Dein identify six aspects of Christianity that they think are potentially relevant for the development of schizophrenia, namely an omniscient deity, a decontexualised self, ambiguous agency, a downplaying of immediate sensory data, and a scrutiny of the self and its reconstitution in conversion (Littlewood and Dein, 2013).

Mental illness, however, poses a special problem for the interpretation of the role of religion and spirituality because religion and spirituality may present themselves as part and parcel of the symptoms of mental disorder. Huguelet and Koening (2009), when answering for writing their book on psychiatry and religion, introduced this problem right in the first paragraphs of their introduction:

> *"Patients facing illnesses may often use religion as a way to cope with the illness. What is problematic, however, is that sometimes symptoms have religious elements (e.g., delusions with religious content). However, clinicians involved in psychiatric care may have noticed that for patients with mental disorders, religion/spirituality also represents an important way of making sense of and coping with the stress that the illness causes. Despite these observations, clinicians often fail to inquire about the religious beliefs, practices, and experiences of patients, sometimes missing an opportunity to help relieve the suffering that psychiatric disorders cause."*
>
> (p. 1)

The problems that Huguelet and Koenig identify, and that they devote their entire book to, can be understood as an instance of what is sometimes called the "religiosity gap" in psychiatry (Mayers, Leavey, Vallianatou, & Barker, 2007). This religiosity gap entails the discrepancy between what a religious or spiritual experience means to the experiencer and how that experience may actually or supposedly be interpreted by a psychiatrist (e.g., as symptomatic of mental illness). Illustrative for the religiosity gap is the following quote of a patient describing her feelings when trying to talk about her receiving visions from God:

> *[I] relayed this experience to psychiatrists in the [hospital] and was sent for EEG tests, was told that I was hallucinating, was, this guy just didn't listen, just obviously hadn't heard anything really that I'd said... I just felt that this really positive experience was just scrutinised and just not, just like mocked. I didn't feel offended, I just thought they were being really stupid, and disregarding this kind of, yeah, really important thing*"
>
> (Heriot-Maitland, 2012, p. 49)

In general, the contents of anomalous experiences (be it spiritual or psychotic) are not a topic of conversation between patient and psychiatrist. Huguelet and Koenig (2009) identify several factors that may contribute to this communicative stagnation: psychiatrists are generally less religious or spiritually interested than the general population; psychiatrists lack knowledge of how to deal with religion and spirituality in clinical practice; there is a long tradition of antagonism between the fields of expertise of the psychiatric profession and clergy whose "customer bases" overlap; psychiatrists may be uncertain of their role and its delineation from the roles of chaplains and clergy, with whom they frequently do not have a very close professional relationship; finally, there may be a fear of actually harming the patient by turning the conversation to the content of his or her psychosis.

Patients, however, do want to talk about their experiences, and in fact do try to bring the content of their experiences into the conversation with their psychiatrist, but most of the time psychiatrists answer only reluctantly or avoidantly (McCabe & Priebe, 2008). For some clients, the actual or perceived gap between their own understanding and their psychiatrist's may be too large to bridge:

> *"Because anytime you talk about spirituality then you're deemed as having a psychotic episode. And... and that's horrific because now I'm afraid to say anything."*
>
> (Michalak, Yatham, Kolesar, & Lam, 2006)

From the side of psychiatric professionals, this tragic incompatibility of perspectives is sometimes recognized, and motivates the present research:

> *"Mental health professionals often recognize religious preoccupations as early signs of a new manic episode. This provides an opportunity to prevent a recurrent episode, but patients discover that their religious life leads to distrust from their clinicians, who feel the urge and responsibility to focus on the biological treatment regime."*
>
> *"Bipolar patients sometimes tend to conceal the experiences they have during the mania from mental health professionals, but still ponder about them or even cherish the memory of their enlightened state or spiritual insights, irrespective of the negative consequences of the manic episode. How should these religious insights be viewed?*"
>
> (Braam, 2009, p. 106)

Although stated in the context of coping with loss of mental health, relationships, careers and social roles that bipolar disorder so often brings about, Braam's words draw attention to the fact that some experiences have a potentially enlightening, insightful content that obviously means something to the experiencer. Religion and spirituality are then no longer merely meaningful as coping strategies, but constitute the core of meaning making itself. It therefore seems of vital importance to at least explore what these experiences do mean to experiencers, especially since the process of recovery is often cast in terms of meaning and purpose, as has been explicated above.

For several reasons, the present research focuses on spiritual and psychotic experiences of individuals with a diagnosis of Bipolar Disorder Type I. First, causes of psychosis, treatment methods, characteristics of the subsequent process of recovery, and expected outcomes vary greatly. Even within the population suffering from BD, there is a large variation in severity of the mood swings, duration of manic, depressed or psychotic episodes, frequency of recurrence of episodes, and degree of recovery. Findings that may hold for one constellation of factors underlying psychosis may not hold for other constellations (Pesut, Clark, Maxwell, & Michalak, 2011). We will therefore limit ourselves only to the bipolar end of the psychosis spectrum. Second, because we are specifically interested in the spiritual content of psychotic episodes, we are necessarily limited to BD Type I, since by definition the occurrence of psychosis is symptomatic of this category, and not of BD Type II. Third, empirical research, and especially qualitative research, on spirituality and bipolar disorder is scant. In a systematic literature review, Pesut et al. (2011) found six relevant publications[18] in the English language, of which only one was a qualitative study (Michalak et al., 2006). Since then, to our knowledge only one new qualitative study on spirituality and bipolar disorder has been published (Ouwehand, Wong, Boeije, & Braam, 2014).

[18] By comparison, Koenig, McCullough, and Larson (2001) reported over a hundred quantitative studies on religion and unipolar depression before the year 2000.

In their qualitative study on bipolar disorder and quality of life, Michalak et al. (2006) identified spirituality as one of six themes that more than one third of their respondents spontaneously mentioned as relevant to their condition[19]. In particular, respondents mentioned their struggle distinguishing "real" spiritual experiences from hyper-religiosity as a symptom of their condition, though hyper-religiosity during mania was not necessarily viewed as distorted. Respondents also mentioned strain in their relationship with their religious community because of their condition. Some felt that their religious or spiritual beliefs actually lifted them up during their lows.

Ouwehand et al. (2014) interviewed ten individuals with bipolar disorder about their spiritual experiences during mania or depression, and how they interpret them in hindsight, and inquired into their expectations of treatment with regard to these experiences. The quest for meaning of the experiences and the question of their authenticity turned out to be major themes for the respondents, next to cherishing blissful experiences, the role of spiritual practice, and expectations and suggestions for integrating spirituality into the treatment.

The present research has some overlap with that of Ouwehand et al. (2014), but differs in some respects. First, the present research has a somewhat narrower focus, in that it explicitly inquires into the meaning of spiritual content of psychoses for the process of recovery, as experienced by the participants. Second, it is somewhat more theoretically inspired and embedded than Ouwehands study: the interviews are structured based on Schilderman's Life Orientation Model (explained below) and interpreted within this framework to explicitly shed light on the process of meaning making.

3.3. Spirituality and recovery

Several years ago, Huber et al. (2011) proposed a new definition of health that in their view should replace the current WHO definition of health[20], dating from 1948, and that they considered outdated. Their new definition, "*Health as the ability to adapt and to self-manage, in the face of social, physical and emotional challenges*", stresses the human capacity for resilience and coping with new situations, rather than striving after "*an unattainable utopian and static state according to which almost everybody to some extent could be considered ill*" (Huber et al., 2016). Moreover, this new definition suits the recovery paradigm very well, because of its focus on self management given the challenges brought about by illness instead of a focus on complete cure.

Huber et al. (2016) subsequently operationalised their new health concept based on interviews and focus group sessions with some 140 participants from a variety of stakeholder domains, including patients. They asked, among other things, what participants considered indicators of health. Their inquiry yielded a total of 32 indicators of health, that could be categorized in 6 dimensions: bodily functions, mental functions and perception, a spiritual/existential dimension, quality of life, social and societal participation, and daily functioning.

---

[19] However, when asked to mention the three most important factors contributing to their quality of life, spirituality was named only once (number of respondents = 35, total count of factors = 92), the most frequently mentioned factors being social support, physical health and mental health.

[20] "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or informity*" (World Health Organisation, 2006, p. 1)

Although the fact that one of the dimensions of health that emerged out of Huber et al.'s study is concerned with spiritual and existential issues is obviously relevant to the current research, even more interesting is the finding that the value attributed to this dimension varies according to the specific stakeholder domain: citizens, patients, nurses and public health actors highly value the spiritual/existential dimension, whereas policy makers, researchers and doctors value this dimension to a substantially lesser degree. This may be taken as another indication of the existence of the so called religiosity gap mentioned above, and stresses the importance of addressing spirituality in healthcare settings.

An extensive systematic literature review by Leamy et al. (2011) underscores the importance of spirituality for recovery from mental illness: out of the 87 publications on personal recovery they reviewed, 36 (41%) indicated spirituality to be part of the meaning making process of recovery. By contrast, a qualitative analysis of 45 personal accounts in recovery from severe mental illness by Wisdom, Bruce, Saedi, Weis, and Green (2008) yielded various identity-related themes, but the authors do not mention any spiritual or religious themes at all. This may simply reflect a personal preference of the authors or the journals that originally published the personal accounts: what is taken to be spiritual for one, does not necessarily have to be spiritual for another. Where some see recovery of identity, self esteem and social enrolement, others would call precisely those the elements of spiritual transformation: *"Growth may take the overt form of skill development and resocialization, but it is essentially a spiritual revalueing of oneself, a gradually developed respect for one's own worth as a human being"* (Lukoff, 2007, p 642).

When religion and spirituality do play a role in recovery, they seem to impact the lives of those in recovery in various ways. Fallot (2007) indicates four areas where religion and spirituality seem to play out for those in recovery: they may strengthen a sense of self and self-esteem, they may provide coping strategies for dealing with symptoms and distress related to illness, they may be instrumental in providing social and moral support as well as a sense of connectedness, and they may instill hope and a sense of purpose in those who are recovering.

Fallot does point out, however, that the role of religion and spirituality is not unequivocally positive: people sometimes use negative religious coping strategies (anger directed towards God, seeing illness as a divine punishment, etc.), they struggle with their belief because of their illness, they may feel marginalized or stigmatized by their religious community because of their illness, and the very same spiritual experiences that may enhance self esteem, confirmation, and sanctioning in individuals may simultaneously be the cause of estrangement from their community, who may not share, understand or sanction those experiences.

Fallot therefore advocates a highly individualized approach to spiritual and religious concerns in recovery from mental illness: *"An individualized approach means that clinicians need to be aware of the multiple and complex ways spirituality can function in the lives of consumers with mental health problems. The roles of spirituality and religion may be tremendously variable at different times, in different situations, and in coping with different kinds of difficulties and stressors"* (p. 265). The current empirical investigation is entirely in line with this individual approach, in that it carefully tries to map out what the meaning is of spiritual experiences during psychosis for a person recovering from mental illness from a first person perspective. In order to remain as close as possible to the experience of the participant, while simultaneously ensuring a wide enough gaze on circumstances and conditions that

have been conducive to these experiences, or that have been influenced by these experiences, we apply Schilderman's Life Orientation Model of spirituality, as explicated below.

3.4. Spirituality as Life Orientation

For a number of reasons, Schilderman's (2017) provisional Life Orientation Mode (LOM) will be used as a background both for initial clarification of concepts and for subsequent interpretation of the empirical findings. First, it roots itself in a theory of consciousness, which is attractive given our choice to view so called spiritual or pathological experiences first and foremost as states of consciousness. Second, Schilderman's model is multi-layered in its approach to meaning and signification, in that it seems to leave room for the inherent, immediate meaningfulness of an experience, but also for its existential meaning, its meaning as it reveals itself in time and as it shows itself in subsequent actions in the life world. In short: it leaves room for the dynamics of meaning making. Third, Schilderman's model explicitly mentions spirituality as an aspect of signification. Fourth, because of the deeply reorienting character of the recovery process, Schilderman's model fits very well with the recovery paradigm in mental health. Resnick (2005) explicitly conceptualizes recovery as *"... an attitude or life orientation. As an orientation, we firmly place the concept of recovery in the domain of process, but like all attitudes, it can also be measured and in some contexts used as an outcome"* (p. 120).

Schilderman's model is rooted in the Essential Embodiment Theory (EET) of Hanna and Maiese (2009). Hanna and Maiese define eight basic structures of consciousness that are inherent in subjective experience. These structures are 1) temporality, 2) intentionality, 3) affectivity, 4) intensity, 5) focus, 6) spatiality, 7) embodiment, and 8) egocentricity. Schilderman then frames eight questions, each pertaining to one of the structures, that an individual may ask him or herself about his or her state of consciousness, thereby opening up the specific realm of meaning and spirituality in which a spiritual carer typically does his or her work: 1) "What choices do I need to make?", 2)"What are my basic concerns?", 3) "Whom or what do I care for?", 4) "How do I feel?", 5) "How do I adapt to my environment?", 6) "How to deal with my body?", 7) "What has priority now?", 8) "Who am I, and what is mine?".

The questions thus translate Hanna and Maiese's abstract, conceptual elements of consciousness from a third person perspective into a first person, experiential perspective. According to Schilderman, asking and answering these questions comprise the process of life orientation, in which each question addresses a specific area or component of the life orientation process, namely: 1) contingencies, 2) final values, 3) emotions, 4) life plan, 5) life world and 6) world view.

Table 1 summarizes this conceptual structure.

	EET	Questions	LOM Component
1	Temporality	What choices do I need to make?	1. Contingencies
2	Intentionality	What are my basic concerns?	2. Final values
3	Affectivity	Whom or what do I care for?	3. Emotions
4	Intensity	How do I feel?	
5	Focus	What has priority now?	4. Life plan
6	Spatiality	How do I adapt to my environment?	5. Life world
7	Embodiment	How to deal with my body?	
8	Egocentricity	Who am I, and what is mine?	6. Worldview

Table 1. Structures of consciousness according to EET, corresponding existential questions as formulated by Schilderman (2017) and derived components of the Life Orientation Model.

Below, the six components of the Life Orientation Model will be further explicated.

1. Contingencies

Schilderman subsumes the existence of contingent experiences under the temporal aspect of consciousness. Contingent events are events that are in fact true (they happened once and for all), but did not occur out of necessity. Time as such has a contingent character, because what happened in the past cannot be changed, whereas what will happen in the future remains in the realm of possibility, and not of necessity. In this sense, all events are contingent by nature. However, when we speak of contingent events within the domain of spiritual care, we usually refer to major life events that are partly or largely beyond our control and that make us question the meaning of our lives: birth, death, illness, unemployment, falling in love, meeting a soulmate, etc. These events force us to take a new stance towards our lives, and we have to make choices how to deal with them. By making those choices we actively engage with the contingent nature of life: by making choices, we commit ourselves, bringing something from the eternal realm of possibility to the temporal realm of actuality.

2. Final values

Most, though not all, of our mental states are intentional: they are directed towards something, they are about something (Searle, 1988; 1992). I believe I will succeed in life, I long for death, I enjoy playing music, I adore my wife, I hate Microsoft Windows, I fear my father, and I am devoted to my work. Underlying these intentional, conscious mental states are what we find of importance, what we value, what we appreciate, or what we abhor or dislike. When we talk about values that give direction and meaning to our lives as a whole, we speak of final values.

3. Emotions

All mental states are affectively colored to a greater or lesser degree: judgements of beauty are not mere cognitive judgements, but evoke, or are evoked by, feelings of pleasure or elation, and when we condemn murder or violence, we do so while being abhorred, disgusted, enraged, and indignified by what we see. Emotions inform us about how we relate to the goings on in our lives, when to take action, and in what general direction: the unpleasantness of being thirsty urges us to drink water, and the anticipated pleasure of sensing a soft breeze of cool air on our wet skins on a hot summer day invites us to take a swim.

4. Lifeplan

We cannot be conscious of everything all the time: some mental contents take priority, or are given priority over others that linger more in the backs of our minds. Events may draw our attention, and, alternatively, we may choose to focus on certain things and not others, depending on what goals we would like to achieve. Actively setting goals, prioritizing those goals and devising strategies on how to achieve them make up plans. Life plans are plans that are created to globally direct the course of our lives: getting an education, finding a partner, raising a family, growing a business, etc.

5. Lifeworld

The spatial aspect of consciousness consists of our minds being embodied, and of our minds operating by means of that body in the outside world. This outside world per se is not yet the life world. The life world is the living world that we inhabit and engage with, the world as it appears to us, as it discloses itself to us, providing us with opportunities and challenges with respect to our life's goals and purposes.

6. Worldview

Consciousness is fundamentally perspectival: because our bodies are always located somewhere in space, we experience the world from that specific vantage point. As Searle (1992) put it*: "The world itself has no point of view, but my access to the world through my conscious states is always perspectival, always from my point of view"* (p. 95). This is not only true in the most direct, physical sense, but holds true with regard to our higher cognitive functioning as well. Our memories, our language, our knowledge base and skills also provide us with a vantage point from where we view the world, and they therefore colour the world that we perceive. Alternatively, the way we perceive the world discloses to us both literally and metaphorically, where we stand, what our point of departure is for our engagement with the world, and ultimately who we are. As perhaps the most elaborate of cognitive structures, our worldview is intimately interwoven with our identity: when our worldview collapses, so do we, and when we collapse, so does the perceived world.

Figure 3 shows the conceptual model inspired by the Life Orientation Model that underlies the current research. It should be stressed once again that the current research is not concerned with the relationship, or the differences or similarities between spiritual and psychotic experiences, but to clarify the role that spiritual experiences during psychosis may have on the recovery process.

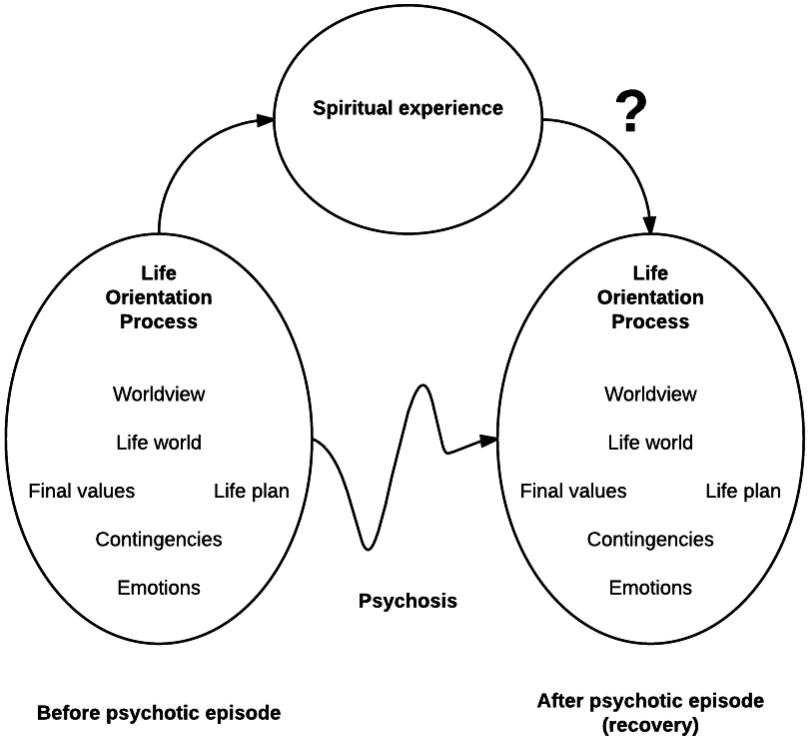

Figure 3. Conceptual model underlying the current research, cast in terms of Life Orientation

4. Research Methods

Below, we will describe in detail the way the research was set up and conducted, how participants were recruited and selected, and explain the way the results were analyzed and reported.

4.1. Research strategy

Because the research is mainly concerned with the *meaning* of spiritual experiences, we chose to perform a qualitative analysis on data obtained during semi-structured interviews. The decision to conduct specifically *semi-structured* interviews was based on a pilot study, that showed the necessity of directing and demarcating the interviews when discussing the topic at hand and to ensure that the relevant topics would be addressed, and that the timeline of events would become clear.

Interviews were conducted at the home of the participants (4 persons) or at the home of the researcher (1 person), and typically lasted around 90 minutes. The interviews were recorded with a voice recorder.

Before the interview started, some time was taken for casual conversation and to clarify the purpose of the research and the way the interview would proceed. Participants were asked to read and sign an informed consent. The original informed consent as well as an English translation can be found in Appendix 1.

The interviews themselves consisted of two parts: during the first part, which lasted on average approximately 30 minutes, the participant was asked to relate in as much detail as possible his or her most significant psychotic episode with spiritual or religious content. In the remaining part of the interview, the participant was asked to elaborate on the meaning the episode carried for his or her life. The participant was invited to reflect freely, while the interviewer monitored whether all components of the LIfe Orientation Model had been addressed, and would inquire explicitly if a component was not touched upon or was mentioned, but seemed to invite or require further elaboration. These explicit inquiries were drawn from a set of previously formulated guiding questions, that either pertained to the period before the psychotic episode, or to the period after the episode, or that inquired whether the content of the episode influenced aspects of life after the episode, and if so, in what way. The list of guiding questions was not rigidly adhered to, but was applied flexibly depending on the flow of, or stagnation in, the conversation. The complete list of guiding questions can be found in Appendix 2.

At the end of the interview, participants were given the opportunity to mention anything they thought might be relevant, but had not told yet.

After the interview, participants filled in four short questionnaires (MHRM, ASRM-NL, QIDS-SR, personal data), and were thanked for their cooperation.

The audio recordings were transcribed verbatim and subsequently analysed using a software tool for qualitative data analysis (Atlas.ti 7.5.16).

4.2. Participants

Five participants were recruited through the Facebook page of a Dutch reform movement consisting of peers and professionals within the psychiatric community, called “De Nieuwe GGZ” (“The New Mental Health Care System”). The precise formulation of the invitation can be found in Appendix 3.

Inclusion criteria were as follows:

1) diagnosed with Bipolar Type I,
2) having experienced at least one psychotic episode with religious or spiritual content, and
3) having recovered according to the person him- or herself, the recovery being corroborated by the Dutch version of the Mental Health Recovery Measure (van Nieuwenhuizen, Wilrycx, Moradi, & Brouwers, 2014)

Exclusion criteria:

1) being in a clearly (hypo-) manic mood, as measured by the Dutch version of the Altman Self-Rating Mania Scale (Altman, Hedeker, Peterson, & Davis, 1997), and
2) being in a clearly depressed mood as measured by a Dutch version of the Quick Inventory of Depressive Symptomatology (Rush et al., 2003), respectively.

The following background variables were recorded: age, sex, education, religious orientation, date of psychotic episode, additional psychiatric diagnoses, and current medication.

4.3. Instruments

In order to establish recovery of participants, the Dutch version of the Mental Health Recovery Measure (MHRM) was administered (van Nieuwenhuizen et al., 2014). It is validated, and found reliable and valid. Furthermore, the MHRM explicitly addresses spirituality as a factor in recovery.

To determine the presence of hypomanic or manic moods, the Dutch version of the Altman Self-Rating Mania Scale was used (ASRM-NL[21]). The original scale in the english language was introduced in 1997 (Altman et al., 1997). The ASRM is easy to use, quick to administer, and found reliable and valid even when patients are psychotic (Altman, 1998). A score of 5 or higher is usually taken as indicative of (hypo-) mania.

To determine whether or not a participant was in a depressed mood, a Dutch translation of the self-rating version of the Quick Inventory of Depressive Symptomatology (QIDS-SR[22]) was administered. QIDS-SR is a 16-item version of a longer inventory, and therefore much quicker to administer. Its is found to be reliable and valid (Rush et al., 2003), it is validated for use with bipolar patients (Trivedi et al., 2004), and although the Dutch version is not completely validated, it is highly recommended and frequently used in routine outcome monitoring in The Netherlands (Meesters, Duijzer, Nolen, Schoevers, & Ruhé, 2016). A score of 6 and below is usually indicative of the absence of depression.

---

[21] Dutch translation by Leyman, 2004

[22] Dutch translation by Altrecht Psychiatric Institution, 2003/2005

4.4. Analytic strategy

Analysis and interpretation of the transcribed interviews were guided by the principles of Interpretative Phenomenological Analysis (IPA) as developed by Jonathan Smith and others (Smith, Flowers, & Larkin, 2009). IPA is rooted in both the phenomenological tradition started by Husserl, and developed by Heidegger, Merleau-Ponty and others, as well as the hermeneutic tradition of Schleiermacher, Heidegger, Gadamer and Ricoeur.

In a practical sense, applying IPA means that the interviews are closely read several times. Significant or striking fragments were noted and coded (open coding), and re-interpreted and recoded as new and different insights developed, and overall themes emerged that captured the meaning of the episodes for the participants as it pertained to the process of recovery that they embarked upon. Simultaneously, fragments in the interviews that pertained to the six components of the Life Orientation Model (i.e., contingencies, final values, feelings, life plan, life world and worldview) were coded in code families (topical coding) and ordered in time (episodic coding) in order to be able to trace changes in their meaning or content in time. Lastly, for each interview the codes were assigned to code families according to the main narrative themes that emerged out of the analysis (rhetorical coding). This code scheme is presented in Table 2.

Open coding	**Topical coding**	**Episodic coding**	**Rhetorical coding**
Individual quotes	LOM components	Before and after the spiritual experience	Narrative themes

Table 2. Coding scheme

After coding, two out of the five interviews were selected for detailed reporting below[23]. Similarities and differences will be noted and commented upon. In both interviews, the main narrative themes are identified and clarified using the Life Orientation Model, and lastly, the relevance of the findings for the recovery process will be indicated.

Figure 4 summarizes the conceptual design of the current research project.

[23] Reasons and criteria for selecting only two interviews are given in section 5.1.

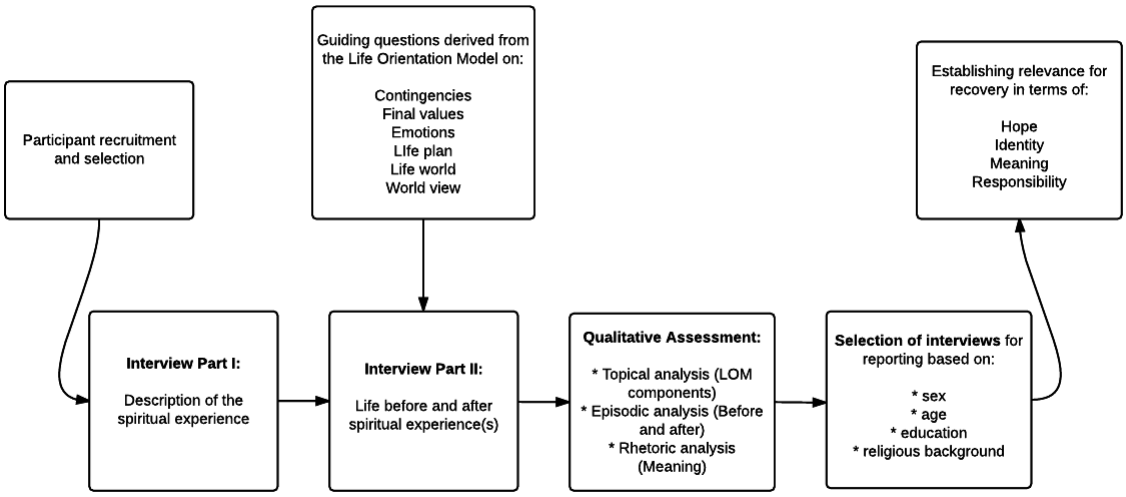

Figure 4. Conceptual research design

5. Results

Below, the results of the investigation are presented. First we will describe characteristics of the persons interviewed. Then we will extensively report on the ideographic results, and lastly close the chapter with a brief summary of the findings.

5.1. Sample characteristics

A summary of the demographic data of the participants can be found in Appendix 4. Participants (4 female, 1 male; 43-55 years old) were well educated, with 4 out of 5 having an academic degree (master's level). Religious beliefs varied, but none of the participants were actively involved in a religious organisation at the time of the interview. All participants scored well on the MHRM, meaning they showed good signs of recovery. One participant was using antipsychotic medication at the time of the interview (lithium). None showed signs of mania according to the ASMR-NL. One participant's score on the QIDS was exactly on the cut off point for complete absence of depression, but scores for all other participants on depression were low.

One participant withdrew her consent to use her interview after analysis when asked to review a summary of the interview. She had suffered another psychotic episode about two months after the interview took place. She considered the interview as a prelude to the psychotic episode, and felt no longer in agreement with the contents of the interview.

Because the dropped interviewed was crucial in the overall picture in the sense that it tied many of the emerging themes together, and because the remaining four interviews by themselves were judged to be too varied to make any sort of generalization, it was decided to select two interviews that were rather far apart in terms of the backgrounds of the participants, as well as with respect to the kinds of stories they related, and to provide in depth reports on those interviews.

Table 3 shows the characteristics of these two participants, Alwin and Marian, whose interviews were selected for detailed reporting. They differed by sex, age, level of education, and religious background.

	Alwin	**Marian**
Sex	Male	Female
Age	54	42
Education	Vocational	Academic
Religious background	Not religious	Protestant Christian

Table 3. Background characteristics of the participants chosen for detailed reporting.

Table 4 shows their scores on the various questionnaires that were administered. Neither of the participants were in manic or depressed moods, and both had good recovery outcomes.

		Alwin	Marian
MHRM	Empowerment	53 (82%)	62 (95%)
	Learning and new potential	66 (88%)	62 (83%)
	Spirituality	9 (90%)	7 (70%)
ASMR-NL		3	0
QIDS-SR		6	0

Table 4: Scores on the MHRM, ASMR-NL and QIDS-SR of the participants chosen for detailed reporting.

5.2. Ideographic results

Below, the results of the two selected interviews are presented. Each presentation starts with a summary of the interview, followed by a description of the spiritual experience(s) the participants chose to focus on, formulated as much as possible in the words of the participants themselves. Then topical and episodic description of life before and after the episode will be presented, with explicit references to the relevant quotations[24] that can be found using the Atlas.ti Quotes List for each participant in Appendix 5[25]. After that, the meaning of the spiritual experiences according to the participant will be related, and finally the results will be discussed in terms of relevance for the process of recovery according to the researcher.

5.2.1. Alwin

5.2.1.1. Summary of the interview

Alwin grew up in a small town in the south of The Netherlands. He always felt a bit different from other people, but at the same time tried to adjust himself as much as possible to not be out of tune. He never felt quite free to do what he really wanted to. When he was 21, he emigrated to New Zealand with his girlfriend, because he was unhappy at home. He planned on growing a business and raising a family. The business flourished, but his girlfriend did not want to have children.

Alwin had been living in New Zealand for some ten years when he took a business trip with a friend to Japan. He had not been feeling well, neither physically nor mentally and was a bit stressed because he did not bring the medication for a viral infection that he suffered. Gradually though, he felt better and better, until he started to feel euphoric: his senses were very sharp, he knew his way around town

[24] Quotations are literal transcriptions of the audio recording of the interview, so they are in Dutch.
[25] References to quotes are given between square brackets. The number before the colon indicates the participant (2 = Marian, 4 = Alwin), and the number after the colon identifies the particular quote. The transcriptions of the complete interviews (in Dutch) can be obtained from the author (alelivelt@gmail.com).

remarkably well, he had premonitions and he was very self confident leading the Japanese employees he was not even in charge of.

One night, he got lost in the Japanese town they were staying in, and when he finally found his way home, he experienced all kinds of weird things, like standing in front of the mirror having the feeling that he could peel off his own face. He had thrown away his Dutch passport, together with other things that reminded him of The Netherlands. When he went out that night and looked at the starry sky, filled with galaxies, he suddenly collapsed and lost consciousness.

Alwin was flown back to New Zealand, diagnosed with bipolar disorder and hospitalized four times within one year. He broke up with his girlfriend, and moved back to The Netherlands.

Back in The Netherlands, Alwin got married, but he and his wife do not have any children, due to his wife being infertile. Alwin does spend a lot of time with children of friends of his.

Alwin explored several alternative practices to develop his intuition. One of these practices was Reiki. To fulfill the requirements for his second degree, one day he applied Reiki from a distance to his father. While performing Reiki this way, Alwin started to see colors and chakra's, while his father later reported that he could not stop crying at that very moment.

When in bed that night, Alwin experienced a kind of stepping out of himself. He saw himself lying down on the bed, with a swollen belly, giving birth. One moment he experienced himself as the mother giving birth, the other moment he experienced himself as the father looking on.

Alwin has been hospitalized several times and is currently unemployed. Back in New Zealand, he had plans for his business and his family, but now he takes life as it comes, and is not making any major plans. In due time, however, he would like to volunteer or work as an expert by experience.

Meanwhile, Alwin is exploring his female side, which is quite strong in him. He is paying a lot of attention to his body, likes hugging and tenderness, being massaged and likes to spend time in saunas. He is cherishing his sensitivity and more freely expresses his emotions, like crying.

Everything that has happened to him has made Alwin more fearful than he was before his psychotic episodes. He has become aware of life's mercurial tendencies, and tries as much as possible to listen to himself, to open up to his partner and other people around him, and to practice letting go of things.

Alwin has become very aware that he has had difficulties going his own way. Even when apparently choosing for himself by emigrating to New Zealand, he again found himself listening more to other people than to himself. Now he is paying a lot of attention to what he really wants and needs, rather than making great plans or fleeing situations. He developed a strong sense of the importance of being oneself, of being an individual with one's own individual purpose in life. He likes to be with people who are also on a quest to discover their purpose in life.

5.2.1.2. Description of the spiritual experience

Alwin mentions two significant spiritual experiences, each taking place in different episodes. The first experience is actually a quality of experiencing, rather than a single experience. When in Japan, Alwin becomes very lucid and has a heightened sensory awareness to the point of clairvoyance:

"… at night, we again went out for dinner, eh…, to this karaoke bar. At one point, I said to this friend of mine, when we drove back, I said: 'Hey, I don't think you're driving the right way!' Then he says: 'What do you mean: I'm not going right? No…!' He says: 'But you have never been here!? How could you know where to go?' I said: 'Yes, but I think we were coming from this direction'. And, eh…, but that was indeed the case, so I was still…, so I knew too…, yes, I was…, at that moment I was very good at orienting myself and all…" [4:10]

"... at one time, it was like something snapped in my head, and then I said: 'Well, I think I will get that gun out the closet over there, and blow my head off…' So this guy says, eh…: 'Indeed', he says, 'there is a gun in the closet, but how could he possibly know?'. It was like, all kinds of these really weird things happened…, these incoherent little things, but it all matched up." [4:14]

"... I said to this woman: 'O yeah, congratulations, of course, because of…, well, the birth of your little one, soon…' Then the guy says: 'Yes, my wife is pregnant indeed'. But you really could not see anything yet, but eh…, yes, I was right, you know." [4:13]

"Well, it was rather like, yes, a kind of clairvoyance, you know, and, well, my sense of smell was very much eh…, activated [...] I could smell someone from a distance of 10 meters, you know…" [4: 40]

The second significant spiritual experience takes place when Alwin had migrated back to The Netherlands again, and consists of Alwin seeing himself giving birth:

"So that night, we went to bed, and at one moment, in the middle of the night, I had eh…, it was, yes, sort of a psychotic episode, but it did not really come through, because I had a kind of out-of-body experience. So, I…, I was hovering over the bed, and I saw myself lying there, and at a certain moment... , I saw myself lying there with a swollen belly, and…, and…, I was lying like this, and I was giving birth, really, you know." [4:27]

[Researcher:] "That other episode was back in The Netherlands. And what,.., could you briefly indicate what was so special about that?" [Alwin:] "Yes, that was the…, the rebirthing experience, you know, or being born again." [R:] "This out of body experience, seeing yourself suddenly, yes, and seeing yourself in a birthing posture?" [A:] "Yes, yes, yes. And then, at a certain moment, I stood at the other side of the bed, saying: 'Yes, he is coming, I can already see his head!' And then I was lying there again, going like: 'Yeah…, yeah…, push…, push,…, I can see him already!' Hahaha… " [R:] "And were you the mother giving birth, so to speak?" [A:] "Yes. And the father too". [R:] "And the father too. But not the child? Or…? [A:] "No." [R:] "No. The way you saw it, it was…" [A:] "I was the mother and the father." [4: 126]

5.2.1.3. Topical and episodic analysis

Contingencies[26]

Events

Before. Early on in the interview, Alwin mentions the fact that as a child he had some traumatic experiences, though he does not provide a lot of details. He witnessed his sister almost getting drowned, and experienced almost drowning himself [4:5]. He also mentions having been verbally and physically abused by his father, again without going into any detail [4:121]. Alwin suspects he has also been sexually abused as a young child, but he is not sure of that [4: 89].

Before/After. Another important contingent event, or rather non-event, in Alwin's life is the fact that he remained without children. His girlfriend in New Zealand did not want children, his wife in The Netherlands suffered fertility problems [4:84; 4:50].

Before/During. A more general type of contingency that preoccupies Alwin is the existence of contingency itself. Several times Alwin mentions how his expectations were not met. In a wide sense, remaining childless is one of those expectations that did not come through [4:84; 4:88], but on a smaller scale just before entering his first episode Alwin describes how Japan was so very different from what he expected (much more beautiful, much greener) [4:79]. He also expected that the area around Kobe, where he stayed, would still bear the scars of a recent earthquake that had been all over the news, but he did not see any of that. During his first psychotic episode, Alwin kept on seeing the images of the earthquake in his mind: *"It was like a hard disk spinning round that did not bear any relation to reality"* [4: 86].

Choices

Before. Two major choices that Alwin made in his life stand out at first sight: his decision to emigrate to New Zealand [4:1] and his remigration back to the Netherlands some ten years later, after his first psychotic episode [4:91]. However, Alwin qualifies these decisions as fleeing the situation: first fleeing his family in The Netherlands [4.2] and later fleeing from facing himself with his mental vulnerability in New Zealand [4:21].

The inability to choose by and for himself is characteristic for Alwin's life before his mental breakdown [4:43; 4:122].

After. While recovering in The Netherlands, Alwin is gradually better able to make choices of his own: the choice to face his fear of living that he felt ever since his breakdown [4:47], the choice to lower his dose of medication [4:36], the choice to explore alternative ways of dealing with his vulnerability [4:96], and the choice to befriend other women and their children, even though it occasionally puts a strain on the relationship with his wife [4:99].

Final values

[26] The LOM component "Contingencies" pertains both to contingent events, and people's responses to those events. Therefore, this component is divided into "Events" and "Choices".

Before. It is unclear what Alwin's core values are in his life before his episodes, except for the fact that he greatly values raising a family [4:84].

After. After his episodes, he becomes very much conscious of the importance of being an individual [4: 74; 4:113], of discovering one's purpose in life [4:72], making his own choices [4:37; 4:97] and being himself, and being authentic and free [4:39; 4:49].

Emotions

Before. Alwin describes himself as being a rather cheerful and sensitive person by nature [4:42], but also felt different from other people and had difficulty fitting in [4:75]. Adjusting to others had become his second nature, so much so that he felt like he gradually lost himself [4:31; 4:43; 4:44]. He felt guilty towards his parents for leaving The Netherlands [4:18], and depressed because of a conflict while visiting them shortly before his trip to Japan [4:83]. Ever since leaving The Netherlands to live with his girlfriend in New Zealand, he had been longing to have children of his own [4:84].

After. Alwin feels more fearful of living after the psychotic episodes [4:45; 4:46]. At the same time he made a conscious decision to face his fears, to open up, and to explore his female side [4:61; 4:62; 4:104]. He rediscovers his sensitivity that he felt he had lost because of his medication [4:101]. He expresses a strong dislike of psychiatric treatment when it is nothing more than symptom suppression because he feels something essential is getting lost because of it [4:35; 4:123].

Life plan

Before. Apart from wanting to raise a family [4:23; 4:48; 4:84], Alwin had little sense of direction in his life [4:4]. Alwin describes his migration to New Zealand and his remigration back to The Netherlands some 10 years later as fleeing his life situation [4:2; 4:31]. In that sense, his lifeplan can partly be seen as avoiding something rather than achieving something.

After. Although Alwin hopes to be able to work as an expert by experience [4:53; 4:34], he currently has no plans for the future [4:51], but this lack of a lifeplan is a conscious choice: he wants to take life as it comes, while exploring his female side and following his intuition [4:64; 4:68].

Life world[27]

World

Before. Alwin spent some 10 years of his life in New Zealand [4:1; 4:67], where he ran a construction business [4:124]. He was living with his girlfriend. Their relationship remained without children because his girlfriend did not want any [4:84]. They did take care though of a young nephew [4:94].

After. After his first episode, Alwin moved back to The Netherlands, where he had his second psychotic episode [4:91]. Alwin is now married, still without children because of his wife's fertility problems [4:50]. He is unemployed [4:52]. He spends some of his time with female friends and their children [4:99], and enjoys conversations with people who have had similar experiences to his [4:71].

[27] The LOM component "Life world" pertains both to the world as experienced and lived in, and to the body as the vehicle for the mind. Therefore, this component is divided into "World" and "Body".

Body

Before. Before his episodes, Alwin was not particularly conscious of his body [4:59], although he always took care to eat healthy food [4:98].

During. During his psychotic episodes, however, his bodily awareness is heightened, and Alwin feels the need to cleanse his body by taking three or four showers a day [4:114]. During the second episode that Alwin relates, he has an out of body experience, seeing himself giving birth [4:27].

After. After his episodes, Alwin remains much more aware of his body than before, and likes to be hugged and massaged, and frequently enjoys a sauna [4:58; 4:115; 4:60]. Alwin has been exploring various alternative spiritual practices, such as Kundalini, Reiki and Qigong [4:96], but guards his boundaries carefully, so that he does not get too much energy [4:63; 4:67].

Worldview

Before. Before his psychotic episodes, Alwin did not have a very explicit worldview, though his outlook on life was generally positive [4:55].

After. His experiences of heightened sensory awareness contain for him a spiritual dimension [4:40]. Alwin sees his rebirth experience as a spiritual experience, having to do with the "*emergence of the inner soul*" [4:29]. He believes that we all have a core that is uniquely individual, and that needs to be discovered and developed [4:30]. Since his rebirth experience, Alwin has a strong urge to explore his female side. He is also interested in alternative views on psychosis, such as shamanistic practices [4:65], and thinks western psychiatry focuses too much on symptom suppression [4:33].

5.2.1.4. Rhetorical analysis (emerging narrative themes)

Theme 1: Children

Before his psychotic episodes, Alwin wanted to grow a business and raise a family. He succeeded in doing the first, but he did and still does not have children. He is very disappointed about that. In his first episode, the theme of children and his unmet expectations come to the fore when he is convinced that his girlfriend is about to give birth to one or more children, which does not happen because in fact she is not pregnant. In the second episode that Alwin relates, he is both giving birth, as well as looking on himself giving birth. He is later interpreting this as a rebirth of himself, but when asked he says he was both the father and the mother, but not the child.

Theme 2: Identity

Alwin has alway adjusted himself to others, to the point of losing himself. In his hypomanic state during his first episode however, Alwin experienced for a limited amount of time a different, powerful self, the self that he could be. In order to become more fully this whole individual he has to make choices in his life, and stop fleeing from situations.

There's a rather big gap between what he wants and expects (his worldview and lifeplan) and his actual life world in NZ. Though positive, he did not seem to have a very outspoken worldview either, and his enactment of what worldview he has, is not coming through because he is listening to others too much, forgetting his own values and goals.

The theme of identity becomes apparent symbolically during the first episode when he describes how he looks into the mirror, being able to peel off his face, and throws away his passport and everything else that belongs to his Dutch past.

During the second episode, the question of his identity perhaps shows up in the fact that he is both the father and the mother, but not the child being born. Alwin does mention, however, that he sees spirituality as the "emergence of the inner soul", as the core of one's being that he had lost over the years. He suggests that antipsychotic medication is preventing this "rebirth" of his inner soul from happening: "*To me…, well, not just to me, I think it's simply true, all this medication puts the lid back on the jar, and then nothing comes out again, until the next psychosis, when the lid pops off again…"* [4:33].

Meaning of the spiritual experiences to Alwin

When explicitly asked in what way Alwin finds his experiences in Japan of a spiritual kind, Alwin mentions the extreme lucidity, the clairvoyance, his sharpened intuition and the heightened sensory awareness that pervaded these experiences. He mentions his rebirthing experience as the spiritual core of his other episode. Both experiences have inspired him to explore his female side, to embark on a journey of self-discovery and to develop his intuition. Alwin explicitly states that during his rebirthing experience he was both the father, and the mother, but not the child. However, immediately after saying this, he explains what to him constitutes the core of spirituality, namely the emergence of the inner soul. Alwin keeps stressing the value of individuality, authenticity and having a core of one's own, and being recognized for that.

5.2.1.5. Relevance of the spiritual experience for recovery

Hope

In contrast to Marian (see section 5.2.2.3. below), Alwin never explicitly mentions hope as a core value in his life, neither before nor after his experiences. However, in various more indirect ways, the theme of hope pervades his story. He rejects a strictly biomedical explanation of his experiences and the suppression of symptoms that constitutes much of the psychiatric treatment. It means he has hope for different, more meaningful ways of dealing with his condition, namely as ways of facilitating and nourishing the "birth of the inner soul", the very soul it seemed he had lost somewhere along the way, a gradual loss that had already started when he was a child. His experiences of extreme lucidity and heightened sensory awareness have shown him new possibilities of being and experiencing that he did not know before. They led him onto a new path of self-discovery, a path that implies that he is hopeful of becoming a more complete, authentic and independent individual.

Alwin describes how he has become more fearful of life ever since his psychotic episodes. There is always fear of relapse, of things getting out of hand again, of being hospitalized again. But there is also a kind of fear that is invoked as soon as we open up to life and life's possibilities. It is the kind of fear we have when faced with the insecurities and risks that are involved when stepping into the unknown. It is precisely this kind of fear that Alwin decided to confront, instead of remaining a hostage of that fear. It betrays that Alwin senses a good deal of hope of improving his condition.

Meaning

At the moment, Alwin finds meaning in his life by exploring his female side, by discovering how to be himself and doing whatever he feels is important, by listening to his intuition, rather than doing what others expect him to do. He is consciously not making any future plans that would make his life filled with purpose, but he is concerned with the inherent meaningfulness of life in the here and now, getting to know himself and developing skills to deal with the challenges that he faces. In due time, he would like to be an expert by experience, and by exploring and developing himself, he is ploughing and fertilizing the ground for that to happen. His spiritual experiences have invited him onto this path of self exploration.

Identity

One of the core themes of Alwin's story is his quest for his true and authentic self. In his hypomanic state in Japan, Alwin was filled with self confidence, and he quite naturally took a leading position among the Japanese workers, guided by his blossoming intuition. This way of being contrasts sharply with the Alwin who is always listening to other people, and never does what he really wants himself. Seeing himself as a mother giving birth makes Alwin aware of his body and his female side, and encourages him to explore that side of his identity. He is opening up to his wife, and actively seeks the company of women and children, as well as peers with whom he can share his experiences, and who concern themselves with questions on the purpose and meaning of their individual lives.

Responsibility

Alwin is actively taking up his life and developing himself towards being an authentic, independent individual. He is consciously making choices to improve the quality of his life, even though it may put him into conflict with others around him. He is carefully exploring various kinds of alternative ways to better manage himself and develop his intuition. He has chosen to lower his medication in order to regain his sensitivity. These signs of taking responsibility can not be traced back directly to the spiritual experiences Alwin described, although they are certainly related to Alwin wanting to be an authentic and independent individual. Alwin did however describe how at one point during his breakdown in New Zealand, when he was so desperate that he was about to kill himself, he made a conscious decision to choose life, and called for help himself: *"I was like, if I don't start doing what I really want, then I will put an end to my life, because then…, then I cannot go on like this. You see, and eh… Then I also had an eh…, yes, I was standing there with a knife on my wrists and then I called an emergency team, fortunately I was clear enough to do so, like, yes, come and get me because it really is not going well, I said, because I'm standing here with a knife on my wrists, and yes, I want to keep on living, but I don't know how anymore"* [4:110]. Even in the depths of crisis, Alwin managed to literally make the decision of his life. Having been able to do so may have been influential in developing his sense of responsibility later on in the recovery process.

5.2.2. Marian

5.2.2.1. Summary of the interview

While studying theology, Marian was a very engaged and active member of her religious community, and felt very much at home amongst her fellow students and her professors, but she always had the feeling that she had to answer for her religiosity to non-believers.

When in her freshman year in university, Marian experienced a traumatic encounter with a friend whom she trusted. After that happened, she accused herself of being too dupable. That way, she could continue to trust people because her friend had not really betrayed her faith, but she had simply been too trusting.

When in her early twenties, Marian started to suspect she had bipolar disorder. She was happy with her self-diagnosis, because although she did not mind the highs, she found the lows terrible and was happy that there would be a pill of some sort to help her get rid of those episodes. A psychiatrist she consulted was not sure and wanted to rule out unipolar depression, so she prescribed anti-depressants.

Mary had always been a rational thinker, and mainly used written language to express her ideas, often in the form of poetry. She also had a passion for photography.

Shortly before she travelled to France for a creative holliday, Marian had an interview before a commission of elders because she wanted to prepare for ministry. She was passionate about her calling, but felt attacked by the elders and suspected that they were not really too keen on having her participate in the program.

Mary traveled to France together with her ex-boyfriend and a group of his friends. Because she had been using antidepressants for quite some time, she felt rather excited at the time of the trip. Marian was feeling particularly elated and thrilled with the beautiful natural surroundings and especially the cloudy skies. At the same time, she felt rather insecure about her company, who questioned her Christian religious identity. She also felt uncomfortable being there with her ex-boyfriend, having to do all kinds of creative assignments that took her, being the rational thinker that she was, out of her comfort zone. Right at the beginning of the trip, she was also reminded of sexual trauma she had experienced a while back.

One day, when she was out in the fields for a drawing assignment, she was suddenly struck with the exquisite beauty of the sun beaming its rays through the clouds down to earth, and it occurred to her that this was God. This was God coming down, touching her heart. She was thrilled with the experience and felt very much connected to her surroundings and her company.

At first, she was happy to talk about this wonderful experience with her ex-boyfriend and others, but gradually she sensed that people were talking about her behind her back, and she felt more and more confused and alienated. She felt like she had a better connection with the animal world, and at one point she left a restaurant where they were all having dinner together, to find herself in an enormous cage filled with cats she could communicate with. But her company reacted bewildered when she tried to tell them what she had just experienced.

On another occasion, she slipped inside a church while on a drawing assignment, and she was again struck by the beauty of the light entering the church through the windows, and she decided to arrange the chairs so that the light would fall on each one of them. She then captured the scene with her photo camera. She was very much in her element, doing her own thing, and when her ex-boyfriend entered the church, he felt like an intruder to her.

Mary became more and more alienated from the group, as her confusion and suspicions that something was not quite alright grew, but nobody would explain anything to her. One day, while she was alone in her room, she was all of a sudden overpowered by a few nurses, sedated, tied down and transported back to The Netherlands, where she was hospitalized.

After being hospitalized in The Netherlands, Marian was first diagnosed with schizophrenia. Marian was devastated because she felt her life was falling apart, and she thought that if it were true, it meant she would never be able to function again in ways she considered worthwhile. She fought against this diagnosis with all her might, until a second opinion some three months later disconfirmed the diagnosis of schizophrenia, and she was diagnosed with bipolar disorder instead.

Mary experienced her encounter with the psychiatric system as highly disruptive: at first, while being psychotic, people would not tell her what was going on, she was diagnosed wrongly at first, she would be left alone at times where she really needed human company, and she felt horrible being locked up with people with severe mental illness without getting adequate support to deal with everything that happened on the ward, such as people automutilating and committing suicide.

After an unsuccessful attempt to continue her theology studies while on medication, Marian decided to switch focus to psychology, in large part because of the disruptive experiences in the psychiatric system. She became a personal trainer, volunteered for the Dutch suicide prevention help line, and currently she is completing a master's degree in psychology.

The focus of her life has shifted from wanting to be a minister in a religious community of like minded people focussed on God toward helping people who are not so lucky as to have the community support that is so dearly needed. Her religious view of life has broadened from a rather traditional protestant Christian view to a more eclectic view, with humanist and buddhist elements.

5.2.2.2. Description of the spiritual experience

While Marian was on holiday in France, she had a theophanic experience of God coming down through the clouds:

> *"And, eh…, at one point I was sitting in some sort of meadow, and the clouds were so beautiful, and suddenly there appeared a clear bit, and the sun came shining through the clouds, and it had rays that went all the way down to the ground. And then I thought: 'This is God'. And that was such a beautiful experience, that was the beginning of the psychosis when everything was still quite beautiful, and, you know, enhanced, positive experiences came up, and eh…, there was a turning point where things became frightening…"* [2:26]
>
> *"In the beginning, it was wonderful. So this…, this part, and I do have photographs of it, so I could show it, like: 'Look, this is the picture I took!' And this, well, this was my experience of*

God, like: 'Now God is coming down, and shining down, and this is my..., well, my beautiful, beautiful experience'". [2:28]

"[Marian:] I'm just looking at what I experienced back then… eh, it was a kind of…, at that moment a very strong approval of my experience at that moment. Like: 'You see, I do have this experience of God. It's alright.' A kind of…, yes, a kind of…, yes it's almost a kind of sanctioning of my experience. [Researcher:] So, receiving an image of God was a sanctioning of your experience, is that what you're saying? [Marian:] Yes, yes. That this thing I did my utmost best for, that it had a right to be, instead of… And that it was alright." [2:73]

"At a certain moment we had to do an assignment in a village, we were all released, and I plunged into a church. Because I was going to see if I could put these chairs…, there were all these different chairs, quite extraordinary. No benches or anything, but they were all chairs. And I arranged the chairs in such a way that the light would shine through the window precisely on a chair. [2:85]

[Researcher:] "In what way was this important to you?" [Marian:] "How I could maybe hold on to this bit of experience of God in time, or that I…, that I thought: 'How could I again…, how could I fulfill this?' or something like that. I also had the feeling that in this, I…, eh..., I was not just receiving, but I could do my own thing in this as well. And how could I transfer it to this other person?" [2:88; 2:89; 2:90]

5.2.2.3. Topical and episodic analysis

Contingencies

Events

Before. A few months before her psychotic episode, Marian had discovered herself that she might suffer from bipolar disorder [2:5]. Her psychiatrist, however, wanted to rule out monopolar depression first, so she got antidepressants, which caused her to be in a hypomanic mood when going on vacation [2:8; 2:9]. Other contingent events that were influential in Marian's story are the fact that she was on holiday with her ex-boyfriend who still wanted to be in a relationship with her, and with whom she was expected to share a bedroom [2:11; 2:13]. That evoked a memory of past traumatic experience [2:17]. Other members of the group she travelled with were, unlike her, not religious and questioned Marian's religiosity [2:17; 2:22]. Lastly, Marian was expected to engage in a lot of drawing and painting during this creative holliday, something she was not familiar with [2:12].

During. During her psychotic episode, Marian had a theophany. God appeared to her in the form of rays of sunlight shining through the clouds: "*Now God is descending, he is shining down, this is my beautiful, beautiful experience*" [2:26; 2:28].

After. After her episode, Marian was drugged and tied down against her will and transported back to The Netherlands [2:39; 2:41]. At first she was diagnosed with schizophrenia [2:45]. Some three months later, the diagnosis was changed to bipolar disorder [2:49]. During her stay in the psychiatric system, Marian was witness to suicidal attempts and automutilation by other patients on her ward [2:51].

Choices

Before: Marian reports that she had been unable to deal with all the changes and contingent events that came up around the time of her trip to France [2:71]: being in a hypomanic mood because of antidepressants, the high temperature, the perceived discord with the elders of her church, and being there with a group of non-religious people.

During. During her theophanic experience, Marian had the distinct feeling that she was simultaneously receiving an experience "*from the other side*" and acting, "*doing her own thing*" [2:89]. So she was being a subject and an agent simultaneously. Right after her theophany, she gradually felt like she was losing grip [2:31; 2:59].

After. When she was diagnosed with schizophrenia, Marian fought against this diagnosis tooth and nail [2:46]. During recovery, she learned not to be captured by her mood swings, enabling her to make adequate, healthy choices and manage change in her life much better [2:1; 2:70].

Final values

Marian's core values have not changed drastically after the psychotic episodes. Her values, now and then, center around being of service to others, being connected and having hope [2:103; 2:101; 2:102; 2:108; 2:105; 2:133; 2:107; 2:106; 2:110; 2:138].

After. The importance of hope, of having a perspective in life, however, has become much more important after the episode [2:104]. New values include being seen (being recognized) by others [2:113] and cherishing tranquility [2:137].

Emotions

Before. Before she went on vacation, and while on vacation, Marian felt insecure, because her identity was challenged, both by her church elders as well as by her non-religious company [2:2; 2:10; 2:11; 2:13; 2:15; 2:16; 2:22]. At the same time she felt joyous, elated by the beauty of clouds and nature surrounding her [2:25].

During. During her psychotic episode, Marian was flooded by a wealth of contradictory emotions. The theophany affirmed her self and the path she was on in her life [2:52; 2:124; 2:126], while she simultaneously doubted her own interpretation of the experiences she went through because others did not seem to understand her [2:77; 2:81]. She felt a strong connection with the world around her [2:34; 2:35; 2:78], but she soon started to feel estranged from the group, scared and unsafe [2:30; 2:36; 2:43; 2:79; 2:80; 2:83]. Marian felt highly confused about what was going on. She sensed something was not quite alright, but could not understand what it was [2:42; 2:44; 2:62; 2:58].

After. Marian initially felt terrible afterwards because of her experiences in the psychiatric system, and the fact that she had been diagnosed with schizophrenia instead of bipolar disorder [2:51; 2:47]. She had the feeling of losing herself because of the medication [2:114], but slowly her feelings became more positive and peaceful again and she gradually regained herself [2:66; 2:64; 2:122]. She also mentions that she gradually disidentified with the theophanic experience: at first, she was one with the experience, later she viewed them as one among many experiences one can have [2:75]

Life plan

Before. Marian was a student of theology and wanted to become a minister [2:96].

After. Marian is now studying clinical psychology, and wants to specialize in diagnostics [2:97; 2:127; 2:54]. She is determined to help improve support for others in the psychiatric system [2:56].

Life world

Before. Marian was a student of theology [2:136], and a member of a protestant christian community [2:94; 2:95].

After. Marian is married with children [2:130]; studying psychology [2:129], and is no longer part of a religious community, but keeps her faith to herself [2:93].

Worldview

Before. Marian was a protestant christian [2:134]. The focus of her life was on the divine rather than on people [2:92].

After. Marian has a more eclectic worldview now, taking elements from christianity as well as buddhism, and valuing other sources of wisdom than just the Bible [2:135; 2:99; 2:100]. The focus of her life is much more on other people than on the divine [2:91]. She views her psychosis in biomedical terms [2:61], and the psychotic experience she had as a creation of her own reality [2:76], in order to escape from an unmanageable reality [2:60].

5.2.2.4. Rhetorical analysis (emerging narrative themes)

Theme 1: Psychiatric trauma

More than anything else, her bipolar disorder and her theophany included, is Marian's story colored by her distressing experiences within the psychiatric system. These experiences include untimely prescription of medication leading to a hypomanic state, being drugged and transported against her will, not being informed about what was going on with her, nor what was going to happen to her, being left alone while tied down, being diagnosed wrongly, and being put on a ward with people automutilating and committing suicide without adequate support to be able to deal with being a witness of all of that. Before her psychotic episode, Marian suspected herself she was bipolar and felt relieved by this discovery, because she expected to be able to do something about it. After her episode she was wrongly diagnosed with schizophrenia at first, and she fought with all her might, and successfully, against this diagnosis. Her experiences with psychiatry and having had the wrong diagnosis made her pursue a degree in clinical psychology with a focus on diagnostics.

Theme 2: Identity

Shortly before and during her creative holiday in France, Marian's identity was rather heavily challenged. Marian was a student of theology, wanting to be a minister. She had just had an interview with a few church elders, and suspected that they did not really like her ideas very much. She then went on holiday with a group of people who did not share her religious outlook on life, and questioned her belief. Being there with her ex-boyfriend, who still wanted to be in a relationship with her, and being assigned the same bedroom that he stayed in, put quite a strain on her, especially since she was reminded of sexual trauma and breach of trust she had experienced a few years earlier. Lastly, Marian was expected to do a lot of drawing and painting during this creative holliday, something that she was

not familiar with, being much more of a thinker, writer and photographer, and that drew her out of her comfort zone. Marian repeatedly mentions the importance for her of doing her own thing. After her psychotic episode and hospitalization, she became a personal trainer, partly because of the training method's focus on discovering what is of value to a person as a starting point for redesigning his or her life. Marian is no longer a member of a religious community and has developed a broader religious outlook on life than the traditional protestant christian worldview that she held before her breakdown.

Meaning of the spiritual experience to Marian

The theophany of God coming down through the clouds was for Marian an intensely beautiful experience that she cherishes up to the present moment, and a confirmation of what to Marian was important in her life. Yet Marian feels that the direct impact of the experience on her life was only marginal. The biggest achievement in her life after the episode was that Marian came to know who she was and that it was alright being herself. Her theophany fitted in with the way her life was unfolding, a confirmation rather than a sudden explosion of insight that drastically changed the course of her life: *"I have been thinking quite hard when I signed up for this [the interview, AL], asking myself: 'Was this experience of God so influential? No, it was more like a continuation of whatever I was engaged with already, like: 'OK, wow, you see, beautiful, I can be in touch with that, it fits with what I'm doing.' It's not like it had a huge impact, it was just like: 'OK, this fits, this is fitting for me'"*[2:123].

5.2.2.5. Relevance of the spiritual experience for recovery

Hope

Mary explicitly mentions hope as a core value in her life. The importance of hope, however, has increased since her mental breakdown, and especially after being wrongly diagnosed with schizophrenia. To Marian, suffering from schizophrenia would have meant an end to the possibility of living a meaningful life. As mentioned before, Marian's theophany was not so much a source of hope, but rather a confirmation of Marian's life and person and in that sense supportive of Marian's struggle against the wrong diagnosis and her fight to regain a future filled with new possibilities and opportunities.

Meaning

Mary finds meaning and purpose in life by trying to be of service to those in need: studying psychology to improve diagnostics in mental health and being a volunteer for a suicide prevention organisation. For all practical intents and purposes, her theophany has not contributed to new meaning and purpose in life, but was viewed by Marian as a confirmation of who she was and of the value of what she had been trying to achieve in her life up to that point.

Identity

First and foremost, Marian has experienced her theophany as a confirmation of her identity, an identity that was challenged heavily at the time of the theophany from various sides: the church elders, the non-religious people she was on holiday with, being there with her ex-boyfriend and being expected to share a bedroom with him, and the drawing assignments that drew her out of her comfort zone. To Marian, her experience of God was an affirmation of her deepest values and everything she had been trying so hard to achieve.

Mary also mentions the importance for her of being connected to people with likewise minds and attitudes, and the importance of being seen, recognized and affirmed by other people. Although Marian herself does not view her theophany as having had a great impact, it is worth noting that her theophany provided exactly this: being seen, recognized and affirmed.

The same holds true for Marian's need to "do her own thing", something that she repeatedly mentions she is trying to achieve. When she is in the church trying to capture the divine light falling on the chairs, after sending her ex-boyfriend away because he feels like an intruder to her, she has the experience that she is simultaneously receiving something "from the other side" and also doing her own thing. In other words, she experiences the possibility that "otherness" is not necessarily of an intrusive nature and needs not be a hindrance to doing her own thing.

Responsibility

Because of her highly disruptive experiences with the psychiatric system and being diagnosed wrongly, Marian took it upon herself to try to make a difference for those who are suffering from mental health problems. Besides working hard to take responsibility for her own stability, and learning the skills needed to maintain balance, Marian also became a personal trainer, a volunteer for a suicide prevention program and is currently working towards a masters degree in psychology, specializing in diagnostics. She also took up the responsibility of being a wife and mother.

Marian's move away from theology towards psychology has to do with the urgent needs she saw around her while being in the psychiatric system. Rather than being comfortable in a religious community where there is already a lot of support available, she wants to bring realistic hope where it is dearly needed. Once again, any direct impact of the theophanic experience may be negligible compared to the huge impact of Marian's traumatic experiences in the psychiatric system, but the question how to be of service to others presented itself too in the church where Marian was trying to capture the divine light with her camera. When asked why doing so seemed important to her, Marian replied: *"How I could maybe hold on to this bit of experience of God in time, or that I…, that I thought: 'How could I again…, how could I fulfill this?' or something like that. […] And how could I transfer it to this other person?"* [2:90].

5.3. Summarized results

The research questions that were formulated in the introduction to this paper are concerned with what participants experienced, what it meant to them, and how it influenced their recovery process. Table 5 presents a summarized overview of the major findings that were reported in the previous section (5.2) as they pertain to these research questions.

The overall picture that emerges out of the analysis, is of two people struggling with and for their identities, identities that were challenged among other things by the respective contingencies of not having children in Alwin's case, and the questioning of her religious identity by peers and elders and the negative experiences in the psychiatric system in Marian's case. The nature of the quest for their identities was for Alwin different compared to Marian: Alwin had to begin to discover who he was, what was important to him, what he was going to do with his life if he could not become a father of a family, how he should go about listening to himself instead of to others. By contrast, Marian seemed to have developed a rather clear identity, that she felt was under attack from the outside world when she

went on holiday. That identity got lost because of her experiences in psychiatry, seeing no hope for the future when she was diagnosed mistakenly with schizophrenia, and not being able to think clearly anymore because of her medication. Where Alwin had to gain himself, Marian had to regain herself.

The nature of the spiritual experiences, and their direct meaning reflect these different stages in the formation of identity. While Alwin's experience can be characterized to be of an immanent nature (it is about sensory experience, discovery of the body, giving birth, emergence of the inner soul), Marian's experience is of a transcendent nature (a theophany, a confirmation "*from the other side"* of who she is and what she is striving for).

Correspondingly, the ways the spiritual experiences were subsequently integrated into their identities and played out in their lives, also differed. Alwin has chosen the path of self-exploration, triggered by his various spiritual experiences, whereas Marian chose a path of service to others in need, that was mainly triggered by what she had experienced while being in the psychiatric system. Her spiritual experience was not instrumental in choosing this path, but was rather a confirmation of basic values and strivings that had already been there, and that had not really changed.

		Alwin	Marian
What was experienced?		Lucidity, heightened sensory awareness, clairvoyance, giving birth	Theophany
Direct meaning		Birth of the inner soul	Confirmation of self
Indirect meaning (LOM)	***Contingent events***	Being childless	Psychiatric trauma
	Choices	Increased ability to choose for himself	Increased awareness of having choices
	Final values	Increased awareness of importance of being an autonomous, authentic individual	Increased awareness of importance of hope and being seen and recognized
	Emotions	Increased fear of life	Disidentification with theophany, first losing and then regaining herself
	Life plan	Conscious decision not to make plans, explore his inner world instead	Helping people in need by improving psychiatric diagnostics
	Life world	Practicing alternative disciplines, remaining childless, actively seeking company of women, children and peers	No longer a member of a religious community, becoming wife and mother, studying psychology
	Body	Increased awareness of the body	Increased satisfaction with the body
	Worldview	Growing awareness that everyone has a core self that needs to be cherished and developed	More eclectic and broad worldview than before, containing christian, humanist and buddhist elements

Table 5: Summary of the major findings of section 5.2.

		Alwin	Marian
Recovery	***Hope***	Experiencing a powerful, sensitive self during a manic phase, awareness of himself as an individual	Confirmation of self experienced in theophany corresponds to a regained and revalued sense of self after recovery
	Meaning	The spiritual experiences invited further self exploration	Overall meaning of the spiritual experience is confirmative of meaning and purpose rather than explosive or innovative
	Identity	The spiritual experiences marked the start of the formation of an autonomous individuality	Spiritual experience provides confirmation of an already existing identity
	Responsibility	Increased ability to listen to and choose for himself	Providing realistic hope and reliable diagnostics to people in need

Table 5 (Continued)

6. Conclusion and discussion

At the beginning of this chapter, some conclusions with respect to the three research questions will be drawn. Then the findings with respect to identity formation will be discussed in the wider context of the relationship between spirituality and recovery. Subsequently, the limitations of the current research will be discussed and finally some possible directions for future research will be suggested.

6.1. Conclusions

Content of the experience

With respect to the first research question, pertaining to the contents of the spiritual experiences, we conclude that Alwin's experiences of lucidity, heightened sensory awareness, clairvoyance, empowered sense of self, increased bodily awareness, and his experience of giving birth are of an immanent nature. There are a few aspects to his experiences that could point to being in touch with a transcendent reality, such as knowing things he could not know, and stepping out of his body when seeing himself giving birth, but Alwin stresses the immanent features of his experiences when he talks about them, and explicitly states he has had no experiences of God. By contrast, Marian's spiritual experience consisted of a vision of God in the form of sunrays shining down on earth through the clouds, an experience that she explicitly characterizes as "*coming from the other side*". Therefore, Marians experience may be qualified as a transcendent experience.

Direct meaning

Alwin and Marian thus had very different experiences, that carried different direct meanings for them, and that implied or demanded different ways of integrating those experiences in their lives and recovery process. A second conclusion that we can safely draw from the above analysis, is that these experiences were in any case meaningful to them. The direct meaning of the experiences can be characterized as a *birth of the self* in Alwin's' case, and a *confirmation of the self* in Marian's case.

Indirect meaning

The experiences were not only meaningful in this directly experienced sense, but these experiences also had a clear relationship to themes pertaining to identity that were already emerging before the acute experience, and they subsequently had a formative or confirmative influence on the further development of the participants' identity after the experience. Both Alwin's and Marian's lives have been drastically altered since the experience, and it is altogether difficult to establish what exactly determined these transformations given the turmoil that a psychotic episode brings about in one's inner and outer life. Especially in Marian's case, her traumatic experiences with the psychiatric system have had a much greater impact on the direction her life took than her spiritual experience. By contrast, Alwin's experiences set him on a path of self discovery and development. Yet also in Marian's case, influences of the religious experience can be traced in her story of recovery: as a newly gained value, or insight in her life, Marian mentions the importance of being seen and recognized for who she is. As a hallmark of her recovery, she regained her identity that was shattered after her experiences in the psychiatric system. But she is very explicit that for her it is not enough to be herself and know who

she is, but it has to be recognized by others as well. The theme of confirmation that was so present in the theophanic experience corresponds to this new core value in Marian's life after recovery.

Both Marian's and Alwin's awareness of having choices, and their capacity to actually make them have improved while recovering, yet the nature of the skills developed differs somewhat between the two. Alwin is much more capable of choosing for himself rather than following other's opinion than before by listening to himself and developing his intuition (self exploration). Marian seems especially better able to disidentify herself from her immediate moods in order to make adequate choices, and has learned how things work for her (self management). Both have learned how to better deal with the emotional turmoil their condition brings about. Neither of them mentions any direct influence of the spiritual experience on their emotional life, but at least for Alwin the experience set him on a path of self exploration, rediscovering himself as a sensitive person with a strong female side, which likely is of benefit when dealing with his emotions. It is worth mentioning that both Alwin's and Marian's spiritual experiences contained elements that foreshadowed the later developed capacities: while manic, Alwin had a very strong sense of self, was in touch with his intuition, and had no trouble making decisions for himself and giving directions to others; Marian mentions how she experienced that while she was in the church capturing the divine light falling on the chairs, she felt she was receiving from the other side while simultaneously being able to do her own thing. Relevant to the process of recovery is that in their manic or psychotic episodes they had already experienced the possibility of this kind of being autonomous in the presence of others.

Both Marian's and Alwin's lifeworlds have changed quite a bit. Alwin moved back from New Zealand, got married and is currently unemployed. He still does not have children. Alwin spends his time exploring himself through various practices such as Reiki, and is searching out female companions, children and peers with whom he can share his experiences. For Alwin, his experiences to a large extent determine what his life world looks like. Marian gave up theology, married and raised a family, became a personal trainer and started studying psychology. She is no longer a member of a religious community like she was before. While she used to have a rather negative body image, she is quite happy with her body now that she is able to better handle her mood swings that used to affect her body weight. Where Alwin has discovered his body, Marian has accepted her body. A major determinant that shapes Marian's lifeworld are her negative experiences within the psychiatric system, much more directly so than her theophany, according to herself.

While discovering himself as an individual Alwin also seems to develop a more explicit worldview, which is founded on the discovery and further development of the autonomous, authentic core of each individual human being, and the quest for purpose and meaning of each human being's life. Alwin interprets his experiences within this type of spiritual worldview. His experiences have set him on a path to further explore them, rather than to suppress them. Marian has gradually broadened her protestant christian faith focussed on God and the Bible to include other sources of meaning as well, such as Buddhism and other people's life stories, and her life is much more focussed on human beings than on the divine. Marian does not attribute any changes in her worldview to her theophanic experience.

To summarize, we conclude that:

1. The spiritual experiences of our participants are varied in content and appearance (immanent and transcendent),
2. these experiences carry meaning for the participants (constitutive and confirmative of identity)

3. this meaning has impacted or guided to some extent the subsequent course of life of our participants, including the process of recovery, and
4. the meaning of the spiritual experiences both reflect and influence an already ongoing process of identity formation

6.2. Spiritual experiences and recovery

In the beginning of chapter 3, we briefly touched upon the question of what constitutes spirituality, and how we can think of the relationship between religion and spirituality. As a working hypothesis, we considered spirituality to be the experiential dimension of people's engagement with whatever is of ultimate concern to them, be it within or outside of any established religious system. But more importantly than this working definition is what kinds of experiences our participants themselves actually consider spiritual. As we have seen, for both Alwin and Marian the meaning of their spiritual experiences is intimately interwoven with the quest for their identities, be it in somewhat different ways. It is for them about becoming, being, remaining and regaining oneself.

It may be elucidating to refer again to Heelas and Woodhead (2005) and look at their characterization of modern day spirituality as subjective-life:

> *"[Subjective-life] has to do with states of consciousness, states of mind, memories, emotions, passions, sensations, bodily experiences, dreams, feelings, inner conscience, and sentiments - including moral sentiments like compassion. The subjectivities of each individual become a, if not the, unique source of significance, meaning and authority. Here 'the good life' consists in living one's life in full awareness of one's state of being; in enriching one's experiences; in finding ways of handling negative emotions; in becoming sensitive enough to find where and how the quality of one's life - alone or in relation - may be improved. The goal is not to defer to higher authority, but to have the courage to become one's own authority. Not to follow established paths, but to form one's own inner-directed, as subjective, life. Not to become what others want one to be, but 'to become who I truly am'. Not to rely on the knowledge and wisdom of others ('To the other be true'), but to live out the Delphic 'Know thyself' and the Shakespearian 'To thine own be true'.* (p.3)

Modern day spirituality, then, is concerned with discovering and exploring one's inner life, without taking recourse to normative societal perspectives or established authority, and thus intimately connected to identity formation. Alwin's and Marian's spiritual experiences within their manic and psychotic states are moments, maybe even crucial moments, in the development of their identities. These experiences are not disconnected from this already ongoing process of identity formation, but rather seem to highlight this very process of becoming and asserting oneself, loosening ties with external authorities, forming one's own opinions, and doing one's own thing. They reflect as it were an already unfolding process of "recovery" from one's past, one's parents and one's education in order to become independent, authentic individuals. In the case of Alwin and Marian, this process is complicated by their condition, their specific sensitivities and vulnerabilities, and the circumstances they find themselves in. But their experiences fit in with this very process of identity formation.

Rather than viewing spiritual experiences as symptoms of disease that need to be recovered from, it is perhaps more helpful to explore the contents of spiritual experiences during psychosis as potential starting points for recovery. As Leader (2013) writes: "*A manic episode can give someone a sense of*

being genuinely alive and connected to the world, of having found one's true identity for the first time" (p. 12). In as much as the process of recovery is precisely about regaining a sense of self, what better starting point for recovery than this experience of genuine aliveness, connectedness and being oneself?

According to the Life Orientation Model, however, the quest for an answer to the question "*Who* am I?" is but one of many questions one may ask to address spiritual concerns. The discovery and exploration of one's subjectivity that characterizes modern spiritual development may be complemented by, or embedded in, an overarching question addressing the specifically orienting character of spirituality, namely: "*Where* am I?". Answering this question means personally engaging oneself with the world, with other people, with other opinions and viewpoints than one's own, recognizing them and being recognized by them. In that sense, Marian's discovery of the importance to her of being seen and recognized, as foreshadowed by the confirmation she received in her theophanic experience, should not be viewed as seeking affirmation from an external authority but as a conscious recognition of the interdependency of self and other and the importance of mutually recognizing each other's personhood.

The orienting question *"Where am I"* can be a starting point for disidentification with one's immediate concerns and emotions, for reflection upon the situation we find ourselves in, for becoming aware of who is there with me, whom I care for, why I do what I do, and to what end. Exploring this orienting question with respect to a spiritual experience during psychosis may open up a person to the possibility of taking up responsibility for their lives and their environment again in view of what is of utmost concern to them.

6.3. Limitations

The goal of the current research was to explore what, if anything, spiritual experiences during psychotic episodes mean to the people who experience them, and what, if anything, it meant for their recovery process. To answer the research questions that derived from this goal, we have reported in detail on interviews with two people diagnosed with bipolar disorder.

The first limitation of the current research is inherent in the qualitative method used to answer the questions. The current research is concerned with the subjectively perceived meaning that the spiritual experiences carry for the persons interviewed for their lives and their recovery processes, but not with the actual factors that causally affected their lives and recovery.

A second limitation also stems from the chosen research strategy, and is concerned with the highly ideographic character of the current research and the limited number of reported interviews, which preclude any generalization of the results. The fact that the quest for identity plays a major role in the stories of both Alwin and Marian, does not imply that this is the case for all people diagnosed with bipolar disorder who have a spiritual experiences. Even Alwin's and Marian's stories revealed quite different concerns related to their identity. On the other hand, discovering identity to be a major theme when addressing spirituality is not too surprising, because we only have to look at Heelas' and Woodhead's characterization of spirituality above to realize that asking after one's spirituality implies almost by definition asking after one's identity.

A third limitation concerns the fact that participants were asked to talk about experiences they had some twenty years ago. Of course, the memories of these experiences likely partly faded away, and

partly have been coloured anew with time. We can say nothing about the reliability of the recalled memories of the events that took place. On the other hand, our main goal is to discover what meaning people assign to their experiences, and not whether they actually took place the way they described. On the positive side, the participants have had quite some time to recover, which allows for assessment of long term implications of the experiences for recovery.

A fourth limitation, or rather set of limitations, has to do with the characteristics of the sample. Our research questions pertain to spiritual experiences during psychosis, and for reasons of parsimony we chose to include only people with a diagnosis of bipolar disorder. The current research tells us something about the meaning of spiritual experiences during psychosis, but does not clarify in what way spiritual experiences affect the recovery process when it comes to bipolarity specifically. Our research also does not distinguish between manic and psychotic experiences. Although these are clinically very different phases of the disorder, they are not always easy to distinguish, and participants themselves are not always very clear about it. In addition, our participants have all been hospitalized after their first psychotic episodes. As we have seen, experiencing the psychiatric system can have a huge impact on the lives of people, and is in itself something one has to recover from. It is hard, even for participants themselves, to tease apart what part of the transformation they underwent when recovering can be ascribed to psychiatric treatment, medication, and positive and negative experiences when hospitalized, and what part may be ascribed to their spiritual experiences.

A fifth limitation has to do with the way we applied the Life Orientation Model of spirituality that was used to derive guiding questions for the semi-structured interviews, as well as to analyze and interpret the findings. The Life Orientation Model is intended to be a dynamic process model that roots itself in a theory of consciousness that informs us of the phenomenal elements of moment-to-moment conscious experience. For practical purposes we have applied the model very crudely as if everything before the spiritual experience is a distinct state of mind, and everything after the spiritual experience is another distinct state of mind. In reality, these different episodes are of course highly dynamic and flowing into one another. It means we have only captured the dynamics of meaning making at a very basic level.

6.4. Directions for future research

Some of the limitations mentioned above quite naturally suggest some possible directions for future research. Aside from increasing sample size to be able to do grounded theory research and make generalization possible, the research questions call for longitudinal research. Recovery processes take time, and are highly individual. Recording the contents of spiritual and psychotic content at an earlier stage may give a much richer, more lively and more reliable description of the actual experiences, and follow up at regular intervals may reveal the time course of the influence of various experiences on the recovery process, and the way these are interpreted at various points on the path to recovery by the experiencers. For instance, to Marian her theophany has had little direct impact on her life, but she also mentions that she had to disidentify from her experience, meaning that at one point it very likely had a great impact on her life.

Second, this line of research should ideally be extended to people having spiritual experiences during psychotic (or psychotic-like) episodes, but who do not end up in the psychiatric system, who do not develop a psychotic disorder outcome, and who do not receive psychiatric treatment. This would enable us to (better) distinguish positive and negative effects of treatment from the impact of the

spiritual and psychotic experiences themselves. Some work in this area has already been done (e.g., Brett, Heriot-Maitland, McGuire, & Peters, 2014; Heriot-Maitland, Knight, & Peters, 2011).

Finally, it may be worthwhile investigating more thoroughly what specifically participants mean when they say their experience is spiritual rather than psychotic (or anomalous). We have explored in the current research what these experiences mean to them, but not why they would qualify as spiritual to the participants themselves. Do they distinguish between these categories at all? If so, what criteria do they use for distinguishing between them?

6.5. Concluding remarks

For sure, both for Alwin but especially for Marian, having experienced the psychiatric system and having been subjected to a biomedical treatment regime significantly impacted their lives not just in a positive sense, and this may to a large extent have overshadowed or even counteracted potential influences of the spiritual experiences that they related.

Whether they be necessary or not, some of the psychiatric interventions that were carried out are especially poignant in the light of the fragile processes of identity formation or preservation that Alwin and Marian were engaged in leading up to their break down. Right after Alwin takes the decision of his life to choose for himself, to not kill himself, and immediately takes responsibility for that by calling for help himself, he is violently taken down, drugged and robbed of his autonomy by the ones he called upon for help. While Marian is struggling to assert her identity and is doing her own thing against the stream of her social surroundings, she too is violently taken down, drugged and robbed of her autonomy by the ones she did not even call upon for help, without any explication whatsoever. The faulty diagnosis and pharmaceutical treatment Marian subsequently received robbed her of what was left of her identity.

Once again, these measures may have been necessary or not, but they certainly did not have a positive impact on Marian and Alwin when it comes to the hallmark elements of recovery: giving them hope, establishing a meaningful frame of reference for their experiences, strengthen or develop their identities, or affirming them as autonomous, responsible individuals. Listening to their life's stories and incorporating those into treatment may be a good starting point for recovery. As part of those life stories, the contents of people's spiritual experiences, may they refer to anything "real" or not, be they pathological or not, may provide major clues to what is of ultimate concern to them, and hence the direction their individual recovery process may take.

Literature

Altman, E. (1998). Rating scales for mania: is self-rating reliable? *Journal of Affective Disorders*, *50*(2-3), 283–286.

Altman, E. G., Hedeker, D., Peterson, J. L., & Davis, J. M. (1997). The Altman Self-Rating Mania Scale. *Biological Psychiatry*, *42*(10), 948–955.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV.* American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5®)*. American Psychiatric Pub.

Amering, M., & Schmolke, M. (2009). *Recovery in Mental Health: Reshaping scientific and clinical responsibilities*. John Wiley & Sons.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.

Arends, C. (2014). *If Billy Sunday Comes to Town - Delusion as a Religious Experience?: The Biography of Anton T. Boisen from the Perspective of Foundational Theology*. LIT Verlag Münster.

Blom, J. D. (2003). *Deconstructing Schizophrenia: An Analysis of the Epistemic and Nonepistemic Values that Govern the Biomedical Schizophrenia Concept*. Boom Koninklijke Uitgevers.

Boevink, W. (2012). TREE: Towards Recovery, Empowerment and Experiential Expertise of Users of Psychiatric Services. In P. Ryan, S. Ramon, & T. Greacen (Eds.), *Empowerment, Lifelong Learning and Recovery in Mental Health* (pp. 36–49).

Boevink, W., Corstens, D. (2012). My body remembers; I refused: Childhood trauma, dissociation and psychosis. In J. Geekie, P. Randal, D. Lampshire, J. Read (Ads.), *Experiencing Psychosis: Personal and professional perspectives* (pp. 119-126). Routledge.

Boevink, W., Kroon, H., van Vugt, M., Delespaul, P., & van Os, J. (2016). A user-developed, user run recovery programme for people with severe mental illness: A randomised control trial. *Psychosis*, *8*(4), 287–300.

Braam, A. W. (2009). Religion/Spirituality and Mood Disorders. In P. Huguelet & H. Koenig (Eds.), *Religion and Spirituality in Psychiatry* (pp. 97–113).

Brett, C., Heriot-Maitland, C., McGuire, P., & Peters, E. (2014). Predictors of distress associated with psychotic-like anomalous experiences in clinical and non-clinical populations. *The British Journal of Clinical Psychology / the British Psychological Society*, *53*(2), 213–227.

Burgess, P., Pirkis, J., Coombs, T., & Rosen, A. (2011). Assessing the value of existing recovery measures for routine use in Australian mental health services. *Australian and New Zealand Journal of Psychiatry*, 45(4), 267-280.

Carrette, J. R., & King, R. (2005). *Selling Spirituality: The Silent Takeover of Religion*. Theatre Arts Books.

Chadwick, P. K. (2009). *Schizophrenia: The Positive Perspective : Explorations at the Outer Reaches of Human Experience*. Routledge.

Claridge, G. (1972). The Schizophrenias as Nervous Types. *The British Journal of Psychiatry: The Journal of Mental Science*, *121*(1), 1–17.

Claridge, G. (1997). *Schizotypy: Implications for Illness and Health*. Oxford University Press.

Clarke, I. (Ed.). (2000). *Psychosis and Spirituality : Exploring the new frontier*. London: Whurr Publishers.

Clarke, I. (Ed.). (2010). *Psychosis and Spirituality: Consolidating the new paradigm*. John Wiley & Sons.

Copeland, M. E. (2002). Wellness Recovery Action Plan. *Occupational Therapy in Mental Health*, *17*(3-4), 127–150.

Dawkins, R. (2009). *The God Delusion*. Random House.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, *11*(4), 11–19.

Deegan, P. (2004, november 4). *Spiritual Lessons in Recovery.* Retrieved from https://www.patdeegan.com/blog/posts/spiritual-lessons-recovery

Eysenck, H. J. (1952). Schizothymia-Cyclothymia As a Dimension of Personality: II Experimental. *Journal of Personality*, *20*(3), 345–384.

Eysenck, H. J., & Eysenck, S. B. G. (1976). *Psychoticism as a Dimension of Personality*. London: Hodder and Stoughton.

Fallot, R. D. (2007). Spirituality and religion in recovery: some current issues. *Psychiatric Rehabilitation Journal*, *30*(4), 261–270.

Freud, S. (2008). *The Future of an Illusion*. Penguin UK.

Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). *Construction of a Scale to Measure Consumer Recovery*. Springfield, IL: Illinois Department of Health and Human Services, Office of Mental Health.

Goodwin, F. K., & Jamison, K. R. (2007). *Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression*. Oxford University Press.

Goodwin, G. (2002). Hypomania: what's in a name? *The British Journal of Psychiatry: The Journal of Mental Science*, *181*, 94–95.

Grof, S. (1992). *The Holotropic Mind : the three levels of human consciousness and how they shape our lives*. San Francisco, CA.

Handelman, D. (1968). Shamanizing on an Empty Stomach. *American Anthropologist*, *70*(2), 353–356.

Hanna, R., & Maiese, M. (2009). *Embodied Minds in Action*. OUP Oxford.

Hanssen, M., Peeters, F., Krabbendam, L., Radstake, S., Verdoux, H., & van Os, J. (2003). How psychotic are individuals with non-psychotic disorders? *Social Psychiatry and Psychiatric Epidemiology*, *38*(3), 149–154.

Heelas, P., & Woodhead, L. (2005). *The Spiritual Revolution: Why Religion is Giving Way to Spirituality*. Wiley-Blackwell.

Heriot-Maitland, C., Knight, M., & Peters, E. (2011). A qualitative comparison of psychotic-like phenomena in clinical and non-clinical populations. *British Journal of Clinical Psychology*, *51*(1), 37–53.

Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., … Smid, H. (2011). How should we define health? *BMJ* , *343*, d4163.

Huber, M., van Vliet, M., Giezenberg, M., Winkens, B., Heerkens, Y., Dagnelie, P. C., & Knottnerus, J. A. (2016). Towards a "patient-centred" operationalisation of the new dynamic concept of health: a mixed methods study. *BMJ Open*, *6*(1), e010091.

Huguelet, P., & Koenig, H. G. (2009). *Religion and Spirituality in Psychiatry*. Cambridge: University Press.

James, W. (1982). *The Varieties of Religious Experience: A Study in Human Nature*. MPublishing, University of Michigan Library.

Jaspers, K. (1965). *Allgemeine Psychopathologie : für Studierende, Ärzte und Psychologen*. *Berlin* : Springer.

Jerrell, J. M., Cousins, V. C., & Roberts, K. M. (2006). Psychometrics of the recovery process inventory. *The Journal of Behavioral Health Services & Research*, *33*(4), 464–473.

Jones, S., Mulligan, L. D., Higginson, S., Dunn, G., & Morrison, A. P. (2013). The bipolar recovery questionnaire: psychometric properties of a quantitative measure of recovery experiences in bipolar disorder. *Journal of affective disorders*, 147(1), 34-43.

Koenig, H., McCullough, M., & Larson, D. (2001). *Handbook of Religion and Health*.

Leader, D. (2013). *Strictly Bipolar*. Penguin UK.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry: The Journal of Mental Science*, *199*(6), 445–452.

Linscott, R. J., & van Os, J. (2013). An updated and conservative systematic review and meta-analysis of epidemiological evidence on psychotic experiences in children and adults: on the pathway from proneness to persistence to dimensional expression across mental disorders. *Psychological Medicine*, *43*(6), 1133–1149.

Littlewood, R., & Dein, S. (2013). Did Christianity lead to schizophrenia? Psychosis, psychology and self reference. *Transcultural Psychiatry*, *50*(3), 397–420.

Lucas, C. G. (2011). *In Case of Spiritual Emergency: Moving successfully through your awakening*. Findhorn Press.

Lucas, C. G. (2015). *Coping With a Mental Health Crisis: Seven steps toward healing*. London: Seldon Press.

Lukoff, D. (2007). Spirituality in the recovery from persistent mental disorders. *Southern Medical Journal*, *100*(6), 642–646.

Lukoff, D., Lu, F., & Turner, R. (1998). From Spiritual Emergency to Spiritual Problem: The transpersonal roots of the new DSM-IV category. *Journal of Humanistic Psychology*, *38*(2), 21–50.

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy*, *14*(4), 317–327.

McCabe, R., & Priebe, S. (2008). Communication and psychosis: it's good to talk, but how? *The British Journal of Psychiatry: The Journal of Mental Science*, *192*(6), 404–405.

Meesters, Y., Duijzer, W. B., Nolen, W. A., Schoevers, R. A., & Ruhé, H. G. (2016). [Reasons for including the Inventory of Depressive Symptomatology (IDS) and its shortened version (QIDS) in routine outcome monitoring by the Foundation Benchmark Mental Health (SBG)]. *Tijdschrift voor psychiatrie*, *58*(1), 48–54.

Michalak, E. E., Yatham, L. N., Kolesar, S., & Lam, R. W. (2006). Bipolar disorder and quality of life: a patient-centered perspective. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation*, *15*(1), 25–37.

Mitchell, L., & Romans, S. (2003). Spiritual beliefs in bipolar affective disorder: their relevance for illness management. *Journal of Affective Disorders*, *75*(3), 247–257.

Mohr, C., & Claridge, G. (2015). Schizotypy--do not worry, it is not all worrisome. *Schizophrenia Bulletin*, *41 Suppl 2*, S436–43.

Mottram, K. (2014). *Mend the Gap - A Transformative Journey from Deep Despair to Spiritual Awakening*. Rethink Press Limited.

Murray, E. D., Cunningham, M. G., & Price, B. H. (2012). The role of psychotic disorders in religious history considered. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *24*(4), 410–426.

Noll, R. (1983). shamanism and schizophrenia: a state-specific approach to the "schizophrenia metaphor" of shamanic states. *American Ethnologist*, *10*(3), 443–459.

Ouwehand, E., Wong, K., Boeije, H., & Braam, A. (2014). Revelation, delusion or disillusion: subjective interpretation of religious and spiritual experiences in bipolar disorder. *Mental Health, Religion &*

Culture, *17*(6), 615–628.
Pesut, B., Clark, N., Maxwell, V., & Michalak, E. E. (2011). Religion and spirituality in the context of bipolar disorder: a literature review. *Mental Health, Religion & Culture*, *14*(8), 785–796.
Resnick, S. G., Fontana, A., Lehman, A. F., & Rosenheck, R. A. (2004). An empirical conceptualization of the recovery orientation. *Schizophrenia research*, 75(1), 119-128.
Roberts, K. A., & Yamane, D. (2015). *Religion in Sociological Perspective*. SAGE Publications.
Rush, A. J., Trivedi, M. H., Ibrahim, H. M., Carmody, T. J., Arnow, B., Klein, D. N., … Keller, M. B. (2003). The 16-Item quick inventory of depressive symptomatology (QIDS), clinician rating (QIDS-C), and self-report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. *Biological Psychiatry*, *54*(5), 573–583.
Schilderman, J.B.A.M. (2017). *The spiritual Mind: A cognitive humanities approach.* Unpublished manuscript.
Silverman, J. (1967). Shamans and Acute Schizophrenia. *American Anthropologist*, *69*(1), 21–31.
Slade, M. (2009). *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*. Cambridge University Press.
Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., … Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry: Official Journal of the World Psychiatric Association* , *13*(1), 12–20.
Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. SAGE.
Tart, C. T. (1969). *Altered states of consciousness: a book of readings*. John Wiley & Sons Inc.
Taylor, E. (1999). *Shadow culture: Psychology and spirituality in America from the Great Awakening to the new age.*
Taylor, E. (2005). States of Consciousness. *Encyclopedia of Religion*, *3*, 1946–195.
Trivedi, M. H., Rush, A. J., Ibrahim, H. M., Carmody, T. J., Biggs, M. M., Suppes, T., … Kashner, T. M. (2004). The Inventory of Depressive Symptomatology, Clinician Rating (IDS-C) and Self-Report (IDS-SR), and the Quick Inventory of Depressive Symptomatology, Clinician Rating (QIDS-C) and Self-Report (QIDS-SR) in public sector patients with mood disorders: a psychometric evaluation. *Psychological Medicine*, *34*(1), 73–82.
van Nieuwenhuizen, C., Wilrycx, G., Moradi, M., & Brouwers, E. (2014). Psychometric evaluation of the Dutch version of the mental health recovery measure (MHRM). *The International Journal of Social Psychiatry*, *60*(2), 162–168.
van Os, J., & Kapur, S. (2009). Schizophrenia. *The Lancet*, *374*(9690), 635–645.
van Os, J., & Reininghaus, U. (2016). Psychosis as a transdiagnostic and extended phenotype in the general population. *World Psychiatry: Official Journal of the World Psychiatric Association* , *15*(2), 118–124.
Weakland, J. H. (1968). Shamans, Schizophrenia, and Scientific Unity. *American Anthropologist*, *70*(2), 356–356.
Weber, M. (1978). *Economy and Society.* Berkeley : University of California Press.
Wisdom, J. P., Bruce, K., Saedi, G. A., Weis, T., & Green, C. A. (2008). "Stealing me from myself": identity and recovery in personal accounts of mental illness. *The Australian and New Zealand Journal of Psychiatry*, *42*(6), 489–495.
World Health Organisation (2006). *Constitution of the World Health Organisation*. Retrieved from http://www.who.int/governance/eb/who_constitution_en.pdf
Young, S., & Bullock, W. (2003). *Illness management and recovery and the role of the Mental Health Recovery Measure (MHRM) in outcomes research*. Ohio Department of Mental Health, Ohio

Coordinating Center for Excellence for Illness and Recovery.

Appendix 1

Informed consent: Dutch original

Ik ben geïnformeerd over het doel van het onderzoek en de geanonimiseerde en vertrouwelijke wijze waarop mijn persoonlijke gegevens verwerkt worden. Ik werk vrijwillig mee, en geef toestemming voor het gebruik van mijn gegevens. Ik ga ermee akkoord dat een audio-opname wordt gemaakt van het interview.

Informed consent: English translation

I have been informed about the purpose of the research, and about the anonymous and confidential treatment of my personal data. I cooperate voluntarily, and I give permission to use my data. I consent to the interview being audio-recorded.

Appendix 2

Guiding questions: Dutch original

1. Gevoelens:
    a. Wat waren je gevoelens voor/tijdens/na de episode?
    b. Trad er een verschuiving in je gevoelsleven op?
    c. Is die verandering in je gevoelsleven permanent?
2. Levensplan:
    a. Wat waren je plannen voor de toekomst voor de episode?
    b. Wat zijn je plannen voor de toekomst na de episode?
    c. Heeft de inhoud van de episode je levensplan beïnvloed?
3. Wereldbeeld:
    a. Wat was je wereldbeeld voor de episode?
    b. Wat is je wereldbeeld na de episode?
    c. Heeft de inhoud van de episode je wereldbeeld veranderd?
4. Contingentie:
    a. Overkwam de psychose je zomaar of hecht je er betekenis aan?
    b. Had je een keuze in wat er gebeurde?
5. Core concerns:
    a. Wat waren je belangrijkste waarden voor je episode? Wat vond je belangrijk in het leven voor de episode?
    b. Wat waren de belangrijkste waarden na de episode? Wat vond je belangrijk in het leven na de episode?
6. Life World
    a. Hoe zag je leefwereld eruit voor de episode?
    b. Hoe zag je leefwereld eruit na de episode?
    c. Heeft de inhoud van de episode invloed gehad op hoe je leven er nadien uitzag?
7. Emplotment:
    a. Op welke manier geef je je plannen gestalte in je leven? Hoe werk je aan de verwerkelijking van je plannen?
8. Enrolment:
    a. Sluit je levensplan aan bij je wereldbeeld of levensovertuiging? Op welke manier?
9. Enactment:
    a. Op welke manier komt je levensovertuiging tot uitdrukking in je dagelijks leven? Is dat veranderd door je psychose?

Guiding questions: English translation

1. Feelings:
    a. What were your feelings before/during/after the episode?
    b. Did a shift occur in your emotional life because of the episode?

    c. Was that shift in your emotional life permanent?
2. Life plan:
    a. What were your plans for the future before the episode?
    b. What were your plans for the future after the episode?
    c. Did the content of the episode alter your life plan?
3. Worldview:
    a. What was your worldview like before the episode?
    b. What was your worldview like after the episode?
    c. Did the content of the episode alter your worldview?
4. Contingencies:
    a. Did the episode just happen to you, or was it a meaningful event?
    b. Did you have any choice in what happened?
5. Core concerns:
    a. What were your most important values before the episode? What was important to you in your life before the episode?
    b. What were your most important values after the episode? What was important to you in your life after the episode?
    c. Did the episode in some way alter your core values?
6. Life world:
    a. What was your life like before the episode?
    b. What was your life like after the episode?
    c. Did the content of the episode contribute towards a change of your life world?
7. Emplotment:
    a. How do you realize your plans in your life? How do you go about making your plans come true?
8. Enrolment:
    a. Is your life plan in tune with your worldview? In what way?
9. Enactment:
    a. In what way do you express your worldview in your daily life? Did the episode have any affect on the way you express your worldview?

Appendix 3

Facebook recruitment text: Dutch original

Deelnemers gezocht!

Heb je een psychose beleefd met een religieuze of spirituele inhoud? Ik ben voor mijn afstudeeronderzoek op zoek naar mensen die daarover willen vertellen.

Ik ben met name benieuwd of en hoe deze ervaring van betekenis is geweest voor je herstelproces. Was het belangrijk voor je wat je hebt ervaren? Of was het allemaal onzin? Wat betekende de psychose voor je wereldbeeld, de diepste waarden in je leven, je gevoelsleven, je toekomstplannen?

Psychosen zijn er in soorten en maten en er zijn vele redenen waarom mensen in een psychose kunnen raken. Ook het herstelproces varieert al naar gelang de oorzaken van de psychose. Om dit complexe onderzoek toch zo eenduidig mogelijk te houden beperk ik me vooralsnog tot mensen met een bipolaire stoornis.

Iets over mijzelf: Ik hoop met dit onderzoek mijn opleiding tot Geestelijk Verzorger aan de Radboud Universiteit af te sluiten. Twintig jaar geleden mondde mijn eigen zoektocht naar zin uit in een psychotische episode. Ik heb die periode nooit beschouwd als symptoom van een ziekte, maar als een richtingaanwijzer naar de toekomst. Ik heb me er niet voor laten behandelen en heb geen medicijnen gebruikt. Twee jaar geleden besloot ik om me om te scholen tot geestelijk verzorger om mijn ervaring en kennis op dit terrein in te zetten ten dienste van andere mensen.

Heb je interesse om mee toe doen aan mijn onderzoek, stuur dan een FB berichtje, of een mail naar xxx@xxx.nl. Alvast hartelijk dank!

Facebook recruitment text: English translation

Looking for participants!

Have you ever experienced a psychotic episode with religious or spiritual content? For my graduate research project I am looking for individuals who would like to relate their story.

I am especially curious what this experience meant for your recovery process. Was your experience important to you? Or was it all nonsense? What did the psychosis mean for your worldview, for the deepest values in your life, your emotional life, your future plans?

Psychoses come in all shapes and sizes, and there are many reasons why people may experience a psychotic episode. The recovery process, too, varies according to what caused the psychosis. To keep this already rather complex research as unambiguous as possible, I will limit this research to individuals who are diagnosed with Bipolar Disorder.

A bit about myself: With this research, I am hoping to fulfill the requirements for a master's degree in Spiritual Care at Radboud University. Some twenty years ago, my own quest for meaning culminated in a psychotic episode. I have never looked upon that episode as a symptom of disease, but rather as a direction indicator towards the future. I have not received any treatment, nor did I ever take any medication. Two years ago, I decided to retrain myself to become a spiritual carer in order to put my knowledge and experience in this area to use for others.

If you are interested to participate in my research, please send me a Facebook message, or email me at xxx@xxx.nl. Thank you very much!

Appendix 4

Demographic data of participants

ID	AGE	SEX	FAITH	ADDITIONAL DIAGNOSES	DATE OF EPISODE	EDUCATION	MEDICATION
LLL1	47	F	Christian (other)	-	06-01-2014	University (MA)	Lithium
LLL2	42	F	Humanist, Christian, Buddhist	-	01-08-1996	University (MA	None
LLL3	54	F	Pagan	-	01-01-1996	University (MA	None
LLL4	55	M	Atheist	PTSS	01-01-1993	Vocational	None
LLL5	52	F	Other	Schizo-affective	01-01-2006	University (MA	None

Scores of participants on measurement instruments

ID	MHRM subscale 1 Empowerment	MHRM subscale 2 Learning and new potential	MHRM subscale 3 Spirituality	ASMR-NL	QIDS-SR
LLL1	65 (100%)	73 (97%)	10 (100%)	4	2
LLL2	62 (95%)	62 (83%)	7 (70%)	0	0
LLL3	48 (74%)	55 (73%)	6 (60%)	0	3
LLL4	53 (82%)	66 (88%)	9 (90%)	3	6
LLL5	53 (82%)	60 (80%)	9 (90%)	0	3

Appendix 5

Quotations list

Appendix 5 has been removed in this version of the thesis to protect the privacy of the participants. For scientific purposes only, appendix 5 may be obtained from the author after signing a confidentiality agreement.