

Article

Religious or Spiritual Experiences and Bipolar Disorder: A Case Study from the Perspective of Dialogical Self Theory

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Abstract: In this article, a case study will be presented of a person with bipolar I disorder, who struggles to interpret his religious experiences and how they are related to the disorder. The analysis builds on a larger study into religious experiences within the context of bipolar disorder (BD). In this previous study, medical and religious explanatory models for religious experiences related to BD often appeared to go hand in hand in patients who have had such experiences. In this case study, the various ‘voices’ in the interpretation process over time will be examined from the perspective of the dialogical self theory of Hubert Hermans, in order to explore the psychological dimension of this process. The case study demonstrates that a ‘both religious and pathological’ explanatory model for religious experiences consists of a rich and changing variety of I-positions that fluctuate depending on mood episode. Structured reflection from a spiritual and from a medical perspective over the course of several years helped this person to allow space for different dialoguing ‘voices’, which—in this case—led to a more balanced attitude towards such experiences and less pathological derailment. The systematic reflection on religious experiences by the person in the case study was mainly conducted without help of mental health care professionals and was not derived from a DST perspective. It could be argued, however, that DST could be used as a helpful instrument for the exploration of both medical and spiritual ‘voices’ in the interpretation of religious experiences in both clinical practice by hospital chaplains and by other professionals.

Keywords: religious/spiritual experiences; bipolar disorder; explanatory models; dialogical self theory

1. Introduction

This article originated in the practice of hospital chaplaincy in mental health care. Persons with bipolar disorder (BD) can have religious experiences, often related to mania, which may give rise to a religious or spiritual quest long after the manic episode has ceased (Ouwehand et al. 2018). For them, finding meaning in those experiences can be a crucial issue afterwards, and is often confusing, as it is unclear just what role the illness plays. (Michalak et al. 2006). Research shows that these religious experiences can have various impacts on their lives, and although they have a transient character for some, for others, the influence can be lasting (Ouwehand et al. 2018, 2019a, 2019b). For this last group, religious meaning making is important, because it is part of their identity and relates to their core concerns in life (Cook 2016). The interpretation of religious experiences related to manic episodes is complex, because the interpretations will vary according to the person’s mood at the time. Qualitative research has shown that stable patients with bipolar disorder often perceive them both as

religious or spiritual, and as having pathological aspects, whereas in psychiatry, such experiences are often exclusively related to psychopathology and researched as religious hallucinations and delusions (Ouwehand et al. 2019b).

According to a quantitative study in the Netherlands, more than half of the patients in an outpatient department for BD who had such experiences wished to address them in treatment (Ouwehand et al. 2020). Although recently more attention is being paid to spiritual narratives in psychiatric practice (Cook et al. 2016), research indicates that patients do not always feel that their quest for meaning is being adequately met in treatment (Ouwehand et al. 2019b; Van Nieuw Amerongen-Meeuse et al. 2018). A medical model is predominant, and the perspective of hospital chaplaincy, which is much more directed to life stories and the way patients try to find meaning in important life events, as a manic episode can be called, is mostly absent in outpatient settings. The interpretation of religious experiences related to BD is therefore a process that has had its ups and downs over the years, and that, to a large extent, takes place outside mental health care.

This case study intends to throw more light on the way a particular person struggles with the influence of his illness on his religiosity and tries to find his way in the various medical and spiritual explanations of his religious experiences over the years. It builds on former research into the interpretation of religious experiences of and by persons with bipolar disorder (Ouwehand 2020). It is based on subjective written self-reflections of one person about his religious experiences and bipolar disorder. It is not representative in the sense that such an extensive systematic self-reflection of one person is seldom seen in clinical practice. However, precisely the degree of detail of his reflections written over a period of six years gives a good view on the development of the interpretation process over time from the perspective of this person. It can therefore contribute to the accumulation of clinical knowledge, and at the same time, gives a good view on the spiritual path of a person with bipolar disorder that is broader than his history with the illness.

The religious quest of Peter, the person with BD in this particular case, for the most part takes place outside the domain of mental healthcare, although some professionals play a role in it. The framework of dialogical self theory (DST) of Hubert Hermans was used to analyse the case. The first author, a hospital chaplain, did the analysis. The authors believe that Hermans' view on the multi-voicedness of the self offers an appropriate view on the often conflicting aspects in the person that are involved in religious meaning-making when a person is stable, or recovered from an acute episode. According to Hermans, the self is not an entity, but a continuous process of change and development expressed in internal dialogues and dialogues with others. The confusion of and conflicts within persons with BD because of mood swings that influence the interpretation process of religious experiences, can be clarified by the DST view on the self. A detailed description of Peter's interpretation process of religious experiences over the years in DST terms is the main aim of this article.

In the following sections, first bipolar disorder will be shortly described (Section 1.1), Second, the importance of cultural dimensions of both personal and medical explanations for illness experiences—an insight that Arthur Kleinman, as cultural anthropologist, contributes to psychiatry—is stressed (Section 1.2). Third, DST, as a valuable social-psychological deepening of the concept of explanatory models of Kleinman, is presented (Section 1.3).

1.1. Bipolar Disorder

Bipolar disorder is a mental illness with a prevalence of 1–2% in the general population, characterized by polarity and cyclicity (Goodwin and Jamison 2007). (Hypo) manic and depressive episodes alternate in a recurring cyclic rhythm, with stable or symptom-free periods in between. The main two variants of the illness are bipolar I disorder, with manic episodes, and bipolar II disorder, with hypomanic episodes. Manic episodes imply a persistently elevated, expansive or irritable mood, inflated self-esteem, increased activity and energy and a decreased need for sleep, extreme talkativeness, and a flight of ideas (Kupka and Nolen 2009). Mania can culminate in psychotic disorganization and implies a greater severity of dysfunction in social and professional life than hypomania does,

the latter not presenting psychotic features (Goodwin and Jamison 2007). Depressive episodes occur in both variants of the disorder, and are characterized by a persistent depressive mood, diminished interest in daily activities, lack of energy, diminished concentration and feelings of worthlessness and guilt, sometimes with recurrent suicidal thoughts. Both manic and depressive episodes can have psychotic features. The prevalence of religious delusions in bipolar disorder is estimated to be 15–38% (Appelbaum et al. 1999; Koenig 2009; Grover et al. 2016). It must be kept in mind that the definition of the concept of religious delusions and hallucinations is controversial (Cook 2015), because there is a lack of agreed definition as to where the boundaries of religiosity and psychopathology lie. The illness shows much individual variety, but in both main variants, depression often represents a considerable disease burden (Kupka and Nolen 2009). During depression, religious experiences are mostly absent and spirituality in general remains stagnant. Moreover, during the euthymic state, religious experiences usually occur less frequently than during mania (Ouwehand et al. 2019a, 2019b).

Psychiatric treatment of the disorder is, in the first place, aimed at reducing the symptoms and remission of the particular current. Secondly, the prevention of relapse is an important treatment aim. In the long term, less frequent, shorter and less severe episodes, together with the preservation of social roles is a more realistic treatment aim than the permanent absence of episodes (Kupka 2009). Psychotropics, psychotherapy and psycho-education are part of the guidelines for the treatment of bipolar disorder. Psychotherapy and psycho-education focus on the recognition of the symptoms and the effect of lifestyle on them, information on the importance of good sleep, regularity in the taking of medication, the monitoring of mood changes and risky behavior, the development of a relapse prevention plan, and the involving of relatives in the treatment, whereby—among other things—feelings of guilt, shame and anger originating in the consequences of manic episodes can be shared (Blom and van den Berg 2009).

Addressing the (religious) content of manic or psychotic experiences regularly happens in clinical practice, but is not included in the guidelines for standard treatment. In a specialized outpatient department for BD, almost half of the patients with religious experiences had shared these with a mental health professional (Ouwehand et al. 2020). However, in other studies, patients report that their religious needs are not being sufficiently met (Ouwehand et al. 2019b; Van Nieuw Amerongen-Meeuse et al. 2020).

1.2. Explanatory Models (Arthur Kleinman)

The problem is that, when they enter the domain of mental health care, persons with a psychiatric diagnosis are confronted with different possible ways of interpreting their religious experiences, and of other illness experiences; this has been, for some decennia, well documented by medical anthropologists. Anthropologists Arthur Kleinman (1988, 1991) and Cecil Helman (2001) refer to the different views on illness and health using the concept of explanatory models. When a person comes into contact with mental health care, personal explanatory models for illness experiences, which often have religious or spiritual connotations, are sometimes in conflict with the medical model conveyed by health care professionals. Personal explanatory models are influenced by folk theories (Helman 2001) about illness and health that are part of the surrounding culture. To give an example, an evolving manic episode might be conceived by an evangelical Christian as a manifestation of the Holy Spirit. In the light of the diagnosis of bipolar disorder, this person will, when in contact with mental health care, probably reconsider this explanation.

A simple distinction between healthy and pathological experiences is not that easy. One of the criteria in clinical practice in making this distinction is the cultural congruence of the content of psychotic experience (Sims 2016). When the content is not culturally congruent, it is more likely to be psychotic. However, experiences of unity or mystical experiences that are not bizarre in terms of content (which is one of the criteria for psychosis) occur twice as much in a sample of bipolar outpatients than in the general Dutch population (Ouwehand et al. 2019a). Religious experiences can therefore be culturally congruent with regard to content and still be related to BD. For the various

spiritual experiences related to individualized forms of new spirituality or New Age spirituality, it will probably be even more difficult for a clinician to discern what belongs to a person's religiosity and is embedded in modern religious trends or what is bizarre and exclusively psychotic. Yet, spiritual healing practices, rooted in popular beliefs, blossom as an alternative healing system (Hoffer 2012; Hoffer and Hoenders 2010), or as part of the new spirituality or New Age religion (Hanegraaff 1996; Heelas et al. 2005). Alternative healing practices are used by 42% of psychiatric outpatients in the Netherlands, according to a study of Hoenders et al. (2016). Hoffer (2012) observes that, owing to their more holistic approach compared to regular mental healthcare, spiritual explanatory models address questions about the meaning of illness, life and death. Religious or spiritual meaning-making encompasses more than simply illness experiences, expressing, as it does, the quest of individuals to find out who they are and to discover their destiny as human beings. In societies in which scientific knowledge is not widespread or part of popular culture, non-scientific explanatory models play a predominant role in the way that people perceive illness (Kleinman 1991), and this can lead to conflict when people start treatment within the medical system (Mitchell and Romans 2003; Stroppa and Moreira-Almeida 2013).

Some qualitative studies in Western societies show, however, that medical and personal (religious or spiritual) explanations for illness experiences are often intertwined or co-exist for the person concerned (Larsen 2004; Marriott et al. 2019; Ouwehand et al. 2019b, 2020). This is not surprising, because in most Western societies, mental health care is easily accessible. A great deal of psychiatric knowledge has been popularized and is available on the internet, therefore becoming part of popular culture. However, most patients are more highly educated in a formal sense, and are much better informed about their illness than patients in the societies in which Kleinman did his research. Psychoeducation of the illness after diagnosis has now become part of the standard treatment and contributes to a process of dialogue within the individual between different explanatory models. Qualitative research shows, for example, that when people with bipolar disorder are stable, they balance the positive 'fruits' of their religious experiences against the derailment of the experiences caused by the 'manic drive' and apparent losses that are due to manic episodes (Ouwehand et al. 2019b). Apparently, they use both spiritual and medical insights to interpret their experiences.

The various explanatory models may fluctuate during the course of a person's life, owing to mood swings, the course of the illness, religious background, the search for spiritual significance of the experiences and communication with others, as is shown by Ouwehand et al. (2019b). This study showed that interpretations of experiences that had occurred during mania, for example, were often seriously challenged during depressive episodes, and in the interpretation process, doubt about the interpretation was a recurring theme over the years. There is not much longitudinal research available about this interpretation process. One three-year follow up study into explanatory models of people with schizophrenia and schizo-affective disorder showed that a religious view of the illness persisted in about one-third of the sample (Huguelet et al. 2010). Although religious explanatory models were not constant, 60% of the participants explained their illness in religious terms at one time or another over the entire study period. Therefore, more research into the fluctuation and development of explanatory models for religious experiences in the context of psychopathology is relevant for clinical practice. This case study is an example of how the process of the interpretation of religious experiences can develop in detail, and the authors presume that the DST perspective contributes to its clarification.

1.3. Dialogical Self Theory (Hubert Hermans)

The aforementioned studies indicate that a combination of medical and religious explanations is widespread among patients—at least in western countries—although these models conflict when it comes to explanations of the nature of psychotic or manic experiences. Arthur Kleinman stressed the need for addressing both medical and personal (often religious or spiritual) explanatory models in clinical practice, in order to give treatment effectively. He developed his theory partly in non-Western countries, and compared cultural and religious concepts about illness and healing to Western psychiatric

concepts. What is instrumental for Western clinical practice is Kleinman's thesis that personal illness narratives often get lost in the diagnostic process, permeated as it is by the medical model. However, the more detailed process of how, in an individual, the process of interaction between the two different explanatory models takes place in its specific aspects, is not clarified by Kleinman. In this situation, Hermans' DST can be helpful.

Dialogical self theory (DST) developed by Hubert Hermans, which adds a psychological dimension to the medical anthropological theory of Arthur Kleinman, may provide a better tool for exploring personal illness narratives, and, in the case of this article, the way people with bipolar disorder interpret their religious experiences. DST takes a biographical, developmental perspective and, in a more specific way than Kleinman's theory of explanatory models, zooms in on the organizational and developmental processes of the self in relation to the external environment. Religious explanatory models appear to be relevant for persons with bipolar disorder (Ouwehand et al. 2019b, 2020), but data on the detailed interpretation process of religious experiences over time within those individuals and on the role of the disorder is in this process, are scarce, and could be clarified by Hermans' theory. In this article, we will therefore explore the interpretation process of religious experiences over the years in a single case, from the perspective of DST. The case study is not meant to evaluate clinical practice: the interpretation process described mostly took place outside mental health care. Moreover, within clinical care, aside from the treatment that patients receive, it is the hospital chaplains, who are not therapists, who support patients in their existential struggle and religious quest. DST is developed in psycho-therapeutical practice, but is used by the authors as an analytical framework for this case study. They believe that the insights from this case study can contribute to hospital chaplaincy and clinical care for those people with BD who struggle with the interpretation of religious experiences and their relation to the disorder; this is done within a phase of stability in which they can reflect on their lives. Hermans argues that different value areas (the things people view as worthwhile, (Hermans and Hermans-Jansen 1999) can be distinguished in self-narratives. A person potentially has many different facets (so-called 'I-positions'), from which things are viewed and valued: "I-positions are understood as characters or parts of the self that are distinguishable and often divergent or even contradictory" (Konopka et al. 2019, p. 34). They are not the same as traits, but "spatial-relational acts" (Konopka et al. 2019, p. 35). They involve different facets of a person, and from these different perspectives, the individual can relate to other real or imagined persons or to other aspects of the self. The 'self' is therefore viewed as a dynamic process of continuous positioning, counter-positioning and repositioning (Hermans and Hermans-Konopka 2010). The different socio-cultural contexts in which people live, the roles they play in those contexts, and the power relations present in their social world, are mirrored in the various I-positions a person can take, and which can be in dialogue with each other, as interacting in a metaphorical space. "Internal I-positions are aspects of one's self, while external I-positions are voices of others" (Konopka et al. 2019, p. 37). Thus, Hermans uses the metaphor of 'landscape of mind' or 'mini-society' within the larger context in which a person lives, as he speaks of the 'self' as a dynamic multiplicity of I-positions (ibidem, p. 39ff).

The metaphors Hermans uses for the development of the self, such as 'landscape' or 'society of mind', have a spatial character which allows for a variety of sometimes contrasting I-positions at the same time, as for example, both a medical and a spiritual evaluation of religious experiences related to BD. In this metaphorical space, I-positions usually do not function totally incoherently or disconnected, but in certain patterns, "similar to how people relate in society, a group, or a family. The quality of their relations determines the functioning and organization of the self" (ibidem, p. 40). In this process, specific internal or external I-positions, the so-called 'promoters', enhance the process of the development of the self. They give a sense of direction in life; provide a compass. For example, in psychotherapy, a therapist can become an external promoter who helps to embrace different, neglected I-positions of a person, supporting a more open attitude towards oneself and others. The voice of the therapist, first an external promoter in the actual therapy, can gradually develop into that of an internal

promoter position within the individual, one who enhances personal growth. However, this could also be the voice of a friend or of a counselling pastor.

In the case of serious mental illnesses, such as BD or schizophrenia, mood swings and psychotic experiences seriously threaten a coherent sense of identity (Cook 2016; Inder et al. 2008; Lysaker et al. 2019; McCarthy-Jones et al. 2013; Warwick et al. 2019). People can experience, for example, the loss of unity of self, or discontinuity in the self in very frightening ways; they may feel possessed, or perceive changes in the boundaries of self during psychosis (Oyebode 2018). In addition, persons with BD may perceive themselves very differently during mania, depression or when they are stable (Ouwehand et al. 2019b). For example, 20% of people who have the experience within a manic period of being an important religious person like Jesus, consider such an experience to be of lasting influence in their lives (Ouwehand et al. 2019a). One of the reasons that 80% do not view this experience as life-changing is that people with bipolar disorder rate this experience, when stable, as exaggerated or as a sign of megalomania.

It is clear that those who have gone through a manic or psychotic episode often, in retrospect, seriously reflect on the meaning of what was experienced during such episodes (Klapheck et al. 2012; Ouwehand et al. 2019b) and assess what remains of value or has lasting influence on their lives. Hermans' spatial metaphors of the self in dialogue might help to clarify the 'multi-voicedness' in this interpretation process; in this article, we focus on religious experiences.

An elaboration of DST focused on religious voices is presented by Hetty Zock (2013). Zock's analysis nuances Hermans' somewhat one-sided view on individualized spirituality as the exclusive way to radical openness and "crucial to the dialogical potential of the self" (Zock 2013, p. 18). She shows that traditional religiosity as well can have the potential to contribute to more reflexive I-positions as meta-positions, from which other I-positions can be observed, third positions that in a dialogical way unify conflicting I-positions, and promotor positions, that stimulate development of the position repertoire of a person. Zock (2013) illustrates, in her analysis of the biography of a modern Islamic woman in the Netherlands, how Islam is connected with various personal and social I-positions that develop over time in the direction of a third position which combines personal autonomy and traditional the Islamic values that her parents taught her, giving her the freedom to experience her faith in her own way. Zock's approach throws a less normative light on both traditional religious and more individualized spiritual voices that may play a role in constituting a person's religious identity and its transformation over time.

1.4. The Case Study

The framework outlined, namely medical and personal religious explanatory models often co-existing in persons with BD, and the extended DST model (Zock 2013), giving room to various functions of 'religious voices' in self-narratives, will serve as the theoretical basis for this case study. It will present the analysis of the development of the interpretation process relating to Peter, a person with BD who has had several religious experiences during the course of his illness. The fact that Peter himself had spent much time reflecting on his own 'case' before we interviewed him made him particularly suitable for analysis from the perspective of DST.

In the analysis, we shall focus on the following questions: Which religious and medical voices resonate in Peter's repertoire of I-positions and how does the dialogue between those voices develop over the years? Peter is one of the respondents in a larger qualitative study into religious experiences and BD (Ouwehand et al. 2018, 2019b). He was interviewed and provided the researchers with extensive documents written over a period of six years, to evaluate the relation between his religious experiences and symptoms of BD. This material will serve to explore Peter's 'society of mind': the different and often contradictory voices that influenced his sense of self and played a role in the interpretation process of his religious experiences. The aim is to ascertain to what extent Hermans' model throws light on the development of Peter's interpretations as he consciously and purposely analyzed his inner life over the years.

2. Method

Peter was interviewed in November 2015 in a larger qualitative study. Methodological aspects of this study are published elsewhere¹ (Ouwehand et al. 2018, 2019b). The case material for this article consists, besides the interview, of five texts written by P during a period of six years: 1. a booklet (named 'A better human being' [*Een beter mens*]) covering a period of 30 years from the onset of his first mania when he was in his twenties, to the time of his 'revelation from God' and his baptism, almost 30 years later (indicated here as Booklet 2013), 2. a short analysis of 'healthy' and 'risky' faith, (H/R Faith [*Gezond en riskant geloof*] 2014), 3. an extensive analysis of symptoms of BD, in relation to, among other things, his faith, called "How do I recognize mania" [*Hoe herken ik een manie*] from the perspective of his relapse prevention plan (indicated here as religious relapse prevention plan, RRPP 2015), and 4. a short personal confession including the persons who influenced his views (Confession [*Belijdenis*] 2015), and 5. a summary of what he called his 'bipolar-religious spiritual' path from the onset of BD to his transfer to his practitioner after a year of psychotherapy. The last document is written after the interview (Bipolar-Religious Spiritual path [*Mijn bipolair-religieus spirituele pad*] 2019). For this case study, Peter sent us a written consent to use the interview text, as well as the written documents. The present article was sent to him and his commentary was taken into account.

All documents were analyzed, and the interview text was reanalyzed with the conceptual framework of Hermans' DST by the first author. Different I-positions were systematically discerned and DST concepts such as meta-position, positioning and counter-positioning, promotor, third position, and internal and external dialogue were used as an analytical framework (see Appendix A). The main focus of analysis was the context in which religious voices and voices from a medical perspective were related to each other and to other I-positions, and how the development of Peter's sense of self developed in the years of reflection on his religious experiences in relation to BD. As far as the authors know, DST was not used by Peter himself, nor by the clinicians with whom Peter had had contact with during the course of his illness. DST is used by the authors as a hermeneutic-analytical tool of a self-narrative (Buitelaar and Zock 2013).

The second and third author examined part of the material, and the I-positions detected within the documents were discussed with the second author. The first and third author have a long professional experience of working in mental health care as hospital chaplains; the third author teaches mental health and religion at a theological faculty. The first four documents were examined by a trainee psychiatrist who participated in the initial qualitative study, and in 2015, conducted the interview together with the first author. These documents then served merely as background information for the interview and were judged by the trainee psychiatrist as coherent, informative and quite readable.

No external check by a medical professional was made for the fifth document. In this document, Peter states that, upon the advice of his psychiatrist, he had undergone psychotherapy for more than a year and only after a psychotherapist had assessed that he was stable enough to do this. After finishing the therapy, care was transferred to a General Practitioner with the support of a primary (mental) health care assistant practitioner. Peter meets the assistant practitioner once every six weeks for half an hour. He checked his observation that symptoms of the illness had decreased with the assistant practitioner and with his best friend after the question of the reviewer if an external check was done, and they confirmed his observation.

It is important to note that, according to Peter, he had not had a depressive episode since 2013 (that is, two years before the interview), only periods of mood elation in which he had contact with a psychiatrist as an outpatient. Depression is often much more present in the lives of persons with BD

¹ Stable participants were interviewed for 1 ½–2 h, by a psychiatrist trainee, to take the illness history and assess severity of the illness, and a hospital chaplain. Main topics were religious experiences that the participants had had during illness episodes and when they were stable, and how they interpreted these experiences in retrospect. Interviews were audiotaped and transcribed verbatim and sent to the participants for control.

than (hypo) mania, and causes doubt and sometimes temporary distancing to any religiosity during a depressive episode (Ouwehand et al. 2019b). It had played a role in Peter's life before 2013 and according to him had diminished owing to his conversion. We did not check this with his former psychiatrist, because Peter had not met him for some years.

3. Results of the Analysis

3.1. Brief Religious and Illness History

At the time of the interview (2015), Peter was in his fifties. He was raised in an atheistic family and went to public (not Christian) schools. At home, "the Bible was only mentioned when there was a reference to it in literary texts," Peter said. According to him, his parents were not anti-religious, but his sister was. The most important values that his parents taught their children were "speaking the truth" and "pursuing justice".

After finishing university, Peter started working as an academic for some years, and later for an international organization with idealistic objectives, for which he had to travel abroad regularly, especially to South American countries. The onset of bipolar disorder was when he was in his twenties (1983 to be precise), but he was only diagnosed much later (in 1999), when he then began to use lithium. About twelve years after the first symptoms, and after his second manic episode, manic and depressive episodes started to recur annually. Peter was declared semi-invalid and his work-associated duties were adjusted (1999). At the time of the interview, more than 30 years after the first symptoms, Peter was involved in a legal procedure that would allow him to leave his job and permanently go 'on sick' owing to bipolar disorder.

Almost thirty years after the onset of the first symptoms of BD, Peter received a "revelation from God", which led to his conversion to Christianity and his baptism in a Baptist Latin American church in the Netherlands, two years later (2012). At the time of the interview in 2015, he had left this church, and up to now, has belonged to a small, critical, metropolitan Christian community with highly educated members. After a period of psychotherapy in 2017, Peter left specialized mental health care and is now being monitored by his general practitioner.

3.2. Development of I Positions

In the following sections, the different I-positions in Peter's position repertoire will be outlined. Two documents, namely the Booklet (2013) and the religious relapse prevention plan (RRPP 2015), describe Peter's history with BD and spirituality/faith, yet from different dominant I-positions. In the Booklet, a dominant voice is the one that is often colored by clear symptoms of BD, Peter argues in retrospect, when evaluating this writing process in 2015. In his RRPP, the voice of a rational analyst comes to the fore, characterized by the perspective of a thoroughly examined psychiatric expertise by which his life story with BD is evaluated.

The dynamics and development of these 'I-positions' will be described in two of the following sections (Section 3.2.1/Section 3.2.3). In the section 'religious voices' (Section 3.2.2), the development of specific religious voices and evaluations of religious experiences in all documents before the interview will be presented. A third position gradually develops that integrates religious and medically informed voices. Finally, we describe the development of this third voice, gaining more weight in Peter's position repertoire, as presented in 'Bipolar-Religious Spiritual Path' (2019) (Section 3.2.4).

3.2.1. "A Better Human Being" (Booklet 2013). From Being Driven to 'I as Captain in My Own Head'

Peter composed the document 'A better human being' (Booklet 2013) during a writing course. It is written from the perspective of 'I as creative writer'. Each of the 44 one-page chapters starts with the lively description of a memory, which is written eloquently and is attractive for the reader, and is called "an anecdote" by Peter. The "anecdotes" are followed by a description of the context in which the event happened, and every chapter concludes with a reflection or evaluative commentary from

the point in time of writing the Booklet, when Peter was “converted and more experienced”, as he himself comments. We will call this I-position ‘I as more experienced with BD and a wiser Christian’, that only appears in the evaluative commentaries. The Booklet anecdotally follows Peter’s life course in three periods: the period of building up his career, in which Peter has two manic episodes and loses his self-confidence (1983–2006, Section 1 in the Booklet); then, a period of three years in which his father dies and his manager challenges him to be more visible in the organization (2009–2011, Section 2); and the period of his first interest in the Christian faith which ultimately leads to his baptism (2011–2013, Section 3).

An important I-position in the Booklet appears to be Peter as intensely experiencing and enjoying life fully in dancing, music, nature, travelling to foreign countries and being in contact with others. We called this I position: ‘I as intensely experiencing and enjoying life fully’. It often forms a coalition with other ‘I’ positions we refer to as ‘I-as acting creatively, in a flow’, ‘I as competent’, and ‘I as free’. Peter often has the feeling of being led, and that things happen with a purpose. Peter writes, for example, about an intense experience of dancing the tango:

The world has turned into a 3D print-out. At first it seems to be an image consisting of a chaotic series of two-dimensional shapes. But if you focus beyond the surface, the image floats, within the confines of the paper, like a hologram before your eyes. We dance in such a 3D picture. It is as though a divine hand is guiding us. (Booklet 2013)

The lively described “anecdotes” in which these I-positions come to the fore often seem to refer to periods of euphoria or (hypo) mania, on a sliding scale. They show that the different aforementioned I-positions are more or less strongly present, depending on the mood or the mental state that Peter is in.

The feeling that things happen with a purpose, or the feeling of being led, which can be part of any form of ‘normal’ spirituality, but in its extreme forms can also be part of (hypo) mania (Ouwehand et al. 2018), was not interpreted as religious or spiritual by Peter in his younger years; he considered himself an atheist at that time. In the interview (2015), he states that spirituality was only present when he was (hypo) manic, not when he was stable, until his encounter with Christian faith. His first “spiritual” experience, related to mania, he describes as follows, written from the I-position of the creative writer:

The following night, I woke up with an urge to go to the beach. In the twilight, an almighty wisdom floated above beach and sea, which would—if I were to ask the right questions—give me the right answers. Water, air and I were one. (Booklet 2013)

An experience of another nature, ‘I as savior’, appears at times in the Booklet. Although Peter does not describe himself as religious, this I-position is evoked for the first time in the highly religious context of a Latin American procession. This ‘savior position’ seemed somehow to evolve from an exaggeration of ‘I as competent’ and ‘I as free’, I-positions that come to the fore in several of Peter’s “anecdotes”, on a continuum that develops when a manic episode is evolving over time. ‘I-as competent’ becomes ‘I-as overconfident’ and ‘I-as free’ develops to ‘I-as free from any inhibition’. These I-as positions in their manic form contrast sharply with the opposite I-position ‘I as a wastrel’ during depression:

I could not take care of myself anymore. Doom was the first thing I felt as I woke up, doom was the last thing I felt while falling asleep. I was sure everything I would undertake was doomed to fail. (Booklet 2013)

Another ‘I’ position, namely ‘I as a conformist’, who tries to meet the expectations of others, also plays a role in the dynamic between the extremities of BD. This ‘I as a conformist’ reinforced the position ‘I as ambitious’, that played an important role in Peter’s professional life. Peter gives several examples of his attempts to meet the expectations of others, in his job as well as in intensive personality trainings he participated in “to become a better human being”. These different voices, colored by euphoria or hypomania, can become involved in confusing dialogues about who Peter is. Peter gives an example of such a dialogue, coming back from an appointment with his psychiatrist.

He (the psychiatrist) said I am not manic, but that it would be a good thing if I were calmer. I did not tell him: 'I think I am the savior', but if he had asked, I would have told him. The savior, that sounds intense. He would have thought I was manic. Am I? No, not really. Euphoric, sure, but that's alright. I am free now, I've never had so many new ideas. But I can't tell other people. I am too far ahead. But, wait a moment. The thought that I was the savior I have had before, and at that moment I really was crazy. Would I be ... nevertheless? Mm, this is painful. I am not the savior, because then I would be manic. Therefore: I am not the savior, but a savior. One of many, but a special one. (Booklet 2013)

Here, we see that the 'I-as savior' and the 'I-as free' become predominant when Peter is euphoric. These positions are counter-positioned by the inner voice of the psychiatrist who would probably have diagnosed Peter as manic. A critical I-position, 'I as critical rational analyst', continuously comparing experiences and evaluations with former ones to get a grip on his illness, is still greatly influenced by the euphoric state in this quote, considering the final conclusion.

In the evaluative commentary on this passage, Peter reveals that he has not shared his internal struggle with other people, because he does not want to express what he calls "stigmatizing thoughts". This fear of being stigmatized is a variant of the 'I as conformist', but it is counter-positioned by a value-laden voice that would have answered honestly when asked, because "speaking the truth" was important in Peter's upbringing. This counter-position is a more sociable I-position that also seeks help and advice at crucial moments. When the interviewer expresses his surprise that Peter, although he is diagnosed with bipolar I disorder, has never been hospitalized, Peter answers that the reason for this is that he listens to people who give him advice, both in external exchange with others about his situation as in internal dialogues (Interview 2015).

However, the fact that Peter's friends and colleagues usually thought he was more energetic and confident than normal (when in a (hypo) manic state, instead of recognizing his behavior as related to BD) reinforced his 'I as ambitious' and 'I as acting creatively, in a flow'. Peter describes, in the second section of the Booklet (2013), named "Inspiration", that his creative plans, evoked by the critical remarks of his manager that he should be more visible, were not connected with other people nor supported by others.

The third of the three sections of the Booklet (2013) is called "Connection". With this title, Peter emphasizes a growing awareness of the importance of connection with others and the community. In his landscape of mind, more space becomes available for 'I as an imperfect person'. Peter describes how he is touched by the story of Jesus not condemning the adulterous woman (John 7:53 ff.) in the Bible: "She is free! I think: nobody would be condemned if everybody were aware of his own imperfection" (Booklet 2013). Although Peter in his commentary on the present article states that he conceives of the story as a revelation to the acceptance of imperfection by all human beings, the researcher recognizes here an accepting I-position towards Peter's own vulnerability and unachieved goals.

Reading the different memories, one gets the impression that Peter moves forwards and backwards in the period of his first manic episodes up until the time he writes the Booklet, between 'I as competent', 'I as ambitious', and 'I as failing in my aspirations', 'I as a wastrel'. From the meta-position as 'more experienced with BD and a wiser Christian' in his evaluative commentaries, Peter recognizes the relation between his first two manic episodes and his career moving into high gear. In his view, he could have become a scientist or an expert in his job. In trying to transcend the dichotomy between 'I as savior' and 'I as a wastrel' that are—in their extremities—related to BD, but play a role in Peter's society of mind when he is stable as well, Peter has developed his creative and self-reflective aspects. We may say that the position 'I as self-reflective' counter-positions the extremes of BD. However, Peter's creativity, when not affected by the illness, also counter-positions his 'I-being a wastrel' that emerges in depression.

As a "turning point" in the understanding of his illness and recovery process, Peter mentions the remark of his psychiatrist who declared that he was a free person, because he was 'captain in his own head'. This position 'I in control' is different from the position 'I as free' or 'I as acting creatively,

in a flow', experienced in euphoria or in (hypo) mania, when Peter acts correspondingly. It points to a meta-position from which he is less 'driven', but one that enables him to make choices. The inner voice of the psychiatrist allows Peter to view himself as not being egotistical by taking better care of himself. This has become a promotor position. The position 'I as conformist' disappears more to the background to make place for an 'I in control' who can choose for his own wellbeing with regard to his illness, is less determined by the dynamics of BD and tolerates his own imperfection.

3.2.2. Religious Voices up until 2015 (Booklet 2013, Healthy/Risky Faith 2014, Confession 2015, Interview 2015). From 'I as Longing for Enlightenment' towards 'I as a Well-Informed Person with BD and a Wiser Christian'

As mentioned above, Peter was not religiously educated. In the interview, he states that he was occupied by spirituality only in manic episodes. Two I-positions in relation to spirituality were present in his position repertoire after his first mania. 'I as secretly longing for enlightenment'/'I as savior', emerging from the spiritual experiences during his first manic episode, which is strongly counter-positioned by 'I as critical rational analyst', arguing that faith is for anxious human beings and that his experience of enlightenment must be pathological. A bipolar friend who was intensely involved in new spirituality at that time fueled Peter's rational distrust of spirituality. His friend was so much obsessed by spirituality, that this evoked the opposite reaction in Peter, who considered himself an atheist.

However, new spirituality² did play a role in his narrative, in the form of intense personality trainings, a coaching trajectory and an autobiographical writing course (Booklet 2013), which had the aim of self-development "to become a better human being". This focus on self-development reinforced the position 'I as ambitious' in his professional life. Peter did not only have personal professional ambitions with regard to his career. His ambitions were much colored by 'I as do-gooder', who had chosen to study political science at a leftist university and acquired a job in a non-profit organization with idealistic aims. Spirituality as a tool to become more successful in his job and to create a better world is thus reflected in Peter's position repertoire in the first decades of his career, next to his aversion to spirituality.

Peter's interest in the Christian faith starts after the death of his father, and develops in different steps. When he sees a light radiating from his father's corpse, it convinces him of the existence of eternity. A second experience of light evokes in him the question whether God exists. In this period, a quest for meaning begins, but Peter is not sure where to seek, because no religious framework is available to interpret his experiences. The voice of Tim Keller in *The Reason for God*, a book Peter happens to come across, convinces him of the importance of seeking a Christian community, and finally, the voices of the Latin American church members he meets lead him to his choosing to become a member of this Baptist church. This choice is also prompted by Peter's feeling that things do not happen coincidentally, but have a special meaning, which can be characteristic for (hypo) mania. In the initial stage of his contact with the Christian faith, the 'I as ambitious' and 'I as conformist' are apparent. Peter is trying to become a good believer. The 'I as intensely experiencing and enjoying life fully' is dominant in Peter's complete immersion into this new religious world, even traveling to South America to visit a monastery and a church before he decides to be baptized in the Netherlands. However, the 'I as critical rational analyst' pops up every now and then in internal dialogues and external dialogues with other believers, questioning Peter's nascent religious views.

Gradually, changes in the relationship between the different positions in Peter's position repertoire become visible in his growing affiliation with the Christian faith. Former spiritual experiences, such

² New spirituality, sometimes also called New Age spirituality, is a concept used in the sociology of religion which refers to other forms of emerging spirituality in modern, secularized societies than traditional, institutionalized religion. One of the characteristics of new spirituality is that it often emphasizes personal spiritual experiences as revelatory and denies any institutional authority. Its focus is in spiritual growth.

as the intense experience of oneness during his first manic episode and the intense experiences of the beauty of nature he had had several times during hypomania, together with experiences of 'I as savior' or the creative I-position that, colored by euphoria, associates and symbolizes continuously, are judged by Peter as a sign of an "inflated ego". Objects Peter had previously attributed a magical power to (also after his conversion), he now divests of their special meaning (Healthy/Risky Faith 2014; Interview 2015). Peter's emerging position 'I as a Christian' strengthens voices representing values such as humility, simplicity and acceptance of himself, including being a person with BD and who does good. This 'I as a Christian' gradually accedes to a third position, incorporating the critical, rational analyst as well, that becomes increasingly 'well informed about BD'. This third position 'I as a well-informed person with BD and a wiser Christian' functions as a counter-position against the strong drive for "transformation and perfection" and a "yearning for the freedom from any form of inhibition in mania", which culminates during periods of (hypo) mania in religious megalomania—"I as savior". According to Peter, faith is based on three things: "trust that love is strong enough to survive crises, trust in the Bible, being supported by a simple text or song, loyalty to one's personal values, which are universal virtues: accepting life conditions, thinking rationally, doing good" (Confession 2015). The emergence of the third position goes hand in hand with Peter's departure from the Latin-American congregation. The pastor does not recognize BD as an illness, and this is one of the reasons for Peter's growing involvement in a small, critical, metropolitan Christian community with highly educated members. His re-evaluation of past experiences and formulation of the quintessence of his faith is influenced by conversations with friends and members of Peter's new community (Confession 2015).

It is interesting that, from the third position as a well-informed person with BD and wiser Christian, Peter evaluates all direct communication with a supernatural reality, as for example, with "an almighty wisdom, that could answer all my questions", but also "religious insights as a lightning strike", and "direct communication with God", or "knowing his will", as a sign of risky faith.

3.2.3. Faith and Religious Experiences in "How Do I Recognize Mania?" (Religious Relapse Prevention Plan, RRPP 2015). 'I as Critical, Rational Analyst': Self-Analysis of Symptoms

In 2015, Peter reanalyzed all past manic and depressive episodes for his relapse prevention plan, as a consequence of conversations with his psychiatric nurse. This person thought that a few sessions about religiosity in relation to Peter's relapse prevention plan would suffice to chart derailment in this domain, but Peter continued to write the document long after the conversations had ended, and his religious relapse prevention plan was not further discussed with his psychiatric nurse, nor with his psychiatrist. The text, named "How do I recognize mania", that rewrites, in a sense, "A better human being" (Booklet 2013), is full of expressions in bold that resemble psychiatric vocabulary and are known as symptoms of mania or depression. 'I as intensely experiencing and enjoying life fully' seems to be absent in the text. The 'I as critical, rational analyst' is predominant, but in this text it is even an I-position as a scrupulous, psychiatrically well-informed investigator, a 'severe judge'. Even the more accepting voices with regard to being vulnerable and imperfect are not heard here. The larger part of the text covers the last five years of his life, from his nascent interest in Christian faith up to the procedure of termination of his job, described as a period of continuously alternating (hypo) manic and depressive episodes, with increasing severity in the last two years, causing him to kneel in public to pray and seeing all kinds of supernatural phenomena.

From the position as 'severe judge', Peter evaluates the many experiences connected to (hypo)mania and initially perceived by him as extraordinary and spiritual are in fact symptoms of the illness. Even the Booklet (2013) was written in a "high energetic condition and purely associative" and therefore influenced by BD, Peter states that now, and in the period before his baptism, he functioned "at high gear". The 'I as severe judge' notices in retrospect Peter's self-deception during mania. At such a time, he argues that faith with its emphasis on humility and obedience will protect him from becoming manic. Even the whole process of writing his "RRPP 2015" is not simply a process of analysis in his view, but of competing with and sometimes tempting voices that intend to document his suffering,

secretly promote his (manic) ideas, or to give meaning to his bipolarity. The 'I as severe judge' has to cut these voices off and to stick to the aim of recognizing symptoms in order to prevent derailment, with a rigorous, self-imposed discipline. This voice of the severe judge is not exactly the same I-position as 'the critical, rational, analyst' I-position in the Booklet. It seems to be more colored by a 'critical and anxious psychiatrist' on the look-out for symptoms of illness and being suspicious of attachment of high value to thoughts that are influenced by mood episodes: "The world is restricted and untruthfully depicted in my head. This alone has to happen and immediately I start to think differently" (ibidem, p. 74).

What is interesting is that, in the second part of the RRPP 2015, Peter analyzes in detail how perception, content of thoughts, feelings and dialogues with others differ when symptoms are absent, in hypomania, in full blown mania, in in-between-phases, and in depression in its different phases. The text shows the fluidity of the self and its inner and external dialogues, all the time evaluating and interpreting each event, thought and emotion in a different way. Every section covers one symptom and ends with a disclaimer that is an instruction for others to help him recognize this symptom. In this second part, the tone is less severe and more accepting. The text seems to be written more from the 'I as well-informed person with BD and wiser Christian' and from a more sociable I-position that reckons with other people who want to help Peter when he is ill.

It would have been better if I were more equanimous, but I recognize myself in the same frame of mind as Maarten Biesheuvel (a Dutch writer with BD) with his worried wife Eva, restraining him. Those two voices struggle in my head, even if I have no symptoms. (RRPP 2015, p. 74)

3.2.4. Bipolar-Religious Spiritual Path (2019). Consolidation of 'I as a Well-Informed Person with BD and Wiser Christian': Acceptance of the Vulnerabilities That Accompany BD

The most recent document discussed here was written four years after the interview. Peter then had more than a year of psychotherapy, which has now been terminated and he only visits his general practitioner for monitoring his BD. The document is a four-page summary of the development of his bipolar-spiritual path, again from his first mania up to the time of writing in 2019.

This document has a more factual tone, perhaps partly because it is a summary of the main events of his life with bipolar disorder. The I-positions that were colored by euphoria or hypomania: 'I as free from any inhibition', 'I as overconfident', or by depression 'I as a wastrel' are absent, but the 'I as severe judge' is also not heard in this text. It is written from a third position that integrates Peter's faith and his medical condition 'I as a person with BD'. From this third position, 'as a well-informed person with BD and a wiser Christian' the spiritual experiences during mania before and after Peter's conversion to the Christian faith are taken as stages on his bipolar-spiritual path. Peter states, for example, that at the time of his first mania his mind became more open and he characterizes the experiences of unity he had then as 'bipolar-religious', without rejecting them as only a sign of BD.

From the same accepting I-position as he writes about his former spiritual experiences, he values his illness, a fact that has manifested itself in his life at certain times. The drawbacks to living with BD, namely "being hypersensitive to stimuli, not trusting his own thoughts, and having to accept disappointments", have formed counter-positions against a too ambitious and inflated I-position and have helped him to lead a more modest, but spiritual life. The document is written from a meta-position of wisdom, as having gained insight during the different stages of his life. Peter now views his "bipolarity" as an instrument on his spiritual path. The 'I as critical, rational analyst' has formed a coalition with religious voices that have developed over time and functions as a promotor position. The third position as a 'well-informed person with BD and wiser Christian' that was already developing during the time of the interview now seems to be more consolidated. In an email with regard to this article, Peter writes that his religious quest "has reached smoother waters", that he once more "can trust his thoughts" and that the "urge for autobiographical writing" has disappeared. His creative I that has done so much writing, probably has to find other ways of expression in the future.

In his commentary on this article Peter adds that his bipolar-spiritual path not only implies new views, but also another lifestyle: less travelling, no television, smartphone or social media, a great deal of reading of wisdom literature and less expressing of opinions, more praying, walking and relaxing. He considers this way of life as an integration of his ideal to become a better human being: a simpler and more attentive lifestyle with less stress and more listening to God, would save the world.

3.3. Summary of the Case

In this case study, we have described how the dialogues between different voices—in the sense of DST—developed in the landscape of a mind of a person with bipolar disorder, who tries get a grip on his illness and on religious experiences related to it. It became clear that religious voices in the initial phase of BD were often colored by euphoria or (hypo) mania. Only during full blown mania did Peter literally experience religious voices as ‘an almighty wisdom’ or ‘God’, he could communicate with. I-positions as ‘I as savior’, or ‘I as enlightened’ were clearly present during manic episodes, but a longing for the feeling of freedom and inhibition, that accompanied these I-positions, was present somewhere in the background at other times as well. During depression and when stable, the ‘I as atheist’ came to the fore in Peter’s younger years. The ‘I as ambitious’ position, emerging strongly several times in Peter’s career, was inspired by leftist ideals of changing the world, and formed a synergy with his striving to be “a better human being”. This was fueled by sessions of intense personality training that fostered self-development and spiritual growth. This synergy was still present at the time of Peter’s conversion to Christianity. In a chaotic period of four or five years of alternating euphoria, (hypo)mania and depression (2010–2015, including the interview), in which Peter was baptized and his working life came to an end, Peter wrote several documents about his life with bipolar disorder, from different meta-positions: ‘I as creative writer’ and ‘I as a severe judge’. Gradually, a third position developed that constructively integrated religious voices and medically informed voices: ‘I as a well-informed person with BD and a wiser Christian’. This third position emerged already in the evaluative commentaries in the Booklet, but only gradually developed fully after Peter had finished his RRPP, after he had been in therapy and wrote the text *Bipolar-Religious Spiritual Path*.

4. Discussion

4.1. DST: A Worthwhile Addition to Kleinman’s Theory of Explanatory Models in the Analysis of Religious Experiences in the Context of Bipolar Disorder

DST proved to be a helpful instrument in gaining more insight into the religious and medically informed voices of a person who has religious or spiritual experiences and is diagnosed with BD. The ‘both religious and pathological’ explanatory model for religious experiences of people with BD, that came to the fore in former qualitative and quantitative research (Larsen 2004; Ouweland et al. 2019b, 2020), appeared to consist, in this case, of a rich and changing variety of I-positions. DST analysis showed the nuanced relations and coalitions between I-positions, the influence of mood elation on I-positions and the transitions in Peter’s position repertoire, owing to a continuous religious reflective process. For Peter himself, this reflective process was a matter of finding truth. For the researchers with a more distanced view appropriate to their role—and it is good to bear in mind that they were not Peter’s hospital chaplains or therapists who shared with him a common goal as the reason for contact—analysis revealed the strong influence of the illness on interpretation on the one hand, and, on the other hand, the healing potential of internal and external dialogue in Peter’s case. On the basis of the analysis of Peter’s reflective self-narratives, our conclusion is that both the structured internal dialogue of reflective writing and Peter’s willingness to conduct a dialogue with others (mental health professionals, relatives, friends, church members and leaders) contributed to the development of a third position that integrated the different I-positions (and thus to his recovery process) and their fluctuations over time, through changing mood episodes, personality and contacts

with other people. In this sense, DST is a contribution from the field of social psychology that gives a more detailed psychological interpretation of the concept of Arthur Kleinman's explanatory models (1988, 1991). Thus, the social-psychological DST has given a more detailed psychological insight than Arthur Kleinman's anthropological theory of explanatory models.

4.2. *Peter's Religious Development: Individualized Spirituality and Traditional Religion*

The intense experience of unity Peter had had during his first mania has been evaluated by him from different I-positions over the years, but has never been accepted as unambiguously spiritual. The prevalence of experiences of unity in people with BD is twice as high as in the general Dutch population and such experiences are significantly related to Bipolar I disorder and mania (Ouwehand et al. 2019a). This makes it difficult for people with BD to interpret such experiences.

Hermans considers receptivity and openness to transcendental experiences, such as Peter has described during his first mania, as characteristic for modern individualized spirituality and crucial for the development of self-consciousness and open communication within the self (Hermans and Hermans-Konopka 2010). He clearly prefers individualized spirituality over traditional religion, which he equates with hierarchy, obedience, and lack of autonomy and mutual dialogue (ibidem 2010). For Peter, however, involvement in a traditional faith tradition—a Latin American Baptist Church and later a small, mainstream protestant congregation—was more helpful. The Latin American congregation was the place where Peter, who had no religious background, put his first steps on a Christian spiritual path and was baptized. Here, he learned to pray and read the Bible and was part of a warm community. At the same time, his symptoms of BD were not recognized in the congregation or by his pastor. The pastor's dismissive attitude towards mental health care made Peter decide to go to another congregation where a more 'rational' belief, as Peter called it, was advocated, with less emphasis on religious experience and more on conducting an ethical life. In the second congregation, a medical explanatory model for illness experiences was more accepted and at the same time religious experience as such was relativized. This attitude and the focus on an ethical lifestyle, Peter states, structured his daily life. Both, from the author's viewpoint, contributed to the integration of his 'rational I' and 'I as a Christian' into a third position.

The case showed a more nuanced perspective on the various functions that religious voices in alternating coalitions with other I-positions can play, than suggested by Hermans when he opposes individualized spirituality and traditional religion. It can be hypothesized that a religious context where scientific knowledge is accepted and religious experience is relativized in favor of other religious dimensions, irrespective of a specific religious or spiritual orientation (whether traditional faith or new spirituality), can contribute to the recovery process of persons with BD. This perspective is much in line with Buitelaar and Zock (2013) analysis of the multi-layered and diverse functions of religious voices from a religious-studies perspective, that contrasts Herman's either traditional or individualized perspective.

For persons with an orientation in new spirituality with its emphasis on spiritual experiences, other challenges than for Peter may be present. New spirituality is characterized by a network character (Heelas et al. 2005; Possamai 2005). Unlike in Peter's case, a long-lasting commitment to a spiritual group, or the possibility of continuous counseling by a religious leader is often absent. Yet, a new spirituality orientation may be attractive for persons with BD who have had religious experiences (Ouwehand 2020), while a critical sounding board can be lacking. In those cases, mental health care professionals can be important for patients by acknowledging the spiritual value of their experiences and stimulating critical dialogue about the meaning and consequences of those experiences.

4.3. *Dialogical Self Theory and Psychopathology*

In this section, we will give some attention to the strengths and limitations of the use of DST in the context of severe psychopathology such as BD. Is the concept of multi-voicedness adequate to describe what happens in mania, psychosis or depression? In the presented case study, the intertwinement

between symptoms of BD and different I-positions and the influence of mood swings on I-positions and coalitions between I-positions was clearly visible, both for Peter and for the researchers. In his Religious Relapse Prevention Plan (2015), Peter demonstrates that he, when he is stable, can evaluate different phases of his illness, can analyze how faith manifests itself in those phases, and what is desirable to do or to avoid during different phases. He also indicates how others can help him recognizing symptoms by questioning solid beliefs, which in DST terms, corresponds with enhancing dialogue between the various I-positions. In full blown mania or depression, a meta-position is not available, and communication with others is much more complicated or impossible, because then a person is immersed in this mental state. Reflection in discursive language is very limited or impossible (Cook 2016). This is the reason that the recognition of illness symptoms when a person can still take a meta-position, is important in psycho-education and a prerequisite for any form of psychotherapy.

The question arises as to how symptoms of psychiatric illness are related to the organization of self in DST. The concepts of ‘voices’, ‘multiple self’ and ‘multi-voicedness’ in DST are considered metaphors for the overall organizing process of the self as the integrating agent in the interaction between different aspects of the self or I-positions (Elliott and Greenberg 1997; Hermans 1997). DST’s use of these concepts is broad and symbolical, and does not take multi-voicedness as dysfunctional and restricted to psychopathology, equating it with concepts such as hallucination or dissociation, as is customary in the psychiatric discipline (Benjamin 1997; Fonagy 1997)³. In our opinion, a strength of the concept of multi-voicedness in DST, precisely when psychopathology is at stake, is that it is an appropriate phenomenological expression of the self-experience of persons with a BD. The fluidity and continuous change in the perception of the self is experienced much more intensely by people with this diagnosis than by undiagnosed persons.

To our knowledge, Hermans does not address BD in his work. Hermans and Hermans-Jansen (1999) discuss psychopathology in general in their explanation of DST. They stress the historical development and cultural aspects of diagnostic categories, as does Kleinman in his work, and point to the danger of a patient’s own identification with illness categories. In DST, beside genetic predisposition and social background, self-organization or self-determination is presumed to be an important factor for change in life, and is connected with values that individuals adhere to. This view is well aligned with principles of self-direction and empowerment in the recovery movement in mental health care (Leamy et al. 2011).

Clinical psychologist Paul Lysaker builds on DST in his work with persons diagnosed with schizophrenia. In his theoretical work, together with philosopher John Lysaker, he focusses on the first-person experience of the loss of a coherent sense of self and lack of agency in the life of persons with severe psychoses (2001). On the basis of clinical work and qualitative studies, Lysaker and colleagues describe the altered sense of self of persons with schizophrenia as a function of diminished dialogues with others and between I-positions (Lysaker et al. 2019). They propose three forms of disturbed dialogue, the ‘barren mode’ when dialogue falters, the ‘monological mode’, when one I-positions dominates most experience, and the cacophonous mode, when dialogue ceases, because there is no reference between the different I-positions any more (Lysaker et al. 2019, p. 188). These three modes each have their influence on the patient’s experience of agency and of contact with others. Psychotherapy, in this line of thinking, can be a means of “entering into a dialogue with patients in order to promote the restoration of dialogue” (ibidem p. 190). Lysaker’s and Hermans’ case study (2007) of a severely ill person with schizophrenia who received four years of therapy to reignite dialogue is an illustration of this approach and shows its utility within a recovery approach.

For persons with BD, the disturbances in dialoguing capacity would probably differ from those in schizophrenia. A thorough description of this illness from a DST perspective would require careful case

³ In an interesting digital discussion about healthy and unhealthy multi-voicedness in Journal of Psychotherapy Integration (Stiles et al. 1997), Elliott, Greenberg, Hermans, Benjamin and Fonagy discuss these theoretically diverging assumptions.

studies and a more theoretical reflection than this article can provide. It also should go more deeply into the nature of depression from a DST perspective, because for most patients with BD, depression is present more prominently than (hypo) mania. In Peter's case, depression diminished along his spiritual path, but qualitative research shows that people can lose any interest in religiosity during depression, seriously doubt the meaning of their former experiences, or keep a distance from any form of religiosity (Mitchell and Romans 2003; Ouwehand et al. 2019b, 2020). What does it mean for people when God's voice is not heard anymore, or when a person feels so enclosed, that no communication is possible anymore?

Moreover, with regard to psychopathology, the cases described by Lysaker seem to be more severe. The initial research of which Peter was part contained persons with BD who were relatively highly educated and who were very well capable of a reflective dialogue about the meaning of their experiences. For this group, DST as a perspective can be used in clinical practice in psychotherapeutic or chaplaincy counseling when patients are stable; then, retrospective exploration of different I-positions and their interaction during (hypo) mania, depression and in the euthymic state can be carried out. This would, just as in the case study of Lysaker and Hermans (2007), be compatible with a recovery approach which takes the patient's self-experience and narrative seriously. Such an approach with regard to religious experiences is largely unexplored territory, and therefore must still be developed, preferably in a multi-disciplinary setting, where both psychopathology and subjective meaning-making is taken seriously. Both Peter's case and a broader study into religious experiences and BD (Ouwehand 2020) make clear that mental health care can connect with a meaning-making process in patients that is taking place anyway, to support recovery, and—where hospital chaplains are concerned—to stimulate spiritual growth.

4.4. Clinical Implications

However, Peter's case contains several points that could be useful for clinical practice, for persons who have had religious experiences and want to reflect on them. First, to write a religious or spiritual relapse prevention plan after a person has followed some form of psychoeducation can be a good starting point for conversation with both mental health professionals and relatives. At least basic knowledge about the illness is necessary before reflection on religious experiences can take place in a clinical context. For Peter, possibly owing to his academic background and the work he did, analysis and reflection is habitual, and this can't be expected of all patients with BD. A shorter version of a religious relapse prevention plan might be helpful as well. DST as a model to look at the different voices within the person can help to clarify which voices are dominant in illness episodes and which when a person is stable; and in this way, reflection can be stimulated. Hospital chaplaincy could assist in the writing process of such a plan; and probably, the process of reflecting and writing is just as important as the final result.

It must be kept in mind that reflection on religious experiences and their possible pathological aspects is not appropriate at any time. Patients in an acute episode often lack enough cognitive clarity for consistent meaning making (Cook 2016) and have a limited capacity for open dialogue. For this reason, in research into the meaning making of psychotic experiences, patients in acute episodes are excluded, and this is also applicable to clinical interventions with regard to the meaning making of experiences related to illness episodes. Stable patients ask both for recognition of the spiritual value of their experiences as for a critical sounding board to evaluate them in mental health (Ouwehand et al. 2019b).

Second, external dialogues about the meaning of religious experiences in the context of BD can be stressful when different people have opposing opinions, especially in the case of conflicting views between mental health professionals and religious leaders (Mitchell and Romans 2003; Stroppa and Moreira-Almeida 2013). In Peter's case, the lack of any contact between his psychiatrist or case manager and his minister places the responsibility of integrating these different voices predominantly on the patient. Peter's psychiatrist had a positive attitude towards his conversion, but the explanation of

symptoms of BD in religious terms by his first minister finally led to Peter's transition to another church. An overt exchange of views between medical professionals and religious leaders could help patients in the reflection process on the meaning of the religious experiences and BD in general.

Third, from DST as a theory, it follows almost naturally that creating opportunities for reflection with peers can be helpful in developing meta-positions and a richer position repertoire. When Peter received the articles with the results of the initial research, after the interview, he was astonished that so many persons were struggling with the same issue, because he thought he was the only one. This is a rather sad conclusion after more than 20 years of receiving mental health care, including psychotherapy. A qualitative study into the meaning making process of religious experiences in BD showed that patients with a longer BD history were often better able to relativize their religious experiences. Their quest for meaning had become less intense and the experiential aspect of their spirituality had become more balanced with other aspects of life (Ouwehand et al. 2019a). This implies that more 'experienced' patients in groups on the subject can be helpful. Of course, exchange in groups does not fit every patient, but it could be offered as an opportunity for religious psychoeducation.

5. Limitations of the Study

One strength of this study is that it gives a detailed description of the process of how an individual with BD can interpret the religious experiences related to his illness. Such a description is new in the literature on BD and religion. As it concerns a case study, conclusions cannot be generalized. The case is uncommon in the sense that the person described had no religious background, converted to the Christian faith and was baptized in a period he retrospectively defined as hypomanic. Usually, religious experiences occur more often in persons who already have a religious view on life or come from a religious background (Ouwehand et al. 2019a). However, the struggle to interpret religious experiences of this person is comparable to other cases.

The material for the analysis for this case consisted of written self-reports and an interview. For the document written after the interview, no check with a psychiatrist was done to evaluate self-assertions about the person's condition. However, a check was done with the person himself on the decision—after a period of psychotherapy—to convey medical care to his general practitioner instead of to a mental health care institute. The decision was taken in cooperation with the psychotherapist who had overseen the medical transfer.

DST was used as a framework for analysis, but was not the framework that the person himself used for his systematic self-reflection. The authors did not compare DST to other possible psychological approaches for analysis. Although such a comparison might indeed be interesting, they are convinced that the DST view on the self resembles the self-experiences of persons with severe mental disorder, and therefore has the potential for the theoretical exploration of mania and psychosis. Intended as a broad framework for several forms of therapy (Konopka et al. 2019), it can be used by both hospital chaplains and other professionals in the exploration of different voices in clinical practice, as well as in interdisciplinary discourse on the meaning of religious experiences within a psychiatric context.

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Appendix A

Important DST concepts (Konopka et al. 2019; Zock 2013):

Self:	landscape of mind inhabited by a multiplicity of I-positions that are in a continuous process of dialogue and change. Community or society of I-positions. The self is in principle dialogical in character and functions in a way similar to society.
I-position:	distinguishable parts or aspects of the self with relative autonomy, that can be convergent, divergent or contradictory.
Coalition of I-positions:	I-positions that reinforce one another.
Meta-position:	a reflective I-position from which other I-positions are seen in their mutual relationships and evaluated.
Third position:	I-position that can encompass or integrate conflicting I-positions. I-position that facilitates innovation and development of the self, it functions as a compass to find direction in processes of change. A promotor can be external: a person who helps to embrace a variety of sides of the person (for example a therapist), or internal: those aspects of the self that enhance integration of different voices within the self.
Promotor position:	
Positioning/counter-positioning:	placing oneself in relation or in opposition to others or to other aspects of oneself.
Internal positions:	aspects of one's self, they can be personal (for example 'I as a meaning seeker') and social ('I as a Christian', 'I as a church member').
External positions:	voices of others in the self; they can be individual or collective (for example professionals, church members), and they can be actual (for example a therapist or parents) or imaginary (for example a deceased person).
Position repertoire:	the bandwidth of I-positions in a person. This bandwidth depends on the contexts the person is in, it can be broader or narrower.

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