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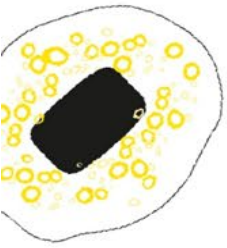

"My heaven turned into copper" – An in-depth, idiographic narrative approach to the role of religion in the psychosis experience of Dutch autobiographical writers

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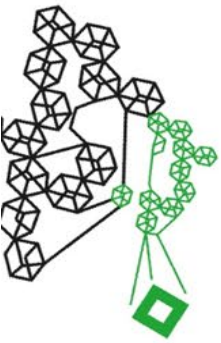

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Abstract

Introduction: Since religion and religious coping can have significant positive and negative influences on religious patients with psychosis and their treatment, patients and researchers alike urge healthcare professionals to familiarize themselves with the role of religion in their patients' lives. Analyses of autobiographical patient stories can inform healthcare professionals and researchers about the patients' lived experience and the extent to which the religious coping theory by Pargament (1997) is applicable to qualitative data like patient stories. *Methods:* Three Dutch books by female Christian authors with a history of psychotic symptoms were selected from the Erasmus University Rotterdam archive of patient stories www.patientervaringsverhalen.nl using purposive sampling with the sampling criteria that the authors should describe their experience with psychosis and religion in detail. The books were each analyzed with a storyline analysis and the role of religion and coping and later compared to each other. *Results and discussion:* Common themes in the books were that religion can play a fluid and sometimes conflicting positive and negative role in the authors' lives, previous experiences with religion and God attachment seemed to influence the religiosity of the authors, and all authors made use of religious appraisals of their symptoms. These results were in line with previous research. Next to that, a similarity was that the theoretical religious coping framework could only partly be applied to the patient experience, as there were several mismatches between theory and experience. *Recommendations, strengths and limitations:* I recommend that healthcare providers adapt a client-centered and non-pathologizing approach to start a conversation about the above-mentioned themes with their patients while staying aware of other themes that might emerge from the conversations. The results of the current study underline the need for more research which utilizes patient stories. The potential relationship between religious trauma and psychosis and the applicability of the religious coping framework to qualitative data like patient stories should also be explored in future research. The strong points of the study are its pioneering methods and aim, and that it sheds light on the experiences of non-English-speaking people with psychosis and the negative sides of religion. Limitations of the study are the low number of books and thus the limited generalizability, the language barrier, and the fact that I conducted the analyses by myself.

Keywords: Psychosis, Religion, Religious Coping, Narrative Analysis, Lived Experience

Introduction

The topic of psychosis has received much attention in psychological research over the past decades (Green et al., 2019; Ritunnano et al., 2022). Many individuals with psychosis try to make meaning of what they are experiencing (Larsen, 2004; Marriott et al., 2019). They often turn to religion, not only in their meaning-making process, but also when coping with their illness (Marriott et al., 2019). Religious coping can impact the individual with psychotic symptoms negatively, positively or both in significant ways (Abu-Raiya & Pargament, 2014). The theoretical framework of Pargament (1997) is often used to assess the form of religious coping in clinical and (mainly quantitative) research settings (Xu, 2016). Because of the important role religion and religious coping can play in the lives of people with psychosis, patients and researchers alike have plead for mental healthcare workers to familiarize themselves with the religious context of their patients (Mohr et al., 2010). However, mental health care professionals have reported feeling hesitant about how to approach the patient's religiosity in the light of the complexity of religion and the patient's psychopathology (Bassett et al., 2015; Parker, 2020). Patient stories are a rich, contextualized source of information about the lived experience of individuals with psychosis, which in turn might generate insights for healthcare professionals when it comes to understanding and approaching their patients' religiosity and its various aspects (van de Bovenkamp et al., 2020). One aspect of religiosity is religious coping. Since the framework of religious coping by Pargament (1997) has quite clear and static classifications of coping and was developed based on quantitative research, the question is to what extent the theory is applicable to the lived experience of religious people with psychosis (Xu, 2016).

Theoretical and Social Background

In the Netherlands, 8% of the general adult population has experienced psychotic symptoms before (GGZ Standaarden, 2022). Psychotic symptoms can occur in several mental illnesses, such as depression, bipolar disorder and schizophrenia, and they require intensive treatment most of the time (GGZ Standaarden, 2022; Noort et al., 2020). When a person experiences a psychosis, they typically have hallucinations and delusions with or without the awareness of their mental illness (Arciniegas, 2015). This means that the person experiencing psychosis might believe that they are seeing, hearing, or feeling things that are objectively not there, or hold beliefs that are incorrectly referred from their surroundings (Arciniegas, 2015). The individuals affected by psychotic symptoms can sometimes, but not always distinguish

these experiences from what is truly happening (Connors & Halligan, 2021).

The topic psychosis has received more attention in the past decades from researchers who explored, for example, the relationship between psychotic symptoms and well-being, and the roles of stigma and childhood abuse (Green et al., 2019; Gronholm et al., 2017; Schrank et al., 2013). However, while approaching psychosis with a quantitative lens has led to interesting and stimulating findings, it can lead to an oversimplified approach in which individual meaning and depth is lost, which is why several authors recommend employing a qualitative approach to gain insight in the experience of the person with psychotic symptoms (Green et al., 2019; Ritunnano et al., 2022; Schrank et al., 2013). The qualitative research into the lived experience of people with psychotic symptoms suggest that a psychosis can cause severe negative emotions and physical sensations, lead to conflicts in one's social life, and cause the individual to struggle with their identity (Marriott et al., 2019; Noiriel et al., 2020; Larsen, 2004). Next to that, religious people with psychosis often experience the role of their belief and their relationship with God as very important and positive, which might sometimes form a contrast to the importance that religion had in their lives before the psychosis (Geekie, 2007; Mohr et al. 2010). They might find it difficult to distinguish between their symptoms and their spirituality, and they might also struggle with their belief as a whole, a lack of support from their religious community, and their self-image as a consequence of their illness (Geekie, 2007; Pesut et al., 2011).

However, religion can also help people cope with their psychosis. Previous research has demonstrated that individuals with psychosis often use their religion and religious beliefs to cope with their illness and the ensuing stress (Marriott et al., 2019; Mohr et al., 2012; Smit, 2015). This can be explained by the hypothesis that people are more likely to use religious coping when they feel that they cannot deal with the situation themselves (Smit, 2015). This can also be the case with psychosis, especially when the person's functioning and perception are severely impacted (Smit, 2015). Religious coping is defined as "a specific mode of coping that is inherently derived from religious beliefs, practices, experiences emotions or relationships" (Abu-Raiya & Pargament, 2014, p. 25). Pargament (1997) and previously him and his colleagues (1990) examined existing research on religious coping. They formulated a theoretical framework of religious coping based on the existing results, and refined the framework by conducting quantitative research with different populations (Pargament, 1997; Xu, 2016). The framework distinguishes between positive and negative religious coping (Pargament et al., 2000; Pargament, 2010; Table 1). Based on this framework, Pargament et al. (2000) developed the questionnaire RCOPE that measures religious coping and can be

used in clinical or research settings. This questionnaire has been validated for different populations, and much quantitative research uses the RCOPE to assess religious coping and explore its relationships with other variables. For example, Rosmarin et al. (2013) and Cetty et al. (2022) found that people with psychosis who engaged in negative religious coping experienced more suicidality, depression and anxiety, and substantially more well-being and fewer negative outcomes when they utilized positive religious coping. Next to that, Rosmarin et al. (2013) hypothesize that psychotic patients benefit especially strongly from positive religious coping in comparison to other patient groups. Therefore, the way that people with psychosis make use of religious coping might significantly affect them in several ways.

Table 1

Overview of positive and negative religious coping strategies

Coping strategy	Pargament's (2010) definition
Positive religious coping according to Pargament et al. (2000)	
Benevolent Religious Appraisal	Redefining the stressor through religion as potentially beneficial
Religious Purification	searching for spiritual cleansing through religious actions
Religious Forgiving	Looking to religion for help in shifting from anger, hurt, and fear associated with an offense to peace
Seeking Religious Direction	Looking to religion for assistance in finding a new direction for living
Religious Conversion	Looking to religion for a radical change in life
Religious Helping	Attempt to provide spiritual support and comfort to others
Seeking Support from Clergy or Church Members	Searching for intimacy and reassurance through the life and care of congregation members and clergy
Collaborative Religious Coping	Seeking control through a partnership with God in problem-solving

Table 1 (continued).

Religious Focus	Engaging in religious activities to shift focus from the stressor
Active Religious Surrender	Active giving up of control to God in coping
Spiritual Connection	Seeking a sense of connectedness with forces that transcend the self
Marking Religious Boundaries	Cleary demarcating acceptable from unacceptable religious behaviour and remaining within religious boundaries
Negative religious coping according to Pargament et al. (2000)	
Spiritual Discontent	Expressing confusion and dissatisfaction with God's relationship to the individual in the stressful situation
Demonic Reappraisal	Redefining the stressor as an act of the Devil
Passive Religious Deferral	Passive waiting for God to control the situation
Interpersonal Religious Discontent	Expressing confusion and dissatisfaction with the relationship of clergy or church members to the individual in the stressful situation
Reappraisal of God's Power	Redefining God's power to influence the stressful situation
Punishing God Reappraisal	Redefining the stressor as a punishment from God for the individual's sins
Pleading for Direct Intercession	Seeking Control indirectly by pleading to God for a miracle or divine intervention

Note. This table was created by combining the coping strategies, which are classified as positive or negative coping in the article by Pargament (2000), and the definitions of each coping strategy (Pargament, 2010).

The impact that religiosity and the different forms of religious coping can have in the lives of people with psychosis gives a reason for cautiously monitoring these factors during treatment (Rosmarin et al., 2013). However, mental healthcare professionals may find it complicated to approach this task, as religious beliefs and psychotic symptoms can overlap, and religion and religious communities can be both harmful and helpful (Bhavsar & Bhugra, 2008; Menezes & Moreira-Almeida, 2010; Murray et al., 2012; Ng, 2007; Weisman de

Mamani et al., 2010). They might also find it difficult to put the pathological view aside and be open-minded to the patient's meaning-making (Bassett et al., 2015; Parker, 2020; Wood et al., 2019). To support mental healthcare professionals in their process of assessing the role of religion in their clients' lives, including religious coping, Richards et al. (2009) recommend beginning with a global approach to shed light on the facets and dimensions of the role of religion in the patient's life. Understanding this role well can potentially enable the healthcare professionals to detect, for example, to what extent a patient might experience their belief, previous religious experiences, community and religious coping efforts as helpful or harmful (Richards et al., 2009; Xu, 2016).

Autobiographic patient stories are a relatively new medium that have been increasingly used in qualitative research for the purpose of getting an in-depth understanding of what patients experience (van de Bovenkamp et al., 2020). Van de Bovenkamp et al. (2020) emphasize that "analysing written patient stories has many advantages as they allow us to gain a broad and in-depth understanding of patient experiences" (par 5). To my knowledge, there are currently no studies that utilize patient stories to explore the experience of religious people with psychotic symptoms, despite their potential as an unstructured and unguided, integrated and contextualized source of the patient perspective and meaning-making (van de Bovenkamp et al., 2020).

Considering the complicated role that religion can play in the lives of people with psychosis, using patient stories as a basis for analysis could help shine light on their lived experiences and the different facets of their lives that religion impacts, such as religious coping. It is uncertain whether the religious coping framework by Pargament (1997) can caption the depth of the patient stories, since the theoretical framework was developed based on and tested with predominantly quantitative research (Xu, 2016). Next to that, Xu (2016) criticizes that there is a lack of research of the religious coping framework that considers the lived experience of the patient. Considering the possible impact of religious coping on well-being and other factors, and the frequent usage of the RCOPE in research and practice, exploring the match between theory and subjective experience can generate further insights for both healthcare professional and for researchers. Thus, patient stories are a promising source, not only for an in-depth analysis of the lived experience of religious people with psychotic symptoms, but also for exploring the match between theory and patient experience of religious coping.

Study purpose

Mental healthcare providers often report uncertainty when it comes to approaching their religious patients with psychotic symptoms in a non-pathologizing way and forming a thorough overview of what role religion plays in their patients' lives, as this role can be complicated (Menezes & Moreira-Almeida, 2010; Wood et al., 2019). Patient stories have the potential to be a valuable, unguided and contextualized source of information of the lived experiences of patients (van de Bovenkamp et al., 2020). With this current study, I aim to provide mental health care professionals with an exemplary analysis of the role and significance of religion and religious beliefs in the lived experience of religious autobiographical authors with psychosis. The role of religion is also characterized by the use of religious coping, which has the potential to positively and negatively affect the patients (Mohr et al., 2010). Since there is a lack of research on the applicability of the well-known religious coping framework by Pargament (1997) to the lived experience of individuals (Xu, 2016), the match between the framework and the lived experiences of the authors is analysed as well. Based on my aim to globally assess the role of religion, including their religious coping behaviours, in the lives of religious patients who have described their psychosis in an autobiographical story, the research question of this study is:

RQ: How do religious autobiographical writers with psychotic symptoms experience the role of religion in their lives?

Methods

Study Design

The current study was of qualitative nature and took a narrative approach, as the aim was to understand, and interpret the lived experience of religious individuals dealing with psychosis and their meaning-making (Marriott et al., 2019; Squire et al., 2014).

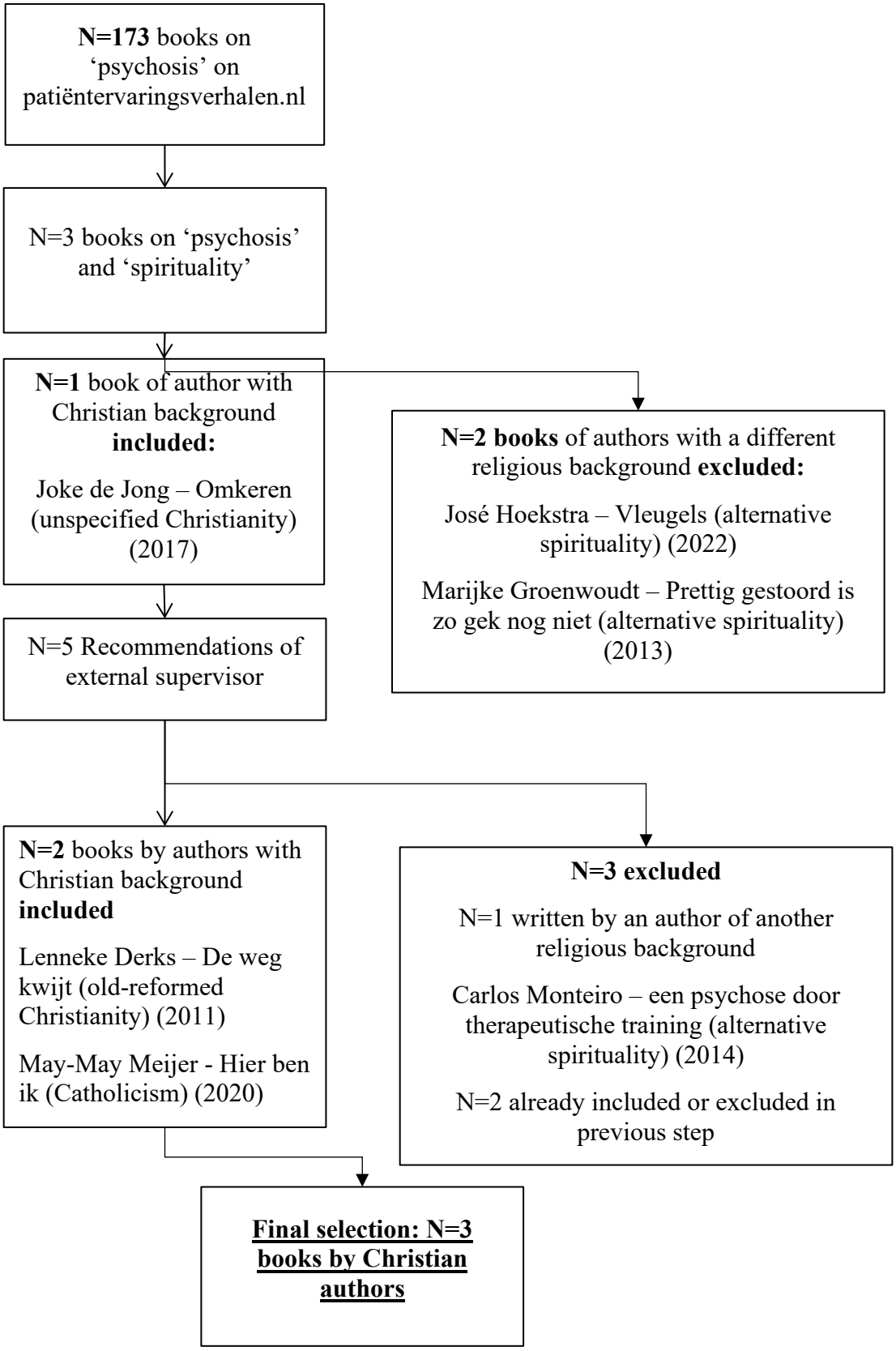
Procedure and Sampling

The autobiographical books about psychosis were selected from the collection *Patiëntervaringsverhalen* [patient experience stories], currently archived at the Erasmus School of Health Policy & Management of the Erasmus University (Patiëntervaringsverhalen, 2022). The website of *Patiëntervaringsverhalen* offers a function to filter its selection of books based on content and keywords. I selected the books in December 2022, so more suitable books might have been added since then. Furthermore, I asked my external supervisor from the Erasmus University for recommendations. Purposive sampling was employed to select the books (Campbell et al., 2020). When determining the inclusion criteria, I took into account Xu's (2016) recommendation to apply the framework of religious coping to a Christian or Jewish context, since the framework is based on these groups. Consequently, inclusion criteria were: (1) the author identified as Christian or Jewish during the events of the book, (2) the book describes one or more psychotic experiences. To explore whether the role of religion is described in detail in the books, I searched for the Christian-specific terms words 'God', 'belief', 'pray', 'devil', 'evil', 'religion', 'church', 'Jesus', 'Christ' in Dutch to see whether these words were mentioned, and consequently I skimmed through several chapters of the books to get an impression of the role of religion in the story.

In November of 2022, there were 173 books on psychosis on the website patientervaringsverhalen.nl. Using the premade filter categories 'psychosis' and 'spirituality' on the website patientervaringsverhalen.nl resulted in three books. Two of these were excluded due to the authors not identifying as Jewish or Christian. From the five recommendations of my supervisor, one of them was written by an author from a different religious background than Jewish or Christian, one of them was also available on patientervaringsverhalen.nl and I had already excluded it due to the author having a different religion, and one of them was already in my selection since I had found it on patientervaringsverhalen.nl. The remaining recommended two books fit the inclusion criteria and were therefore included in my selection (Figure 1).

Figure 1

Flowchart of book selection process



Materials

Autobiographical books

As the books are publicly available and partly anonymized already, the names and backgrounds of the authors will be described without anonymization. In Table 2, an overview of the book selection and characteristics can be found.

The first book is titled *Omkeren* [turning around] and was written by Joke de Jong (de Jong, 2017). I did not manage to find out which specific stream of Christianity Joke identifies with, as there is no mention of that in the book or online. The second book was written by therapist Lenneke Derks in cooperation with her patient Truus Vogel and is called *De weg kwijt* [lost] (Derks, 2011). Here too, I did not manage to find out which specific sect she belonged to, as she does not mention the name or traits that could differentiate her sect from others. Lastly, the book *Hier ben ik: De weg van psychose en depressie naar het licht* [Here I am: The way from psychosis and depression to the light] by May-May Meijer (Meijer, 2020) was selected. May-May does not mention explicitly which stream of Christianity she belongs to, but by doing research on her preferred church, the Saint Vitus church in Hilversum, I concluded that she identifies the most with the Catholic stream.

Table 2

Overview of selected autobiographical books

Book title	Publisher, year	Name of individual with psychosis	Gender	Diagnosis	Type(s) of religion	Treatment(s)
Omkeren [Turning around]	Boekscout, 2017	Joke de Jong	Female	Not specified	None specified (Childhood) Christianity (Adulthood)	Psychiatric hospitalization; alternative medicine treatments
De weg kwijt [Lost]	Boekscout, 2011	Truus Vogel	Female	Mention of mania	Old-reformed Christianity (Childhood) non-specified Christian sect (Adulthood)	Psychiatric hospitalization; alternative medicine treatments
Hier ben ik [Here I am]	Paris Books, 2020	May-May Meijer	Female	Schizophrenia; schizoaffective bipolar disorder	None specified (Childhood) Catholic (Adulthood)	Psychiatric hospitalization

Analysis

First step of analysis: Narrative analysis

Based on the recommendations of Marriott et al. (2019), who recommended the narrative analysis approach to analyse the lived experience of people with psychosis in a holistic way, the 12-step protocol of narrative analysis by Murray and Sools (2014) was used as the basis for analysis (Table 3).

Table 3

12-step protocol of narrative analysis by Murray and Sools (2014)

Part	Step
1 Introduction	1. Formulate case title
	2. Introduce case
2 Storyline analysis	3. Formulate storyline title
	4. Identify and describe storyline elements and breach
	5. Write narrative summary of storyline (I-form; author's perspective)
	6. Draw conclusions regarding your research question based on steps 3-5 and discuss your findings
3 Interactional narrative analysis	7. Positioning of storylines
	8. Positioning of storytellers/listeners
	9. Conclusion and discussion of what is at stake
4 Contextual analysis	10. Positioning of storylines in the wider social, societal and political context
	11. Positioning of storytellers/listeners and interactional patters in wider contexts
5 Comparative analysis of storylines, interactional patterns and/or contexts	12. Make comparison of similarities and differences between cases

Due to the limited resources that could be dedicated to the research, I chose to execute three parts of the protocol: introduction, storyline analysis and comparative analysis. By first introducing the case, then analysing the storylines and its elements in depth and finally comparing the books to each other, I aim to provide a bottom-up analysis of the books that starts narrow and becomes increasingly wider in order to identify themes for discussion and draw conclusions in the end (Murray & Sools, 2014). To prepare for the analysis, I read each book once without taking notes and a second time while taking notes and marking passages

about religion and coping. The analysis itself was an iterative process.

At first, I conducted initial and descriptive draft storyline analyses for each book to get an overview. This resulted in three storylines per book. For Truus Vogel and May-May Meijer, I decided on the starting and ending points of the storylines based on their hospitalizations, since both of them describe two hospitalizations in their book. In their cases, the first storyline was therefore about the time before the first hospitalization, the second storyline focuses on the first hospitalization, and the third storyline covered the second hospitalization and the ending of the book. In Joke's case, I followed the structure of the three life phases that she mentions in the beginning of her book: 1987 to 1999, 2000 to 20007, 2008 to 2010. These divisions were preliminary. Based on the results of this first version of the analysis and a thorough discussion with my supervisor, I decided that it is possible to make one integrated storylines analysis per book, as each book has one main underlying narrative structure exemplified in the story's overall logic and breach. However, conducting an efficient analysis also required me to make decisions on how much information from the books I should include. I excluded parts of the book in which nor religion nor their psychosis experience was of relevance, such as descriptions of daily behaviours like cooking (Guest & McQueen, 2008). My analysis globally covers the books as a whole from their starting- and ending points.

When deciding on the storyline title of each book, I integrated elements from the Biographical-Narrative Interpretative Method (BNIM) by Wengraf (2004). In the BNIM approach, the researcher attempts to find particular incident narratives (PINs), thus experiences that the storyteller, not the researcher, deems to be important and crucial (Wengraf, 2004). These PINs can later be connected to the research question of the researcher. Based on this, I took and sometimes adapted quotes which describe the essential breach of the storyline. To form the storyline title, I combined them with quotes that capture the role of religion.

Unlike the characterizations of the agent, settings and means, for which I could select and combine suitable parts and details of the book, the storyline element of the agent's goal required a more specific and sharp selection in order to find the author's overarching goals. As a tool to simplify the selection, I searched the document for the words 'wens' [wish], 'doel' [goal], 'hoop' [hope] and the first-person conjugations of the verbs 'willen' [to want], 'wensen' [to wish], 'vrezen' [to fear]. This was not my only method of determining the goal of the agent, but rather a supportive tool, since I also had to make judgements about which

wishes and goals are present in the whole storyline and whether there were other relevant goals that did not show up during the word search.

Second step of analysis: Role of religion and religious coping theory

To answer the research question, I combined an inductive-experiential approach and an deductive-mixed approach. Firstly, for exploring the lived experience of the authors regarding the role of religion in their lives, I employed an inductive-experiential approach (Byrne, 2021; Thomas, 2006). The aim of the inductive approach is characterized by Thomas (2006): "to allow research findings to emerge from the frequent […] themes in the data, without the restraints imposed by structured methodologies" (p. 238). Next to that, I employed an experiential orientation, which means that during this first step I aimed to focus on the author's own descriptions and meaning-making to build an overview of their belief while bracketing as much as possible a theory or my own view to it (Byrne, 2021; Thomas, 2006).

The second step was to explore the match between their own experience of religion and the framework of religious coping by Pargament (1997), taking a deductive approach and a mixed experiential and partly critical orientation (Byrne, 2021). The deductive technique that I used in my analysis is called "pattern-matching" (Hyde, 2000, p. 85). In this case, I compared the theory to the storyline analyses for matches and mismatches (Hyde, 2000). Pargament et al. (2000) classify each religious coping strategy as positive or negative based on e.g. the relationship between the coping strategy and their participants' mental and physical health and level of distress. I first identified religious behaviours of the authors, determined whether the behaviour matched the description of a coping strategy in the framework of Pargament (2010), and identified how the author experienced the religious behaviour. This means that I searched for the author's descriptions of how they felt and whether the religious behaviour had a positive, neutral or negative effect on them. Here, I took a mostly experiential stance, meaning that I based my analysis on how the participants themselves experienced their religious coping behaviour and the impact thereof (Byrne, 2021). I also employed a critical view occasionally, e.g. when wondering about the intention behind an author's (ambiguous) religious behaviour. An example of an ambiguous experience was when the author explicitly states that the outcome of a religious behaviour had no effect on her while also describing the occurrence of negative physical and mental states. In these specific situations, I examined the descriptions and word-choice of the authors from a more distant, interrogative perspective (Byrne, 2021).

Reliability and validity

Multiple measures were taken to increase the reliability of the analysis and its outcomes. Firstly, a form of cross-checking was employed by repeatedly letting my supervisor(s) read my drafts and consequently discussing their critical feedback to decide on what can be improved (Franklin & Ballan, 2001). Furthermore, I strove for 'thick description' for the sections in which I present the sample, procedure, and the analysis (Ponterotto, 2006). I described the authors' past and current religious backgrounds, mental health history, and treatments to draw a comprehensive image of their context. Next, when describing my procedure, I explained the manner in which I approached the analysis and the iterative process of reaching the final version of the analysis. Finally, in the presentation of my results, I presented verbatim quotes of the book authors to increase internal reliability and to create a thick, illustrative overview of what I base my interpretations on (Franklin & Ballan, 2001; Ponterotto & Grieger, 2007). Regarding the validity of my results, I analysed the data from two different lenses: the inductive-experiential approach of exploring the perspectives of the authors without imposing judgement or criticism on it, and the deductive-mixed approach when applying the religious coping theory on the data (Pargament, 1997). Applying two different perspectives to data with the aim to reach a more holistic outcome is an example of theory triangulation (Franklin & Ballan, 2001). Furthermore, I reflected on my personal bias as a possible limitation in the discussion section (Franklin & Ballan, 2001).

Results

In the following section, the introduction, storyline analysis and interpretation of each book are presented. The interpretation starts with a more global focus on how the clients characterize their (lived experiences with) belief and the importance thereof in their lives, and subsequently the match between the theoretical framework of religious coping by Pargament (1997; Table 1) is explored. In the end of the results section, the comparative analysis of the authors' lived experience of religion and the match between the theory and framework in each book is presented.

Omkeren [Turning around] – Joke de Jong

The following section is based on the story of Joke de Jong (2017). The in-text page references refer to her book.

Introduction

Case title. "I have turned around… Now I have the right relationship to the Creator."

Case Introduction and Global impression. Joke de Jong lives in the province of Friesland in the Netherlands (de Jong, 2017). At age 20, in 1987, she had her first psychosis. In her book "Omkeren" [Turning around], she describes a period of approximately 20 years in which she repeatedly struggled with psychotic symptoms and eventually managed to find more peace. One important theme in the book is her relationship with faith. While she has always felt religious, she started having more intense and significant religious experiences after her first psychosis. As of the last update on her life in 2015, Joke is not married and she lives a simple and quiet life in a small town in Friesland. She still sometimes hears voices, but she has managed to feel less impacted by them. Her religion is still something that gives her a lot of strength and support (de Jong, 2017).

Joke's book is sometimes written in a confusing manner, as her storytelling is not always chronological. It is also noticeable that she does not tend to be very detailed in her descriptions of people and places, but when she mentions religious images or 'visions', her writing style is more detailed. I personally enjoyed reading the book, although I got lost sometimes. Despite the occasional lack of detail, I felt with Joke and I noticed how she became more calm and accepting as the story progressed.

Narrative Summary

Once around when I was 20, I experienced something very incomprehensible when I suddenly heard a pleasant voice talk to me. Before I knew it, other voices came that brought a very negative energy with them. With everything they said to me, I felt drawn to a dark place, because the voices commented on everything I did in a negative way. They screamed and mocked me when I felt negative emotions or moods because of their terror. Then, something very special happened. I looked at a candle with an image of Jesus on the cross on it. I had a vision and I became a different person. I asked God let the negative energy flow away and I felt cleaned and refreshed. However, the darkness wanted me to belong to it and focus on it to keep me away from Christ and his love. I started losing hope that I would ever get rid of the voices. I practiced with grounding; it gives me happiness to connect to my body! There is peace now and I don't fight anymore. I appreciate hearing the voices way more and I see it as a gift from God now. I have turned around… I stand in the right relation to the Creator. The darkness has brought forward the light and through this process I have received healing.

Storyline analysis

Storyline title. *Suddenly I can handle the darkness of the voices; I don't fight anymore and see them as a gift from God now.*

Agent. The agent of the storyline is Joke de Jong, although the voices in her head also play a significant and active role in the story. Ultimately, most of the story is written in first person singular and follows the actions of Joke. Joke is an agent who deeply struggles with her psychotic symptoms; they can make her feel like there is *"no light, [only] complete darkness"* (p. 12). She feels especially affected by the angry voices in her head, who *"scream and mock"* (p. 19) her. However, Joke is persistent and keeps trying to find ways to ease her symptoms. Next to that, Joke is a very religious agent, feeling that *"God is in [her] heart"* (p. 53).

Acts/events. In 1994, seven years after the beginning of Joke's illness, Joke experienced something that she describes as a vision. She went to an art exposition in a church where she saw a candle: *"I looked at a candle with an image of Christ on the cross. In that moment, I felt nailed to the ground and I felt deeply moved. […] I saw a lifelike image of Jesus in his death struggle. […] I felt a deep sadness and I cried without making noise […] It was a vision."* (p. 24).

This was a significant event for Joke. She describes that she *"was a different person"*, and that this was her *"first contact with Christ"*, but that she *"did not understand anything"* (p. 24). This indicates that she perceives this event as very important and impactful as the starting point of her religious journey. Despite that, the event is not explicitly described as positive at the time, as Joke describes that a significant inner change took place but the feelings of confusion and overwhelm were on the foreground. Joke started giving form to this inner change in the same year, when she meets a religious woman who introduces her to the church. Despite the belief *"shocking [her] at first"* (p. 25), believing is described as something that almost naturally happens to Joke without any effort from her side: " *I came to the church and saw what it meant for people […]. I gave my life to Him in prayer […] Everything went better and the voices were scared, and went to the background."* (p. 25). She also describes religion as something that she *had always believed in a way, but now [she] could give direction to it"* (p. 25). These passages describe how Joke becomes a believer in a seemingly involuntary way, as something that was predetermined for her.

However, her religious journey is not described as linear. In the same year, she describes a break in her relationship to God: *"After a year, my heaven turned into copper; I had the feeling that God had left me and that I could not reach him anymore with my feelings in prayer. […] That was a terrible feeling of loneliness."* (p. 25). Her choice to use the word *"copper"* in this context showcases the cold feeling of loneliness and desperation that she experienced in this moment, showing how important her belief was to her. It is also notable that she says she *"had the feeling"* instead of presenting the break in her relationship to God as a fact. This indicates that God might not have left her after all, but that it was her own, possibly faulty, perception.

A few years later, in 1997, Joke gets a divorce from her husband that she met in church and she decides to live by herself. During a prayer session with other church members, Joke describes another religious vision, underlining how significant and positive the experience felt: *"I turned around and saw Jesus Christ standing in front of me. He was peace, harmony and perfect love, and it felt so good. […] I felt absolutely no judgement from Him.* (p. 29) Joke makes sense of this experience by explaining that it was needed for her to understand *"who God is*" (p. 29), by which she places the vision as another important milestone in her relationship with a loving Jesus. Her view of God and Jesus in regards to her illness is later characterized by yet another *"vision"*, which shows he how the voices in her head are an enemy of her and Christ: *"I was shown that I always put a knife in the heart of Christ when I find myself in the unreal world of the voices. Then I form a community with the*

enemy instead of Christ" (p. 29). This is an essential event in the book, as it positions her psychotic symptoms as an antagonist to God, potentially paving the way for an internal struggle.

As the story and the years progress, Joke moves into the old farmhouse of her dad in 1999 and lives a calm life there without a human partner until 2010. She spends a lot of time reflecting on the nature of the voices and trying to drive them away. She describes one of the voices as *"the most treacherous of them all"* (p. 41) and concludes that it must be *"the voice of Satan"* (p. 42). The voice is therefore characterized as an ungodly force that is trying to challenge her belief. Contrary to my expectation, Joke does not seem to develop an internal struggle, as she manages to see the voices as a test and not as something from within herself.

Setting. Most of the storyline takes place in a cognitive setting: Joke's mind is a turbulent place, with Joke trying to deal with multiple of angry voices *"who screamed for hours in a row"* (p. 51). With time, Joke learns to *"enclose [herself] well from them"* (p. 71). The conflict in her mind is resolved when Joke accepts the voices as a gift of God, leading to *"calm and peace"* (p. 69). Some physical places are briefly described in the book, such as the old farmhouse that she moves into: *"The characterful house with a shed, barns and a big land is located next to a small road. There is little traffic and therefore it is a nicely calm place"* (p. 39). This humble and peaceful description of the house amplifies the impression of her lifestyle as calm and isolated.

Means and/or helpers. During the storyline, Joke tries several techniques to make the voices go away. She monitors her symptoms and the factors that influence their activity, such as *"taking care of [her] social contacts"* (p. 35) or hiring a healer to *"clean up harmful earth signals"* (p. 43), two methods that help temporarily. Next to that, she also tries *"cry[ing] heavily"* (p. 19), medication, or ignoring the voices. An important helper in the storyline is Joke's belief. Engaging in religious activities makes her feel happy, comforted and protected from the voices in her head. For example, Joke describes how she asks God to *"let the negative energy flow away"* (p. 53) and how she feels *"cleaned and refreshed"* (p. 53) afterwards, showcasing that she uses prayers to deal with the negative feelings caused by the voices. Another helper are grounding exercises. In 2009, Joke starts doing exercises to become more connected to her body and mind. She describes how she *"[feels] a power in [her] stomach and [she] was so happy all week"* (p. 63).

Purpose, intention, desired or feared goal. From the beginning on, Joke is unhappy with the presence and the effect of the voices. She *"wishe[s] to become completely insensitive to [the voices]"* so she can *"reach liberation"* (p. 54).

Breach. The breach in this storyline is between the element means and the element of the goal. Joke is determined to find ways to get rid of her symptoms, as she sees them as the antagonist to Christ. However, even with the help of prayers and distractions, Joke keeps hearing the voices and they do not lose their aggressive and mean character*: "Sadly, everything came back to me and I felt that all kinds of things were happening to my energy again."* (p. 42).

The breach is resolved in the end when Joke adapts the means and the goal. Instead of trying to fight the voices and becoming *"insensitive"* (p. 54), Joke finds a way to accept the voices by seeing them as a gift from God: *"People often don't understand me and I feel misunderstood in who I am. […] I appreciate the hearing of voices way more and I see it as a gift from God. […] Just let it be. Christ was also humiliated and insulted"* (p. 64). Now, the voices are no longer antagonists in Joke's mind, but a special gift by the God that she loves and worships. This is the turning point in the story, as Joke's struggle with the voices seems to be over. After several decades, Joke makes meaning of her illness by seeing it as something positive between her and God. This results in the impression that the story of Joke has a happy, complete ending, making space for a new storyline in her life.

Interpretation through the lens of religion and religious coping

Religion has a significant role in the story of Joke. It seems that she had her religious awakening during her psychosis. Her religious belief is not only something that she is passionate about, it also provides her with social support, comfort, strength and stability during her illness. Next to that, Joke perceives the voices in her head to be antagonists of her belief, which seems to strengthen her inner fight against the voices. However, religion is also her source of acceptance and peace in the end, as she argues that the voices are a gift from God. Therefore, her religion is important not only when it comes to coping with her illness and its consequences, but also for finding acceptance and solving the breach in the end. Her religious behaviours are described mostly in social contexts in the beginning and become more private as the story progresses.

Religious coping theory. This following section is based on Table 1. In the book of Joke, there are several behaviours that seem to match the definitions of several religious

coping strategies from Pargament's framework quite well. To begin with, Joke feeling like *"a different person"* after her first vision and consequently joining a church matches the description of Religious Conversion very well, as the religious vision was her trigger to radically change her life. Religious Conversion is classified as a positive coping mechanism. In Joke's case, her new-found religion also seems to have a positive and supportive effect on her life and well-being. When Joke struggles with her psychotic symptoms, she asks God in prayer to *"let the negative energy flow away"* (p.53) and she feels *"cleaned and refreshed"* (p. 53). If achieving this feeling was Joke's aim, then this act can be seen as an instance of the positive coping strategy Spiritual Cleansing.

Joke's behaviour matches two more positive coping mechanisms. She reaches the conclusion that the voices in her head are *"a gift from God"* (p. 64).This way of reframing her illness as a gift from God is a match with the coping Benevolent Religious Appraisal. Doing this seems to have a positive effect on her, as she describes that she *"experience[s] […] more love and peace"* (p. 66). Moreover, she engages in a behaviour that matches the coping Religious Forgiving well, accepting that *"people often don't understand [her]"* (p. 64) and comparing herself to Christ. In the passages that follow, Joke describes that she feels more *"happiness"* (p. 65) which showcases that this coping occurred in a more positive context. Contrary to these instances of helpful coping, Joke also feels abandoned by God at one point in the story, causing her to experience a *"terrible feeling of abandonment"* (p. 25). This hurtful abandonment that Joke expresses in her relationship with God matches the negative coping strategy Spiritual Discontent well.

On the other hand, when Joke describes how one of the angry voices in her head is the voice of Satan, she makes meaning of the situation by framing one of her psychotic symptoms as an act of the devil. This is a good match with the definition of the coping Demonic Reappraisal. Yet, despite this coping being classified as negative, Joke's act of framing the voice as the devil leads to her to *"loosen"* (p. 42) herself from the voice and take it less seriously. Joke therefore assigns a positive outcome to this negative coping strategy, which is a mismatch between her experience and the theory.

De weg kwijt [Lost] – Lenneke Derks/Truus Vogel

The following section is based on the story of Truus Vogel. The in-text page references therefore refer to the book written by Derks (2011).

Introduction

Case title. "I never had a warm home or felt wanted. All that talk about belief, God, Jesus and the church had not affected me positively."

Case introduction and global impression. Lenneke Derks wrote this book in cooperation with Truus Vogel (Derks, 2011). The book is about the early adulthood of Truus. She grew up in a very strict, old-reformed family with an abusive father and a lack of emotional and physical affection. As an act of rebellion, she got married early to a man named Freek and distanced herself from her parents. In "de weg kwijt" [lost the way], Truus describes her first psychotic episodes.

Truus' book is written in a straightforward and direct way, with many shorter sentences and a lack of adjectives or reflective descriptions. Similarly to the book of Joke de Jong, people and places are not described in detail. The focus is on Truus' experience and emotions. In the end of the book, it seems that Truus still has quite a way to go in order to process her traumatic past. What I appreciated about the book is that it is significantly different from the other two books by shining light on the negative consequences that religiosity can have.

Narrative summary

I am Truus Vogel, and in my twenties I had my first psychosis. I grew up in an old-reformed family. In the name of our dear Lord, my sisters and brother were beaten by our father. When I was 19, I got married to Freek to get out. It was not real love, and I often had the feeling: I can't go on anymore. Back then, I was a member of a sect based on the Christian belief. Eventually, I got very confused. I went to the sect leader Hans, because I thought that he needs to help me. Hans thought that I should go back home to Freek, but I did not want to go back. People from the sect came to visit me, but they were all scared of me. I was hospitalized, and I went to therapies and did my best to get better. I went back to Freek, but it did not work, so I filed for divorce. I called Hans and explained my situation, but he did not want me to come to him and told me that I needed to choose to join the sect again first. After not getting better during therapy, I applied to be hospitalized in a therapeutic community; I felt the need to take

it into my own hands. There, I started getting better, but I was still struggling with my upbringing, which was all about The Lord. I am convinced that if I had been born in a better family, I would have never struggled with being psychotic.

Storyline analysis

Storyline title. *They say that I have to wait, but I don't feel like it anymore. I knew it would be difficult, dealing with the things I had not processed yet from my upbringing, which was all about the Lord.*

Agent. The agent of the story is Truus Vogel, which can be seen not only in the fact that a majority of the sentences in the book have the structure first-person singular plus conjugated verb in the active form; it is also introduced in the first pages of the book: *"I am Truus Vogel, I am 54 years old and the mother of three children […] This is my story"* (pp. 8-9). At the beginning of the story, Truus is 23, married to a man named Freek, and working in retail. She is an agent who grew up in a very strict, deeply religious and abusive home where she had to fulfil the strict expectations of her parents: *"My whole youth was characterized by fear. I was not allowed to make a lot of noise and I had to act in accordance with the biblical rules"* (p. 8). Truus has clearly defined needs and expectations, she is self-aware and *"[doesn't] mince her words"* (p. 15). However, when it comes to making major decisions, for example ending her unhappy marriage with her husband Freek, Truus can be passive and reliant on others, believing that she *"won't manage on [her] own"* (p. 113), leading her to *"not go through"* (p. 59) with decisions. Truus is therefore a self-aware agent with clear wishes and needs who initially lacks assertiveness to pursue her needs actively.

Acts/events. After Truus' first psychosis is triggered, she is confused and goes to Hans, the leader of the sect. He tells her: *"'I can bring you to the station. […] You have to figure out by yourself where you want to go.'"* (p. 23). It is noticeable that Truus reacts to this by blaming herself for going to Hans: *"In retrospect it was really stupid of me"* (p. 23). Truus does not question Hans' behaviour, however. After getting lost, she asks strangers on the street to call Hans, who immediately picks her up. For a while, Truus stays at his home, and several people from the sect visit her, but Truus remembers: "*They were all scared of me"* (p. 43). Truus does not feel comforted by or close to them. She seems to believe that her illness scares them away. She does not seem to perceive herself to be in control, as she thinks that *"they were making all kinds of choices together behind [her] back"* (p. 44). However, this passage also suggests that the people around her consciously do not involve her in their

decision-making. This continues when they organize a hospitalization at the crisis centre for Truus while she is not made aware of that plan*: "[It was said that] we will take the car [and] then we will drive somewhere"* (p. 44). It can therefore be said that Truus is placed in the passive role somewhat involuntarily by the people around her. However, from her descriptions, it seems that she does not actively seek out ways to change her role. Struggling with strong psychotic symptoms at the hospital, Truus describes: *"I was being punished by the devil"* (p. 79). This point of the story can be seen as the climax: Truus has no support system to fall back onto, her symptoms are very strong, and she is excluded from the sect. Truus makes sense of her illness by seeing herself as a victim of the devil's punishment with little control over her own situation.

Her hope returns when she decides to apply to a therapeutic community. However, her psychologist decides that *"[she] was far from being able to leave"* (p. 113) her current treatment. Truus describes a *"need to take it into [her] own hands"* (p. 113) and applies secretly. The therapeutic community accepts her with the condition that she finalizes her divorce. Despite believing that divorcing is a *"heavy condition"* (p. 114), she accepts. It seems that this situation makes her intrinsic motivation come forward, as she describes her motivation to *"work on [herself]"* (p. 113). Truus does not accept the passive role and actively chooses to take her future into her own hands by going to the therapeutic community and accepting their condition. In the end of the book, Truus looks back on the past events, concluding that her psychosis was a result of her traumatic upbringing: *"I am convinced that I would never have struggled with [psychosis] if I had been born in a better family. […] I really was on my own. I had to fight it by myself"* (p. 146). While Truus again frames herself as somewhat powerless against her circumstances, the passage also raises the impression of a more independent Truus who has the drive to actively improve her life.

Goal/purpose. Truus dreams of a marriage in which the *"married people do a lot together and have a lot of fun"* (p. 12). On the one hand, Truus wants to *"make something"* out of the marriage with her husband Freek (p. 13). Later on, Truus lets go of this goal and develops the desire to process her youth, *"become better, work on [her]self"* and find out *"how it happened that [she] got confused"* (p. 116).

Means and/or helpers. Truus employs several means in order to reach her goal of making her marriage work. Truus describes how she resorts to asking Hans for advice regarding her unhappy. He doesn't validate her feelings and blames her for the problems: "'*This is all your fault*" and *"if you give, then you shall eventually receive'"* (p. 12). This

conversation seems to cause Truus to feel frustrated and misunderstood *"Hans didn't listen well"* (p. 12). Based on her description, the talk with Hans did not have the desired outcome, as she seemed to have hoped for someone who understands her. Truus decides to try relationship therapy with Freek, but the situation between them remains *"unchanged"* (p. 65). After several failed attempts to improve her marriage, Truus decides to apply for divorce and get her own house. She asks Hans for his support, but he "*thought that he was done with helping"* (p. 74) and makes clear that Truus is not a member of the sect anymore. Truus seems to feel disappointed and abandoned, she had "*hoped that [she] could always count on Hans"* (p. 74). Again, reaching out to Hans does not help her in the way that she had expected.

In the therapeutic community, the group and staff members are *"patient"* (p. 135) and *"understanding"* p. 135), which motivates Truus to be more open and *"take responsibility for [herself] and [her] behaviour"* (p. 136). Thus, the therapeutic community is described as an important helper and environment in which Truus can learn to deal with her problems.

Setting. It is noticeable that there are few detailed descriptions of the locations; the focus of the descriptions are on the things that are done and said by Truus and others, such as Hans and Freek. These descriptions can be used to derive information about the setting and sphere. The home of Freek and Truus seems to be a lonely and unsafe place for Truus, as she doesn't *"have anything to do all day [since] Freek was working and barely cared for [her]"* (p. 61) and at home she is "*being bullied by Freek"* (p. 22). In contrast, Truus describes her new home after the divorce from Freek as a "*cute ground floor apartment with a little garden*" where she was *"slowly getting stronger"* (p. 142). The descriptions make her house seem like a cosy, light place that gives her freedom and energy and helps her heal from her painful experiences.

Breach. The breach in the storyline is between the storyline element means and the goal(s). Truus wants to improve her marriage, but her attempts to improve her marriage by asking Hans for advice or doing relationship therapy do not help Truus to depart from the *"dead-end"* (p. 66) in their relationship. Therefore, she reaches the conclusion that she *"no longer feels like [waiting]"* (p. 67). Truus adapts the goal and starts focusing more on herself. She also adapts the means and joins the therapeutic community to fulfil her new goal. This seems to be successful based on Truus' own reflections: *"I learned what was good for me and what wasn't. […] I also learned that from myself, just by thinking about what I wanted and what I was able to do."*(p. 137). Therefore, the breach appears to be solved in the end.

Interpretation through the lens of religion and religious coping

The role of religion in this story of Truus has two sides. On the one hand, Truus is a member of a Christian sect. It is noticeable that Truus does not mention engaging in religious rituals such as praying or going to a mass. She mainly has intense and frequent contact with Hans, who she admires and who takes care of her until a certain point. Truus does not describe contact with other members of the sect except for when they come to visit her at Hans' house. Therefore, it is unclear whether Truus assigns importance to religious scriptures, rituals and community. Her religious upbringing is the other side of the role of religion in Truus' story. She seems to have religious trauma from her strict and abusive parents who used their belief to justify their behaviour. Truus' past keeps weighing her down, as she struggles with a lack of assertiveness, shame and self-stigma during the storyline. Truus does not seem to write off religion completely, however, which can be seen in the fact that she voluntarily joined the sect after leaving her parents' house. She does not mention her reason for joining the sect.

Religious coping theory. This following section is based on Table 1. There are some of Truus' behaviours that resemble the religious coping strategies as described by Pargament (2010); however, especially in Truus' case, her individual experience and the theory do not always seem to be a good match. Truus describes multiple times how she asks for *"help from Hans"* (p. 12). Truus' acts of reaching out to the leader of her religious group for advice and support is a match with the description of the religious coping Seeking Support from Clergy or Church Members. This coping strategy is classified as a positive coping. Reaching out to Hans does sometimes lead to positive outcomes for Truus, as Hans helps her when she is lost by *"[coming] to pick [her] up"* (p. 33) and providing her with safety by letting her stay at his house. On the other hand, there are instances in which asking Hans for help seems to lead to negative feelings and consequences for Truus. She describes how he *"didn't listen well"* (p. 12) and blames her for all problems when she asks him for advice. When Truus reaches out to Hans for support after she separates from Freek, Hans refuses to help her and explains that she is not part of the sect anymore. Truus seems to feel disappointed and hurt, remembering that she *"had hoped that [she] could always rely on Hans"* (p. 74). Thus, there are several instances in which Truus engages in the coping Seeking Support from Clergy or Church Members with negative outcomes for Truus, which is a mismatch with the positive classification of the coping according to Pargament et al. (2000). There is one behaviour that seems to match the theory well. When Truus feels "*depressed and […] really bad"* (p. 78) ,

she blames the problems that she is experiencing on the devil: *"I was being punished by the devil"* (p. 79). This way of meaning-making fits the coping Demonic Reappraisal. Therefore, she seems to engage in this coping in a moment where she feels worse than usual, showing that the negative classification of this coping strategy seems to be a fit in this situation as well.

Hier ben ik [Here I am] – May-May Meijer

The following section is based on the story of May-May Meijer (2020). The in-text page references therefore refer to her book.

Introduction

Case title. "Christ, I thank you for your loving support and your encouragement to write this book. Here I am."

Case introduction and global impression of book. May-May Meijer was born in 1972 in Delft. She is a Dutch writer, peace activist and mother (Meijer, 2020; may-maymeijer.nl, n.d.). She used to work as a teacher and researcher at the Vrije Universiteit in Amsterdam before her first psychosis . Regarding health care and the treatment of religious psychotic patients, May-May finds it important that religiosity is not only seen as part of the illness (Meijer, 2020).

May-May's book is written in a detailed, straightforward and immersive way. May-May sheds light on the stigma surrounding psychosis, the possibly strong the side effects of medication and how much religion means to her (Meijer, 2020). I get the impression that she did not hold back uncomfortable, intimate or painful details when writing the book. She also describes how people with psychosis can still experience very positive events and how they can find sources of support and motivation to keep going.

Narrative Summary

I have schizophrenia, I am divorced and I barely have work. I want to have a normal life again. Next to that, I am depressed, and I think that the depression is caused mostly by the side effects of my medicine and my circumstances. I feel worthless. One day in spring, I feel alive again, and I see that I forgot to take my medicine. Because I feel so much better, I decide to secretly lower the dosage. I start experiencing symptoms again and together with my sister we drive to the clinic. Five nurses take me and drag me to the isolation cell, but I hear the church bells and I think that Christ will support me. Let us strive for love, peace and

make an end to hunger. When Christ asks me to drive on the opposite way of the highway, I am willing to do it. However, I love my son Noah unconditionally, so when a nurse tells me to take my medicine, I put my medication in my mouth and swallow it with water. Christ tells me: 'What a shame, I have to go looking for a new Aphrodite.' I don't care anymore, I want to be able to be a mother for Noah again. Luckily, Christ is back the next morning and tells me: I love you. On Christmas evening, I go to church, where everyone is welcome, even us psychiatric patients. I feel the close presence of Christ and I think that everyone in the church is feeling it. A nurse tells me: 'May-May, you are doing well, I think it would be good to discuss your discharge soon.'

Storyline analysis

Storyline title. *The love of a mother is the closest to Godly love. I love Noah unconditionally, so I take my medicine.*

Agent. May-May Meijer is the writer and agent of the book. Grammatically, this can be seen in the fact that a majority of the sentences is written in first person singular with a conjugated verb in the active tense; content-wise, this story is introduced as May-May's story and the reader experiences the events from her perspective. May-May lives in Bussum and works part-time at a news outlet for Iranian women. She is a very loving and devoted mother who gains energy from being around her son Noah and *"[seeing] him happy"* (p. 12). She worries that she is a *"worthless mother"* (p. 28) due to her illness, showing that she finds it important to be a good mother. May-May is an empathetic agent who cares deeply about peace and who "*gets teary eyed when [she] reads about what is happening to people in Syria"* (p. 42). She is also a reflective, religious agent who wonders about the *"starting point of […] the earth, the universe"* (p. 74) and *"feel[s] a lot of love for Christ"* (p. 98). However, she can also be quite strict with herself, describing herself as *"worthless"* (p. 28) because she is unable to live her old lifestyle due to her illness.

Acts/events. In the beginning of the storyline, May-May feels depressed and she has *"nothing to do"* (p. 18). She describes how she feels *"empty"* (p. 18) and walks rounds around the coffee table to pass time while thinking repeatedly: *"I have schizophrenia… I am divorced… I don't have a job"* (p. 18). While she hints at the desire *to "think of a goal [herself] or get busy"* (p. 19), she feels like this is impossible because her brain feels *"bruised"* (p. 19). In this passage, May-May seems to be placed in a passive role against her will, as she describes her inability to be more active.

During her hospitalization, Noah gives her a book which is a very special gift in May-May's eyes: *"A poem in which motherly love is compared to the Godly love […] I love Noah unconditionally."*(p. 93). In this event, May-May's belief is connected with her strong love for Noah. The event's full impact can be seen a few hours later, when May-May agrees to take her medicine although she had been denying it before. It seems that May-May perceives this decision as not fully conscious: *"My answer surprises me too"* (p. 94). She describes how Christ is disappointed and tells her that he *"has to go looking for a new Aphrodite"* (p. 94). May-May seems to be feeling unsafe since *"there is no harmony without Christ"* (p. 94), but at the same time she "*couldn't care less anymore"* since she *"want[s] to be a mother for Noah again"* (p. 94). Her love for Noah seems to have triggered May-May's impulsive act of taking the medicine again despite the negative side effects. Based on her description, it seems as if she is relatively passive and the love for Noah took over her actions. She seems to be caught between two evils; either pleasing Christ by not taking the medicine, or taking the medicine so she can go home to her son Noah. She prioritizes Noah, but this results in losing her position as Christ's Aphrodite. This might come across as confusing and paradoxical to May-May, as she is acting out of motherly love, which *"comes the closest to Godly love"* (p. 93) according to the poem, but Christ still seems to disapprove. Despite this outcome, May-May does not describe any anger or regret. However, May-May is relieved when Christ *"luckily returns the next day"* (p. 94).

May-May gets discharged from the clinic and goes back home for a short while before being hospitalized again. While driving, she describes how she hears the voice of Christ that asks her if she is *"ready to die for the good cause"* and to *"enter the highway against traffic"* (p. 113). She describes how she obeyed to this order without mentioning any doubts or fear. Christ tells her*: "Okay, you don't have to do it. I wanted to know if you would do it"* (p. 113). May-May is submissive during this test of loyalty, but she seems to actively choose to follow his order. Christ can be characterized as somewhat cruel and unpredictable in this passage, differently from his usual loving and supportive description. This passage has clear similarities with the Biblical story of Abraham who is asked to sacrifice his only son (Moltz, 2001). He is determined to do so, but an angel stops him in the last moment (Moltz, 2001). May-May is in a similar position to Abraham in this situation, showcasing her special and important relationship with God. After her psychosis is over, May-May goes to a church mass on Christmas Eve with other patients from the clinic. She feels that *"everyone is welcome in the church, even [the] psychiatric patients belong there"* (p. 144). The Saint Vitus church is a place where May-May feels free from the stigma of her illness and where she can passionately

express her belief in God. Soon after this mass, she is discharged from the clinic. This act of visiting the Christmas mass at the end of the storyline gives the impression of a happier May-May who is actively and closely in touch with God and her belief.

Purpose, intention, desired or feared goal. May-May has multiple (contradicting) wishes and goals. On the one hand, she wants to be a good mother for Noah. She describes: *"I want to see [Noah] grow up. See him get his first boyfriend or girlfriend"* (p. 33). In alignment with that, she wants to *"make [herself] useful"* (p. 36) "*have a normal life again, […] find a job"* (p. 21). On the other hand, she describes wanting *"to escape the deep pain [and] the illness schizophrenia"* (p. 16) and considering *"jump[ing] out of the window"* (p. 16), which forms a contrast to the goals of wanting to be there to Noah and working on her desired lifestyle. Finally, May-May seems to see it as her purpose to *"strive for peace and make an end to hunger"* (p. 79) together with Christ as "*his wife, Aphrodite"* (p. 107). At first glance, these two goals do no conflict; however, in the breach of the storyline, the underlying contradictions between these two goals and the first set of goals become clearer.

Means/ and or helpers. In the beginning of the storyline, May-May is still taking her medications regularly but they cause several uncomfortable side effects, such as *"depression [and] a lack of energy"* (p. 39), weight gain and appetite loss. When the psychiatrist tells her that May-May has to *"take the medication for the rest of [her] life"* (p. 39) she doesn't think that she can "*endure that"* (p. 39). After May-May forgets to take her medicine once, she starts feeling *"so much better"* (p. 42) and decides to lower her dosage secretly. May-May starts experiencing psychotic symptoms again, leading to a hospitalization. One essential helper during her hospitalization and recovery is May-May's son Noah, who seems to be the main motivation for May-May to get better. His visits bring her a lot of joy and she looks forward to them: "*My heart skips a beat when I hear their voices in the hallway"* (p. 93). During one of his visits, she describes saying to herself: *"You have to get better"* (p. 32).

Another helper is her belief in God and Christ. May-May describes that he *"supports [her] from the sky"* (p. 114). Her contact with Christ supports her throughout her treatment by helping her feel safe and loved, even when her symptoms are at their strongest. Finally, May-May employs different means to reach her goal of contributing to world peace. She describes *"praying in silence for peace on earth, the end of hunger and illnesses and health for everyone"* (p. 154), writing a *"long letter to president Barack Obama [with] a call for peace"* (p. 45), and working at a newspaper that *"gives a voice to Iranian women"* (p. 16).

Setting. May-May has a very illustrative writing style. In the beginning of the storyline, she is grieving her old life. This also becomes apparent from her descriptions of her old house and new house. It is difficult for May-May to accept that the old house with *"[her] favourite red beech tree"* (p. 12) is not her home anymore. Her new house is furnished with *"things that are [hers], but [she] had no idea what [she] liked when [she] had to furnish the house in a short time"* (pp. 14-15). The contrast between the two houses demonstrate the life changes May-May went through leading to grief, emptiness and depression. The Saint Vitus church near the Rembrandthof clinic is, in contrast to her new house, a place where May-May feels *"good"* and *"where [she] belongs"* (p. 144). It seems like being at the church brings peace to May-May and somewhat soothes her pain. Next to that, it is an important location for her belief, as it is *"His home"* (p. 144) and she feels close to Christ there. The Saint Vitus church is described as a place of calm, warmth, acceptance, and peace.

Breach. The breach in this storyline is between the storyline element goal and means. This is due to the fact that May-May's goals contradict each other, with the consequence that there are no means that can help her reach both of these sets of goals. May-May wants to fight for world peace with Christ and be his Aphrodite and *"Maria Magdalena"* (p. 93), and at the same time she wants to get her normal life back and be a good mother to Noah. This second set of goals can only be achieved by taking her medication. However, May-May does not want to take her medication again, and she describes how Christ disapproves of the medication as well. She explains that the *"medication makes [her] sick"* (p. 131), but when she doesn't take the medication, she is an "*acute danger for herself and others"* (p. 85). The breach is therefore characterized as impossible to solve. May-May adapts both her means and her goal in the end. She prioritizes her son over being obedient to Christ by taking the medication again, while also still striving for a good relationship with Christ. Regarding the side-effects of the medication, she describes: "*search[ing] for the optimal dose of the medicine [to] balance between […] not getting sick again and as little medicine as possible to [limit] the side-effects*" (p. 149). Therefore, the breach is not fully resolved in the end, but May-May is actively balancing both her goals and means in the end. It seems like the medicine is supporting this process, as it makes the gap between her two sets of goals smaller and makes her feel *"less like Maria"* (p. 142).

Interpretation through the lens of religion and religious coping

Religion plays a role in the background of the story in the beginning, which changes after May-May starts experiencing psychotic symptoms again. May-May actively seeks closeness with Christ and she engages in religious activities, such as going to church. It is an important part of her identity and one of the driving forces that help her to keep going. However, her loyalty towards her belief seems to have the tendency to be harmful during her psychosis. This can be seen in the situation where she is willing to drive on the highway against traffic because of God's order, or where she believes that God would disapprove of taking her medicine again. The role of religion in May-May's life is paradox. Her belief seems to have positive and negative effects at the same time, as it seems to be improving her mental health while also holding her back from pursuing her goals and be there for her son by taking the medication. In the end, the negative effects of religion seem to weaken as she starts taking her medicine again, which leads to and supports her with striving for a healthier balance in her goals and her relationship with Christ.

Religious coping theory. This following section is based on Table 1. May-May describes several instances in which she uses religious activities to cope with her circumstances. It is noticeable that several of these behaviours are a match with more than one religious coping strategy from the framework. When May-May goes to the Saint Vitus church on Christmas Eve, she describes that she *"feels the closeness of Christ and [has] the feeling that everyone in the church feels it"* (p. 144), leaving a *"deep impression"* (p. 145) on her. This description makes the mass seem like an intimate event that connects the church-goers to each other. May-May's visit to the mass can be seen as an broad example of Seeking Support from Clergy or Church Members if one of her intentions was to feel connection and intimacy with other believers. Alternatively, it could also be an example of Spiritual Connection if her intention is to feel close to God.

Furthermore, May-May describes how Christ *"supports [her] from the sky"* (p. 114) and how she seeks out *"contact […] with Christ"* (p. 79) in difficult times. Per definition, this could be an example of Spiritual Connection, Collaborative Religious Coping and Religious Focus, since the characteristics of all three coping strategies are combined in this behaviour. May-May seeks out the contact with Christ when she is in need of support while struggling with the stressor: her illness. Another example of a good match between May-May's behaviour and the religious coping framework can be seen when May-May describes how God leaves her when she takes her medication again. She characterizes Christ as someone

who can punish behaviour that he deems unfitting. This way of meaning-making matches the negative religious coping Punishing God reappraisal. Although May-May states that she *"couldn't care less anymore"* (p. 94), she also feels *"cold"* (p. 94) and surrounded by *"evil powers"* (p. 94). Therefore, classifying this coping as negative in this example seems justified.

On the other hand, obeying Christ's order to *"drive on the highway against the traffic"* (p. 113) can counterintuitively be seen as an example of two positive coping strategies. May-May consciously and actively gives the control over the situation to Christ, which fits the definition of Active Religious Surrender. On the other hand, if May-May obeys because she wants to strengthen her relationship with Christ, this act also matches the coping strategy Spiritual Connection. It is noticeable that this dangerous act fits two positive theoretical coping strategies, as it is possible that May-May would have gotten physically hurt if she had not turned around *"just in time"* (p. 113).

Comparative analysis

Joke de Jong was introduced to religion in her early twenties and it seems that the beginning of her psychosis also triggered the beginning of her religiosity. Joke's belief and her religious community seem to provide her with support and stability during the beginning of her illness. However, as the story progresses, she seems to isolate herself by moving into a secluded home and focusing on her illness and God in private. The role of religion in May-May's autobiography has some clear similarities and differences with the case of Joke. First of all, May-May is already Catholic before the events of the book. In the beginning, May-May is going through a depression and does not engage in many religious activities. Like Joke, May-May starts focusing more on her belief as her illness progresses. Her belief and the church become an important source of strength, motivation and comfort during her illness. While May-May finds her direct relationship with Christ very important, she does not turn her back to the outside world like Joke does. Furthermore, Joke reaches the conclusion that her symptoms were not an illness, but a gift from God, while May-May seems to mainly hold the more medical view that she experienced a psychosis. For both May-May and Joke, their belief seems to be an important part of their identity and purpose.

In May-May's story, potential negative sides of religion come to the foreground more than in the story of Joke. The fact that May-May believes that Christ would disapprove of the

medication, and that she obeyed Christ's order of driving on the opposite way of the highway, showcase that religion can also play a negative role in her safety and recovery. For Truus Vogel, religion seems to have a predominantly negative role. Unlike May-May and Joke, Truus grew up religious. She was brought up in a strict, old-reformed family in which she had to endure mental and physical abuse. During her early adulthood, Truus distances herself from the church and concludes that her religious upbringing contributed to her psychosis. Although Truus does not describe any religious acts like praying, religion continues to play a role in Truus' life as she joins an unspecified Christian sect as a young adult. Unlike May-May and Joke, Truus is not religious anymore at the end of the book. However, it must also be named that the sect members cared for Truus after she first developed psychotic symptoms, so like Joke and May-May, she received some support from the church community.

Religious coping theory

Regarding the match between the authors' lived experience and the framework of religious coping, there are some findings that apply to all three authors. To begin with, in each case there are instances of religious coping behaviour that do not fully match the framework. In some cases, the described behaviour leads to negative consequences while fitting the definition of a positive coping mechanism, which was especially frequent in the case of Truus Vogel. Sometimes, the behaviours fit more than one of the theoretical coping mechanisms, like it was the case for May-May. However, there are also good matches between theory and lived experience in each of the three books. Globally, it can be said that the theory could not be applied to the lived experience of the three authors seamlessly. Regarding differences between the authors and their coping, it is noticeable that Joke and May-May seem to engage more in positive coping, especially in the context of their personal relationship to God. There are numerous examples in which May-May and Joke engage in religious coping and experience positive consequences, such as feeling refreshed or safe. Truus, on the other hand, seems to mainly experience negative effects of her coping efforts, especially when seeking advice from sect leader Hans. There are no descriptions in her story in which her coping behaviour occurs in her personal relationship with God, which is strikingly different from Joke and May-May.

Discussion

This current study focused on the lived experience of the role and importance of religion in the books of Dutch autobiographical writers with psychotic symptoms. Another aspect was the extent to which the theoretical framework of religious coping by Pargament (1997) was applicable to this lived experience. A number of overlapping themes were found, such as the spectrum of the role that religion can play in their lives, the potential influence of past religious experiences on later religiosity, religious appraisals of psychotic symptoms, and the role of God attachment in religiosity and coping. Lastly, another overlapping theme was that there were matches, but also mismatches between the theoretical framework of Pargament (1997) and the lived experience of the authors.

To begin with, the three books can be ordered on a spectrum ranging from a generally negative role of religion to a mainly positive role of religion. The idea of such a spectrum has been explored and demonstrated in previous research as well (Huguelet & Mohr, 2004; Koenig et al., 2020; Menezes & Moreira-Almeida, 2010). What was noticeable in the cases of the three authors was that religion could play both a positive and negative role in their lives at the same time, and that the role could change over time. This matches the findings of previous researchers such as Menezes and Moreira-Almeida (2010) who found that the role of religion can fluctuate. Similarly, there are often mixed findings on how religion influences aspects of the patient's lives and illness. Koenig et al. (2020) paint a mostly positive view of the relationship between religion and markers of wellbeing, while Mohr & Huguelet (2004) found that religiosity can act as a buffer to suicidality but also increase suicidal ideation and feelings of shame in people with psychotic symptoms. The patient stories thus underline the double and sometimes paradoxical role of religion in the psychosis experience that has been demonstrated in previous research.

Furthermore, the authors' past experiences with religion seemed to have influenced their belief. Two of the authors were not brought up religious but they had a positive association with religion in the past, while one author was raised by parents who justified their abuse with biblical rules. This latter author was the only one of the three authors who describes her past as traumatic, which she experienced as a trigger for her psychosis and a reason to become less religious. She also seemed to experience fewer positive consequences from her religious coping efforts. Research into the psychology of religion has demonstrated the effects of childhood experiences on religious beliefs in adulthood (Łowicki & Zajenkowski, 2019). They found that "empathetic concern and exposure to credible religious

acts during childhood were positively related to […] overall religiosity" (Łowicki & Zajenkowski, 2019, p. 9). On the opposite end, being raised in a church with rules and values that one does not identify with can cause severe feelings of shame and religious trauma, which individuals might find difficult to talk about and which might lead to a decrease in religiosity later (Downie, 2022; ter Kuile & Ehring, 2014). Therefore, these findings match the observations of this current study, as they showcase that the lack of empathetic religious experiences and the presence of negative or even traumatic religious experiences might lead to decreased religiosity. Beyond that, there is some evidence that traumatic experiences might even cause a psychosis, which might also be true for religious trauma (Campodonico et al., 2022; Morrison et al., 2010). To my knowledge, there are no studies that explore the direct relationship between religious trauma and psychosis, which raises the question whether there is possibly an undernarration of this relationship in practice and research (Prince, 2023). Thus, while this hypothesis cannot be compared to previous research, it might stimulate future research.

A third theme in all three books was the (occasional) religious appraisal of their psychotic symptoms. Two authors appraised their symptoms as a gift from or a connection with God, while another interpreted them as a punishment from the devil at one point. This finding can be placed in existing research: Many religious individuals with psychosis use religious explanations like these to make sense of their illness (Grover et al., 2014; Huguelet et al., 2010). Making use of religious appraisals in the light of a psychosis can have implications: Individuals who use a religious appraisal to make sense of their psychotic symptoms might be less likely to seek help, adhere to the treatment and take their medication (Grover et al., 2014; Harris, 2018). Randal and Argyle (2005) and Huguelet et al. (2010) argue that mental healthcare professionals do not necessarily need to agree with or adapt this way of meaning-making; an open, empathetic and non-pathologizing mindset can not only contribute to a good therapeutic relationship, but also to a more thorough understanding of the lived experience of the patient (Grof & Grof, 2017; Randal & Argyle, 2005). This manner of inquiry matches the non-guiding and client-centred nature of the BNIM interviewing technique, which can be used to shed light on experiences of vulnerable people (Moran et al., 2022; Wengraf, 2004). The aspect of dealing with the religious appraisal of clients can be placed in a broader discussion, namely what is needed to provide appropriate spiritual healthcare to clients who would like to discuss spiritual matters (Breitbart, 2009; Koslander et al., 2009). Some members of religious communities and also healthcare workers might believe that the healthcare worker has to assign similar (religious) meaning and worth to

events and symptoms like the client. Others believe that the healthcare provider does not need to match the level of religiosity and meaning-making of the client, as long as they are open-minded to their client's approach, which is similar to what Randal and Argyle (2015) and Huguelet et al. (2010) argue (Breitbart, 2009; Koslander et al., 2009). There is no consensus on this matter yet, but the two sides appear to be growing towards each other (Holmberg et al., 2020).

A fourth overlapping theme is that authors with a more personal relationship to God seemed to benefit more from their belief and religious coping. They more frequently described positive feelings and experiences, as well as more successful religious coping activities, compared to the author who did not seem to have a strong personal relationship with God. When placing this finding in the context of previous research, the difference between the authors could possibly explained by their attachment to God. In the study of Cooper et al. (2009), individuals with a secure attachment to God, thus individuals who trust in God's availability and presence in their lives, engaged in positive religious coping more frequently and drew strength from their contact with God. A difference can be seen for individuals who expected God to be absent or who feared God; they were shown to be less likely to engage in positive coping or be satisfied with their belief (Cooper et al., 2009; Hernandez et al., 2010). Therefore, a patient's perceived relationship with God might be correlated with their way of coping, like it might also have been the case for the authors of the autobiographical books (Cooper et al., 2009). A small but striking detail is that the two authors with a close relationship with Christ wished to be the bride of Christ and spent a lot of time focusing on him, which bears resemblance to the concept of mysticism in Christian women who desire being with Christ in isolation from the rest (Hollywood, 2003).

Finally, regarding the match between the religious coping theory and lived experience, there were good matches between the authors' experiences and the theory, and there were behaviours that stood in a less clear relation to the theory. In some cases, one activity fit multiple forms of coping, and in other cases, activities with negative outcomes fit the definitions of positive coping mechanisms, and vice versa. The details and nuances of the patient stories seem to make it more difficult to compare the authors' behaviour with the rather static and clearly defined framework of Pargament (2010). Xu (2016) already suspected that there might be more mismatches between theory and individual experience when applying the theory to a more qualitative setting. She mentioned the possibility that activities that would theoretically be classified as positive coping could lead to negative consequences and vice-versa (Xu, 2016). I could find only one study that applied the framework on

qualitative data, in which the researchers found that the classification of a coping as positive or negative might not always match the experiences of the person, and that cultural and religious differences might play a role in the mismatch (Nikfarid et al., 2018). These results showcase that it is possible for the theory of religious coping by Pargament (1997) and the subjective and comprehensive experience of a religious person with psychotic symptoms to mismatch and clash, which is in line with Xu's (2016) criticism of the framework. However, there is little research that investigates this matter.

Implications for future practice and research

Mental health professionals often have limited time to delve deeply into each of their patient's religiosity. I can recommend a few specific areas and topics for mental healthcare professionals to be mindful of. To begin with, professionals should be aware that religion can play both a helpful and harmful role (at the same time), and the role can shift. I therefore recommend mental healthcare professionals to form an understanding of their clients' experience religiosity as helpful and harmful and to monitor possible changes. Screening for and talking with clients about negative experiences with religion, religious appraisals of symptoms and the degree of God attachment is my second recommendation, as these aspects might influence the helpful/harmful role of religion, treatment, and coping efforts. However, due to the small scope of this study, these factors are likely not exhaustive, and I advise the professionals to look out for other important aspects of religiosity that their patients might mention. Furthermore, I recommend that mental healthcare professionals take a respectful and open-minded stance when inquiring about these aspects. They could potentially use the principles of the client-centred BNIM interviewing method as inspiration, as the method has been shown to help (vulnerable) people open up (Moran et al., 2022).

My final recommendation for clinical practice concerns the use of the religious coping framework. The results of this current study showcased that applying the framework on patient stories can go seamlessly sometimes, but also result in several partial or mis-matches. I recommend that the RCOPE should carefully be used in clinical settings with the awareness that it might not give an exhaustive representation of the patient's lived experience. For a comprehensive understanding of whether the coping is helpful or not, I recommend the professional to ask the patient for their perspective to get an impression of their lived experience.

In future research, it should be explored whether there is a relationship between religious trauma and the development of psychotic symptoms, as one author named religious

trauma as a causing factor for her psychosis and there is scientific evidence for a general relationship between trauma and psychosis. I recommend to extend this study to more patient stories of people with psychosis and other classifications, since the number of books in this current study was quite low. Seeing the diversity of the three books, it is very likely that further research will yield new insights and contribute more to the accessibility and visibility of the patient experience. It should also be explored whether mismatches between the religious coping framework and the lived experience of individuals emerge in other studies. The results could form the basis for more future research objectives and refined recommendations for the usage of the religious coping framework and the RCOPE.

Methodological reflection

Generalizability and the use of questionnaires

The aim of this current study was to provide an in-depth analysis of the experience of a number of religious individuals with psychotic symptoms as an example for mental healthcare professionals, who are often tasked with forming an understanding of what each of their patients is going through in order to deliver care that fits the needs of the patient (Reynolds, 2009). This current study was of idiographic nature, as it emphasized the details of the lived experience of a small number of individuals (De Luca Picione, 2015). In the field of psychology research, the generalizability of idiographic research has been criticized and placed as inferior to the generalizability of nomographic research (Salvatore & Valsiner, 2010). The consensus is often that more data, larger samples and questionnaires lead to better generalizability (Einola & Alvesson, 2020; Myers, 2000; Salvatore & Valsiner, 2010). However, human experiences are always subjective, unique, and bound to a specific context by nature (Salvatore & Valsiner, 2010). Positioning my findings in the context of existing scientific research and literature allows me to say something about how similar or different my findings are from previous research and theories, and what the implications might be for the research on psychosis and religion, and the practice of mental healthcare (Kuper et al., 2008; Salvatore & Valsiner, 2010). This process is called abductive generalization (Salvatore & Valsiner, 2010). It must be said, however, that three books are quite a low number of patient stories, which is why I recommend to extend this research in the future to stimulate more insights into the lived experiences of patients.

Furthermore, while questionnaires such as the RCOPE are generally considered a reliable and effective way to measure psychological constructs, there might be more nuances

to it (Einola & Alvesson, 2020). Possible issues are unclarities in terms of wording, biases and unwanted influences of the environment or the researcher, mismatches between the context of the respondents and the context of the questionnaire, and an overreliance on questionnaires when exploring nuanced and complex topics, which can lead to oversimplification (Einola & Alvesson, 2020). The theoretical framework of religious coping was not seamlessly applicable to the lived experience of the authors in this study, which could implicate that the same might be true for other individuals. Therefore, nomographic questionnaire research might not always be as reliable and valid as often claimed (Einola & Alvesson, 2020; Salvatore & Valsiner, 2010). At the same time, idiographic, qualitative research like this current study can still be generalizable and valuable, not just despite, but also thanks to its focus on details instead of bigger populations (Salvatore & Valsiner, 2010).

My approach to narrative analysis

Since the application of narrative analysis in the context of (mental) health psychology is quite pioneering (Murray & Sools, 2014), I was not able to consult much previous research when making choices during my analysis. One of my choices was to write each book into one storyline analysis; other possibilities would have been to divide the book into multiple storyline analyses, e.g. based on positive and negative parts of religion and fluctuations in religiosity. Furthermore, due to the richness of the data, I had to make choices on what details to include or not, since my time and resources were limited. This might have influenced the results as well due to a potential loss of nuance. While the richness, subjectiveness and details of patient stories are an advantage, they can also be a disadvantage in research. The time-restraints that students and researchers often have can make it almost impossible to analyse a larger number of books while also ensuring depth. I personally found it very helpful that there is a step-by-step narrative analysis guide, since it made it easier to navigate through the data and analyse it in an organized and in-depth way (Murray & Sools, 2014). Despite there being a guide, there are still choices that I needed to make by myself, such as the number of storyline analyses per book. I decided to conduct one storyline analysis per book, but future narrative research could make different choices in the process of narrative analysis, such as dividing each book into multiple storyline analyses instead of one based on themes or separate side storylines. Provided that they have the resources for a more extended analysis, including more details of the books to increase the thoroughness of the analysis might increase the depth of the study and generate more findings.

Strengths and limitations of the current study

Strengths

One strength of this current study was that the patient stories were originally written in Dutch. Much of the qualitative psychosis research in English language uses data from English-speaking countries (Noiriel et al., 2020). This current study contributed to the representation and accessibility of what non-English-speaking people with psychosis experience. Moreover, while research on religion and its effects on wellbeing has been mostly positive, there are researchers who criticize that these positive findings can be influenced by social desirability and methods that are susceptible to bias, therefore possibly leading to an overly positive view of the relationship between religion and wellbeing (De Oliveira Maraldi, 2018). Next to that, religious journals are often funded by churches or other institutions that explicitly position themselves in favour of religion, which can influence the publications of the journals (Wiebe, 2009). By shedding light on the trauma and negative experiences that Truus Vogel has endured under the name of religion, I hope to have given more space to the less positive role that religion can play in someone's life. Finally, another strength of this current study is its pioneering methodology and aim. The application of narrative analysis on patient stories is a newly emerging and promising form of research for making the lived, contextualized experience of patients more accessible to healthcare professionals and other stakeholders (van de Bovenkamp et al., 2020; Murray & Sools, 2014). The current study is also one of few studies that explores the match between the theoretical framework of religious coping and qualitative data.

Limitations

The main limitation of the current study is the small number of autobiographical books that were analysed. While it is difficult to assess whether saturation has been reached in a qualitative study (Aguboshim, 2021), it is very likely that this study did not capture the variety of lived experiences of religious people with psychotic symptoms, especially seeing how diverse the three books were. Next to that, the experiences of each author were unique and contextualized. This means that the results of this study are presumably not generalizable to the experiences of the whole population group, and that further research might generate more or even conflicting findings. This underlines the necessity to conduct more research with patient stories. Furthermore, there was a language barrier. The autobiographical books were written in Dutch, which is not my mother language. For this report, the quotes from the

books had to be translated. Regardless of the researcher's level of language skill, translating someone's words to a different language might change the content or the meaning of the message due to personal biases (Squires, 2008). Lastly, I conducted the analyses by myself. While I did receive regular guidance from my supervisors, I screened the books based on my knowledge of religion, and I conducted the analysis independently. Next to that, my personal bias might have played a role (Franklin & Ballan, 2001): I grew up in a Western country and distanced myself from the catholic church as I grew up. Also, due to my study and clinical experience, I am familiar with the medical/pathological view. These two factors sometimes made it more difficult for me to be open to the authors' way of meaning making, which I counteracted with conscious effort to reflect on and let go of my biases as much as possible. Other researchers might have selected different books based on other criteria, and they might also reach different results in their analysis, even if they use my selection of books.

Conclusion

In this research, I employed an idiographic, narrative analysis approach to gain an in-depth understanding of the role that religion and religious coping can play in the lives of patients with psychotic symptoms, and to what extent the existing framework of Pargament (1997) can be applied to their experiences. The results of the analysis of three autobiographical books showcase how religiosity in the lives of the authors can be characterized by a number of aspects: a positive and/or negative and fluid role of religion, the influence of previous experiences with religion and God attachment, and religious appraisals of psychotic symptoms. These findings could also be placed in existing research. In all three books, there were matches and mismatches between the theoretical framework of religious coping by Pargament (1997) and the lived experience of the autobiographical writers. Mental healthcare professionals are recommended to not only rely on the RCOPE for a thorough assessment of the coping behaviour of their patients with psychotic symptoms to reduce the risk of missing important nuances. I advise them to inquire about the above mentioned themes and their patients' experiences with religious coping in an open-minded and non-pathologizing way. Since their patients' experiences are likely different in some ways from the cases that were included in this study, they should stay open to other emerging aspects that their patients deem as important. Due to this diversity in lived experiences, it is very likely that further research might generate more or even conflicting insights, which emphasizes the need for more patient-story-based research. The current study also underlines

the need for further exploration of the match between the religious coping theory and qualitative data such as patient stories.

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