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Sweet Delight and Endless Night: A Qualitative Exploration of Ordinary and Extraordinary Religious and Spiritual Experiences in Bipolar Disorder

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ABSTRACT

The authenticity of religious and spiritual experiences during mania is an important subject for bipolar patients. The exploration of such experience in bipolar disorder is the central point of this qualitative study. A psychiatrist and a hospital chaplain conducted 35 semi-structured interviews with recovered participants, recruited from mental health care institutions in the Netherlands, the patients' association and via the internet, about their religious and spiritual experiences during illness episodes and in stable times. A variety in types (such as divine presence, unity, mission, meaningful synchronicity) during mania was reported, which were on a sliding scale with experiences/views in stable times in more than half of the interviews. During depression, absence of religious or spiritual experience was predominant. The reported experiences were viewed by most participants as both authentically religious or spiritual but also related to the disorder, requiring therefore language that transcended medical terminology. Also indicated is the relevance of the results for fundamental discussions about the nature or religious experience.

Every Night & every Morn
Some to Misery are Born
Every Morn and every Night
Some are Born to sweet delight
Some are Born to sweet delight
Some are Born to Endless Night

— William Blake, "Auguries of Innocence"

INTRODUCTION

The study of religious and mystical experiences is a broad and important field in the psychology of religion. Because of its diversity within different religious and cultural contexts and its interface with psychopathology, it is also a difficult field to research. Hood, Hill, and Spilka (2009 Hood, R., Hill, P., & Spilka, B. (2009). *The psychology of religion*. New York, NY: Guilford Press.) took a clear stance on empirical research into religious experience in their handbook on the psychology of religion: It is *interpreted* experience, and a definition by its inherent characteristics is not fruitful. What is called religious within one tradition might be viewed as superstitious or merely anomalous within another tradition, and what persons with bipolar disorder (the subjects of the current Dutch study) perceive as religious or spiritual experiences are viewed in a psychiatric context as delusions and hallucinations with religious content. The variety of religious experience is much larger than William James (1902 James, W. (1902). *Varieties of religious experience*. Retrieved from https://worldu.edu/library/william_james_var.pdf) described in his classical *Varieties*, when religious experiences in various cultures and experiences of common people are included (Dein, 2010 Dein, S. (2010). Judeo-Christian religious experience and psychopathology: The legacy of William James. *Transcultural Psychiatry* 47(4), 523–547. doi:10.1177/1363461510377568). In the present study on the religious and spiritual experiences of persons with bipolar disorder in the Netherlands, we follow the interpretative position of Hood et al. (2009 Hood, R., Hill, P., & Spilka, B. (2009). *The psychology of religion*. New York, NY: Guilford Press.) and include all experiences that are perceived by the participants with bipolar disorder as religious or spiritual.

A second important issue in the research field of religious experience, directly relevant for the present study, is the distinction between pathological and healthy religious experience. There is a large body of literature in which the relation between psychosis and religious experience is examined (Boisen, 1960 Boisen, A. T. (1960). *Out of the Depths: An Autobiographical Study of Mental Disorder and Religious Experience*. New York, NY: Harper & Brothers. Retrieved from https://archive.org/stream/outofthedepthsan012920mbp#page/n7/mode/2up ; Dein & Littlewood, 2011 Dein, S., & Littlewood, R. (2011). Religion and psychosis: A common evolutionary trajectory? *Transcultural Psychiatry*, 48(3), 318–335. doi:10.1177/1363461511402723 ; Fulford & Jackson, 1997 Fulford, K., & Jackson, M. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry, & Psychology*, 4, 41–65. doi:10.1353/ppp.1997.0002 ; Hunt, 2000 Hunt, T. (2000). Experiences of radical personal transformation in mysticism, religious conversion, and psychosis: A review of the varieties, processes, and consequences of the numinious. *The Journal of Mind an Behavior*, 21, 353–397.Retrieved from http://www.jstor.org.proxy.library.uu.nl/stable/43853939. ; Menezes & Moreira-Almeida, 2010 Menezes, A., Jr., & Moreira-Almeida, A. (2010). Religion, spirituality and psychosis. *Current Psychiatry Reports*, 12(3), 174–179. doi:10.1007/s11920-010-0117-7 ; Mohr et al., 2010 Mohr, S., Borras, L., Betrisey, C., Pierre-Yves, B., Huguelet, P., & Huguelet, P. (2010). Delusions with religious content in patients with psychosis: How they interact with spiritual coping. *Psychiatry: Interpersonal and Biological Processes*, 73, 158–172. doi:10.1521/psyc.2010.73.2.158 , ; Sims, 2016 Sims, A. (2016). Psychopahtology and the clinical story. In C. C. Cook, A. Powell, & A. Sims (Eds.), *Spirituality and narrative in psychiatric practice* (pp. 25–39). London, UK: RCPsych Publications.). Apart from the theoretical implications, this is an important topic for clinical practice because different explanatory models (Kleinman, 1988 Kleinman, A. (1988). *The illness narratives*. New York, NY: Basic Books.) used by therapists and

clients may, when it comes to treatment, result in confusion (Mitchell & Romans, 2003 Mitchell, L., & Romans, S. (2003). Spiritual beliefs in bipolar affective disorder: Their relevance for illness management. *Journal of Affective Disorders*, 75, 247–257. doi:10.1016/S0165-0327(02)00055-1 ; Stroppa & Moreira-Almeida, 2013 Stroppa, A., & Moreira-Almeida, A. (2013). Religiosity, mood symptoms and quality of life in bipolar disorcer. *Bipolar Disorders*, 15, 385–393. doi:10.1111/bdi.12069).

Only a few studies into psychosis and religious or spiritual experience focus on bipolar disorder. However, discussions on Internet forums about the authenticity of religious and spiritual experiences during mania frequently appear on sites about bipolar disorder or psychosis, which indicates that interpretation of such experiences during illness episodes is an important topic for patients (Bipolar Wellness Centre, n.d. Bipolar Wellness Centre. (n.d.). *Why spirituality may be important to your quality of life*. Retrieved from http://www.bdwellness.com/Quality-of-Life-Areas/Spiritual ; Cole, 2015 Cole, C. (2015, August 31). *Is mania a spiritual experience?* Retrieved from http://www.ibpf.org/blog/mania-spiritual-experience ; Hendriks, 2015 Hendriks, H. (2015, July 29). Psychotisch onderuit: Manisch-depressief en psychose. Retrieved from https://www.psychosenet.nl/category/spiritualiteit. ; Loberg, 2012 Loberg, E. (2012). Religion and mental illness—How we define “hyper” religious and what does that mean. *Psych Central*. Retrieved from http://blogs.psychcentral.com/manic-depression/2012/09/18/religion-and-mental-illness-how-we-define-hyper-religion-and-what-does-that-mean/ ; Van Jost, 2014 Van Jost, B. (2014, December). Mania and hyper-religiosity. Retrieved from http://ibpf.org/blog/mania-and-%E2%80%9Chyper-religiosity%E2%80%9D . Michalak, Yatham, Kolesar, and Lam (2006 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*, 15, 25–37.), in a qualitative study into the relation between bipolar disorder and quality of life, concluded that for one third of the participants, spirituality was a valuable aspect of quality of life. The struggle to disentangle “real” spiritual experience from hyperreligiosity was an important theme for this group.

In clinical practice, the experiences during episodes that are perceived as religious or spiritual by patients are usually seen as pathological, and increasing preoccupation with spirituality is considered a sign of evolving mania (Braam, 2009 Braam, A. (2009). Religion/spirituality in mood disorders. In P. Huguelet & H. Koenig (Eds.), *Religion and spirituality in psychiatry* (pp. 97–114). New York, NY: Cambridge University Press. ; Brewerton, 1994 Brewerton, T. (1994). Hyperreligiosity in psychotic disorders. *The Journal of Nervous and Mental Disease*, 182, 302–304. PMID:10678313. ; Jerrell & Shugart, 2004 Jerrell, J., & Shugart, M. (2004). A comparism of the phenomenology and treatment of youths and adults with bipolar l disorder in a state mental health system. *Journal of Affective Disorders*, 80, 29–35. doi:10.1016/S0165-0327(03)00045-4). The diagnosis of mania is the essential building block for the diagnosis of bipolar I disorder. Mania is characterized by a constant heightened, expansive, or irritable mood, accompanied by overestimation of oneself and increased vitality and activity and a decreased need for sleep. Depressive episodes are characterized by a lasting depressive mood and loss of interest, decreased vitality and activity, and accompanied by feelings of worthlessness and guilt, often culminating in suicidal thoughts and plans (Kupka et al., 2015 Kupka, R., Goossens, P., Bendegem, M., Daemen, P., Daggenvoorde, T., Daniels, M., … Van Duin, D. (2015). *Multidisciplinaire richtlijn bipolaire stoornissen* [Multidisciplinary guideline on bipolar disorders]. Utrecht, the Netherlands: De

Tijdstroom. Retrieved from http://www.ggzrichtlijnen.nl ; Kupka & Nolen, 2009 Kupka, R., & Nolen, W. (2009). Classificatie en diagnostiek [Classification and diagnostics]. In R. Kupka, E. Knoppert-Van Der Klein, & W. Nolen (Eds.), *Handboek bipolaire stoornissen* [Manual of bipolar disorders] (pp. 15–41). Utrecht, the Netherlands: De Tijdstroom Uitgeverij BV.). Psychotic features can mark both manic and depressive episodes. In bipolar II disorder, no manic but only hypomanic and depressive episodes occur. In hypomania, symptoms can be the same as in mania, but no psychotic features are present and there is less impairment in daily functioning. In bipolar disorders (hypo)manic, depressive, and mixed episodes (with characteristics of both conditions) alternate with periods of recovery with much individual variation in duration of episodes and gravity. The prevalence of bipolar disorder I and II in the Netherlands is estimated at 1.9% of the general population (Regeer, Ten Have, Rosso, Vollenbergh, & Nolen, 2004 Regeer, E., Ten Have, M., Rosso, M., Vollenbergh, W., & Nolen, W. (2004). Prevalence of bipolar disorder in the general population: A reappraisal study of the Netherlands Mental Health and Incidence Study. *Acta Psychiatrica Scandinavica*, 110, 374–382. doi:10.1111/j.1600-0447.2004.00363.x). Quality of life is markedly impaired in patients with bipolar disorder, even when they have recovered (Michalak, Yatham, & Lam, 2005 Michalak, E. E., Yatham, L. N. & Lam, R. (2005). Quality of Life in Bipolar Disorder: A Review of the Literature. *Health and Quality of Life Outcomes*, 3(72). doi:10.1186/1477-7525-3-72), and the suicidal risk for bipolar patients is estimated at 5% among never-hospitalized patients with bipolar disorder of moderate severity and 19% for the group with severe bipolar disorder (Goodwin & Redfield Jamison, 2007 Goodwin, F. K., & Redfield Jamison, K. (2007). *Manic-depressive illness. Bipolar disorders and recurrent depression*. New York, NY: Oxford University Press.).

Because of the presupposed relation between hyperreligiosity and mania in psychiatry, it is not surprising that religious experience related to bipolar disorder is usually studied from the perspective of psychopathology. The scant empirical research that is available investigates the association between mania and delusions/hallucinations with religious content by comparing different diagnostic groups of inpatients (Brewerton, 1994 Brewerton, T. (1994). Hyperreligiosity in psychotic disorders. *The Journal of Nervous and Mental Disease*, 182, 302–304. PMID:10678313. ; Cothran & Harvey, 1986 Cothran, M., & Harvey, P. (1986). Delusional thinking in psychotics: Correlates of religious content, *Psychological Reports*, 58, 191–199. PMID:3961063. ; Kroll & Sheehan, 1989 Kroll, J., & Sheehan, W. (1989). Religious beliefs and practices among 52 psychiatric inpatients in Minnesota. *American Journal of Psychiatry*, 146(1), 67–72. doi:10.1176/ajp.146.1.67) or differences in religious background and diagnosis related to the severity of religious delusions (Getz, Fleck, & Stratowski, 2001 Getz, G., Fleck, D., & Stratowski, M. (2001). Frequency and severity of religious delusions in Christian patients with psychosis, *Psychiatry Research*, 103(1), 87–91. PMID:11472793.). Gallemore, Wilson, and Rhoads (1969 Gallemore, J., Wilson, W., & Rhoads, J. (1969). The religious life of patients with affective disorders. *Diseases of the Nervouw System*, 30, 483–487.PMID: 5810555.) found an increased prevalence of conversion and salvation experiences in the recovered group with affective disorders (52%), compared to the control group who had never been mentally ill (20%). Surprisingly enough, in only four cases (n = 62) had such experiences occurred during mania, according to the participants; they usually occurred when the participants were well. Two review studies about the relationship between religion and spirituality and bipolar disorder emphasize the importance of including religion and spirituality as a possible determinant in the course of bipolar disorder (De Fazio et al.,

2016 De Fazio, P., Gaetano, R., Caroleo, M., Cerminara, G., Giannini, F., Jaén Moreno, M., … Segura-García, C. (2016). Religiousness and spirituality in patients with bipolar disorder. *International Journal of Psychiatry in Clinical Practice*, *19*, 233–238. doi:10.3109/13651501.2014.1000929 , ; Pesut, Clark, Maxwell, & Michalak, 2011 Pesut, B., Clark, N., Maxwell, V., & Michalak, E. (2011). Religion and spirituality in the context of biplar disorder: A literature review. *Mental Health, Religion and Culture, 14*(8), 1–12. doi:10.1080/13674676.2010.523890 ,). At the same time these reviews reveal the lack of empirical studies to draw relevant conclusions for clinical practice.

Dutch research into patients' expectations with regard to religion and spirituality in general indicates that mental health care patients value religion and spirituality as important for illness management and that this interest is underestimated by professionals (Pieper & Van Uden, 2005 Pieper, J., & Van Uden, M. (2005). *Religion and coping in mental health care*. Amsterdam, the Netherlands: Rodopi.). Religious and spiritual experiences during episodes of illness are interpreted differently by patients and professionals, and this is experienced as problematic from the patients' perspective (Borjes, Van Eerd, Sisselaar, Verhaar & Vink, 2001 Borjes, M., Van Eerd, I., Sisselaar, A., Verhaar, B., & Vink, M. (2001). *In de geest van … Cliënten over levensbeschouwing* [In the spirit of……cliënts on philosophy of life]. Amsterdam, the Netherlands: APCP. ; Ouwehand, Wong, Boeije, & Braam, 2014 Ouwehand, E., Wong, K., Boeije, H., & Braam, A. (2014). Revelation, delusion or desillusion: Subjective interpretation of religious and spiritual experiences in bipolar disorder. *Mental Health, Religion & Culture*, 17(6), 1–14. doi:10.1080/13674676.2013.874410 ,).

The concept of religious or spiritual experience is difficult to delimit because religion and spirituality in Western societies are, according to sociologists of religion, in a process of transformation. This process is characterized by waning traditional religious institutions, authorities, rituals, and dogmas toward waxing multiple spiritual expressions in informal networks. An increasing emphasis on the experiential and personal appears as a feature of modern religiosity and spirituality (Bernts & Berghuijs, 2016 Bernts, T., & Berghuijs, J. (2016). *God in Nederland 1966-2015*. Utrecht, the Netherlands: Uitgeverij Ten Have. ; De Hart, 2011 De Hart, J. (2011). *Zwevende gelovigen*[The Floating Faithful]. Retrieved from https://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2013/Zwevende_gelovigen_Oude_religie_en_nieuwe_spiritualiteitm , 2014 De Hart, J. (2014). *Geloven binnen en buiten verband* [Believers within the fold and without]. Retrieved from https://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2014/Geloven_binnen_en_buiten_verband ; Kronjee & Lampert, 2006 Kronjee, G., & Lampert, M. (2006). Leefstijlen en zingeving [Lifestyles and meaning in life]. In W. Van De Donk, A. Jonkers, G. Kronjee, & R. Plum (Eds.), *Geloven in het publieke domein. Verkenningen van een dubbele transformatie*[Faith in the public domain. Explorations of a dual transformation] (pp. 171–195). Amsterdam, the Netherlands: Amsterdam University Press. Retrieved from http://www.wrr.nl/fileadmin/nl/publicaties/PDF-verkenningen/Geloven_in_het_publieke_domein.pdf). We do not go into the problem of defining religion and spirituality as concepts extensively, as the definition problem has already been excellently presented by others (Berghuijs, Pieper, & Bakker, 2013 Berghuijs, J., Pieper, J., & Bakker, C. (2013). Being 'spiritual' and being 'religious' in Europe: Diverging life orientations. *Journal of Contemporary Religion*, 28(1), 15–32. doi:10.1080/13537903.2013.750829 , ; Hood et al., 2009 Hood, R., Hill, P., & Spilka, B. (2009). *The psychology of religion*. New York, NY: Guilford Press. , p. 9ff.; Streib & Hood, 2016b). In this article we follow Streib and Hood (2016b) in "The Bielefeld-based

Cross-cultural Study on 'Spirituality,'" arguing as they do in favor of the term "religion" over "spirituality" in scientific research, for reasons of intellectual clarity. Following Ernst Troeltsch's typology of religion in church, sect, and mysticism (by which Troeltsch, 1923 Troeltsch, E. (1923). Die Soziallehren der christlichen Kirchen und Gruppen [The social teaching of the Christian Churches] In: H. Baron (ed), *Gesammelte Schriften* [Collected Writings] (3rd ed., Band 1). Tübingen, Germany: J.C.B. Mohr. Retrieved from https://archive.org/details/gesammelteschrif01troeuoft , meant nonorganizational forms of religion that focus on personal religious experience) we define spirituality as the "privatized, experience-oriented" type of religion. The concept of "spirituality" is important for self-definition in individuals, but in the current study, as in "The Bielefeld-based Cross-cultural Study on 'Spirituality,'" it is considered an emic term that should be regarded empirically as self-description, not as a separate concept in any theory of religion. In sociological research it becomes apparent that self-definition as encompassing the religious and spiritual overlap to some extent for certain groups in modern Western societies, but figures differ country by country. The group that identifies itself as both religious and spiritual is much larger in the United States (47% according to General Social Survey Chicago 2016)[11] The variables 'religious person' and 'spiritual person' in GSS 2016 were computed as in Dutch research in the sociology of religion 'God in Nederland, (GiN)' [God in the Netherlands] (Bernts & Berghuijs, 2016 Bernts, T., & Berghuijs, J. (2016). *God in Nederland 1966-2015*. Utrecht, the Netherlands: Uitgeverij Ten Have.), to attain a fourfold r/s typology: 'religious nor spiritual,' 'only religious,' 'only spiritual,' and 'religious and spiritual.'View all notes than in the Netherlands, for example (20% according to God in the Netherlands; Bernts & Berghuijs, 2016 Bernts, T., & Berghuijs, J. (2016). *God in Nederland 1966-2015*. Utrecht, the Netherlands: Uitgeverij Ten Have.) and younger generations define themselves more than older generations as exclusively spiritual (De Hart, 2011 De Hart, J. (2011). *Zwevende gelovigen*[The Floating Faithful]. Retrieved from https://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2013/Zwevende_gelovigen_Oude_religie_en_nieuwe_spiritualiteitm ; Possamai, 2005 Possamai, A. (2005). *Religion and popular culture. A hyper-real testament*. Brussels, Belgium: P.I.E. Peter Lang.).
Moreover, the subjective significance people attach to the concepts "religion" and "spirituality" has only recently become a subject of empirical study (Eisenmann et al., 2016 Eisenmann, C., Klein, C., Swhajor-Biesemann, A., Drexelius, U., Streib, H., & Keller, B. (2016). Dimensions of "spirituality:" The semantics of subjective definitions. In H. Streib & R. W. Hood (Eds.), *Semantics and psychology of "spirituality." A cross-cultural analysis* (pp. 125–151). Cham, Switzerland: Springer International. ; Streib, Keller, Klein, & Hood, 2016 Klein, C., Silver, C., Streib, H., Hood, R., & Coleman, T., III. (2016). "Spirituality"and mysticism. In H. Streib & R. W. Hood (Eds.), *Semantics and psychology of "spirituality." A cross-cultural analysis* (pp. 125–151). Cham, Switzerland: Springer Internaional.).
In "The Bielefeld-based Cross-cultural Study on 'Spirituality'" (Streib & Hood, 2016a Streib, H., & Hood, R. W. (Eds.). (2016a). *Semantics and psychology of spirituality. A cross-cultural analysis*. Cham, Switzerland: Springer International.), Klein, Silver, Streib, Hood & Coleman III (2016 Klein, C., Silver, C., Streib, H., Hood, R., & Coleman, T., III. (2016). "Spirituality"and mysticism. In H. Streib & R. W. Hood (Eds.), *Semantics and psychology of "spirituality." A cross-cultural analysis* (pp. 125–151). Cham, Switzerland: Springer Internaional.) investigated the relationship between the religious and spiritual self-rating of participants in their study, and through Hood's Mysticism Scale it was found

that mysticism is an inherent aspect of what people today understand as "spiritual" (in Germany and the United States). Their study does not explore other anomalous experiences or paracultural phenomena that increasingly gain interest both in and outside the Dutch churches (Berghuijs, 2016 Berghuijs, J. (2016). Multiple religious belonging in the Netherlands: An empiritcal approach to hybrid religiosity. *Open Theology*, (3), 19–37. doi:10.1515/opth-2017-0003 ; De Hart, 2011 De Hart, J. (2011). *Zwevende gelovigen*[The Floating Faithful]. Retrieved from https://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2013/Zwevende_gelovigen_Oude_religie_en_nieuwe_spiritualiteitm). In the current study we included not only the so-called numinous and mystical experiences but also paranormal and anomalous experiences, such as out-of-body experiences and contact with deceased persons. We use the term *New Spirituality* as a broad term for different emerging forms of religion, where the focus is on individual experience and a "true inner self," a holistic and cyclic perspective on transformation and history, the immanence of the divine, and syncretistic tendencies (De Hart, 2011 De Hart, J. (2011). *Zwevende gelovigen*[The Floating Faithful]. Retrieved from https://www.scp.nl/Publicaties/Alle_publicaties/Publicaties_2013/Zwevende_gelovigen_Oude_religie_en_nieuwe_spiritualiteitm). According to recent research, 25% of the Dutch population are members of a church, 7% belong to other religions than Christianity, and 68% have no religious affiliation. Forty-two percent of the population believe in God or "something higher," and 58% are agnostic or atheist (Bernts & Berghuijs, 2016 Bernts, T., & Berghuijs, J. (2016). *God in Nederland 1966-2015*. Utrecht, the Netherlands: Uitgeverij Ten Have.). Dutch statistical figures show a decrease of actual experiences of God or a higher power, from half of the population in 2006 who "certainly" or "perhaps" had such an experience to one third in 2015 (Bernts & Berghuijs, 2016 Bernts, T., & Berghuijs, J. (2016). *God in Nederland 1966-2015*. Utrecht, the Netherlands: Uitgeverij Ten Have.). We mention this here to give a context to the religious and spiritual experiences described in the present study, because an important question is whether such experiences of people with bipolar disorder differ from experiences found in the general population.

Keeping in mind the developments in the religious landscape as just summarized, the current study addresses the following question: How do people with bipolar disorder express their own ordinary and extraordinary religious or spiritual experiences during illness and during stable periods? Because so few empirical studies are available, we would like to contribute to a more comprehensive understanding of the topic by a retrospective, phenomenological description of religious and spiritual experiences. More insight into the variation of content and aspects of such experiences can help clinicians establish a better relationship with patients who struggle with the experiential aspect of their spirituality.

METHODS

Research design

The analytical approach of choice of the current study was Interpretative Phenomenological Analysis (IPA; Biggerstaff & Thompson, 2008 Biggerstaff, D. L., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, 5, 173–183. doi:10.1080/14780880802314304 , ; Smith & Osborn, 2008 Smith, J., & Osborn, M. (2008). Interpretative phenomenological analsysis. In J. Smith (Ed.), *Qualitative psychology* (pp. 56–80). Los Angeles, CA: Sage.). From a philosophical point of view, IPA combines two traditions: phenomenology and hermeneutics. In qualitative research the phenomenological approach is used as a method to describe phenomena as richly as

possible by "bracketing" the researcher's theoretical presuppositions. Rather than explaining the narrative of the participants by theory, the researcher provides plausible insight and understanding into the life world of participants by rich, descriptive narrative. In the hermeneutical tradition the necessity of interpretative processes for understanding human expressions is presupposed. The researcher is never free from preunderstanding while interpreting a narrative. In IPA the interpretative influence of the researcher on the analyzing process is presumed. The interviews were carried out after recovery, for two reasons. The first reason is based on the theoretical assumption in recovery literature, that reflection on the meaning of life and meaning of the experience of illness is an important aspect of recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011 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*, 199, 445–452. doi:10.1192/bjp.bp.110.083733). Retrospective accounts of religious and spiritual experiences that have happened during episodes of illness are, next to psychiatric diagnosis, constructed narratives that can play a positive role in recovery. However, too much mood disturbance and cognitive confusion will not contribute to consistent reflection on meaning and the recovery process (Cook, 2016 Cook, C. (2016). Narrative in psychiatry, theology and spirituality. In C. Cook, A. Powell, & A. Sims (Eds.), *Spirituality and narrative in psychiatric practice* (pp. 1–14). Glasgow, UK: Bell & Bain.); therefore data collection during episodes of illness is unfeasible in the present design. Second, we regarded it as unethical to conduct a 2-hr interview with patients undergoing an acute episode.

Recruitment procedure

In the recruitment procedure we aimed at recovered participants with a variety in age, religious and educational background, and duration of the illness. The participants were enlisted in three ways: first by practitioners of two mental health institutions—Altrecht and Eleos (17 participants)—and second in a peer support project (nine participants), carried out by the patients' organization for those with bipolar disorder. Third, owing to recruitment procedures via mental health care professionals turning out to be laborious, participants could apply in reaction to a blog (Ouwehand, 2015 Ouwehand, E. (2015, July 13). *Tussen hemel en hel: Onderzoek naar spirituele ervaringen en de bipolaire stoornis* [Between heaven and hell: Research into spiritual experiences and bipolar disorder]. Retrieved from https://www.psychosenet.nl/category/spiritualiteit/) on an interactive website for professionals and peers with psychotic disorder (38 applications, of whom only nine persons could be included, because sufficient participants with the same religious or spiritual affiliation had already been included). Probably not all mental health professionals are informed about the spiritual life of their patients, and religious or spiritual experience could especially be a difficult subject in treatment because of its association with mania. Participants with a strict (orthodox or pietistic) background, as well as participants of religions other than Christianity, and participants belonging to ethnic minorities were hard to find. Another group difficult to include was recently diagnosed patients. From the 10 participants with a relatively recent diagnosis (varying from 6 months to 2½ years), a mere two had had only one manic episode. The other eight already had gone through more than one manic episode or had a delayed diagnosis.

Data collection

The interviews were semistructured and lasted approximately 2 hr. Five relevant topics were addressed, of which the first three are presented in the present article: first (as the

main objective of the study), religious or spiritual experiences during mania, during depression, and after recovery; second, diagnosis and course of the bipolar illness; third, present religious attitude of participants (including the religious upbringing). The last topic served to discuss the main objective in a context relevant for the participant. The possible questions are recorded in the appendix. The fourth (interpretation of the experiences after recovery) and fifth topics (expectations of treatment with regard to the experiences) will be presented in another publication. The interviews were carried out by a hospital chaplain (the first author) and a psychiatrist or trainee psychiatrist. The first author acted as the main interviewer. Interview instructions and procedures can be found in the appendix. Assessment of recovery was examined with the Altman Self-Rating Mania Scale (Altman, Hedeker, Peterson, & Davis, 1997 Altman, E., Hedeker, D., Peterson, J., & Davis, M. (1997). The altman self-rating mania scale. *Biological Psychiatry*, 948–955. doi:10.1016/S0006-3223(96)00548-3), the Quick Inventory of Depressive Symptomatology–Self-Report (Rush et al., 2003 Rush, A., Trivedi, M., Ibrahim, H., Carmody, T., Arnow, B., Klein, D., … Keller, M. (2003). The 16-item Quick Inventory of Depressive Symptomotology (QIDS), clinician rating (QIDS-C), and self-report (QIDS-SR): A psychometric evaluation in patients with chronic marjor depression, *Biological Psychiatry*, 54(5), 573–583. PMID:12946886.). The Clinical Global Impressions Scale for use in bipolar illness (Spearing, Post, Leverich, Brandt, & Nolen, 1997 Spearing, M. K., Post, R. M., Leverich, G. S., Brandt, D., & Nolen, W. (1997). Modification of the Clinical Global Impressions (CGI) Scale for use in bipolar illness (BP): The CGI-BP. *Psychiatry Research*, 73, 159–171. PMID:9481807.) was filled in by the cointerviewer. Two participants had somewhat higher self-ratings on manic symptoms, and six participants reported somewhat higher levels of depressive symptoms, but this did not interfere with the ability to participate in the interview, also according to clinical judgment of the psychiatrist or psychiatrist trainee.

Data analysis

The interviews were audiotaped and transcribed verbatim. The transcripts were sent to the participants for possible correction, of which a few persons made use. Two participants did not consent to audiotaping; a written report of the interview was corrected by them afterward. Interview texts were analyzed in NVivo10. The first author and the resident psychiatrist, who was cointerviewer in the first 10 interviews, both coded the first interview independently and developed a code list. The next five interviews were analyzed by either one or the other, and the common code list was adjusted accordingly after several discussion sessions. Because of the different professional backgrounds of the interviewers, we needed this initial thorough exchange of both a clinically psychiatric way of observing together with a theological/counseling approach. This exchange aimed at facilitating a dialogue in which presuppositions were minimalized, or—at least—balanced. In this way we were able to construct a code-tree that reflected the participant's expressions and attribution of meaning and at the same time would contain valuable diagnostic information. The four remaining interviews were analyzed by the first author, who discussed the results with the cointerviewer. After the first 10 interviews, the sample was extended to 35 participants in total with more varied religious background, and the research question of religious experience in stable periods was added. In the subsequent coding and analyzing process the first 10 interviews were reanalyzed. The whole process was discussed with the Ph.D. supervisors and within a network of Ph.D. students with experience in qualitative research. Clarification of the code names was a returning point in the discussions. "Ineffability," for example, is an aspect of religious experience as well as of psychotic

experience (Clarke, 2010 Clarke, I. (2010). Psychosis and spirituality: The discontinuity model. In I. Clarke (Ed.), *Psychosis and spirituality. Consolidating the new paradigm* (pp. 101–115). Chichester, UK: Wiley & Sons. , p. 102), which makes exact description difficult. The code names, closely related to literal formulation of the participants, evoked different connotations in the Ph.D. supervisors, each using their own jargon of different professional backgrounds (theology, psychiatry, and social studies). In the article, we present code names with the definitions we used in analysis.

Ethics

Participants were informed about research aims and procedure by mail and telephone and signed a consent form before the interview took place. On request they were provided with the topic list for the interview. Four participants had a previous counseling contact with the first interviewer, because in the initial phase of the study it was difficult to find participants. In three cases the participants knew the interviewing psychiatrist; this could have created a bias. A discussion about this resulted, in one case in the replacement of the cointerviewer. The study was approved by the Regional Medical Ethical Committee of the University Medical Centre Groningen (METc2014.475) and the Scientific Committee of Altrecht Mental Health Care (2015–05/oz1501[22] Registration numbers of the two committees, respectively.View all notes).

RESULTS

Sample characteristics

The sample characteristics are summarized in Table 1.

[TABLE 1]

Most participants had been raised as Christians, three as Muslims, and six had no religious background. During the course of their lives, the spiritual attitude and views of most of the participants had changed. As in the general population, the religious interest of some participants shifted from more traditional religious views to forms of New Spirituality, sometimes without entirely leaving church or mosque. Buddhism, mindfulness, and the spiritual teachings of Eckhart Tolle were popular in the New Spirituality group. The affiliation in this group varied: from reading esoteric literature to participation in intense courses as Landmark, Psychosynthesis, or other alternative therapies. Other participants moved to a less orthodox or evangelically oriented church in the course of their life.
The group members were as a whole highly educated. About half of them had a job or were engaged in a course or study; the other half were occupied in voluntary work or were unemployed. Two thirds of the group were married or involved in a relationship. Most of the participants had regular contact with either mental health care professionals or with a general practitioner for medication. Thirteen participants had attended training or education in religious studies, theology, philosophy (10), and/or New Spirituality (5) at different educational levels, mostly in addition to other professional education.

Religious and spiritual experiences during different episodes

In the next three sections we first describe religious and spiritual experiences during different phases of the illness and when recovered: during mania, depression, and when participants were stable, numbered 1, 2, and 3. *Types* referred to religious or spiritual themes in the experience, for example, the *presence of God. Aspects* referred to accompanying phenomena, for example, *physical sensations* or *changed awareness*,

occurring in religious and spiritual experiences with varied content. *Aspects* might resemble psychiatric symptoms, but in this study they are described from the perspective of participants, staying close to their own vocabulary.

1. Religious and spiritual experiences during mania

The frequency of reported experiences and the variation in *type* and *aspects* was much higher during mania than during depression or in stable periods. Many participants were eager to tell about their religious or spiritual experiences in mania, and some started the interview immediately with this topic. In four of the 35 interviews, religious or spiritual experiences during mania were absent. In the next two sections we report the different *types* and *aspects* in order of prevalence. Quotations of *types* and aspects during manic episodes can be found in Table 2.

Types of religious or spiritual experience during mania.

[TABLE 2].

The two most frequently reported types of religious or spiritual experience, both in about half of the interviews, were 1a. *The presence of a transcendental or divine reality*, subdivided in *Presence of God/Light* and *Experiences of Unity*, and 1b. *Mission/Vocation*. A third type, appearing in somewhat less than one third of the interviews, was the experience of 1c. *Meaningful synchronicity*: experiencing everything as having a special meaning, different from what occurs in daily life. A reservoir of different types of experiences, which were each mentioned by only a few participants, was categorized as 1d. *Other Positively valued experiences* and 1e. *Negatively valued* experiences.

1a. The presence of a transcendental or divine reality.

The *presence of a divine* reality was mentioned in 10 interviews, as an intense presence of God, Jesus, the Holy Spirit, or a supernatural Light. This was described by some participants as a sense of presence, by others as an apparition or a divine voice speaking to them: “Such an intense closeness of God. Yes. As if God was sitting in the room” (P1). Akin to the experience of divine presence was the experience of a sense of *unity* or connection to a divine or transcendental reality in one fourth of the interviews. It could be felt as a connection with other people, with nature, with the cosmos, with God, or with one’s deeper self. P28 recounted his first admission to a psychiatric ward, 1 year before the interview:

I was tied down to a bed and I was lying flat on my back, being transported through the hospital. I really had the feeling: I am one with everything. … It was so extraordinary! In the preceding weeks I have had similar experiences. Feeling a kind of unity, between human beings, and actually between everything you can see. (Man, New Spirituality)

1b. Mission or vocation

About half of the participants reported experiences of having an important *mission* or *vocation* in or for the world. P29, a young man, mentioned his mission to help peers. He had had a hard time accepting his diagnosis and only slowly began to appreciate his fellow clients and professionals who were trying to help him. During a manic episode, an angel appeared to him with the message that he should change society and help other young people like him.

Because they were all special people, like prophets, coming from God to do something on earth. It was my responsibility to make it easier for them to fulfil their mission. (P29, Evangelical)

For a part of this group, their mission or vocation during mania was strongly linked to ethical imperatives or critical standards they felt compelled to realize in their lives. Their vocation varied from helping others who were in need to propagating one's religious convictions or pursuing justice. Some participants reported that they had identified themselves during mania with a holy person or being with a godly mission, for example, with the suffering Christ (P18) or a prophet (P33).

1c. Meaningful synchronicity

A third type of religious experiences had to do with the changed relationship that participants perceived between objects, people, or situations. Everything becomes meaningful and has a special value during mania. P18 described religious experiences he had on successive days at exactly four o'clock in the morning and the meaning of the number four. The numerical value of events or texts disclosing itself during mania was mentioned by a few others as well. Several participants mentioned a strong sense of noncontingency: perceiving nothing as coincidental anymore. P28 reported his perception of synchronicity between things happening in his body and around him as if there was a relation between the two. By others a sense of noncontingency was felt in encountering other people:

I thought I had just met the people who had some special message for me, or I had to do something for them. Each encounter had a special meaning. (P33, Evangelical)

1d. Other positively valued experiences.

Varied religious or spiritual experiences, often reported by only a few participants, are summarized in this subsection. These concerned experiences that are called paranormal in New Spirituality literature and popular culture and experiences that occur in Christian or anthroposophical circles. These are found in fewer than half of the interviews: *Apparitions and voices, Symbols/symbolic images or visions,* and *Out-of-body experiences*.

A few participants reported *apparitions* of deceased persons, either only as a sight or with the possibility of communicating with them. Some others mentioned apparitions of angels or beings of light that moved up and down between heaven and earth, like P7, a mainstream Protestant woman: "They are so approachable, really present, tangible." Others mentioned *voices*, either from outside or from within the head, of deceased persons, holy beings or of "something Higher" (P6). A few others had seen strong *images, symbols*, or *visions* during mania, which were perceived as three-dimensionally present. Others again described that the contact with the body was much looser or even lost, which sounded like *out-of-body experiences*.

1e. Negatively valued experiences

The phenomena just mentioned were experienced as comforting by the participants, but in one third of the interviews a dominant feature of the manic experiences was fear. Negative experiences that were reported specifically as religious or spiritual concerned the experience which we coded as the *Annihilation of the person*. Some participants who had *experiences of unity* during a developing mania explained that this could culminate in the experience of dissolution of the ego or of an overwhelming flow of energy that seemed to annihilate the person, which was very frightening. A second negative religious experience

was coded as *Sin & Evil*. A few participants reported the appearance of frightening biblical sights or the fear of having sinned against the Holy Spirit. P33, a young woman who had come into contact with an African Pentecostal Church in a period of a gradually developing manic episode, described satanic manifestations that were inflicting her body. She was the only participant who reported this kind of drastic experience: "falling on the floor, making strange sounds, while not making them myself. Shaking and making strange bodily movements." However, most of the terrifying experiences during mania had no religious content, and some participants told us that increased praying or meditating helped them to cope with their fear and desperation. Frightening experiences were often reported next to positive religious or spiritual experiences in the same interview.

Aspects of the religious and spiritual experiences during mania

The apparent *aspects* of the religious and spiritual experiences are presented in the next section. These are *aspects* related to *emotionality* and *physical sensations*, on one hand, and *altered awareness*, on the other hand, by which we meant changes in perceiving the outer reality.

1f. Positive & negative emotions

Strong *Positive & negative emotions* were often reported as accompanying religious or spiritual experiences. On the positive side, the words that participants used to describe this experience differed in intensity from "pleasant," "euphoric," "high," "lovely," and "contentment" to an intensification of feelings into "total happiness," "so much love," "perfect peace and silence," "exceptional beauty," "enormous freedom," and "being in paradise." Fear characterized negative experiences and could be as intense as its positive counterparts.

1g. Fusion

A much less mentioned aspect was *Fusion*, by which participants meant feeling the same as another person, whereby someone's mood changed with the other person's mood, or as *fusion* or merging with another person.

1h. Physical sensations

Changing body awareness and *physical sensations* were mentioned in one third of the interviews. Some participants felt an extension of the body, a gradual expanding. Others could hardly feel the physical body anymore, or mentioned leaving the body. Other *physical sensations* that were mentioned by participants as accompanying their religious and spiritual experiences were involuntary movements of the limbs or the eyelids, shivering and vibrations, experiencing strong hot or cold sensations, having no control over the limbs anymore, feeling that an electric wire or firework was burning through in the head, and being unable to move or feeling very heavy.

1i. Energy

Abundant *energy* as a physical sensation was mentioned by others. It was so overwhelmingly strong in P28 that he had the feeling of losing all control. Others described a feeling of divine or healing energy, floating through the body, or overflowing through the hands. Strong energy could manifest itself quite unexpectedly, like a twinge or stab, but was felt by others as running through the whole body.

1j. Intensity

Intensity was more of a qualification concerning all the aspects just mentioned and was expressed by adjectives as "intense," "vehement," and the like. Sometimes the intensity of experiences was described as overwhelming.

1k. Altered awareness

Other aspects had to do with the *altered awareness* of participants. We discerned the aspect of *insights*, by which we did not refer to the concept of insight into one's own condition used in clinical practice but insights that participants perceived in the nature of reality or of themselves. It had to do with viewing everything in a completely new way, discovering reality as never perceived before, or seeing relationships between things that were formerly never observed. *Perceiving oneself in another dimension* is the aspect of "realness" of what people were seeing or experiencing. This could vary from observing that the outer world had changed to actually participating as a person in this other reality such as in a dream or movie. The tangibility of heavenly beings moving up and down, mentioned by P7, was an example of such "realness" she perceived herself as part and parcel of, to the extent that she felt she could go up with them to heavenly spheres. P2 explained that the border between seeing things and actually experiencing them as in a dream was very thin, as if it happened at the same time. This involvement in another reality could be felt as inevitable and very powerful, as being drawn into, being taken over, or being addressed by this other reality. We called this *other-dimensional association*. P25 described it as if outside reality were animated or personalized and were connecting with her: "At the beginning you are just yourself and then the illness strikes you. Then everything changes, as if a new dimension is directing itself to you" (Woman, New Spirituality).
Situations, thoughts, or the performing of actions were perceived as happening automatically or due to an invisible power. A contrasting aspect to this being involved or driven by a transcendent power was the perception of P3 that by performing certain actions he would bring things to a conclusion. He himself was the driving force in a changing world around him.

2. Religious and spiritual experiences during depression

For many participants decreased vitality and a barren emotional life, which are characteristic of depression, applied to spiritual life as well: For them, spirituality was absent or at a low level. The reported frequency of religious and spiritual experiences and their variation was much lower than during mania. Quotations of *types* and *aspects* during depressive episodes can be found in Table 3.

Types of religious and spiritual experiences during depression.

[TABLE 3]

As the most important *type* of experience we coded 2a. *Absence of faith/spirituality*, and the more personalized version of it, *absence of the divine*. Taken together, more than half of the participants mentioned this spiritual barrenness. Other, much less prevalent types were 2b. *Guilt and punishment*, 2c. *Religious doubt*, and 2d. *The presence of evil*; together these themes occurred in 14 interviews. In one third of the interviews, 2e. *Trust and confidence* appeared, not always as an emotionally strongly felt experience but as an important theme. 2f. *Suicidality* in relation to belief and spirituality was a theme in 11 interviews, which contained both positive and negative experiences.

2a. Absence of faith/the divine

For many participants, the *absence of faith or spirituality* was a recurring condition when becoming depressed. It usually was described in a negative way, as *absence* of religious or spiritual experiences. When it was described positively, with expressions like "indifference," "a dark hole," "flatness," "absolute emptiness," "paralyzed," "being totally stuck or blocked," "a frozen state," and "total despair," participants usually did not qualify this state as spiritual or religious. This emptiness and being stuck manifested itself in various aspects of life, of which spirituality was only one. In the interviews, the depressive condition was not spontaneously elaborated on by participants, contrary to the often enthusiastic descriptions of experiences during mania. P5 described her depressive state as follows:

You can believe in everything and think that you've come to the end of it all. But you always start at zero when you're in a depression. To me it was such an intense emptiness that I … the whole faith comes undone, because you feel nothing at all and just empty and can't experience anything at all. (Woman, New Spirituality)

On a more personal level, participants did not experience the presence of God or Light anymore, such as they had felt during mania. P25, who had intensely communicated with God during mania, described herself as feeling enclosed during depression:

I had the feeling I had completely turned in on myself. Very frightened, very uncertain, the world around me was an unsafe place. I also felt a wall between me and the rest of the world. (Woman, New Spirituality)

P22 characterized a depression as "an assault on my faith." This *absence of the divine* was felt by some participants as a distance, by others as abandonment.

2b. Guilt and punishment

P14 recounted her depressions as repeatedly recurring periods of preoccupation with guilt and death (Woman, raised Protestant, New Spirituality). The feeling of not being able to meet the expectations of others was a recurring theme in her life, which strongly manifested itself during depressions. Feelings of guilt varied in participants from feeling worthless in God's eyes or blaming themselves for their meagre faith, to more intense feelings of being punished for not being a faithful church member anymore (P6) to the fear of going to hell because of lack of faith (P33). Participants more often blamed themselves for the lack of spirituality during depression than expressing feelings of disappointment or anger toward God. Only one respondent expressed her anger toward the divine explicitly.

2c. Religious doubt

Several participants expressed how difficult it was for them to believe in a divine presence or help from above at moments they could not feel anything at all. A few related *religious doubt* specifically to the experiences they had had during mania: All conclusions they had drawn based on religious or spiritual experiences during mania seemed illusionary during depression. Doubt could grow so strong that belief or spiritual outlook on the whole became unsettled, such as in P24. After his mystical experiences, aroused by intense Sufi practice during his first manic episode, he ended up in a depression:

At that moment everything collapsed. Because you build up a picture and you think: this is my path, it is predestined. And then you experience depression and you really start to doubt. My whole spirituality collapsed and after this I did not bother with any of it for a year.

2d. Presence of evil

A contrasting experience to divine absence is the *presence of evil* during depression, which was reported by five participants. It was described as a tangible atmosphere: "as very black clouds around me" (P10), or as a presence of frightening evil spiritual beings (P6). Others mentioned biblical texts of threatening content such as the Apocalypse in the Book of Revelation with which they were occupied during their period of depression.

2e. Trust and confidence

Next to negative experiences, in one third of the participants the theme of *trust* or *confidence* appeared. This varied from spontaneously occurring texts from the Bible at the time of deepest despair, to moments of divine intervention. Five participants described a definite spiritual moment of turn in their depression. P17, a mainstream Protestant woman, opened her Bible at the moment she was thinking of committing suicide. She then read the text, "Therefore choose life" in Deuteronomy 30:19. For her this was a clear indication God wanted her to live and not to die. P13 described the moment he was crouching in the corner at the hospital, absolutely desperate, when a sudden recollection of Viktor Frankl's philosophy marked the beginning of his way upward:

One of his statements that inspired me was: life has its meaning, absolutely. If I were to die today, would life lose its meaning because of that? That is impossible! That was a very impressive experience. (Man, agnostic, humanistic)

Not all experiences of trust and confidence were as pronounced as the examples just mentioned. For several participants, intensified praying/meditating or reading holy texts was a way of coping with their desperation. The recollection of divine helps at other times, or the recognition of one's experiences in Biblical texts such as the Psalms, helped them to put up with their situation although they did not actually feel trust at that moment.

2f. Suicidality and religiosity

Suicidality was a theme about which we did not deliberately ask, but it came forward in relation to belief or spirituality in 11 interviews. For some of the participants their belief or spirituality was a protective factor. They declared at moments of suicidal thoughts their belief prevented them from doing so, or as in the case of P17 just mentioned, a text from the Bible helped her to choose life. Two participants reported a divine intervention while actually trying to commit suicide. For a few others, heaven seemed to lure them as an attractive place, during depression—"then it will be finished and I will be there (in heaven) and then everything will be all right" (P1, woman, Evangelical).

Aspects of religious and spiritual experiences during depression

Because religious and spiritual experiences were less present during depression, it was impossible to classify aspects of them in the same way as with religious and spiritual experiences during mania. Only some participants made remarks about certain aspects specifically referring to *religious or spiritual* experiences, for example, the presence of 2g. *fear* accompanying the experience. More frequently general features of depression such as melancholic feelings, superficiality or absence of emotional life, low energy, and the like were mentioned, but they were not related to reported religious or spiritual experiences or given any religious meaning. Participants often mentioned the absence of a vivid emotional life and therefore the lack of a spiritual life as well.

3. Religious and spiritual experiences when recovered

It was not easy for all participants to answer the question about religious or spiritual experiences in stable periods. In the interviews, much more focus was placed by them on religious significance of experiences during mania. Besides, differences in views on what religious experience actually is clearly came to the fore. We discerned five *types* of answers to the question of whether people had religious or spiritual experiences when they were stable: 3a. *A sliding scale* between religious experience/views in stable periods and during mania, 3b. *No religious or spiritual experience* when stable, 3c. *Ordinary religious and spiritual experiences* like a beautiful sunset, 3d. *A clear distinction* between religious and spiritual experiences during illness episodes and in stable periods, and 3e. *Regular paranormal experiences* unrelated to the disorder. Quotations of the aforementioned *types* can be found in Table 4.

3a. Sliding scale

[TABLE 4]

In more than half of the interviews a continuity appeared between experiences in both stable periods and in manic episodes. We coded this as a *sliding scale*. This sliding scale included momentary religious or spiritual experience (coded as *altered awareness* and *being easily affected*) occurring in both periods. In other cases a continuity in religious attitude or views appeared, which concerned a sense of meaningfulness and purpose in life in both manic and stable periods (coded as *Meaningfulness* and *Lasting aspirations*).

Altered awareness

Several participants reported moments of God's presence, feeling unity with other people, nature or the world, and seeing images or hearing voices in stable periods, which were intensified during mania. They occurred and passed by spontaneously, but sometimes they were triggered by intense spiritual practice or ritual. We coded this as *expanding consciousness*.

Easily affected

The emotional aspect of *being easily affected* in religious matters or becoming very enthusiastic about spirituality was experienced by several participants in stable periods. They usually valued it as a pleasant capacity. P34, an orthodox Protestant woman was clearly moved while talking about her experiences of intense happiness:

I can have this intense happy feeling, yes, of peace, I have always had it. I think I am sensitive for it. When I was walking along the beach once, I felt the wind caressing my cheeks and I thought God caressed me.

The aforementioned religious and spiritual experiences in stable periods were of shorter duration and less intense, participants reported, although the content could be the same as in mania.

Meaningfulness

On a broader level, when talking about the religious attitude and views of participants, a gradual difference between stable and manic periods appeared in the sense of *meaningfulness* participants felt. The overflow of meaning and sense of noncontingency and the sometimes grandiose aspirations during mania took more moderate shapes when participants were recovered. Expressions like "synchronicity," "things do not happen by coincidence, they have a purpose," "divine direction," "God uses people," "karma," or "an intrinsically meaningful process" used by participants to describe their religious attitude and views point to this sense of *meaningfulness* or purpose participants had in life.

Lasting aspirations

Aspirations during mania were felt by several participants as exaggerated, but those aspirations could still be an important theme for them when recovered. Two experts by experience, for example, felt a strong imperative to carry out their mission when recovered by helping peers.

3b. No religious or spiritual experiences in stable periods

For other participants, religious or spiritual experiences were absent in stable periods. They exclusively considered very intense and extraordinary experiences (during mania) as spiritual or religious.

3c. Ordinary religious and spiritual experiences

Some participants started to declare that they had no religious or spiritual experiences when recovered, but by a more in-depth exploration it was possible to come up with associations for them. Ordinary experiences, such as being moved by a sunset or the sight of grandchildren, the feeling of a deep silence when walking, experiencing tranquility while praying or reciting Koran, or feelings of gratitude, were mentioned as religious or spiritual experiences in daily life when recovered.

3d. Clear distinction

A few participants indicated there was a *clear distinction* between religious and spiritual experiences during mania and when recovered. This was the case when they evaluated in retrospect a religious or spiritual experience during mania and had come to the conclusion that it had belonged to the illness and had not been genuinely religious. P3, an orthodox Protestant man who rejected his mystical experience during mania as an illusion, emphasized spontaneous moments of gratitude in daily life as religious experiences. He considered all experience as originating in God. In other cases, the religious or spiritual experience during mania had an *immediate* and direct quality, whereas the divine revealed itself in stable periods in a more indirect way, for example, through a text or by another person.

3e. Regular paranormal experiences

Two participants reported paranormal experiences they had had since childhood, which they did not relate to bipolar disorder at all but viewed as intrinsically belonging to their life and to their spirituality. P12, who reported different paranormal experiences, told us he had been familiar with them since he was 17.

And then suddenly I found myself up against the ceiling … and I saw myself below lying on my bed. But I've also seen my father and sometimes my mother-in-law sitting at the foot of my bed. They are both deceased.

P12 considered such experiences as natural because his mother always had spoken about them in this way.

DISCUSSION

The aim of this phenomenological interpretative study was to explore religious and spiritual experiences of persons with bipolar disorder during both illness episodes and when recovered. The data showed a variation in types and aspects of such experiences, especially during mania: experiences of the presence of a transcendental reality, experiences of unity, experiences of vocation/mission or of meaningful synchronicity, and

various other less frequent religious or spiritual experiences of a paranormal or supernatural kind. Negative experiences were present as well. *Aspects* of such experiences, which were found in experiences of varied content, concerned emotional and physical life and were characterized by high intensity; other aspects had to do with a changed awareness. Such a phenomenological description of the patient's perspective on the topic is new in the scientific literature up to now, wherein the focus on the pathological character of religious experiences has usually been emphasized. The majority of the participants clearly viewed the reported experiences as religious or spiritual while using medical terms such as "manic," "psychotic," "symptoms," and so on. This implies that although regarded as having religious or spiritual value, the experiences were, nevertheless, related, in the eyes of the participants, to bipolar disorder. Merely defining such experiences as hallucinations and delusions within a pathological context deprives them of their meaning and importance.

Mohr and Pfeifer (2009 Mohr, S., & Pfeifer, S. (2009). Delusions and hallucinations. In P. Huguelet & H. Koenig (Eds.), *Religion and spirituality in psychiatry* (pp. 81–97). New York, NY: Cambridge University Press.) and Sims (2016 Sims, A. (2016). Psychopahtology and the clinical story. In C. C. Cook, A. Powell, & A. Sims (Eds.), *Spirituality and narrative in psychiatric practice* (pp. 25–39). London, UK: RCPsych Publications.) tried to clarify the patient's perspective by distinguishing between the content and form (Sims, 2016 Sims, A. (2016). Psychopahtology and the clinical story. In C. C. Cook, A. Powell, & A. Sims (Eds.), *Spirituality and narrative in psychiatric practice* (pp. 25–39). London, UK: RCPsych Publications.) or type (Mohr & Pfeifer, 2009 Mohr, S., & Pfeifer, S. (2009). Delusions and hallucinations. In P. Huguelet & H. Koenig (Eds.), *Religion and spirituality in psychiatry* (pp. 81–97). New York, NY: Cambridge University Press.) of psychotic symptoms such as delusions and hallucinations. The content of psychiatric symptoms can be religious or not, and form or type refers to the psychiatric classification of symptoms. According to Sims, the content of the experiences reflects the predominant interests of the person and arises from his or her social and cultural background, whereas the phenomenological form (e.g., delusion or auditory hallucination) reveals the psychiatric diagnosis. Mohr and Pfeifer and also Sims pleaded for a respectful and interested attitude toward the patient's belief and spirituality. In our analysis we distinguished between *content* and *aspect*. Aspects we found cannot completely be equated with Sims's conceptualization of forms. The *insights* aspect, for example, might refer to a delusion in the psychiatric sense and is sometimes judged as such by participants afterward. But insights also might refer to the noetic feature, which James (1902 James, W. (1902). *Varieties of religious experience*. Retrieved from https://worldu.edu/library/william_james_var.pdf) viewed as one of the defining marks of religious experience. It then may have a transformative power that transcends the manic episode. Strong *energy* going up and down the spine can phenomenologically be described as a feature of mania (Podvoll, 1990 Podvoll, E. M. (1990). *The seduction of Madness*. New York, NY: HarperCollins. , p. 75). However, this description resembles the kundalini experience that is part of kundalini-yoga in New Spirituality but originates in the Upanishads, philosophical writings in Hindu tradition. A snake, goddess, or energy can be awakened by asanas (bodily attitudes and postures) and kumbhakas (retention of the inhaled air) and transform, through the different chakras, into an experience of transcendence. This experience is accompanied by intense heat (Eliade, 1969 Eliade, M. (1969). *Yoga. Immortality and freedom* (Bollingen Series LVI). Princeton, NJ: Princeton University Press. , p. 245ff.). On the Internet, spiritual experiences during mania and

kundalini are associated in recovery stories (e.g., Cole, 2015 Cole, C. (2015, August 31). *Is mania a spiritual experience?* Retrieved from http://www.ibpf.org/blog/mania-spiritual-experience). This study showed that participants, to describe intense experiences whether religious or psychotic or both, use language that transcends medical terms. Both ways of perceiving religious experience, the spiritual and the pathological, might be true for patients with other diagnoses as well. There is a vast body of literature on psychosis (i.e., schizophrenia) and spirituality, but only few studies explore the way patients make sense of their religious experiences and cope with them (Clarke, 2010 Clarke, I. (2010). Psychosis and spirituality: The discontinuity model. In I. Clarke (Ed.), *Psychosis and spirituality. Consolidating the new paradigm* (pp. 101–115). Chichester, UK: Wiley & Sons. ; Brett, 2010 Brett, C. (2010). Transformative crises. In I. Clarke (Ed.), *Psychosis and spirituality. consolidating the new paradigm* (pp. 155–175). Chichester, UK: Wiley & Sons. ; Klapheck, Nordmeyer, Kronjäger, & Bock, 2012 Klapheck, K., Nordmeyer, S., Kronjäger, H., & Bock, T. (2012). Subjective experience and meaning of psychosis: The German Subjective Sense in Psychosis Questionnaire (SUSE). *Psychological Medicine*, 42, 61–71. doi:10.1017/S0033291711001103 ; Brett, Heriot-Maitland, McGuire & Peters, 2012 Klapheck, K., Nordmeyer, S., Kronjäger, H., & Bock, T. (2012). Subjective experience and meaning of psychosis: The German Subjective Sense in Psychosis Questionnaire (SUSE). *Psychological Medicine*, 42, 61–71. doi:10.1017/S0033291711001103 Mohr et al., 2010 Mohr, S., Borras, L., Betrisey, C., Pierre-Yves, B., Huguelet, P., & Huguelet, P. (2010). Delusions with religious content in patients with psychosis: How they interact with spiritual coping. *Psychiatry: Interpersonal and Biological Processes*, 73, 158–172. doi:10.1521/psyc.2010.73.2.158 ,). Romme and Escher (2000 Romme, M., & Escher, S. (2000). *Making sense of voices*. London, UK: Mind Publications.) showed that people who hear voices have different kinds of explanations for this phenomenon. Many of them do not meet the criteria for psychiatric diagnosis and apply religious or spiritual explanatory models to their voices. Pathology cannot be assessed by the content and form of religious experiences alone. Cultural and religious context of the experience, the presence of other psychiatric symptoms, and the effect of the experience on the person over time should be considered as well (Jackson & Fulford, 1997 Jackson, M. C., & Fulford, K. W. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry and Psychology*, 4, 41–66. doi:10.1353/ppp.1997.0002 ; Lukoff, 1985 Lukoff, D. (1985). The diagnosis of mystical experiences with psychotic features. *The Journal of Transpersonal Psychology*, 17, 155–181. ; Mohr & Pfeifer, 2009 Mohr, S., & Pfeifer, S. (2009). Delusions and hallucinations. In P. Huguelet & H. Koenig (Eds.), *Religion and spirituality in psychiatry* (pp. 81–97). New York, NY: Cambridge University Press. ; Sims, 2016 Sims, A. (2016). Psychopahtology and the clinical story. In C. C. Cook, A. Powell, & A. Sims (Eds.), *Spirituality and narrative in psychiatric practice* (pp. 25–39). London, UK: RCPsych Publications.). Such a careful approach is not always present in clinical practice, however, where patients feel their religious and spiritual experiences are viewed by clinicians as merely pathological (Borjes et al., 2001 Borjes, M., Van Eerd, I., Sisselaar, A., Verhaar, B., & Vink, M. (2001). *In de geest van … Cliënten over levensbeschouwing* [In the spirit of……cliënts on philosophy of life]. Amsterdam, the Netherlands: APCP. ; Kohls, 2011 Kohls, N. (2011). *Assergewöhliche Erfahrungen - Blinder fleck der psychologie?* Berlin, Germany: Lit Verlag Dr.W. Hopf. ; Ouwehand et al., 2014 Ouwehand, E., Wong, K., Boeije, H., & Braam, A. (2014). Revelation, delusion or desillusion: Subjective

interpretation of religious and spiritual experiences in bipolar disorder. *Mental Health, Religion & Culture*, 17(6), 1–14. doi:10.1080/13674676.2013.874410 ,).
In this study, in more than half of the interviews a sliding scale appeared between religious experiences, attitudes, and views in stable periods and during mania. Experiences of *altered awareness* and *being easily affected* by religious matters arose in daily life in a milder way and lasted for a shorter period. On a broader level, *insights, a sense meaningful synchronicity*, and the experience of a strong *vocation* during mania could be in line with insightful and creative ideas in stable periods, and with a sense of coherence and purpose in life as experienced by participants when recovered. This last result is in accordance with the study of Mitchell and Romans (2003 Mitchell, L., & Romans, S. (2003). Spiritual beliefs in bipolar affective disorder: Their relevance for illness management. *Journal of Affective Disorders*, 75, 247–257. doi:10.1016/S0165-0327(02)00055-1), who found that religious and spiritual ideas were of great importance to 78% of the patients with bipolar-in-remission in their study. The "sliding scale" aspect of the experiences presented raises relevant questions for further study. Why do some participants notice a continuity in their experiences and others do not? Do such experiences simply reflect religious commitment (Wiebe, 2004 Wiebe, P. (2004). Degrees of hallucinatoriness and christic visions. *Archive for the Psychology of Relgion*, 26, 201–225. doi:10.1163/0084672053598058)? To what extent is the religious background and affiliation of people determinative? In our sample, religious affiliation was certainly higher than in the whole patient population with bipolar disorder, but six participants without any religious background or affiliation had religious or spiritual experiences during mania as well. In his review study of religious delusions and hallucinations, Cook (2015 Cook, C. (2015). Religious psychopathology: The prevalence of religious content of delusions and hallucinations in mental disorder. *International Journal of Social Psychiatry*, 61, 404–425. doi:10.1177/0020764015573089) argued that both personal religiosity and the content of primary psychopathology (religious hallucinations) can influence delusional content of other psychopathology (religious delusions) and vice versa. Longitudinal studies are needed to clarify such relationships over time.
Another question for further research could be how the finding of a continuity between "normal" religious experiences and religious experiences during mania might relate to neuroscientific studies on the underlying brain states of such experiences. Neuroscience could shed more light on the question of to what extent moments of religious experience during mania in participants with bipolar disorder differ from religious experiences after recovery or from religious experiences in persons without diagnosis. Neuroscience could clarify what happens in the brain when an apparently blissful experience turns into a horrifying one as well. Neurologist McNamara (2009 McNamara, P. (2009). *The neuroscience of religious experience*. New York, NY: Cambridge University Press.), for example, viewed delusions as a breakdown in the decentering process that he has regarded as characteristic for religious experience. Decentering is a phase of reduced agency and volition, which normally leads to a more integrated and skillful Self. McNamara stated that proper stimulation of the brain circuit leads to religious ecstasy, but overactivation, such as during mania, results in various forms of religiously tinged aberrations. From the results of the present study it could be argued that the integration process of decentering religious experiences in persons with bipolar disorder is dependent not only on the disorder but also on the way people interpret their religious experiences/delusions afterward. McNamara valued this argument in his discussion of remaining religiosity in patients with epilepsy after a temporal lobectomy (p. 81ff). We agree with Maselko (2013 Maselko, J. (2013).

The neurophysiology of religious experience. In K. Pargament, J. Exline, & W. Jones (Eds.), *APA handbook of psychology, religion and spirituality* (pp. 205–220). Baltimore, MD: United Book Press.) that the theoretical assumptions of the researcher about religion will largely determine which regions of the brain will be studied.

In this study, the most frequently reported feature of depressive episodes consisted of absence of spirituality and distance from a divine reality. Negative experiences of evil, guilt, and religious doubt occurred less frequently. In one third of the interviews, experiences of trust were mentioned during depression, often in spite of the present despair. Stroppa and Moreira-Almeida (2013 Stroppa, A., & Moreira-Almeida, A. (2013). Religiosity, mood symptoms and quality of life in bipolar disorcer. *Bipolar Disorders*, 15, 385–393. doi:10.1111/bdi.12069) found in their study of 168 bipolar outpatients that intrinsic religiosity and positive religious coping were strongly associated with fewer depressive symptoms. We do not know whether this conclusion is applicable to this sample, because it had a different research design. Participants in this study had a stronger affinity with religion than might be expected of the average group of people with bipolar disorder. Possibly, in retrospect, signs of spiritual struggle or distress, also known as "negative religious coping," were less prevalent in this sample. A more specified picture of negative religious coping in relation to the interpretation of religious experiences requires further study.

Descriptions of everyday religious experiences in our study clearly showed a considerable variety in how participants reflected on such experiences. In analysis, it appeared to be impossible to classify everyday religious and spiritual experiences because of the different subjective interpretations. This was in contrast to the finding that most participants easily could elaborate on religious or spiritual experiences during mania, irrespective of their interpretation afterward. Perhaps religious language as such has the quality to express what people experience during psychosis *and* during extraordinary religious states (Goodwin & Redfield Jamison, 2007 Goodwin, F. K., & Redfield Jamison, K. (2007). *Manic-depressive illness. Bipolar disorders and recurrent depression*. New York, NY: Oxford University Press.). This could be a reason for the more-than-average interest of the sample in different forms of religious education.

For future research two directions might contribute to the applicability of the findings of this study to clinical practice: The first would involve estimating the prevalence of religious and spiritual experiences among patients diagnosed with bipolar disorder. In Cook's review of religious hallucinations and delusions in mental disorder, the religious content of delusions reported varied from 20% to 60%. According to Cook, the differences in conceptualization between studies make overall conclusions difficult. In our view, a comparison between religious experiences in episodes of illness and in recovered periods would contribute to the understanding of the phenomenon as well. Second, further exploration of the interpretative processes involved in the integration of the religious and spiritual experiences in the life story of participants would be desirable. To the extent that they seek help, their explanatory models for such experiences have to be related to scientific models used in clinical practice.[33] Lundmark (2010 Lundmark, M. (2010). When Mrs B Met Jesus during radiotherapy. A single case staudy of a christic vision: Psychological prerequisites and functions and considerations on narrative methodology. *Archive for the Psychology of Religion*, 32, 27–68. doi:10.1163/008467210X12626615185667), in a case study of a patient with cancer who saw an apparition of Christ, carefully examined different psychological explanations for this vision. An important question for clinical practice is how to communicate such

explanations in a way that the patient feels respected.View all notes An exchange of theoretical perspectives on religious experiences would contribute to understanding their cultural and personal embeddedness (Cobb, Dowrick, & Lloyd-Williams, 2012 Cobb, M., Dowrick, C., & Lloyd-Williams, M. (2012). Understanding spirituality: A synoptic view. *BMJ Supportive & Palliative Care*, 2, 239–243. doi:10.1136/bmjspcare-2012-000225 ; Kohls, 2011 Kohls, N. (2011). *Assergewöhliche Erfahrungen - Blinder fleck der psychologie?* Berlin, Germany: Lit Verlag Dr.W. Hopf. ; Mohr & Pfeifer, 2009 Mohr, S., & Pfeifer, S. (2009). Delusions and hallucinations. In P. Huguelet & H. Koenig (Eds.), *Religion and spirituality in psychiatry* (pp. 81–97). New York, NY: Cambridge University Press.). This would be helpful when confronted by the dichotomy of "religious/spiritual" or "ill." Therapists need not be neutral; they may have their own opinion of what these experiences mean, but it is important that they have respect for how patients interpret their own experience and how it can be related to their spirituality. This will promote a trusting relationship in which therapists can also introduce their own perspective or frame of reference.

LIMITATIONS OF THE STUDY

In this study data analysis and data collection were intertwined as is recommended in qualitative research in order to reach more depth in the findings. We first sampled 10 interviews about which a previous publication appeared on a specific, explorative subject (Ouwehand et al., 2014 Ouwehand, E., Wong, K., Boeije, H., & Braam, A. (2014). Revelation, delusion or desillusion: Subjective interpretation of religious and spiritual experiences in bipolar disorder. *Mental Health, Religion & Culture*, 17(6), 1–14. doi:10.1080/13674676.2013.874410 ,). In this study the first interviews are included: The sample is analyzed in its entirety, whereby the first 10 interviews were reanalyzed according to emerging themes.

Effort has been made to include participants with varied religious/spiritual and cultural background and educational level in the sample. In striving for this we used three types of recruitment. Although we managed to recruit individuals with different religious backgrounds, our sample is still not representative of the general clinical outpatients group with bipolar disorder.

CONCLUSION

This qualitative study aimed to explore the religious and spiritual experiences in subjects with bipolar disorder. Different types and features of such experiences during mania, depression, and in stable periods were presented. Religious or spiritual manifestations during episodes of illness were experienced by more than half of the participants on a sliding scale with experiences and perspectives when recovered. The questions of when and how such experiences are supportive for recovery are still to be investigated, whereby the subjective interpretation of clients and knowledge of their religious views and attitude is indispensable.

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APPENDIX

INTERVIEW PROCEDURE

First Part of the interview (approximately one hour)

Demographic data

Age, gender, single/married or cohabitant, children

Formal education, work/volunteer

Diagnosis

Since when have you had the diagnosis bipolar disorder? Which kind of bipolar disorder do you have?

How many (manic/depressive) episodes have you experienced?

Do you use medication?

Do you have a therapist? Do you agree that we may contact your therapist when your diagnosis is not clear to us?

Religious background and development

Were you brought up in a religious household? Could you tell us more about how important religion/spirituality was in your family? How did your faith/spirituality change over the years?

How important is faith/spirituality for you at the moment? Would you describe yourself as a religious or spiritual person? What does that mean to you?

Are you member of any organized form of religion or spirituality? (How much involved, is it important)

Do you follow a certain spiritual path? (Explanation of the path)

How often do you go to church, mosque/synagogue or to a religious or spiritual gathering?

How often do you pray or meditate/perform religious rituals in your daily life?

Do you read about religion/spirituality? How often, what kind of literature?

Did faith or spirituality play a role in your life before you were diagnosed ?

Experiences during mania

Can you recount which religious or spiritual experiences you have had during a manic episode?

Here we asked as precisely as possible what the participant had seen, heard, felt, experienced etc. When the participant started to elaborate on the interpretation we tried to bring the account back to the experience itself. The interpretation of the experience was explored in the second part of the interview.

If you have had more than one manic episode, did you have more religious or spiritual experiences than you just told us about? Did you have different kinds of religious or spiritual experiences or the same? How did they differ?

Experiences during a depressive episode

How did you experience faith/spirituality during depression?

Did you have any religious or spiritual experience during depression? Or were they absent? How was your faith/spirituality colored during depression?

Religious experience in stable periods.

Could you tell us about religious or spiritual experiences you have had in stable periods? Perhaps the more common religious experiences in daily life?

When participants did not come up with experiences immediately, we referred to subjects they mentioned about their religious outlook and upbringing or we gave examples of less extreme religious or spiritual experiences than in illness episodes. It was often difficult to relate to the question after the recollection of intense religious experiences during mania.

Evaluation

Have you told us what you wanted to say or are there other remarks you want to make? Do you have any suggestions for us as researchers? How do you evaluate the interview? Do you want the literal text sent to you to make corrections or give further explanation?

The second part of the interview was about the interpretation of the experiences, the supportive/undermining factors in handling the experiences and bipolar disorder in general and treatment expectations. The results of this part of the interview will be presented in another publication.

Instructions

- Introduction of the study (why, history etc.), of the interviewers and of the role of the psychiatrist as interested listener instead of a clinical diagnostician. Explanation of personal involvement of the interviewers in the study. It is important to establish a relationship with the participants, since religious experiences are not often shared with psychiatrists and participants possibly feel restraint to talk about the subject with a psychiatrist.

- Signing or collecting the informed-consent form.
- The topic list is a guideline. The questions are meant as examples for the interviewers, but the aim is to explore more in depth what participants have experienced, by asking to elaborate on what they are pointing out initially. There is no need to follow the topic list strictly. When participants start with a recount of their experiences or how they experienced hospitalization, that is OK.
- The psychiatrist asks about the diagnosis and progression of the illness till it is clear or asks permission to consult participant's therapist. Sometimes not all topics on the list can be addressed.
- The description of religious and spiritual experiences and the process of interpretation after recovery are the most important topics and should be divided as topics as much as possible. This can be a challenge, because persons with bipolar disorder can be very associative.
- The first interviewer is in direct contact with the interviewee, invites him or her to elaborate on the experiences and guards the process when participants become too associative. The second interviewer controls whether the important topics are dealt with and is responsible for timing.
- At several times in the interview, the interviewer summarizes what the participant has told and asks for feedback.
- Evaluation at the end of every interview, additional documents can be sent to the researcher.

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TABLES

Table 1. Sample characteristics.

Average age (23–69)	**45.6**
Sex	
Men	18

Average age (23–69)	**45.6**
Women	17
Civil status	
Married/cohabiting	23
Married/cohabiting with children	14
Single	14
Education	
Higher education (10 university; 11 higher vocational education; 5 intermediate vocational training)	26
Higher education, unfinished	5
Secondary education	4
Original religion/spirituality	
Protestant: 8 strict reformed; 8 mainstream	16
Roman Catholic	9
No religious background	6
Muslim Sunni	3
New Spirituality [a]	2
Present religion/spirituality	
New Spirituality[b]	16
Protestant (5 mainstream, 6 Evangelical, 3 strict Protestant)	14
Roman Catholic	5
Muslim (1), Sunni (1), Sufi (1)	3
Anthroposophist	1
Humanist/agnostic	1
Diagnosis	
Bipolar I	27
Bipolar II	5
Bipolar NOS	1
Rapid cycling	1
Schizoaffective disorder	1
Medication	
Using medication	31
No medication	3
Unaffiliated	1
Average duration illness (years; 0.5–32)	11.5

Note. n = 35.
[a] One person mentioned it together with a Christian affiliation.
[b] Five persons mentioned it together with a Roman Catholic (three) or Protestant (two) affiliation.

Table 2. Coding example Religious and spiritual experiences during mania.

Main c.	Subcode	Subcode	Quote	P
Types	1a.Transcendental reality	Presence of God/Light	"An intense closeness of God. Yes, as if He is sitting in the room"	P1
		Experiences of Unity	"I really could see this connectedness, that everything is connected to everything else."	P24
	1b. Mission or Vocation	Helping others/pursuing	"Being confined to the hospital was meant to be so that I could do my job as expert-by-experience much better"	P23
		justice Evangelization	"Especially in the train. I went by train on purpose and I thought that I had to tell the people I was sitting next to about God"	P33
		Identification	"I felt like Jesus in his last days, lonely and misunderstood".	P18
	1c. Meaningful synchronicity		"When I listened to that recorded fragment, yes, something actually broke in me. It was at a moment when I was feeling really bad and suddenly when I heard it, it had a great deal of meaning for me."	P37
	1d. Other positively valued experiences	Apparitions &voices	"During psychoses I always feel the presence of the deceased and I have the feeling I can communicate with them"	P5
		Images, symbols & visions Out-of-body exp.	"I saw crosses everywhere", "I was literally drawn into the Apocalypse of John"	P8, P18
			"And then I realized where my soul was located. It had ascended"	P8
	1e. Negatively valued experiences	Annihilation of the person	"It's as though I don't exist, as though I'm just a shell and in another dimension. That's a frightening feeling"	P32
		Sin & evil	"I thought: what if I have sinned against the Holy Spirit? It was as if I was at the edge of Purgatory"	P22
Aspects	1f. Pos/neg emotion		"I received the message: be not afraid. Very comforting!" "So much fear, I thought I would end up badly"	P25 P28
	1g. Fusion		"Everything he said I could see in his body, a kind of glowing. I could feel it"	P2
	1h. Physical sensations		"I felt vibrations and at night I had fireworks in my head, my limbs moved automatically and my eyes started to blink"	P28
	1i. Energy/power		"This powerful feeling, this energetic feeling, yes it remained all the time"	
	1j. Intensity		"I have experienced things of extraordinary beauty and profound humanity"	P19
	1k. Altered awareness	Insight	"All kinds of pennies had dropped; suddenly I understood it all"	P20
		Perceiving oneself in another dimension	"It started as a fantasy, and then I found myself in a world scene, in which I could see things, but experienced them myself at the same time"	P37
		Other-dimensional association	"I thought the songs on the radio were for me, from God, in a manner of speaking"	P33

Table 3. Coding example Religious and spiritual experiences during depression.

Main c.	Subcode	Subcode	Quote	P
2. Types	2a. Absence	Of faith/spirituality	"More like indifference, very flat. I experienced that as a very unpleasant period of my life. Because I had no mental depth. I do not experience deep joy or such things. … So that 1 ½ years can be seen as without God, nothing at all, just at a zero point."	P1
		Of the Divine	"You feel the total godlessness." "If I'm manic, I feel more that God is near. If I'm depressed, I'll manage it alone, I can only do it with my mind."	P11 P38
	2b. Guilt & punishment		"Well, it's very clear that psychoses often went together with punishment. About death and cot-death and about it being my fault, not paying attention, something like that. And again with punishment (hit)."	P14
	2c. Religious doubt		"Especially in those depressive periods, real doubt and yes, is that really true? And particularly because I don't feel it, and if I read, for example, what I wrote earlier or something I think: yes, I thought so then, but not anymore."	P37
	2d. Presence of evil		"Spirits—really terrifying at that moment. I remember that I had one of those jumpers with hoods, and I pulled the hood over my head because I was afraid the spirits would fly into my ears. It's something I don't like to think about."	P6
.	2e. Trust & confidence	Sense of/thought	"It's always been the ground beneath my feet—the thought God loves you and He's your Father and He cares for you—yes I knew that, but I didn't really feel it."	P34
	2f. Suicidality	Prevention	"Through faith, I had the idea, yes, my life I received from God, so it's not up to me to put an end to it."	P3
		Intervention	"I even had it once during an admission into hospital, I had already put my belt around my neck, but something prevented me from pulling it. And suddenly I saw so clearly in front of me, yes, call it the figurine of Jesus, again I don't like that sort of thing … but it's what I saw: this is not what I mean. And that literally prevented me from pulling the belt."	P23
		Enticing prospect	"Then again I had the thought: Then it will be over and then I'll be there (in heaven) and it will be all right."	P1
Aspect	2g. Fear		"Threatening Bible texts will then enter your head if you are depressed. Fear-ridden texts feed your depression, and they rise to the surface."	P11

Table 4. Coding example Religious and spiritual experiences when recovered.

Main Code	Subcode	Quote	P
3a. Sliding scale	Altered awareness	"This experiences of enlightenment, I had it at other times too, but I thought I could better suppress it. Then I concentrated on daily life actually."	P2
	Easily moved	"I can be easily moved, for example by a song of praise, then I can easily start crying … and then I have this intense feeling of happiness and I know it is a little bit manic."	P34
	Meaningfulness	"It is very special that he (leader of a prayer session on a New Wine conference) received words for me. He told me several things that really hit the spot. … I often prayed to God: What is my thing? And eventually I got to know what 'my thing' was and I got carried away and became really enthusiastic about it. This time my enthusiasm did not stop anymore." (First mania develops afterward.) "But we visited such conferences before, in former years we received also encouraging and consoling images or words during a prophetic session like that, so to say."	P22
	Lasting aspirations	"I've already been working as an expert by experience for 9 years. At that moment (when admitted to the hospital for mania) I very strongly felt: this is my mission. And I still have the idea I have a mission to reform psychiatry. It isn't for nothing that I remained in this profession."	P23
3b. No religious experiences		"No, I did not have religious experiences before I was in Istanbul. There it started, experiencing guidance and connection between everything."	P24
3c. Ordinary religious or spiritual experiences		"Experiences you are not deliberately looking for, which come by themselves, only by focusing on them. I always have those moments when I am occupied with small children, or in a beautiful forest or garden, busy with plants. Especially with children because they do not have a second agenda."	P36
3d. Clear distinction		"As a believer, I view God as Someone who is active in everything, thus it can just be at a spontaneous moment that I think: I want to thank Him for something, or I need His help. For example when I sit in the car and see the beautiful sunshine, I can feel very grateful"; "Psychotic belief is untrue. The experiences are real experiences in psychosis; they are only based on the wrong convictions."	P3
3e. Regular paranormal experiences		"Then I feel my father coming to sit at the foot of my bed, or my mother in law, they are all deceased. … It has nothing to do with psychosis; I have never had such experiences during psychosis."	P12

Notes

1 The variables 'religious person' and 'spiritual person' in GSS 2016 were computed as in Dutch research in the sociology of religion 'God in Nederland, (GiN)' [God in the Netherlands] (Bernts & Berghuijs, 2016 Bernts, T., & Berghuijs, J. (2016). God in Nederland 1966-2015. Utrecht, the Netherlands: Uitgeverij Ten Have.), to attain a fourfold r/s typology: 'religious nor spiritual,' 'only religious,' 'only spiritual,' and 'religious and spiritual.'

2 Registration numbers of the two committees, respectively.

3 Lundmark (2010 Lundmark, M. (2010). When Mrs B Met Jesus during radiotherapy. A single case staudy of a christic vision: Psychological prerequisites and functions and considerations on narrative methodology. Archive for the Psychology of Religion, 32, 27–68. doi:10.1163/008467210X12626615185667), in a case study of a patient with cancer who saw an apparition of Christ, carefully examined different psychological explanations for this vision. An important question for clinical practice is how to communicate such explanations in a way that the patient feels respected.