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Mental Disorder, Meaning-making, and Religious Engagement

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Abstract: Meaning-making plays a central role in how we deal with experiences of suffering, including those due to mental disorder. And for many, religious beliefs, experiences, and practices (hereafter, religious engagement) play a central role in informing this meaning-making. However, a crucial facet of the relationship between experiences of mental disorder and religious engagement remains underexplored—namely the potentially *positive effects* of mental disorder on religious engagement (e.g. experiences of bipolar disorder increasing sense of God's presence). In what follows, I will present empirical findings from two recent studies of mine which shed light on the extent to which participants experienced these positive effects, specific components of these effects, and how they fit into their understanding of their mental disorder and its relationship to their religious identity. In doing so, I will draw on and expand Tasia Scrutton's *Potentially Transformative* view (2015a, 2015b, 2020) according to which mental disorders may provide opportunities for spiritual growth. My empirical results align with and help deepen an account according to which mental disorders are potentially spiritually transformative by providing further insight into such instances: specifically, which symptoms and internal and external factors are often involved, as well as which religious beliefs, experiences, and/or practices are often affected. After presenting these results and articulating their relevance for a potentially transformative view of mental disorder, I will then address some potential objections to the theoretical account as well as some limitations of the empirical work, before sketching possible promising directions for future research.

Keywords: Depression, Anxiety, Benefit-finding, Christianity, God

1. Introduction[1]

Despite the prevalence of mental disorder among those who are religious and relatedly, the importance of religious beliefs and practices in making sense of and coping with experiences of mental disorder, multiple facets of the relationship between mental disorder and religion remain underexplored. I will focus on one such facet of the relationship between 'religious engagement'—by which I mean religious beliefs, experiences, and practices—and experiences of mental disorder. By 'mental disorder' I mean a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or development processes underlying mental functioning—and which is often associated with significant distress or disability (adapted from the DSM-V).[2] Previous work has focused almost exclusively on the effects of religious engagement on mental disorder - both negative and positive (e.g. religious beliefs exacerbating symptoms of mental disorder like guilt or anxiety, regular worship service attendance decreasing the incidence of suicidal ideation) (Borras et al., 2007; Fallot, 2007; Cruz et al., 2010; Bonelli & Koenig, 2013; Khalaf et

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[2] The full definition from the DSM-V: "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or development processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above." The NIMH definition includes similar features but distinguishes between severe mental disorders and mental disorders that include also milder versions. "Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below). Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI."

al., 2015).[3] And the majority of research addressing the impact of mental disorder on religious engagement has focused on the *negative effects* (e.g. posttraumatic stress disorder after traumatic experiences leading to a decrease in belief in God) (Fontana & Rosenheck, 2004; ter Kuile & Ehring, 2014). This thus leaves the potential *positive effects* of mental disorder on religious engagement (e.g. experiences of bipolar disorder increasing a sense of God's presence) relatively underexplored, both empirically and theoretically.[4]

This lacuna is worth addressing for many reasons, perhaps most notably, the fact that meaning-making—roughly, focusing attention on positive effects potentially resulting from experiences of suffering—plays a crucial role in making sense of and dealing with suffering, including suffering resulting from experiences of mental disorder (Baumeister, 1991; Helgeson et al., 2006; Park 2010; Huguelet, 2017). Thus, in what follows, I will focus on empirically investigating the positive effects on one's religious and/or spiritual life that may result from experiences of mental disorder, and providing a conceptual framework for making sense of these positive effects. In doing so, I will specifically focus on religious engagement in Christianity—thus future mentions of 'theology' should be understood to refer to 'Christian theology' and mentions of 'religion' and 'spirituality' should be understood to refer to 'the Christian religion' and 'spirituality within Christianity', respectively.

Tasia Scrutton presents account according to which we ought to understand depression as potentially (spiritually) transformative, in that it may "become the occasion for the person's spiritual growth" (2015b, 275). I will draw on and expand this account to one according to which we ought to understand mental disorders more generally as potentially spiritually transformative, and will present results from two recent empirical studies in which I investigated whether and in what ways our participants experienced their mental disorders in this way. Thus, in what follows, I will first sketch a view according to which mental disorders are potentially spiritually transformative—drawing on research on the role of meaning-making processes in experiences of mental disorder. Then I will present findings from two

[3] See Fallot (2007) and Bonelli & Koenig (2013) for meta-analyses on both the negative and positive impacts of religious engagement on coping with mental disorder. While religious engagement seems to most often be associated with improved mental health, some studies highlight its association with mixed or decreased mental health for those with bipolar disorder (Cruz et al., 2010) and schizophrenia (Borras et al., 2007) and anxiety-related disorders (Khalaf et al., 2015).

[4] Note that here I am referring to any positive effects specifically of *experiences of mental disorder* themselves, and not positive effects of adopting strategies of religious coping for mental disorder. For example, 'the positive effects of one's experiences of depression on one's belief in God' would be a part of this category while 'the positive effects resulting from one's experiences of depression prompting one to pray more' would not be.

recent empirical studies I conducted on participants' experiences of their mental disorder and its effect on their religious engagement and then will articulate the connections between these findings and a Potentially Spiritually Transformative account. Afterwards, I will address some limitations of and possible objections to this account and sketch relevant directions for future research.

2. Potentially Spiritually Transformative Account

According to Scrutton's *Potentially Transformative* (hereafter, PT) account, experiences of depression are potential "opportunities for spiritual growth"—as mentioned above, I will take this account as one which can be fruitfully applied to mental disorders more generally.[5] She distinguishes it from two other kinds of accounts frequently found in Christian communities. The first are *Spiritual Illness* (hereafter, SI) accounts according to which mental disorders are things that are caused or at least allowed by God as a result of one's sin, shortcomings, or evil supernatural forces. The second are *Spiritual Gift* (hereafter, SG) accounts according to which mental disorders are a kind of gift, reward or "indication of (and means of furthering) holiness or closeness to God." (Scrutton 2015b, 275). These views (most commonly, an SI view) often play a crucial role in shaping understanding of, and guiding responses to, mental disorder in Christian individuals and communities; however, they also often remain unarticulated or unaddressed in any thorough, nuanced way—a situation which lends itself to oversimplifications of these views in ways that are misleading and/or harmful to those who experience mental disorder.

These oversimplified versions of SI and SG views which are often operative in Christian communities tend to 'over-spiritualize' mental disorder—in other words, view it as having a solely spiritual etiology (e.g. divine punishment or divine blessing) and correspondingly a solely spiritual treatment (e.g. prayer and repentance on an SI view or lack of a need for treatment altogether on an SG view). Additionally, in virtue of its etiology, these views often tend to see a mental disorder (or what might be mistakenly diagnosed as a mental disorder, according to such accounts) as either inherently bad (SI view) or inherently good (SG view). Thus, SI views may lead to blaming and stigmatizing individuals with mental disorder.[6] In

[5] Note that Scrutton herself acknowledges this as a possibility, but does not explore it in detail.

[6] Pickard and others have compellingly argued against close connections between responsibility and blame—especially in engagement with and treatment of mental disorder—proposing a 'responsibility without blame' framework (Pickard 2011; Pickard & Ward, 2013). They explain that attributions of responsibility for one's mental disorder or symptoms ought not, without further argument, lead to attributions of blame. Relatedly, the most sophisticated versions of SI and SG views may not justify attributions of blame in addition to attributions of responsibility for one's mental

contrast, SG views may lead to an elevated spiritual status for individuals with mental disorder, as well as a focus on further cultivating or at least avoiding treatment for the disorder—additionally, it may also lead to a sense of shame in individuals who do not experience their mental disorder as a 'spiritual gift'. Relatedly, these over-spiritualizing views then often result in denial or diminishment of the role of non-spiritual (i.e. biological, psychological, social, and environmental) factors and their role in the etiology and treatment of mental disorder.

Because of all of this, both views often fail to capture or accurately reflect many peoples' experiences of mental disorder and are experienced as misleading, at best, and extremely harmful, at worst (Stanford, 2007; Lloyd & Waller, 2020). As mentioned above, Scrutton presents a PT view as an alternative to SI and SG views; however, I think it is best understood as a different kind of theory of mental disorder. SI, SG as well as non-spiritual accounts of mental disorder such as Biomedical and Biopsychosocial theories are all theories which address *the nature* of a mental disorder—in other words, the kind of thing that a mental disorder is, which the etiology of the disorder speaks to. SI and SG theories see a mental disorder as a fundamentally spiritual thing (the former, a 'bad' spiritual thing and the latter, a 'good' spiritual thing), with spiritual causes which thus ought to be treated spiritually. In contrast, Biomedical and Biopsychosocial theories see a mental disorder as a fundamentally non-spiritual thing (specifically a 'bad' non-spiritual thing), with non-spiritual causes (e.g. genetics, upbringing, etc.) which thus ought to be treated non-spiritually (e.g. medication, therapy, etc.).

In contrast to this, a PT view addresses *the meaning* of a mental disorder—in other words, what it means for the life, identity, religious engagement, etc. of the person who experiences the mental disorder. Insofar as it does not posit a specific etiology of mental disorder, it need not underweight the importance of either spiritual or non-spiritual dimensions of the mental disorder. And relatedly, it need not view mental disorders as inherently positive or negative, rather focusing on them as *potential* sources of meaning.[7] Rather than an alternative to SI, SG, Biomedical, and Biopsychosocial views of mental disorder, one may adopt any of these views—or

disorder. However, as my focus is on SI and SG views as they are often *communicated or perceived* in Christian community, I will often refer to attributions or perceptions of 'responsibility', 'blame', and 'fault' for mental disorder together, as this accurately reflects how the views are often expressed in lay Christian contexts.

[7] Note that Scrutton also in some places claims that a PT view of mental disorder (or depression) is one according to which the mental disorder is "inherently bad and undesirable". (Scrutton 2015, 275). Thus, this is another way in which my take on a PT view of mental disorder differs from hers.

even a 'mixed view' according to which there are both spiritual and non-spiritual dimensions of one's mental disorder—while also holding that it may be potentially transformative, or even less expansively, that one may be able to engage in meaning-making about it. However, it is worth noting that some views—such as SI views, especially those oversimplified versions often present in Christian communities, may make meaning-making more psychologically difficult (see Finley, 2022a, 2022b).

Meaning-making refers to positively 'reframing' or 'reinterpreting' a negative experience and/or shifting focus to previously unappreciated positive dimensions or effects of it and is increasingly understood to play a crucial role in how people experience and deal with many kinds of suffering (Baumeister, 1991; Helgeson et al., 2006; Park 2010).[8] We can understand meaning-making processes as those involved in drawing out both specific, concrete effects (say on one's relationships or career) as well as those that are more general and theoretical (say on one's values or worldview). For example, if one sustains a serious physical injury, meaning-making processes might be involved in one's reflections on both the fact that the injury and recovery helped them get closer to their family and that it helped them more fully appreciate their human limitations.

It is helpful to think about the process of meaning-making as falling in between on the one hand pure fabrication and on the other, pure discovery of the 'meaning' of an experience. For example, take the negative experience of painful chemotherapy treatments for cancer. One might cite the fact that one has gone into remission as a positive effect of this experience; however, this is often not what is meant by 'benefit-finding' or 'meaning-making' because it is an obvious and indeed the intended positive effect of the treatment—instead, this is an example of 'pure discovery'. On the other hand, one might claim that this treatment has increased one's cognitive abilities as another positive effect; however, this would be an instance of 'pure fabrication' rather than legitimate benefit-finding or meaning-making. Meaning-making and instead involves a kind of 'sifting through' one's experience for previously unnoticed positive effects or a 'shaping' and reframing of one's

[8] 'Benefit-finding' and 'Posttraumatic growth' are two related concepts which are sometimes conflated with meaning-making (Calhoun & Tedeschi, 2014; Proffitt et al., 2007). 'Benefit-finding' and 'posttraumatic growth' often more exclusively focus on purely positive or beneficial effects drawn from negative experiences, while meaning-making can also encompass meaning drawn from such experiences that is more ambiguous in valence. For my purposes, it is not important to distinguish between them - thus for simplicity, in what follows, I will simply refer to 'meaning-making'.

interpretation of events with a focus on the positive elements or dimensions.[9] And while these meaning-making processes may sometimes occur intentionally (i.e. one actively tries to distill meaning from an experience) it may also happen unintentionally or unconsciously (i.e. even when one is not actively looking for meaning in an experience, meaning may nevertheless 'present itself') (Heintzelman, 2013; Flaskas, 2018).

Meaning-making processes are increasingly understood to play a crucial role in how people experience and deal with many kinds of suffering, including suffering as a result of mental disorder (Proffitt et al., 2006; Park, 2010). For many, these processes are deeply informed by their religious beliefs, practices, and communities—and this kind of 'religious meaning-making' is at the heart of a PT approach to mental disorder. We might understand specifically religious meaning-making processes as those in which one collaborates or works with God (through prayer, reading Scripture, etc.) and/or one's religious community to craft this meaning out of one's experience.[10] Work on the role of 'religious coping' in the midst of suffering (Ano & Vasconcelles, 2006; Pargament et al., 2013) as well as the importance of specifically religious or spiritual meaning-making in experiences of mental disorder (Huguelet et al., 2016; Huguelet, 2017) has investigated the importance of such processes. However, the specific components of religious meaning-making which I will focus on—the role of specific symptoms, external factors, and effects on religious engagement—remain largely unaddressed. Although I have so far only sketched the contours of a PT, meaning-making focused approach to mental disorder, it provides a helpful framework for the following sections. I will now present results from two empirical studies of mine which address: (1) participants' overall experiences of positive and potentially transformative effects of their mental disorder on their religious engagement; (2) the specific character of these effects—including symptoms often involved and facets of religious engagement often impacted; as well as (3) internal and external factors correlated with these effects.

[9] We might think of meaning-making as akin to digging on a beach for 'buried treasure' as opposed to on the one hand, seeing the treasure just sitting on top of the sand ('pure discovery') or crafting an object meant to look like treasure out of the sand ('pure fabrication').

[10] For more on the role of narrative in philosophy of religion and theology see (Finley & Seachris, 2021).

3. Study I

Methods

We recruited participants for this study largely through the National Alliance for Mental Illness (NAMI) as well as through local churches and Christian organizations. After providing informed consent, participants answered questions to ensure they met our participation criteria of having had experience with both mental disorder and 'the Christian religion or faith'—this included current and/or past experience.[11] If they fulfilled these criteria, they then provided demographic information as well as further details about their experience with Christianity (their denominational background and whether they currently identified as Christian) and mental disorder (diagnoses they had received from a medical or psychiatric professional). Of our initial 157 participants, 150 were included in our analyses—7 did not fulfill the criteria mentioned above and thus were directed to the end of the questionnaire. Of these 150 participants, 38% identified as Non-denominational Christian, 29% as Protestant, 16% as Catholic, 8% as non-Christian, and 9% as 'other'. Additionally, participants reported the following mental disorders: 66% major depressive disorder, 49% anxiety disorders (including generalized anxiety disorder, social anxiety disorder), 15% posttraumatic stress disorder, 13% bipolar disorder, 5% eating disorders (including anorexia, bulimia), 4% dissociative identity disorder, 4% obsessive compulsive disorder, 3% borderline personality disorder, 2% substance abuse disorders, and 1.5% schizophrenia.[12]

[11] The procedures of the current study were approved by the Human Subjects Review Board at Hope College. Prior to engaging with the study, all participants provided informed consent and were free to withdraw it at any time. Given the sensitive nature of the subject material, participants were also free to skip questions or select the response 'prefer not to disclose' on all questions, and information on mental health resources was provided to participants upon completion of the study. Additionally, as required by our HSRB, we changed all mentions of 'mental disorder' to 'mental health symptoms' to minimize potential negative effects on participants; however, we made clear to participants throughout the study that we were asking about their experiences of things like major depressive disorder, bipolar disorder, etc. as opposed to their experiences of things that might referred to, loosely, as 'depression' or 'anxiety' but would not fulfill diagnostic criteria for serious mental disorder. We also used the phrase 'religious and or/spiritual life' rather than 'faith' to include many different components of religious engagement and to make questions more inclusive to participants who did not identify as religious (but who still had had significant experience with Christianity); and we used it rather than 'religious engagement' for comprehensibility.

[12] The religious categories were mutually exclusive while the mental disorder categories were not. Additionally, our participants were (14% men, 82% women, 2% non-binary, 2% prefer not disclose); (5% American Indian or Alaskan Native, 6% Black or African-American, 5% Hispanic, Latino, or

We then asked participants to select from a comprehensive list of symptoms those which they thought had 'impacted their religious and/or spiritual life in a positive way' (see Appendix A).[13] For each symptom they selected from this list, they were then asked to 'please describe the positive impacts of' that symptom on their 'religious and/or spiritual life' (e.g. 'please describe the positive impact of *large mood swings* on your religious and/or spiritual life') in a free-response box. After this block of questions, participants were then asked to select from a list of resources (e.g. prayer, professional therapy, Christian friends or community) any of which they thought were helpful in their symptoms having the aforementioned positive impact (see Appendix A). They were then asked to do the same for those they thought were unhelpful and/or may have prevented their symptoms from having this positive impact. After this, participants were given a free-response box to respond to the question: do you believe or hope that any of your experiences of these mental health symptoms could impact your religious and/or spiritual life in a positive way in the future? And finally, participants were asked to characterize the overall impact of their mental health symptoms on their religious and/or spiritual life by selecting one of the following options: mostly positive, somewhat positive, equally positive and negative, neutral, somewhat negative, mostly negative (see Appendix A). For those who participated in a voluntary semi-structured interview (approximately 20-60 mins.), their answers on this questionnaire informed the questions drawn from a standardized framework which provided them with mainly open-ended prompts to expound on their initial questionnaire responses (see Appendix B).[14]

Spanish, 82% White, <1% Asian, Native Hawaiian or other Pacific Islander); (9% 18-24, 20% 25-34, 23.5% 35-44, 16.5% 45-54, 23% 55-64, 8% 65+).

[13] The list of symptoms was taken from RDoC (Insel 2010) - which is a framework focusing on the individual symptoms present in mental disorder and their underlying biological mechanisms (often shared across many mental disorders) rather than the mental disorder themselves. We asked participants about their symptoms (e.g. mania), rather than their disorder (e.g. bipolar disorder), because of the larger shift towards symptom-focused approaches in research on mental disorder (reflected in RDoC) and because it enabled us to get a finer-grained understanding of how participants' mental disorder affected them, as well as a more generalizable understanding because the symptoms mentioned are common to multiple different mental disorders (e.g. mood swings are common in multiple mental disorders).

[14] Although we asked about both positive and negative interactions between participants' mental disorder and religious engagement, I will here focus on positive interactions - and as I mentioned, specifically the positive effects *of* mental disorder *on* religious engagement. Furthermore, although we addressed many components of these interactions, I will only address the following limited set of results in order to do so in more detail.

We used a 'thematic analysis' approach in analyzing all interview transcripts and responses made through free-response boxes (i.e. responses to 'please describe the positive impacts of _____ {large mood swings | depression} on your religious and/or spiritual life', and 'do you believe or hope that any of your experiences of these mental health symptoms could impact your religious and/or spiritual life in a positive way in the future?'). This is a "method of identifying, analysing and reporting patterns (themes) within data" (Braun and Clarke 2006: 79).[15] In doing so, we used a 'hybrid approach of deductive and inductive' processes of analysis (Fereday and Muir-Cochrane, 2006). The 'deductive', essentially 'top-down' process, involved analysis of the text responses on the basis of prior understanding drawn from previous research on the topic which informed an initial set of 'benefits' we thought we were most likely to find (e.g. increased empathy, increased reliance on community). We then recorded our findings of recurrent themes or patterns in the benefits mentioned in participant responses and pared them down to those that (1) were an effect of the symptom cited rather than the effect of treatment of the symptom, (2) were religiously and/or spiritually relevant, and (3) appeared in at least three separate participant responses. We then engaged in the 'inductive', essentially 'bottom-up' process, which involved using findings from the first round of analysis to revise and reformulate the initial framework/categories. We grouped sets of benefits together to come up with a taxonomy of kinds of benefits reflecting the components of religious engagement that they impacted. We settled on categorizing benefits according to whether their effects were mostly behavioral (effecting things participants *did*), affective (effecting things participants *felt*), or epistemological (effecting things participants *believed or thought*). Although these categories are closely related and to some extent overlapping, they helpfully structured our results. We then went back through the questionnaire and interview texts to further pare down our list of benefits to those that occurred most frequently. In our second study, below, we asked participants specifically about the ten most frequently occurring benefits and thus I will present and explain these results from study 1 with the connected results from study 2 in more detail below.

[15] This analysis was carried out by myself and a student research assistant.

Results & Initial Discussion

Overall impact

A first notable finding is that, when asked to 'characterize the overall impact of your mental health symptoms on your religious and/or spiritual life' 25% of our participants selected 'mostly positive' and 19% selected 'somewhat positive'.[16] First, it is important to note that this does not mean that no other participants experienced *any* positive effects of their mental disorder on their religious engagement, merely that, on balance for these other participants, the negative effects on their religious engagement equaled or outweighed any positive effects. Additionally, it is also important to note that this does not mean that these participants experienced their mental disorders as a positive influence *on their life overall* nor that the positive effects on their religious engagement in any way *negated its negative effects*. Many participants made this clear in their questionnaire and interview responses. For example, take the following quotes from two participants,

> . . . it's similar to like, well, if you're in a lot of pain, what can you do to make the pain more positive? Well, it doesn't [sic]. *Prayer and meditation doesn't make the pain positive. It doesn't make the mental pain positive.* It does make it a place where learning can happen…I haven't ever felt like this means that the hard mental health stuff is, is good in itself, but it does become a place where I can learn how to be with God or how to…how to notice God being with me. And in another way, which deepens and enriches my faith… so I guess, you know, I can be grateful for what that has brought to me. But in my opinion, *it doesn't mean that well, it makes it all worth it or anything like that*.[17] (emphasis mine)

> So, *I don't consider my mental health issues to be a positive*. Yeah, I just…I don't. I mean, people say, yeah, that they've built you know, they've created a strength in you that you wouldn't have otherwise had, you know, and maybe that's true. But *that doesn't mean that they're a good thing for me. I still think they're a negative thing.* That's the way that I feel about it. You know, whether I'm interacting with God or people, you know, how I interact with the church. There might be positive byproducts of mental illness, *but that doesn't mean that the mental illness is a positive thing. I don't believe that*. (emphasis mine)

[16] 23% selected 'equally positive and negative', 8.5% 'neutral', 13% 'somewhat negative', 11.5% 'mostly negative'.

[17] Participant quotes have been lightly edited for clarity and removal of any identifying information.

These participants (along with many others) spoke to both the deep suffering their mental disorder had caused them in their life overall, and the positive and often transformative effects it had had on the religious or spiritual facets of their life. The fact that a quarter of participants selected 'mostly positive' speaks to the potential for mental disorder to have positive and transformative effects on religious engagement—that is, on their religious beliefs, experiences, and practices.

Symptoms

When given a list of symptoms, participants most often selected the following as those that had a positive impact on their 'religious and/or spiritual life': feelings of loss and/or hopelessness (67); depression (61); feelings of anxiety (57); increased fears and/or worries (41); and guilt (32).[18] After selecting these symptoms, participants were then asked to provide a short response specifying the nature of the positive effect. One thing to note is that these results do not justify claims about the frequency of the involvement of these symptoms *over other symptoms* in having a positive effect, because these results are likely impacted by the relative frequency of the symptoms themselves. For example, feelings of anxiety are more common than hallucinations, but that doesn't mean that when they occur, the former is more likely to have a positive effect on religious engagement than the latter. Furthermore, we should again keep in mind that participants were not necessarily reporting that these symptoms had had a positive effect *on their life overall*—and indeed, again, their short-answer responses made it clear that many would not endorse this claim. However, these results are notable insofar as they indicate that a good portion of our participants did experience positive effects of their mental disorder on their religious engagement, that they were able to trace these effects to the influence of particular symptoms, and that these are some of the symptoms on which future research on the topic might fruitfully focus.

[18] The list of symptoms was taken from RDoC (Insel 2010) - which is a framework focusing on the individual symptoms present in mental disorder and their underlying biological mechanisms (often shared across many mental disorders) rather than the mental disorder themselves. We asked participants about their symptoms (e.g. mania) rather than their disorder (e.g. bipolar disorder) both because of the larger shift towards symptom-focused approaches in research on mental disorder (reflected in RDoC) and because it enabled us to get a finer-grained understanding of how participants' mental disorder affected them, as well as a more generalizable understanding because the symptoms mentioned are common to multiple different mental disorders (e.g. mood swings are common in multiple mental disorders).

External factors

When given a list of 'external factors' (e.g., professional therapy, medication, religious community, etc.) and asked to select those which 'were helpful in your symptoms having this positive impact', participants most often selected the following: prayer (92); professional therapy (91); religious friends or community (83); reading Scripture (80); books, articles, or other reading (77). Note again that these results don't justify claims about the relative efficacy or impact of these external factors *over other external factors* on the list because, again, frequency of experience likely plays a role. For example, fewer participants may have taken medication than have participated in therapy, but that doesn't yet indicate whether one is more likely to contribute to positive effects than the other. Furthermore, for many participants, it was clear that a mix of factors, including those that were explicitly religious (e.g., prayer) and those that were not (e.g., therapy) were most impactful.

Also striking was the finding that the factor 'Christian views of mental health' was selected *least* often as contributing to positive effects; however, when asked which of these same factors 'may have prevented your symptoms from having this positive impact' it was selected *most* often, by quite a large margin. This finding was also corroborated by the many mentions of 'unhelpful', 'misleading', 'stigmatizing', 'false', and 'unbiblical' 'Christian views on mental health' and their influence in many questionnaire and interview responses. Obviously, what counts as 'Christian views of mental health' will likely differ greatly depending on the individual, community, denominational background, etc. (Stanford, 2007; Lloyd & Waller, 2020). The goal with this question was to gauge the *effects* of these views, or at least these views as they were communicated to participants, while bracketing questions about their specific content.

4. Study II

Methods

Participants were recruited through the National Alliance for Mental Illness (NAMI), Amazon's Mechanical Turk, as well as through local churches and Christian organizations.[19] Similar to the study above, after providing informed

[19] The logistical details of this study are the same as the study above regarding HSRB approval, informed consent, mental health resources, and skipping questions.

consent, participants answered questions to ensure they met our participation criteria of having had experience with both mental disorder 'the Christian religion or faith'—this included current and/or past experience. If they fulfilled these criteria, they then provided demographic information as well as further details about their experience with Christianity (their denominational background and whether they currently identified as Christian) and mental disorder (diagnoses they had received from a medical or psychiatric professional).

Of our initial 105 participants, 42 participants finished the longitudinal study and were thus included in our analyses.[20] Of the 42 participants, 22.5% identified as Non-denominational Christian, 32.5% as Protestant, 30% as Catholic, 5% as non-Christian, and 10% as 'other'. Additionally, participants reported the following mental disorders: 56.5% major depressive disorder, 54% anxiety disorders (including generalized anxiety disorder, social anxiety disorder), 18% posttraumatic stress disorder, 7.5% bipolar disorder, 7.5% personality disorders (including borderline personality disorder, schizotypal personality disorder), 5% premenstrual dysphoric disorder, 2.5% dissociative identity disorder, 2.5% schizotypal personality disorder.[21]

This was a longitudinal study in which participants first filled out an initial questionnaire in which they responded to the questions mentioned above and then answered a set of questions (including free-response, multiple choice, and Likert scale questions) addressing their understanding and experience of their mental disorder, their religious identity, and the relationship between them. After this initial questionnaire, participants read five different 5-page/3,000-3,500-word firsthand narrative accounts of someone else's experiences with mental disorder and religious engagement.[22] After reading each of the narratives, participants responded to a short set of questions designed to test comprehension and prompt engagement (e.g., 'list two symptoms that Lucia mentioned in the narrative'). Then, after the fifth narrative and corresponding questions, participants filled out a final questionnaire in which they answered the same set of questions mentioned above in the initial questionnaire.

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[20] In order to retain participants, most participants were given incentives ($5, $5, $10) in the form of Amazon gift cards for completing the initial questionnaire, final questionnaire, and follow-up interview, respectively. Those who participated through Mechanical Turk were paid an equal amount in incentives spread out over all days of the study because of MTurk payment requirements.

[21] Again, the religious categories were mutually exclusive while the mental disorder categories were not. Additionally, our participants were (34% men, 66% women); (13% Black or African-American, 3% Hispanic, Latino, or Spanish, 8% Asian, 76% White).

[22] They did so over the course of 10 days with at least 24 hours between reading each of the narratives.

On the initial and final questionnaire, we used the following validated measures. The Centrality of Religiosity Scale (CRS) (Huber & Huber, 2012) which included questions like 'Without a connection with God or sense of spirituality, my daily life would feel meaningless' and (reverse scored) 'I wonder whether God has abandoned me' to measure participants' level of 'religious identification' or the degree to which they saw their religious and/or spiritual life as central to their sense of self or self-narrative. Because of the length of this measure (21 questions) and potential participant fatigue, we used a shortened version of this measure on the final questionnaire (7 questions), which was highly correlated with the full measure ($r=.94$, $p<.001$).[23] Similarly, we used an adapted version of the (15 question) Personal Disability Identity Scale (PDIS) (Zapata 2019) in which we substituted mentions of 'mental health symptoms' for 'disability'. Thus, this measure included questions like 'My mental health symptoms give me perspective on what matters in life' and (reverse scored) 'Because of my mental health symptoms, I will never become the person I want to be'. We used this to measure participants' level of identification with their mental disorder or the extent to which they saw their mental disorder as central to their sense of self or self-narrative.[24] Additionally, we also asked participants to categorize a list of things—including the ten most frequently occurring benefits mentioned above (e.g. sense of empathy, reliance on God)—according to whether they felt they had increased, decreased, or been unaffected by their mental disorder (see Appendix C). Finally, some participants participated in a voluntary, follow-up interview in which they were again asked questions based on their questionnaire responses in order to gather further details about these responses (see Appendix D).

Results & Initial Discussion

In the following sections I will only focus on one set of results from this study. Participants were given a list of possible effects of their mental disorder and asked to categorize each effect according to whether it 'overall has increased', 'overall has decreased', has gone through a 'mix of increase & decrease' or whether they were

[23] All correlations were calculated by finding the Pearson correlation coefficient - which is a measure of the correlation between two variables.

[24] Notably, both of these measures measured participants' level of specifically *positive* identification - in other words, how positive they understood their connection with their religion or their mental disorder to be. Thus, someone who, for example, saw their mental disorder as an inescapable, largely negative yet essential part of their identity would likely not have received a high PDIS score.

'unsure/have not experienced' the effect. The list of effects was composed in part by the most frequently cited positive effects on religious engagement in participant responses in Study I above. Below I start with those effect that are more behavioral and then move on to those that are more affective, and then epistemological. For each of the effects, I will note how many participants reported that it increased as a result of their mental disorder, briefly explain the purported effect and provide some paradigmatic quotes from participants in both the first and second studies on questionnaires and in interviews regarding this effect.

Engagement in religious practices

The first behavioral effect of mental disorder—reported by 50% of participants in our second study—was an increased engagement in religious practices including prayer, reading the Bible, repentance, etc.[25] For example, one participant explained that,

> …*my anxiety seems to prompt me to be scrupulous and establish habits of prayer, repentance, etc.* Given that I think that most of us today are prone to go about our lives thinking we are generally good and there is no need for mercy and reparations, I think that being (what feels like) a bit scrupulous lends me to arrive at the virtuous mean. I think today's world pulls me to laziness and thinking I am better than I am and *my anxiety helps me overshoot the mean,* hopefully arriving at some sort of appropriate middle ground. (emphasis mine)

Reflected in this quote is a means by which multiple participants thought their mental disorder played this positive role—namely, their experiences of specific symptoms prompted them to pay more attention to and ultimately address some felt need or perceived shortcoming they had previously overlooked and/or become desensitized to. For example, this participant reported that their experience of amplified anxiety and guilt prompted them to recognize the depth of their need for repentance and reliance on God and thus engage in religious practices that addressed this. In a similar vein, other participants reported that their experience of hopelessness prompted them to turn to Scripture more for comfort, stability, etc. The two effects below—increased reliance on God (often enacted or cultivated through prayer, Scripture reading, etc.) and increased engagement with religious community (often through things like church and Bible study attendance)—also serve as two

[25] 31% reported a 'mix of increase and decrease' and 10% an 'overall decrease'.

additional specific instances of this more general effect of increased engagement in religious practices.

Reliance on God

50% of participants also reported that their experience of mental disorder had overall increased their reliance on God.[26] For some, their mental disorder caused intense suffering which then increased their sense of need (even desperation) for God, which then prompted them to intentionally rely more on God. For example, see the following participant quotes:

> My symptoms have been so chronic, extended, and intractable *I find myself desperate and humbled enough to surrender more readily to intently seeking God*…Since I have such low times and bouts of depression, *I rely on Jesus* and go to him so much more. Because of that I also think *my trust in him has increased* because He has gotten me through some very difficult times. (emphasis mine)

> *Anxiety taught me to trust and depend on God for everything that I could/can not fix on my own. It forced me to TRUST and to literally give all my burdens to God,* the Infinite Wisdom and Omniscient One, instead of wearing my mind out trying to figure it all out in my limited wisdom, knowledge, and understanding of whatever was happening in my life. (emphasis mine)

In these quotes we see, similar to what was mentioned in the section above, that for some participants, their mental disorder drew their attention to and likely amplified their felt need for God. For many, the intensity of their suffering served as motivation for them to more intentionally reach out to or otherwise cultivate their trust in and reliance on God. Many mentioned explicitly doing this through specific practices like prayer, increased Scripture reading, etc., while others focused more on the change brought about in their 'inner state' and felt sense of reliance.

Engagement with community

While there was a clear trend amongst participants regarding an increase in reliance on God, in regard to engagement with community, our findings were more complex. 38% of participants reported that their mental disorder caused them to pursue increased engagement with their religious community and 31% an increase in

[26] 31% reported a 'mix of increase and decrease' and 10% an 'overall decrease'.

engagement with their non-religious community. For example, as two participants explain,

> Mental health struggles have pushed me to be *more honest with my religious community*, as I've kind of accepted, like anxiety is part of my brain and how it works…which increases, I think, how comfortable I am and just my authenticity there. (emphasis mine)

> I have learned to be able to experience a *reliance on my faith and community* whenever I reach the end of myself and look to God and others to help me grieve more fully and effectively. (emphasis mine)

However, many participants also spoke of experiencing the opposite or a more mixed effect—29% reported a decrease in engagement with their religious community as a result of their mental disorder and 33% reported a mix of increase and decrease; and 14% reported a decrease in engagement with non-religious community, with 29% reporting a mix of increase and decrease. For some of these participants, their decrease in engagement seemed clearly tied to a *Spiritual Illness* view of mental disorder in these communities, which resulted in a range of harmful responses to them. For example, as the following participant writes,

> as far as the Church, it's been such a struggle…[I've often been] met with *'I haven't had enough faith or I would have been healed'* . . . whether *'I have unconfessed sin'* or '*I haven't prayed enough'*…and it's really, really been a challenge to kind of get past the hurt of that and just to be able to go…it's been a real struggle of trying to reckon with that—not everybody by any means—but kind of that *a lot of people in the Church have seen me as like somebody to be fixed, instead of just being somebody to care for or to help or just to welcome in."* (emphasis mine)

And another participant with a history of psychosis (delusions and hallucinations) which often had religious content felt their religious community failed to recognize and appreciate the spiritual relevance of their experiences, instead embracing a kind of biopsychosocial approach to mental disorder. This undermined the participants' religious belief and their ability to engage in theological meaning-making, and alienated them from the community,

> . . . part of the reason that I lost my faith is because of what felt to me like hypocrisy in the church regarding my illness…so that I felt like on the one hand you read, you believe in prophecy, you believe there's this other world, you believe all these things.

> *But then when somebody experiences them, you say, no, this is too far.* This is not what we think. And there's no place for that…to me, it felt like there was no place for anything outside of like…I don't know, like a very sedate kind of version of Christianity or something, and so I just…*part of the reason that I no longer could believe in it had to do with how I was treated afterwards and how me and my experience was interpreted by people who believed.* (emphasis mine)

The clear divergence in experiences here was a very common theme across responses in both studies, in questionnaire and interview responses and reflects sharp differences in how communities more generally, but especially religious communities, understand, talk about and treat mental disorders and those who experience them. However, it is important to note that many participants experienced both views that 'over-spiritualized' mental disorder (like SI views) and those that 'under-spiritualized' it (like biopsychosocial views) as ultimately corrosive to their relationship with religious community and their ability to make sense of their mental disorder in relation to their religious engagement. Greater understanding of this dynamic is especially important because, as was addressed in findings from our previous study, connection with religious community was one of the 'external factors' most often identified by our participants as enabling positive effects of their mental disorder.[27]

Sense of purpose

Another interesting result was that 48% of participants cited an increase in their sense of purpose resulting from their mental disorder.[28] For many of our religious participants, this increase in a 'sense of purpose' seemed to be specifically an increase in a sense of 'God-given purpose' or 'calling' as well as their desire to fulfill or enact it. For example, one participant said that,

> All the experiences I have had with symptoms of depression have worked together to deepen my faith and have *allowed me opportunities to come alongside others* to help them see their worth and how much God cares for them. (emphasis mine)

[27] There is much more to say on this topic and participants' responses were extremely varied and nuanced on this component of religious engagement. I am currently conducting additional research on this topic—specifically investigating 'Christian views of mental disorder', how they are communicated both explicitly and implicitly in Christian communities, and the effects that this has on those in the congregation (see Finley, 2022b).

[28] 33% reported a 'mix of increase and decrease' and 10% an 'overall decrease'.

And another participant expressed a similar sentiment, explaining that

> While I wish I did not attempt suicide it has shown me how much I am loved and supported by my church family . . . *It has drawn me into closer relationship with God* and a thankfulness that I am still here. *It also has pushed me to start pursuing my calling.* (emphasis mine)

For many participants, like those quoted above, their increased sense of purpose involved helping others who were experiencing mental disorder or some other kind of suffering and they attested to the fact that not only had their sense of purpose increased but that they had also acted to fulfill this purpose.

Sense of God's presence

Closely related to but distinct from an increased reliance on God is an increased 'sense of God's presence' which 55% of subjects reported experiencing as a result of their mental disorder.[29] For example, one participant stated,

> When I've hit rock bottom, I've always come out stronger in my faith. In a weird way, it always *made me feel super close to God* when I was so hopeless because I literally felt like he was the only one who loved me at times—like he was the ONLY one on my side. (emphasis mine)

Another went so far as to claim that "I can think of at least one season in which feeling hopeless prompted me to turn to God and again, I would say that *some of my most meaningful encounters with God* happened when I was depressed/lost/hopeless." (emphasis mine) This statement reflected a common sentiment that not only did participants' mental disorder sometimes led to an increased sense of God's presence, but furthermore that it made this happen more reliably or intensely compared to times when they were not as saliently experiencing symptoms of mental disorder. While not as common, other participants reported a specifically perceptual dimension to their sense of God's presence and how it came about through their experience of symptoms. For example, many participants reported audibly hearing the voice of God as a result of their mental disorder, one in the midst of a suicide attempt. And another explained,

[29] 29% reported a 'mix of increase and decrease' and 10% an 'overall decrease'.

> I would experience intense euphoria and *feel close to God when I was hypomanic*. I believed the racing thoughts and hyperactivity was because I was living life the way God had planned and he was sending me messages. (emphasis mine)

Obviously, interpretations of such reports are complicated by the fact that delusions and hallucinations often have religious content (Winters & Neale, 1983; Johnson 2018).[30] And it is important to note that while some participants pointed to such experiences as some of their most theologically meaningful experiences, others looked back on similar experiences and strongly disavowed their contents, refusing to draw any theological meaning out of them.

Empathy

Another benefit, reported by the largest portion of participants (83%), was an increase in empathy or compassion for others resulting from their mental disorder.[31] Many participants attested to the fact that their experiences with mental disorder had increased their understanding and lessened their judgment of others undergoing various kinds of suffering, especially suffering due to mental disorder. For example, one participant explained,

> Depression impacted my spiritual life positively because it humbled me, enlightened me, and *made me more empathetic to those who struggle from it. I gained a greater sense of understanding of how depression can consume your mind, heart, emotions, and even physical well being* if you have/had chronic depression as I did at one period during my life. My whole body was in intense pain for days. I finally understood the phrase from all the commercials for depression medicines or comments doctors/people would make that "DEPRESSION HURTS." It literally does! (emphasis mine)

Similarly, another participant more soberly focused on the humbling aspect of it noting that “The only "positive" from a "Christian" perspective of living with a mental illness is [that it is] a humbling experience, which *makes me more empathetic* to people who battle other types of medical conditions that are disabling or cause them pain and suffering” (emphasis mine). Also notable is that there were clear connections for many participants between this increase in empathy and an increase

[30] I unfortunately cannot address such issues here.

[31] 10% reported a ‘mix of increase and decrease’ and 5% an ‘overall decrease’.

in their sense of purpose—again, often specifically to help others experiencing mental disorder.

Understanding of Scripture

55% of participants reported that they thought their understanding of Scripture increased as a result of their mental disorder.[32] For example, one participant explained that their experience of mental disorder "has made me relate to some characters in the Bible who are maybe harder to understand if you've not experienced severe anxiety and kind of made me look at some of the stories in a new way." Another expresses a similar sentiment along with specific examples,

> I think the fullness of human experience is represented in scripture. So as I experienced a fuller human experience by allowing myself to feel the depth of the emotions that were already inside me, *I read scripture with more awareness* and kind of 'having eyes to see', you know, I grew up in such a kind of a happy clappy world and so that's all I saw in scripture. But as soon as my experience grew, *I now have different eyes to look back and read the Psalms, for example, or to read the stories of Jesus' own anguish or anger differently.* (emphasis mine)

Both participants explain that their mental disorders are valuable insofar as they give them access to unique kinds of knowledge and insight. Many participants in both studies pointed to specific stories and ideas in Scripture that they thought they were able to more fully understand in light of their experiences with mental disorder; furthermore, they also often cited misapplication or misunderstanding of some of these stories or ideas as things that contributed to their stigmatization and/or alienation from their religious community.

Understanding of God & Belief in God

Relatedly, 50% of participants said that their mental disorder increased their understanding of God and 48% said it increased their belief in God.[33] For example, two participants explained,

[32] 17% reported a 'mix of increase and decrease' and 7% an 'overall decrease'.

[33] Regarding 'understanding of God' 31% reported a 'mix of increase and decrease' and 10% an 'overall decrease' and regarding 'belief in God', 26% reported a 'mix of increase and decrease' and 7% an 'overall decrease'.

> I've dealt [with] a lot of suicidal ideation and I've experienced both where God has felt silent and also working very near, and neither of them were dependent on what I was doing. So I would say the one thing that I…well, *I mean, I knew it, but [it's different when] you experience it,* that there's just the comfort that *there's nothing too dark or too hard that he doesn't, that's too much for him and I think there's the comfort in that.* I guess I've learned people can't, but God can, you know." (emphasis mine)

> Physical pain and disability has been part of my life since 1986. Although it can often distract from spiritual practice, it also creates a situation in which I am part of a community that is often excluded and oppressed. From this, *I've come to understand in a visceral way that God is on the side of the Oppressed.* (emphasis mine)

These participants attest that they seemed to gain a kind of experiential knowledge and thus deepened understanding of God's character. And another participant below speaks to the way in which their experiences with mental disorder impacted their beliefs about faith and healing—and thus their conception of God—again noting that their experiences challenged their previous understanding of these concepts,

> . . . experiences like this, what I like to call, "Question you have for God that have [n]o answers this side of Eternity," force you to reevaluate your faith in terms of *what you believe about who God is; what His word the Bible, says about "healing"* . . . For me, these experiences forced me to wrestle with my faith, *take God OUTSIDE of the neat theological box of my understanding about who He is,* how He works (or how I think He should work), and how to partner with him to navigate the suffering and deep pain/angst of loss/hopelessness . . . (emphasis mine)

And another refers specifically to their belief in God's existence and how it was impacted by their mental disorder, explaining that

> I think *before, my belief in God was more simplistic*, *and now it's just deeper*, and actually a lot darker…like I didn't realize how painful and truly evil the world could be before, or something, and so I think I didn't fully understand the nature of God. But now I think I get it more, but sometimes I wish I didn't…. *It actually makes it harder to believe in God, because it's hard to wrap my head around the state of things, but I think it's actually strengthened my belief.* (emphasis mine)

This participant highlights the fact that, although their experience with mental disorder in a sense undermined or challenged some of their previously held beliefs about God—it ultimately made their view of God more accurate and strengthened

it. Unsurprisingly, for some participants an increase in understanding of and belief in God went 'hand in hand' with an increase in a sense of God's presence and reliance on God. However, we saw interesting 'splits' in other participants—for example, some reported feeling more distant from God (i.e., a decrease in a 'sense of God's presence') as a result of their mental disorder but at the same also reported that this distance, and the suffering they experienced actually ended up increasing their understanding of and belief in God.

Other religious beliefs

In addition to noting changes in their understanding of Scripture and God, participants reported that other religious beliefs were impacted by their mental disorder as well—especially those related to faith, healing, and 'the Christian promise'. For example, one participant notes a change in their understanding of faith,

> I wanted to die. I begged to die. I was angry at a God that allowed me to hurt inside so bad with no justice or relief. I learned that people who were faithful prayed for me when I was dying. I learned they saw something I couldn't. *I struggled to learn what faith was* and how could a person hope that things would get better. I learned that I needed to live in the moment and that faith would bring tomorrow. (emphasis mine)

This participant articulated that their previous understanding of faith was challenged and ultimately deepened by their experience with mental disorder. Another participant explained how their experience of mental disorder impacted their understanding of God's goals, stating that before their experiences with mental disorder "I would have probably said, oh, God wants us to be healthy, happy, and that's kind of the most important thing." But, they continue,

> I think now—not that he just wants us to be miserable, I'm not saying that at all—but I see it so differently. And that the most work he's done in my life is through my suffering and that *my happiness is not the biggest goal on Earth by any means.* And that the way he's changed me, the way he's brought me into a deeper relationship with Him has been through my suffering. (emphasis mine)

And relatedly, another participant said that their experiences with mental disorder,

> . . . clarified for me *what the Christian promise really is*. It is not that things will work out for you here. Your entire life might be horrible. *The promise, rather, is for that to be redeemed eventually* and perhaps for some moderate divine consolation along the way (but not even that is a guarantee!) (emphasis mine)

This participant spoke to how their experiences with mental disorder helped them realize that they had previously misconceived of the 'Christian promise'—specifically what one ought to expect by way of 'healing' or a 'cure' as a Christian, when dealing with mental disorder. This idea was also reflected in multiple quotes presented in previous sections and was a clear theme in participant responses about the influence of religious community, and 'Christian views of mental disorder'. Participants' previous views seem to often reflect SI views of mental disorder according to which it results from some kind of sin, personal failing, or supernatural attack—and relatedly, that one ought to expect healing from or amelioration of mental disorder as a Christian, as a result of God's intervention, one's repentance, etc. Again, overwhelmingly, participants experienced communities with these views as exacerbating their symptoms, promoting isolation and stigmatization, and ultimately undermining their ability to integrate their mental disorder and religious life.[34]

Correlates of benefits

A final finding is that participants' reporting some of the above benefits as a result of their mental disorder was correlated with their level of identification with their religion and with their mental disorder—in other words, roughly, how central those things were to their self-concept or sense of identity. A Pearson correlation coefficient (a measure of the correlation between two variables) was calculated, using participants' scores on the Centrality of Religiosity Scale (CRS) (Huber & Huber, 2012) and whether they reported that each of the effects above had increased for them. There was a moderate, positive correlation between the two for the following effects: engagement in religious practices (r=.5), understanding of Scripture (r=.5), reliance on God (r=.4), sense of God's presence (r=.4), and understanding of God (r=.4). I then did the same using participants' scores on a version of the Personal Disability Identity Scale (PDIS) (Zapata 2019), and found that there was a moderate, positive correlation between the two for the following effects:

[34] Other effects that we asked about that increased for a significant portion of participants as a result of mental disorder include: understanding of self, sense of morality, sense of hope, self-confidence, and emotional intensity.

engagement in religious practices (r=.4), sense of God's presence (r=.4), and empathy (r=.4). In other words, for the effects listed above, participants who identified more strongly with their religion and/or their mental disorder were more likely to report that they had increased.

In summary, in our two studies we addressed the positive effects of mental disorder on Christian religious engagement. In our first study, 25% of participants said the impact of their mental disorder on their religious engagement was 'mostly positive' and 19% said it was 'somewhat positive'. We also found that 'feelings of loss and/or hopelessness', 'depression', 'feelings of anxiety', 'increased fears and/or worries', and 'guilt' were the symptoms selected most often as positively affecting religious engagement. And 'prayer', 'professional therapy', 'religious friends or community', 'reading Scripture', and 'books articles, or other reading' were selected most often as external factors contributing to these positive effects. Finally, the following facets of religious engagement were most often mentioned by participants as positively affected by their mental disorder: those that were behavioral (engagement in religious practices, reliance on God, connection with community, and sense of purpose), affective (sense of God's presence and empathy), and epistemological (understanding of Scripture, understanding of and belief in God, and changes to other religious beliefs). In our second study, we found what portion of participants experienced an increase in these effects as a result of their mental disorder and further found that some of these increases were correlated with participants' level of 'identification' with their religion and/or their mental disorder.

5. Discussion

Limitations

Although the findings presented above offer compelling initial evidence of the positive effects of mental disorder on religious engagement, there are a few limitations to note. One potential limitation is that our participant pool was self-selecting insofar as they needed to identify as having had experience with both mental disorder and Christianity. Furthermore, in both studies while we had fairly representative sample with respect to Christian background, diagnosis, and age our participants especially in the first study were largely white (82%) women (82%)—and in our second study we had somewhat more gender and racial diversity but still participants were 76% white and 66% women. This thus limits the generalizability of our findings as does our sample size. However, this sample size enabled us to gather very in-depth data about participants' experiences, which points to the

importance of further research on these topics on larger, more diverse and representative sets of participants.

Another potential limitation derives from the fact that participants sometimes had trouble keeping the 'direction of causality' straight on some of our questions. Specifically, in response to questions about the positive effects *of* mental disorder *on* religious engagement participants sometimes responded more generally about positive interactions between religious engagement and mental disorder, specifically, the former's effect on the latter (e.g., going to church helped me cope with my depression). While the quotes above are from responses with the correct interpretation, some of our quantitative results from both studies may be inaccurate (either higher or lower) because of this. However, this tendency among participants also speaks to the fact that many participants understood their mental disorder and religious engagement to be tightly connected.

And a third potential limitation, specifically for results from our second study, derives from the fact that we asked participants about potential positive effects of their mental disorder on their religious engagement in terms of an 'increase and decrease' rather than a more value-laden 'positive and negative' framework. We did so, so as not to influence participants regarding the value of these effects; however, this means that there may be a gap between those effects that participants viewed as 'positive' and those effects that they reported as 'increasing'. For example, the participants like those above who spoke about their beliefs in God and other religious ideas being challenged and weakened as a result of their mental disorder before ultimately arriving at what they took to be a more accurate belief may have selected 'decrease' or 'mixed' (because it lessened their confidence in the belief) to describe the impact of their mental disorder on their belief in God; however, they may have understood this effect to have ultimately been positive insofar as it brought them closer to more accurate beliefs.[35] This then means that assuming that the increases in effects addressed above are all positive (and decreases are all negative) may be slightly inaccurate to some participants' views.

Interpretation & Significance

The two studies above are some of the first to specifically investigate the potentially positive effects of mental disorder on religious engagement—because of this, these studies were exploratory and aimed at getting a broad sense of the potential for

[35] There may also be those who, for example, a result of the stigmatization they faced in church decreased their engagement with their religious community, however, that may have been an overall positive effect on their religious engagement.

further, more specific research on this topic. Thus, our specific, quantitative findings are less important than some of the broad patterns and correlations that we found, specifically: (1) that many of our participants did seem to engage in theological meaning-making around their experiences of mental disorder, resulting in positive and potentially transformative effects on their religious engagement; (2) the symptoms, external factors, and components of religious engagement most often cited as involved in these positive effects; and (3) the correlation between dimensions of identity (religion, mental disorder) and these effects.

Overall, our findings are surprising insofar as they challenge how we often conceptualize mental disorder and its effects; as well as how we often conceptualize suffering and its relationship to religious engagement. We often think about mental disorder and its effects as solely negative and harmful, which is understandable given that symptoms of mental disorder often negatively affect processes and capacities that are central to how we understand ourselves and interact with the world—it often causes a 'reality-distorting' kind of suffering. An undermined sense of control or agency, mood swings, increased emotional instability, a sense of hopelessness, experiences of mania are all common symptoms of mental disorders and can disrupt our sense of self on the deepest level. And those symptoms and the stigmatization that often results from them, as well as difficulties thinking or communicating, and increased emotional intensity and sensitivity can affect our ability to connect with others. And finally, hallucinations, delusions, a disordered sense of time, difficulty concentrating, and fractured attention can disrupt, most foundationally, our ability to think clearly and to perceive the world around us. However, our results indicate that, for many people, those same symptoms can have positive and even transformative effects.

Furthermore, we often focus on the ways in which intense suffering undermines trust and/or belief in God (and other components of religious engagement)—as the extent of interest and work in philosophy and theology on the Problem of Evil, and more recent work on instances of mental disorder as relevant to the Problem of Evil in particular, speaks to. Mental disorder, in causing great suffering, is assumed to undermine trust and/or belief in God and otherwise negatively affect religious engagement. And again, this is understandable given the fact that intense suffering does have these effects for many. However, our results indicate that suffering due to mental disorder can, in some cases, bolster, deepen, expand and otherwise transform trust in and/or belief in God—and other components of religious engagement.

However, although a surprising number of participants reported experiencing positive effects of their mental disorder on their religious engagement it is important

to note the range of experiences in our participants. A significant portion of participants in both studies did not report that their mental disorder had positively affected their religious engagement—and instead reported that it had either had no impact, or a negative impact. Furthermore, some participants who did report experiencing positive effects nevertheless seemed to experience them as fairly limited effects—those that might be rightly understood as positive, but likely not transformative. And then there were those participants who reported that their mental disorder had had positive and perhaps even transformative effects on their religious engagement—many of whom, as addressed above, maintained that the fact that their disorder had had these transformative effects did not change the underlying fact that it was still a bad thing, that had caused them great suffering that was not outweighed by or deemed 'worth it' in light of the transformative effects.

Thus, whether and to what extent mental disorder positively affects or transforms religious engagement clearly differs between people—as do underlying beliefs about the value and 'goodness' or 'badness' of one's mental disorder. This speaks to the importance of the 'potential' in a Potentially Transformative view. On the one hand, it is important to emphasize that these effects are potential insofar as they may not happen for some, and crucially, that this is not grounds for blame or shame (e.g., 'you could experience these positive effects if only you tried harder', 'had more faith', etc.). This is a pitfall of SG views, which often motivates blame or fault-finding by others or the individual themselves if they do not experience their mental disorder as a gift or as a means of positive or transformative effect on her religious engagement.

The fact that these effects are merely potential and not inherently the result of the underlying 'goodness' of the mental disorder, means it is all the more important to study specific factors that may be involved in enabling or undermining these positive effects. Our results indicate that how an individual understands herself and the extent to which she identifies with her mental disorder and/or her religion, as well as the content of the 'Christian views of mental disorder' that surround her, and how she is treated by her religious community in light of them plays an important role in enabling or undermining these positive effects. Additionally, often a combination of factors that are explicitly religious (i.e., prayer) and those that are not (i.e., therapy) seem to further enable these positive effects.

Participants' understanding of their mental disorder and beliefs about its potential to affect their religious engagement also seems to have had an impact on whether it does have this effect. In our first study, some participants who reported that they didn't experience any positive effects of their mental disorder, additionally

noted that they thought that experiencing such effects would be impossible. Others went even further in saying that they didn't understand what we were asking on that part of the questionnaire and still others claimed that we had a consistent error or typo on that part of the questionnaire. After asking for clarification on these comments from some participants in follow-up interviews it became clear that these comments reflected a difficulty on the part of participants in even conceiving of their mental disorder as positively affecting their religious engagement. Although there may be multiple things motivating some of these responses—including the fact that these participants' experiences may just seem incompatible with any kind of positive effect—I think that they may indicate a lack of conceptual openness to or conceptual space for even entertaining the PT view. This is important because, as Scrutton explains,

> an aspect of the fact that transformation relies heavily on the person's response is that the experience is more likely to be or to become transformative *if the person believes it is or may be transformative* —that is, if they themselves (implicitly or explicitly) adopt or are open to a PT theology. (emphasis mine) (Scrutton 2015b, 281)

In other words, one's understanding of their mental disorder and its potential for impacting one's religious engagement (or other aspects of one's life) positively or transformatively can have an important impact on whether it does have this impact. This is an interesting feature of mental disorder, beyond its effects on religious engagement: that one's understanding of the mental disorder can affect one's experience of it (Hacking 1986; Luhrmann et al., 2015). This points to another important area for future research, investigating whether, how, and to what extent people's views about mental disorder, and specifically their views about a PT view of mental disorder can be affected.[36]

Many of the findings presented above speak to the importance of meaning-making in mediating these positive effects. This kind of research is important because it not only helps expand our understanding of mental disorder, religious engagement, and their connection but it also can provide practically applicable insights. As addressed above, individuals' and communities' understanding of mental disorder and its possible effects can impact whether or not it has these effects. Thus, the results of these studies—both the quantitative results and the specific

[36] In the second study above, we began investigating these questions by having participants read and engage with firsthand narratives of experiences of the impact of mental disorder on religious engagement and then measuring the impact of this on their beliefs about mental disorder and its effect on religious engagement generally and for themselves personally.

examples provided by participants through their questionnaire and interview responses—and future studies like it can provide those that experience mental disorder with direction, so to speak, for where to look for these benefits or meaning in their experience. Learning in more detail about the meaning-making processes that others in similar situations go through can affect how one looks at one's own experience through impacting attention allocation, interpretation of experience, etc. For example, if I experience mania as a result of my bipolar disorder, and I know that others who have experienced this symptom report that it increased their reliance on and trust in God, and furthermore, I read firsthand accounts of how it has done so, this might inform how I think about my own experience, effecting what aspects I pay more attention to, the things that I bring up in my prayers, or in therapy, etc.—and this may ultimately contribute to me experiencing this benefit as well.

Although this research is unique in its investigation of the positive effects of mental disorder on religious engagement, a number of our findings align with previous work on the role of meaning-making in suffering, and on the potentially beneficial effects of mental disorder. First, our findings of mental disorder increasing some participants' self-reported *empathy, sense of purpose,* and *engagement with community* are consistent with the growing body of psychological literature which addresses similar effects of other kinds of suffering (e.g., physical disease & pain, natural disasters, grief, etc.). Many studies indicate that different kinds of suffering result in increases empathy (Lim & DeSteno, 2016; Greenberg et al., 2018; Stellar et al., 2020; Qi et al., 2020) as well as cooperative and altruistic (prosocial) behavior (Stocks et al., 2009; Eisenberg & Miller, 1987, Batson et al., 2002; Bastian et al., 2014; Wang et al., 2018; Timm et al., 2021; Kang & Skidmore, 2018). Similarly, research specifically on mental disorder has found that it can increase sense of purpose (McCreery & Claridge, 2002; Roberts, 1991) as well as empathy and engagement with community (O'Connor et al., 2007).

Additionally, our findings of increases in *engagement in religious practices* as well as of *reliance on, sense of, understanding of, and belief in God* are also broadly consistent with research demonstrating that various kinds of suffering may increase religious meaning-making (Gran & Wegner, 2010; Stephens et al., 2013; Banerjee & Bloom, 2014). Also relevant is work in cognitive science of religion—which addresses the cognitive processes which underlie religious engagement—and increasing interest in its intersections with mental disorder (e.g. investigating the relationship between hallucinations and religious experiences) (McCauley & Graham, 2020; McKay & Ross, 2021).

Objections

Finally, I will address a few potential objections to a PT view and my results. The first is that *a PT view is only plausible for those experiencing less severe forms of mental disorder.* While this objection does not directly challenge a PT view or my results, it does question their scope and applicability. Setting aside questions about what counts as a 'severe' form of mental disorder, the results presented above attest to the fact that a PT view is plausible even for those with more severe forms of mental disorder. Recall that some of the quotes above were from participants who had experienced psychosis (hallucination and/or delusion), hospitalization, and suicidality. Furthermore, across both studies we had participants with schizophrenia, dissociative identity disorder, severe major depression, bipolar disorder, severe posttraumatic stress disorder, and severe generalized anxiety disorder report that their mental disorder had had at least some positive effects on their religious engagement.

Of course, symptoms and mental disorders often deemed 'more severe' are often less common and thus there may be fewer experimental and anecdotal accounts of their positive and transformative effects; however, this does not mean it does not occur—and our findings provide at least preliminary evidence that it does. However, it is also worth noting that, depending on the kinds of symptoms being experienced, it may be incredibly difficult if not impossible for an individual to actively engage in conscious 'meaning-making' and experience positive effects in the midst of that experience. However, this of course does not preclude such meaning-making about the experience occurring after the fact, nor does it preclude meaning-making occurring in the midst of the experience—albeit perhaps in a less conscious and/or less communicable way.

A second potential objection is that *at least some of the allegedly positive and transformative effects presented above may be merely a form of psychological adaptation—in other words, just a way of coping with or attempting to inure oneself to suffering.* Again, while this objection does not directly challenge a PT view or my results, it does challenge an unarticulated assumption that seems to motivate it: namely, that when engaging in theological meaning-making of the sort presented above, people are for the most part experiencing a positive effect or transformation that is in some sense 'truth-tracking' rather than merely the result of coping mechanisms and/or perhaps of some kind of self-deception. For example, for our results to be meaningful, it must be the case that when (at least some) participants report experiencing an increase in their understanding of God, their understanding of God has really increased. In response to this objection, it is first important to note that the effects above may be

both truth-tracking *and* the result of coping mechanisms—in other words, roughly, the fact that these effects may make lessen a person's suffering does not in itself undermine their legitimacy. However, it is of course the case that for any individual experience of one of these positive effects, it is possible that it is *merely* the result of some kind of self-serving self-deception. And furthermore, this worry may be further heightened by the fact that religious content is common in certain symptoms of mental disorder (e.g., a common kind of delusion in schizophrenia is that one believes oneself to be a kind of messiah) (Winters & Neale, 1983; Johnson, 2018). While there is no way to completely dismiss this worry, engaging in theological meaning-making, insofar as it involves repeated appeals to external frameworks for meaning-making (e.g., Scripture, community) may offer some protection.

And a final objection is that *a PT view minimizes or romanticizes the suffering of those with mental disorder.*[37] This objection specifically points to potentially negative practical effects of a PT view such as: contributing to misunderstanding of and decreased support for those experiencing mental disorder, especially within religious communities; and decreasing motivation of those experiencing mental disorder to seek out support. As addressed above, PT views (in contrast to SG views) are able to acknowledge the deep suffering caused by mental disorder while affirming the potential for positive and transformative effects resulting from it. Above I emphasized that the latter did not negate or minimize the former and that this perspective was reflected in the views of many of our participants as well. However, even though a PT view as outlined above might not be undermined by this objection, it is still the case that an oversimplified version of a PT view could be applied to harmful effect. As Scrutton acknowledges, whether or not a 'PT response' to suffering is helpful or harmful

> is of course, dependent on the manner and situation in which it is given, on the relationship between the sufferer and the person who ministers to them, and on whether and how such a response has been requested by the person who suffers or whether it has been imposed upon them. (Scrutton 2015a, 108)

I agree that these factors would make a big difference to whether such a PT response was received as helpful or harmful; and furthermore, that even if a PT view is true,

[37] Note that Scrutton addresses two adjacent worries: "(2) a PT view diminishes the sufferer's motivation to recover by failing to uphold the reality of evil as evil, and (3) a PT view encourages glib theoretical responses to suffering that are pastorally unhelpful." (Scrutton 2015a, 100, 106).

that does not necessarily make it pastorally prudent to articulate it in response to some instances of suffering.[38]

Summary & Directions for Future Research

In these studies, we found that many participants who experienced mental disorder as Christians reported positive and sometimes even transformative effects on their religious engagement. We also found interesting patterns concerning the symptoms, external factors, and components of religious engagement often involved in these effects; as well as correlations between these effects and how participants understood their identity with respect to their religion and mental disorder. These findings align with a *Potentially Transformative* view of mental disorder as well provide further specificity about the ways in which these transformative effects may occur. These insights are important for informing practical ways of addressing and engaging with mental disorder in religious communities; as well as for bolstering understanding of the interactions between mental disorder and religious engagement and providing a foundation for future research endeavors.

There are many potentially fruitful paths forward for research on this topic. First, more philosophical work ought to be done to continue constructing PT theologies of mental disorder in general, and of specific mental disorders. Relatedly, further empirical work is needed to investigate specific mental disorders and/or symptoms (perhaps starting with those mentioned most often by participants in our studies) and their interactions with particular facets of religious engagement (again, perhaps starting with those addressed above). For example, our results might suggest an investigation into connections between a sense of loss or hopelessness and engagement in specific religious practices. Future studies could also address in more detail the interplay and relationship between different facets of our relationship to

[38] One potential means of communicating about this (or other) views of mental disorder is through narrative, which 'shows the view in action', so to speak, rather than the more common approach which is to simply describe the view (e.g. 'here's specifically how I experienced transformative effects of mental disorder in my life' vs. 'you can experience transformative effects from your mental disorder'). Being 'shown' rather than 'told' how to approach one's mental disorder, especially through a first-person narrative, is plausibly a much more disarming (because of the vulnerability of the speaker and the fact that they are not explicitly prompting the listener to do anything) and powerful (because it provides specific examples that may guide the listener's own reflection and meaning-making) form of communication. This was our motivation in adding the firsthand narrative component to our second study addressed above and motivates further work of mine on the topic. For more on this, see (Finley, 2022a) and for more on the role of narrative in theology and philosophy of religion see (Finley & Seachris, 2021).

God—sense of presence, reliance, understanding, belief—and how they are impacted both positively and negatively by mental disorder. Another exciting area for further study is examining differences in views of mental disorder between religious communities—both between different denominations within Christianity and between Christianity and other religious traditions—how these views are communicated (explicitly, implicitly, etc.) and how they impact their congregants in terms of both their understanding and experience of mental disorder.

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APPENDIX A

Study 1 Questionnaire Details

(Q1-Q6) *(Informed consent, questionnaire criteria questions, demographics questions)*

(Q7-Q13) *(Questions specifying religious and denominational background and current identification, mental disorder identification and/or diagnosis)*

(Q14) Do you believe that your experience of any of the following symptoms may have impacted your religious and/or spiritual life in a **positive** way? Please select all that apply. *[Symptom list adapted from Mayo Clinic and RDoC common mental health symptom lists.]*

- Large mood swings, emotional instability
- Mania (hyperactivity, racing thoughts, rapid speech, elevated mood)
- Depression
- Feelings of loss and/or hopelessness Feelings of guilt
- Anxiety
- Increased fears and/or worries
- Increased anger and/or irritability
- Decreased sense of agency or control
- Altered sense of self or identity
- Major changes in ability to think clearly and/or concentrate
- Issues with memory (short-term or long-term)
- Delusions and/or hallucinations
- Paranoia
- Difficulty with relationships (understanding and/or relating to others)
- Difficulty communicating with others
- Major changes in appetite and/or eating habits
- Major changes in sex drive
- Very low energy
- Very high energy
- Physical pain
- Alcohol and/or drug abuse
- Other—please specify

(Q14a-Q14v) Please describe the **positive impacts** of {*symptom selected in response to Q14*} on your religious and/or spiritual life. *(For each symptom participant selected on the list above participants were given this prompt with the symptom filled in in place of the { })*

(Q15-16) *(Questions about which of the following resources were helpful or unhelpful in mediating positive impact)*

- Prayer
- Meditation
- Reading scripture
- Christian views or approaches to mental health
- Christian friends or community
- Non-Christian friends or community
- First-hand accounts from others who have dealt with similar or related issues
- Books, articles, or other reading
- Aesthetic experiences (e.g. visual art, music, etc.)
- Medication
- Professional therapy (one-on-one therapy, focus groups, etc.)
- Other—please specify
- None of the above
- Prefer not to disclose

(Q17) Do you **believe or hope** that any of your experiences of these mental health symptoms could impact your religious and/or spiritual life in a **positive** way **in the future**?

(Q18) How would you characterize the **overall impact** of your mental health symptoms on your religious and/or spiritual life? *(Participants were only able to select one option)*

- Mostly positive
- Somewhat positive
- Equally positive and negative
- Neutral
- Somewhat negative
- Mostly negative

APPENDIX B

Study 1 Interview Framework Details *(Question numbers listed (e.g. 'Q11') correspond to the questionnaire questions the interview questions were based on—they were filled in with the relevant information from the participants' responses between the { }s)*

(Q2-Q6) Ask questions to clarify any answers to demographic questions if necessary

(Q7-Q11) On the questionnaire, you said that you have experienced {*content of response about denomination and Christian background*}, can you say more about how this affects/affected you?

(Q13) On the questionnaire, you said that you have experienced {*diagnosis if provided | 'mental health symptoms' if diagnosis not provided*}, can you say more about how this affects/affected you?

(Q14a-Q14v) *(Ask them to say more about their answers to these questions about the positive impact of specific symptoms)*

(Q15-Q16) *(Ask them to say more about their answers to these questions about which of the resources were helpful or unhelpful in mediating positive impact)*

- *If participant mentions 2+ resources* → Which of these resources were most helpful and why?
- *If participant mentions 2+ resources* → Which of these resources were least helpful/most harmful and why?

(Q17) *If participant provided a response to this question* → You said that you believed or hoped that {*content of response to this question}*, can you say more about this?

(Q18) You characterized the overall impact of your mental health symptoms on your religious and/or spiritual life as {*answer to this question}*, can you say more about why you chose this answer?

APPENDIX C
Study 2 Questionnaire Details

(Q1-Q8) *(Informed consent, questionnaire criteria questions, demographics questions)*

(Q9-Q12) *(Questions specifying religious and denominational background and current identification, mental disorder identification and/or diagnosis)*

(Q13a-Q13o) *(Adapted PDIS measure questions - e.g. 'My mental health symptoms give me perspective on what matters in life', (reverse scored) 'Because of my mental health symptoms, I will never become the person I want to be')*[39]

(Q14a-Q14p) *(Adapted CRS measure questions - e.g. 'Without a connection with God or sense of spirituality, my daily life would feel meaningless' and (reverse scored) 'I wonder whether God has abandoned me' to measure participants' level of 'religious identification'.)*[40]

(Q15a-Q15d) Please rate your agreement with the following statements (strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, strongly agree, prefer not to answer)

- God has played a role in impacting my mental health symptoms
- God is not involved with or connected to my mental health symptoms
- My mental health symptoms are separate from my religious and/or spiritual life
- My religious and/or spiritual life has helped me better understand my mental health symptoms

(Q16) How would you characterize the overall interaction between your mental health symptoms and your religious and/or spiritual life? *(Participants were only able to select one option)*

- Mostly positive

[39] We used an adapted version of the (15 question) Personal Disability Identity Scale (PDIS) (Zapata 2019) in which we substituted mentions of 'mental health symptoms' for 'disability'.
[40] We used the Centrality of Religiosity Scale (CRS) (Huber & Huber, 2012).

- Somewhat positive
- Equally positive and negative
- Neutral
- Somewhat negative

(Q17) Please categorize the below depending on how they have been impacted by your experience of your mental health symptoms (only the box you put them in matters, the order inside the box doesn't matter). Drag and drop items into groups. Within each group, rank items by dragging and dropping them into place. *(Participants were presented the following randomized list drawn from benefits reported on Study 1 as well as 'filler benefits' that were not reported by a significant number of participants (e.g. 'sense of morality'))*

relationships with religious community
reliance on God
sense of responsibility for symptoms
motivation
sense of control
self-image or confidence
relationships with non-religious community
understanding of God
sense of morality
belief in God
understanding of Scripture
closeness with God
understanding of self
sense of purpose
focus on self
emotional intensity
sense of hope
understanding of reality
religious or spiritual practices (church, prayer, etc.)
empathy for others

Overall has increased

Mix of increase and decrease

Overall has decreased

Unsure / have not experienced impact

(The following options resulted from our analysis of Study 1 detailed above: relationship with religious community, relationship with non-religious community, reliance on God, closeness with God, understanding of God, belief in God, understanding of Scripture, religious or spiritual practices, sense of purpose, and empathy for others.)

(The following options were included as plausible distractors: emotional intensity, self-image or confidence, understanding of self, focus on self, motivation, sense of control, sense of hope, sense of responsibility for symptoms, sense of morality, and understanding of reality.)

APPENDIX D

Study 2 Interview Framework Details

(Q2-Q8) *(Ask questions to clarify any answers to demographic questions if necessary)*

(Q9-Q10) On the questionnaire, you said that {*content of response about denomination, Christian background, and religious and/or spiritual life*}, can you say more about this and how it affects/affected you?

(Q11-Q12) On the questionnaire, you said that you have experienced {*diagnosis if provided | 'mental health symptoms' if diagnosis not provided*}, can you say more about how this affects/affected you?

(Q13a-Q13o) *(Ask them to say more about their answers to these PDIS questions)*

(Q14a-Q14p) *(Ask them to say more about their answers to these CRS questions)*

(Q15a-Q15d) You said that you {*answer to the question*} with the statement {*statement a-d}* can you say more about this?

(Q16) You characterized the overall impact of your mental health symptoms on your religious and/or spiritual life as {*answer to this question}*, can you say more about why you chose this answer?

(Q17) When you were asked to characterize that list of things (e.g. reliance on God, sense of hope, etc.) you said that your {*selection from list}* {*increased, decreased, both increased and decreased},* can you say more about why you said that? *Options from list to ask about*

- ‘relationship with religious community’ & ‘relationship with non-religious community’ (were asked about together)
- ‘religious or spiritual practices (church, prayer, etc.)’
- ‘understanding of Scripture’
- ‘understanding of God’ & ‘belief in God’ (were asked about together)
- ‘closeness with God’ & ‘reliance on God’ (were asked about together)
- ‘sense of purpose’
- ‘empathy for others’