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ARTICLE

Narratives & spiritual meaning-making in mental disorder

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Abstract

Narratives structure and inform how we understand our experiences and identity, especially in instances of suffering. Suffering in mental disorder (e.g. bipolar disorder) is often uniquely distressing as it impacts capacities central to our ability to make sense of ourselves and the world—and the role of narratives in explaining and addressing these effects is well-known. For many with a mental disorder, spiritual/religious narratives shape how they understand and experience it. For most, this is because they are spiritual and/or religious. For others, spiritual/religious narratives still often influence secular approaches to mental disorder, more than approaches to other disabilities (e.g. intellectual, physical) or causes of suffering (e.g. physical disease). Such narratives are often harmful, especially insofar as they 'over-spiritualize' mental disorder; and undercut 'spiritual meaning-making'. Here I address the impact of spiritual/religious narratives that helpfully avoid over-spiritualizing mental disorder while enabling spiritual meaning-making about it. First, I address the role of narratives in meaning-making more generally; then, I present results from my recent empirical study testing the impact of such narratives on participants' meaning-making about their mental disorder. I conclude by addressing implications and potential worries.

Keywords Narrative · Mental Disorder · Meaning-making · Self-narrative · Story · Depression · Anxiety

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Narrative & meaning-making[1]

Meaning-making in psychological literature refers to 'positively reframing' certain aspects of a negative experience and/or drawing positive meaning from those experiences. It is sometimes conflated with *benefit-finding* which, while related, occurs when one focuses on specific, concrete positive effects resulting from a negative experience—in contrast to meaning-making which occurs when one focuses on positive effects that are more general and theoretical (e.g. effects on one's worldview) (Helgeson, et al., 2006; Park, 2010). For example, if you sustained a serious physical injury, reflections on the fact that the injury and recovery helped you gain a sense of resiliency would count as benefit-finding; whereas meaning-making might involve gaining a fuller appreciation for your human limitations and the value of life as a result of your experiences. Although distinct, benefit-finding and meaning-making are clearly connected and one often leads to the other—we should see them as lying on a spectrum—with 'benefit-finding' picking out those instances on the more specific and concrete end of the spectrum, and 'meaning-making' those instances that are more wholistic and abstract. For simplicity, in what follows, I will simply use 'meaning-making' to refer to both kinds of processes.

It is helpful to think about the process of meaning-making as that between pure discovery and complete fabrication of the meaning of an experience. For example, take the overall negative experience of undergoing 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 not what is often meant by 'meaning-making'—instead one has merely *discovered* an obvious, intended positive effect of the treatment. On the other hand, one might claim that this treatment has increased one's cognitive abilities; however, this would be an instance of *fabrication* rather than legitimate meaning-making. Meaning-making processes instead often involve focusing one's attention on previously underappreciated effects of one's experience and reframing one's experience to focus on these dimensions. As is clear from the examples above, while meaning-making is often spoken of as '*positive* reframing', it often includes distilled meaning that is not straightforwardly positive in valence—thus, I will include instances of meaning in what follows that are not solely 'positive' for the meaning-maker; however, all of the instances are those in which the meaning is something weighty and relevant for the meaning-maker in terms of how she's understanding her experience and/or identity.

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 (Park, 2010). In doing so, these processes often draw on one's beliefs, values, past experiences, etc.—in other words, important parts of one's

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sense of self, identity, or self-concept. Especially relevant is one's *diachronic sense of self* which is responsible for the "sense of coherence and integration to one's life, allowing [one] to perceive a sense of continuity through time" (McLean, 2015, p. 19). And, according to much work in philosophy and psychology, this diachronic sense of self is best captured by or reflected in one's self-narrative (Brockmeier, 2015; Bruner, 1991; Hutto, 2017; McAdams, 2011; McLean, 2015). A *self-narrative* is, roughly speaking, a story that we tell ourselves about who we are—it is often a single, unified narrative arc in which one's memories, current experiences, and future goals are temporally, causally, and often thematically connected. It serves as the basis for our subjective sense of self or identity and provides a kind of organizing framework into which new experiences must be integrated.[2]

Self-narratives affect both one's experiences and interpretations of these experiences. As Marr and Peterson (2013) explain, "narrative representations thus appear to function as high-level generative models… structuring our expectations about daily experiences and providing an organizing framework for interpreting incoming sensory information." (Marr & Peterson, 2013, p. 4). First, they will often impact one's expectations for their experiences—consequently drawing attention to elements of one's experience that align with it and obfuscating those that don't. They may sometimes even act as filters—determining which experiences we accept as important enough to be integrated into our self-narrative and, on the other hand, those that we minimize or ignore. As Bruner (1991) explains, "The narrative structures we construct are not secondary narratives about data but primary narratives that *establish what is to count as data*…they define what constitute the data of those accounts." This is especially important to note because experiences of suffering, like those that occur in mental disorder, often challenge one's self-narrative and in order to move on from or even continue living in the midst of suffering these experiences must be integrated into one's self-narrative to enable one to draw some meaning from it.

Self-narratives also provide a conceptual framework for interpreting and connecting our experiences to each other and to other components of our self-narrative (e.g. beliefs, goals, etc.). Many processes play a role in self-narrative construction—determining the meaning of, and the temporal, causal, and thematic connection(s) between, individual components of the self-narrative—including the following four groups of processes widely acknowledged to play central roles. Those involved in (1) *memory reconstruction* – impacting the content of one's memories; (2) *minimal self-reference* – impacting one's relationship (sense of ownership and agency) to memories; (3) *temporal structure* – impacting the temporal relationships between memories; and (4) *metacognition*—impacting the meaning or saliency relationships between the memories (Gallagher, 2003).[3] While the fourth set of processes is most

[2] There is disagreement over whether the self-narrative *constitutes* the self or merely *describes and impacts the experience of* the self but note that only the latter, weaker claim is required for my purposes. Relatedly, I do not need to clearly distinguish between the concepts of 'self', 'identity', 'self-concept', etc. nor clarify the specific relationship between them.

[3] Note that these processes involved in the construction and maintenance of one's self-narrative may operate intentionally (e.g. one tries to determine which of two events from one's past happened more recently), but need not and often do not. More often, they operate somewhat automatically and below the level of one's conscious awareness.

explicitly associated with meaning-making, all of them work together to encode memories and shape the meaning drawn from experiences. For example, ascribing meaning to a past experience of suffering may occur along with alterations to one's subjective sense of how long ago it happened (temporal structure), an increased sense of agency over these experiences (minimal self-reference), as well as alterations in the saliency of different components of the memory upon subsequent reconstructions (memory reconstruction).[4]

Communal narratives (those of families, churches, religions, and cultures) play an important role in shaping self-narratives and informing meaning-making (Brockmeier, 2015; Lindemann, 2001; McLean, 2015; Nelson, 2003). These narratives contain information about the social identities and attributes of those belonging to the communities (or in some cases, those outside of the community) and thus can shape what is possible for self-narratives of individuals—to positive or negative effect. Notably, while these processes—those involved in constructing and maintaining self-narratives and mediating the effects of communal narratives—may sometimes occur intentionally (e.g., one actively tries to distill meaning from a particular experience or think about what is possible within a particular communal narrative) they may also occur unintentionally or unconsciously (e.g., even when one is not actively looking for meaning in an experience, meaning may nevertheless 'present itself', or when one is impacted by communal narratives one is not consciously aware of and/or does not consciously endorse it) (Flaskas, 2018; Heintzelman & King, 2013). However, while individual and communal narratives often impact us without us being aware of them doing so, there is also ample evidence that intentional exposure to and engagement with such narratives can similarly impact us (Hawke, et al., 2014; Green, 2021; Zhuang & Guidry, 2022). Thus, both individual and communal narratives serve as interpretive frameworks which inform meaning-making. And this meaning-making is integral to how individuals understand and experience their suffering, including (and most relevant for my purposes) that due to mental disorder. The role of narratives, especially the self-narrative, in explaining and addressing the effects of mental disorder is well-known (e.g. engaging in narrative therapy to reshape one's self-narrative) (Freedman & Combs, 1996).

Notably, those in the US with mental health concerns are more likely to seek help from spiritual or religious leaders than from psychologists or psychiatrists combined (Heseltine-Carp & Hoskins, 2020; Oppenheimer, et al., 2004)—thus resulting in spiritual and religious leaders often acting as 'frontline' mental health care workers and 'gatekeepers' to mental health treatment and services. For many of those with a mental disorder, spiritual and/or religious narratives play an important role in how they understand and experience it. For the vast majority, this is because they are spiritual and/or religious – 89% of those in the US and 93% globally identify as religious, spiritual, or both (Feltzer, 2020; Pew Research, 2012). Additionally, even those who do not identify as religious and/or spiritual are often influenced by religious or spiritual narratives in their understanding and experiences of mental disorder (Park, 2005;

[4] Although for simplicity's sake I sometimes speak as if this is a process with distinct steps: (1) encode memory of experience, (2) draw meaning from experience, (3) alter one's self-narrative in light of this—it is likely an iterative process in which all steps occur in tandem.

Pargament & Mahoney, 2016; Shaw, et al., 2005). This is perhaps due to the fact that religion and spirituality have long played a role in attempting to understand mental disorder and its origins and that mental disorder is a phenomenon that seems to cry out for some deeper explanation. Kosarkova, et al., 2020 explain, those who experience mental disorder and identify as neither religious nor spiritual may yet be "disappointed by the material world and turn to the sacred" in order to make sense of their experiences. Again, interestingly, this spiritual or religious dimension seems to be rooted much more deeply in our conceptual frameworks for mental disorder than it does for other kinds of disability (e.g. intellectual or physical) or other instances of suffering (e.g. physical disease, loss).

Unfortunately, these spiritual or religious narratives are often misleading (at best) or stigmatizing and harmful (at worst) leading to *over-spiritualization* of mental disorder—reducing it to the spiritual realm in its etiology and treatment—while subsequently failing to provide a conceptual framework for *spiritual meaning-making*, necessary for drawing spiritual meaning from one's experience (e.g. it's meaning in relation to one's individual spirituality, religious community, etc.) (Scrutton, 2015a; Finley, 2023). The role of spirituality or religion in mental disorder is also further complicated by the fact that religious content is common in many symptoms of mental disorder (e.g. delusion, hallucination)—and these symptoms can sometimes look strikingly similar to things typically seen as 'legitimate' instances of spirituality or religiosity (e.g. an auditory hallucination vs. a religious experience of 'God speaking to you') (Cook, 2015). Again, despite the importance and complexity of these interactions between mental disorder and religion and spirituality, there is a lack of philosophical work addressing it, and even in psychology much of the research on these topics focuses on religious coping or the protective role of elements of religiosity against mental disorder—failing to sufficiently address the topic of spiritual meaning-making.

I address this gap, focusing on the impact of religious and/or spiritual narratives on meaning-making in mental disorder—often alongside other forms of what I will call 'religious engagement' including religious and/or spiritual beliefs, experiences, and practices. As the vast majority of work on this topic has thus far has focused on religion and/or spirituality grounded in monotheistic religions, especially Christianity, I will do the same. While 'spirituality' refers to a much broader range of phenomena typically centering around a connection to 'something more than and beyond oneself' than 'religion', I will sometimes use the terms interchangeably as their use is often not standardized in literature on the topic, we used both terms in our study, and many of our participants similarly used them interchangeably. Thus, future mentions of 'religiosity' and 'spirituality' should be understood to refer to instances of religiosity and/or spirituality broadly grounded in the Christian tradition. However, many of the themes and concepts drawn upon will be shared across many monotheistic (and even non-monotheistic) religions (e.g. relationship with God, the meaning of suffering, the importance of religious practice, etc.).

Empirical investigation

In this study we investigated whether and to what extent reading individual narratives—specifically those capturing firsthand experiences of mental disorder and its interrelationship with religious engagement, as well as the meaning-making surrounding these experiences—would impact participants who had had similar experiences. We were motivated and informed by two important sets of research: research attesting to *the importance of narratives in and of experiences of mental disorder* (Hawke, et al., 2014; White, et al., 1990) and *the importance of narratives in spiritual and religious meaning-making* (Finley & Seachris, 2021; Proffitt, et al., 2007). Both of these literatures provide compelling evidence that narratives play a crucial role in helping individuals to make sense of their experiences of mental disorder and religious identity, respectively—and that they play an equally central role in structuring and informing communal-level understandings of (and stigma towards) mental disorder and communal meaning-making in religious communities. Our study builds and expands on this research insofar as it explores the importance of narratives in *spiritual* meaning-making about *mental disorder.* Ultimately, our results indicate that reading and engaging with our narratives impacted participants' (1) sense of identity or self-narrative and its connection to their mental disorder and religious engagement, and (2) understanding of the relationship between their mental disorder and religious engagement.

Methodology

We ran a longitudinal study for which we recruited participants through the National Alliance for Mental Illness (NAMI), Amazon's Mechanical Turk as well as through local churches and Christian organizations. After they provided informed consent, participants were asked questions to ensure they met our participation criteria of having had (current or past) personal experience with both 'the Christian religion or faith' and mental disorder.[5] If they fulfilled these criteria, they were then asked to provide demographic information and further details about their experience with mental disorder (diagnoses, whether they had received them from a medical professional) and religious identification (denominational background, current identification).

[5] 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, we were required to use the term 'mental health symptoms' rather than 'mental disorder' 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 be 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.

We began with 105 participants (because of anticipated drop-off), 42 of which completed the entire study, thus those are the only participants included in our analyses.[6] These participants reported experiencing (through free response) 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. Additionally, the ten symptoms reported (through multiple choice options) by most participants were: 86% anxiety, 62% feelings of loss and/or hopelessness, 50% increased guilt, 47% increased fears and/or worries, 45% increased anger and/or irritability, 43% increased depression, 43% mood swings, 38% major changes in ability to think clearly and/or concentrate, 33% very low energy, 31% issues with memory.[7] Additionally, our participants were 34% men, 66% women; 13% Black or African-American, 3% Hispanic, Latino, or Spanish, 8% Asian, 76% White. They reported the following as their highest degree: 15% high school diploma, 5% associate degree, 37.5% bachelor's degree, 40% master's degree, 2.5% doctorate degree. And they identified as 22.5% Nondenominational Christian, 32.5% Protestant, 30% Catholic, 5% non-Christian, and 10% 'other'.

Participants then filled out an initial questionnaire in which they were asked a few general questions about their mental disorder and religious engagement (including their religious beliefs, experiences, and practices) and interactions between them. Additionally, we used the following 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 self-narrative. We also 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 self-narrative.[8]

[6] 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.

[7] Religious denominational affiliations were mutually exclusive while the symptom options were not—and neither were mental disorders, as we gathered this inforamtion through free response. 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).

[8] 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

Additionally, we asked two sets of questions designed to measure participants' understanding of the relationship between their mental disorder and spirituality—the first addressing over-spiritualization of their mental disorder, the second addressing spiritual meaning-making towards their mental disorder. The first set of questions addressed the *nature* of mental disorder, to what extent participants saw it as a *spiritual phenomenon*—which has implications for its etiology and treatment (e.g. 'How do you understand your mental health symptoms?'). In contrast, the second set of questions addressed to what extent participants saw their mental disorder as having *spiritual meaning* (e.g. 'My religious and/or spiritual life has helped me better understand my mental health symptoms'). While for some, their answers to these questions are likely related, the two issues are separable—in fact, one may adopt a wholly non-spiritual view of the etiology of their mental disorder (e.g. it was caused by one's genetic pre-disposition coupled with their environment) as well as the treatment (e.g. it ought to be treated by professional therapy and medication) while still embracing a spiritual meaning-making view (see Finley, in preparation).

This questionnaire (and the rest of our questionnaires) included short-answer open-ended questions, multiple choice, and Likert scale questions. After the initial questionnaire, participants completed a series of 5 questionnaires over the course of 10 days (with at least 24 hours between the questionnaires). As a part of each questionnaire, participants read one of five different 3,000–3,500-word firsthand non-fiction narrative accounts of a different person's experience with mental disorder and religion and then responded to questions designed to test comprehension and prompt engagement (e.g., 'list two symptoms that Lucia mentioned in the narrative'). On the final questionnaire, they were asked most of the questions on the initial questionnaire (including the aforementioned measures).

Each narrative that participants read was constructed from a single interview from a participant in a previous study of ours (Finley, 2023). We selected which participant interviews we used, as well as the content retained or cut, and the organization of the narrative in order to counteract typically misleading or harmful features of narratives of mental disorder often found in Christian communities. Such narratives often 'over-spiritualize' mental disorder—viewing it as a solely or mostly spiritual phenomenon. The two most common instances of this are accounts according to which mental disorders are seen as 'spiritual illnesses' or 'spiritual gifts', so to speak. According to *Spiritual Illness* accounts, mental disorder is caused or at least allowed by God as a result of one's sin, shortcomings, or evil supernatural forces—and thus ought to be 'treated' through prayer, repentance, etc. In contrast, *Spiritual Gift* accounts maintain that a mental disorder is an indication of or reward for holiness or closeness with God—and thus (in most cases) ought not be treated but rather embraced, to some extent, as a means of deeper connection with God (Finley, 2023; Scrutton, 2015b).

Research indicates that these kinds of over-spiritualizing accounts are frequently encountered in Christian communities, especially Spiritual Illness accounts, and are often applied in misleading and harmful ways (Ayvaci, 2016; Lloyd & Waller, 2020; Stanford, 2007). They 'reduce' mental disorder to the spiritual realm—often dimin-

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 a high PDIS score.

ishing or denying the biological, psychological, and environmental dimensions of mental disorder, especially in considering the etiology of the disorder (e.g. genetic predisposition, traumatic experiences) and treatment (e.g. medication, therapy). They also tend to see mental disorder as inherently either good or bad: Spiritual Illness accounts see mental disorder as an inherently bad thing that comes about as a result of negative spiritual forces (e.g. sin, God's punishment), whereas Spiritual Gift accounts see it as an inherently good thing resulting from positive spiritual forces (e.g. virtue, God's blessing). Both kinds of accounts are inaccurate to the experiences of many of those with mental disorder and can lead to diminished willingness or ability to get professional treatment (Ayvaci, 2016); as well as a sense of blame for and often shame about one's mental disorder (with Spiritual Illness accounts) or a romanticization of mental disorder (with Spiritual Gift accounts).

We created our narratives to challenge the above misleading and harmful features of narratives about mental disorder by doing the following. First, each of the narratives highlighted the *multidimensional nature* of the participant's mental disorder—including biological, psychological, environmental, and spiritual dimensions—in order to counteract overly reductionistic accounts of mental disorder mentioned above. For example, the following narrative excerpt addresses the intertwining impact of medication and theological teachings on the speaker's understanding and treatment of their mental disorder,

> I've been doing a new medication, and that seems to be a piece of the puzzle… it helps me not feel so much anxiety or responsibility for the things that I've gone through. It's interesting, I've also been listening to this preacher whose emphasis is like, you know, we don't even have a clue how much God loves us. And that just really sparked my brain. I've been judging myself less and just telling myself things that are more uplifting than judgmental. But I don't think I could have really done that before...I did that sometimes, but only for short periods of time, it was always such a struggle. It was like, my brain wouldn't let me think that way. But now, taking the medication, and just knowing about the stuff going on in my body and my brain with all of this, it just clicked, like, this really isn't my fault, and it's also not all my responsibility to fix.[9]

In presenting more nuanced pictures of mental disorder, we challenged over-spiritualizing accounts of mental disorder, like those mentioned above, as well as over-medicalizing accounts—roughly, those which hold that mental disorders are largely or solely due to biological factors such as genetics, neurochemistry—which, while they are less common in religious communities than over-spiritualizing accounts still often occur in more self-identified 'progressive' religious communities. This tendency towards reductionism is also seen in the broader culture in the fact that even nominally *Biopsychosocial* views of mental disorder, according to which mental disorders are ostensibly due to a mix of biological, psychological, and environmental/social factors often in fact collapse into a focus on the biological factors (and reduction of the other factors to the biological dimension). This is sometimes referred to

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

as the 'bio-bio-bio' view of mental disorder (Read, 2005). In contrast to the over-spiritualizing accounts, these over-medicalizing approaches minimize or deny the importance of non-biological (e.g. psychological, environmental, and spiritual) dimensions of many mental disorders (Saten & Lilienfeld, 2014; Smith, 2014). Similar to over-spiritualizing approaches, over-medicalizing approaches have been found to lead to increased stigmatization and fear towards those who experience mental disorder as well as a decreased sense of agency in those who experience it (Haslam & Kvaale, 2015). Thus in presenting a multidimensional account we can counteract the extremes of both of these reductionistic approaches.

Second, our narratives focused on *the spiritual meaning-making of the narrator*—how they made sense of what their experiences of mental disorder meant for their identity, specifically spiritual elements of it. Relatedly, the narratives also highlighted both *positive and negative effects* of the narrator's mental disorder on their religious engagement, often specifically highlighting positive effects (e.g. increased sense of empathy, increased sense of God's presence) of their mental disorder in the midst of and often through the suffering it brought about (for more see Finley, 2023). Both these features challenge the views mentioned above which focus on etiology and tend to approach mental disorder as inherently negative (Spiritual Illness views) or inherently positive (Spiritual Gift views). For example, in the following excerpt from one of the narratives, the subject highlights both the benefits derived from, as well as the suffering brought on by their mental disorder—and also points to the importance of their meaning-making processes in making sense of their mental disorder and its role in their life and identity,

> A lot of what I've experienced with my mental disorder I think has been really impactful for me, in a good way. And I think there are some really unique benefits from that, from the symptoms and how they impact how I see and understand things. But, to be clear, I also really hate my mental disorder [laughs]...I mean, it really *really* sucks. It is one of the most painful things...and I really resent God for letting this happen, if he did. But I also hold that together with some of the good things it brings about…A lot of the benefits that I feel like I experience have come from like really trying to think hard about like "Are there any silver linings I can pull from this?" "Are there any benefits I can try to focus on?" So, it's taken a lot of effort to like think through what those might be and try to make them more a real part of my life.

In summary, in the narratives read by subjects we presented nuanced and complex accounts of experiences of mental disorder and their connection with religion, that resisted easy categorization and challenged over-simplified predominant narratives. In doing so, we sought to impact participants' views of their own mental disorder, its connection to spirituality/religion, and how all of this impacted their sense of identity. To elicit further engagement with the narratives, after reading each of the narratives and answering comprehension questions, we presented participants with a (7 question) measure of Narrative Engagement (NE) (Busselle & Bilandzic, 2009) which included questions like 'I was mentally involved in this story while reading

it' and (reverse scored) 'I had trouble imagining the persons, emotions, and events described in the story'.

After reading their 5th narrative and responding to the questions mentioned above, on their final questionnaire participants filled out a set of questions about their own experiences with mental disorder, spirituality/religiosity, and interactions between them—many of which were identical to those asked on the initial questionnaire, including the CRS and PDIS measures. In what follows I will use the following shorthand to refer to participants' scores on the above measures: Centrality of Religiosity Scale score = 'REL ID score', Personal Disability Identity Scale score = 'MD ID score', and Narrative Engagement score = 'NE score'.

Hypotheses

In our study we investigated if and how participants' views were impacted by reading firsthand narratives addressing connections between their mental disorder and spirituality and/or religion. This was determined through analysis of changes in their answers to the aforementioned sets of questions to test the following hypotheses. Hypothesis 1: *participants' MD ID and REL ID scores will increase* over the course of the study (specifically, their scores on day 5 will be higher than those on the initial questionnaire). Hypothesis 2: *participants' responses to questions about the nature of mental disorder will change to reflect a more balanced view*—cutting between over-spiritualizing and over-medicalizing accounts (specifically, their scores on day 5 will be closer to the 'mid-point' of the scoring range than those on the initial questionnaire). Hypothesis 3: *participants' responses to questions about the meaning of mental disorder will change to reflect a more important and more positive role for spirituality and/or religion in meaning-making about mental disorder* - one more amenable to spiritual meaning-making. Hypothesis 4: *these changes will be correlated with participants' NE scores.* In brief, we hypothesized that, as a result of reading these narratives, participants will come to identify more closely and positively with their mental disorder and religion/spirituality, and will also shift away from over-spiritualizing views of mental disorder and towards those that enable spiritual meaning-making.

Hypothesis 1: results & discussion

Our first hypothesis—that *participants' MD ID and REL ID scores will increase* – was partially confirmed. Although participants' REL ID scores increased, this result was not statistically significant. However, there was a significant increase in disagreement with one of the statements in this REL ID measure: 'I wonder whether God has abandoned me' ($p < .001$). Additionally, the increase in participants' MD ID scores was very statistically significant ($p < .00005$) as were changes in participants' responses to 10 of the specific statements in this MD ID measure. The most significant ($p < .001$) were increased agreement with 'I have found benefits to having mental health symptoms' and increased disagreement with the statements: 'Because of my mental health symptoms, I will never become the person I want to be' and 'Because of my mental health symptoms, I don't pursue my dreams'.

Participants' initial and final REL ID scores were not correlated with any of the demographic features that we tracked (sex, race, education level, or religious affiliation), nor were they correlated with participants' MD ID scores. Similarly, participants' initial and final MD ID scores were not correlated with their sex, race, or religious affiliation; however, they were correlated with their education level. Participants' initial MD ID scores were strongly correlated (r = .5) and their final MD ID scores were moderately correlated (r = .4) with their education levels—in other words, those participants with more education more strongly (positively) identified with their mental disorder and were less likely to feel like it was an impediment to them.[10]

The fact that MD ID significantly increased for participants, while REL ID did not may be due in part to the fact that people are often prompted to reflect on the religious facets of their self-narrative and identity—and this identification is often seen as positive, and is encouraged; in contrast, identification with one's mental disorder is more often seen as negative and is discouraged.[11] Relatedly, people are likely more often exposed to narratives involving religious identification, than they are to narratives involving identification with one's mental disorder. Thus, after engaging with narratives wherein identification with religion and mental disorder were central themes, this may have been less likely to greatly change participants' pre-existing level of identification with their religion than it was to change their level of identification with their mental disorder. Although prima facie, it may seem that increased identification with one's mental disorder is a negative thing, recall that this is specifically an increase in *positive* identification—identification with one's mental disorder as something that adds to rather than takes away from one's experience. This is clear in the significant increases in disagreement with the negatively coded statements: 'Because of my mental health symptoms, I will never become the person I want to be', and 'Because of my mental health symptoms, I don't pursue my dreams'. As a result of engagement with the narratives, aspects of participants' self-narratives may have shifted away from negative associations with or assumptions about their mental disorder to positive ones. And again this makes sense given that in our narratives, narrators emphasized some of the positive effects of their mental disorder alongside the negative (thus avoiding romanticizing or over-spiritualizing their mental disorder).[12]

[10] All correlations were calculated using a Pearson correlation coefficient—which measures the correlation between two variables.

[11] Additionally, Those with higher levels of education may have started with higher initial MD ID scores because of increased exposure to research and narratives (in an academic context) concerning mental disorder and/or disability more generally (e.g. Disability Pride, treatments for specific mental disorders, life stories of those who lived well with a mental disorder), that may have opened up the 'conceptual space' for them to identify with it positively. It may also be the case that because they have attained higher levels of education while experiencing their mental disorder they may be less likely to see it as a limitation.

[12] Although I have referred to identification with mental disorder and spirituality/religion as positive, at least insofar as it is captured by these measures, I make no claims about the long-term positive effects of such identification. It may be the case that increased identification with one's mental disorder (or religion), while positive in the short term may have further negative effects down the line. For example, if one comes to identify more closely with one's depression and then causes harm to a loved one while experiencing a deep bout of depression—the increased identification may in turn lead to an increased sense of shame or responsibility on the part of the individual for causing this harm (among other things).

Hypothesis 2: results & discussion

Our second hypothesis—that *participants' responses to questions about the nature of mental disorder will change to reflect a more balanced view* – was confirmed. There was a statistically significant change in participants' views of the nature of their mental disorder away from both over-spiritualizing and over-medicalizing views towards a more balanced view ($p < .00005$ and $p < .05$, respectively), one that was open to both dimensions of mental disorder.[13] There was a particularly strong correlation ($r = .8$) between participants initially reporting a more spiritual view of mental disorder and shifting towards a more balanced view that was, in contrast to their previous view, less exclusively spiritual. Interestingly, participants' responses on these questions were not correlated with either their MD ID or REL ID scores—those who more closely identified with their religion were not more likely to view their mental disorder as more spiritual—nor were they correlated with any of the demographic features that we tracked (sex, race, education level, or religious affiliation).

Again, these results make sense in light of the fact that our narratives highlighted the multidimensional nature of mental disorder. As addressed above, the narratives contained explicit mentions of both biological (e.g., medication) and spiritual (e.g. relationship with God) factors influencing their mental disorder—as well as their connection with each other.

Hypothesis 3: results & discussion

Our third hypothesis, that *participants' responses to questions about the meaning of mental disorder will change to reflect a more important and more positive role for spirituality and/or religion in meaning-making about mental disorder*—was partially confirmed. While participants increased their agreement with most questions addressing the importance of spirituality and/or religion in meaning-making about mental disorder, all but one of the changes were not statistically significant. There was a statistically significant ($p < .01$) increase in agreement with 'My religious and/or spiritual life has helped me better understand my mental health symptoms'. This result was not correlated with participants' sex, race, religious affiliation, or education nor was it correlated with their MD ID scores, it was however moderately correlated ($r = .3$) with their REL ID scores. Regarding questions addressing the positivity of the role played by spirituality/religion in meaning-making, again, participants increased in agreement on most questions, however, most of the changes were not statistically significant. However, there was a statistically significant ($p < .05$) change

[13] On a 5-point scale, most participants initially responded to questions about the 'spiritualizing' vs. 'medicalizing' nature of mental disorder indicating that they favored the former—however, some participants favored latter. Splitting participants into these two groups, the former group changed from an average score of 4.02 to 2.54 (higher scores 3.5-5 indicating a more spiritualizing view) ($p < .00005$), while the latter group changed from an average score of 2.00 to 3.60 (lower scores 1-2.5 indicating a more medicalizing view) ($p < .05$). Interestingly, both groups of participants actually 'overshot' the middle point, indicating that the narratives had an even stronger effect than predicted—those who originally had an over-spiritualizing view not only shifted to a view closer to the middle, but one that was slightly medicalizing, and vice versa.

in participants' responses to the statement "How would you characterize the overall interaction between your mental health symptoms and your religious and/or spiritual life?' indicating an increase in positivity. Again, participants' responses were not correlated with their sex, race, religious affiliation, or education—however, they were strongly correlated with their MD ID ($r = .5$) and REL ID ($r = .6$). In other words, those who more strongly identified with their mental disorder and/or their spirituality/religion were more likely to think that their spirituality/religion played a positive role in meaning-making about mental disorder.

Again, these results make sense in light of the fact that our narratives focused on the meaning-making of the narrators towards their mental disorder—specifically their spiritual meaning-making. They often emphasized how various components of their religious engagement (e.g. beliefs about God, religious practices, sense of God's presence, etc.) impacted the perceived meaning of their mental disorder. Furthermore, these narratives also highlighted the positive (and negative) effects of narrators' mental disorder that emerged through the narrators' meaning-making. These results also align with the results cited above in support of hypothesis 1—namely increases in participants' *positive* identification with their mental disorder, and to a lesser extent, their spirituality/religion.

Hypothesis 4: results & discussion

Finally, our hypothesis that *these changes will be correlated with participants' NE scores*, was partially confirmed. There was a statistically significant, moderate correlation between participants' NE scores and their shift towards a more balanced view of mental disorder ($r = .4$, $p < .01$). However, while there were also correlations between *all* of the changes mentioned above (changes in MD ID and REL ID scores and responses to statements addressing the role of spirituality/religion in meaning-making about mental disorder) and participants' NE scores, the rest of these correlations did not reach the level of statistical significance. Additionally, none of these findings were correlated with participants' sex, race, education, or religious affiliation.

It is important to take the lack of statistically significant correlation between many of our results and participants' scores on the aforementioned NE measure with a grain of salt as an indicator of the influence of their narrative engagement. This measure was initially intended to merely *prompt* rather than *measure* narrative engagement and it was not developed specifically for this medium, length, or kind of narrative and thus it may not have been well-suited to measuring our participants' narrative engagement. Additionally, many participants may have been merely unaware of the extent of the narratives' effect on them.

This seemed to be reflected in some participant responses in their follow-up interviews. In answer to a question explicitly asking them how they thought the narratives affected them, multiple participants explained that while they enjoyed them, they did not think they affected their thinking on any of the matters addressed in the questionnaire; however, many of these participants also repeatedly cited specific elements of the narratives (e.g. 'when Lucia mentioned that she felt God's presence more clearly through her experience of depression, that made me realize I had sometimes felt that as well') in their answers to questions about their own experiences.

This indicates that the narratives *did* impact at least some participants' thinking on these matters even when they were not explicitly aware of this impact—and this is a well-documented feature of the effects of narrative (Flaskas, 2018). Thus, while it is possible that a lack of correlation of NE scores with some of the effects mentioned above points to something other than narrative engagement as a cause of the changes, I think one of the above explanations is far more plausible. Because all of our questionnaires (after the initial one) consisted entirely of reading and engaging with the narratives, it stands to reason that the changes cited above were due at least in part to participants' engagement with the narratives.

General discussion

Narrative mechanisms

Returning to the narrative mechanisms addressed above can shed further light on our results—namely, how they may have occurred. First, recall that narratives impact how we *take in information*—by shaping our expectations, they guide attention to elements of our experiences that align with them and obfuscate those that don't. Second, recall that narratives also provide conceptual frameworks for how we *interpret and integrate new information* that we have 'taken in', so to speak—highlighting certain connections (thematic, causal, temporal, etc.) between disparate elements of a narrative (e.g. particular memories, experiences, elements of experiences) over others. Third, recall that *self-narratives* provide the framework for integrating this new information, through processes involved in memory reconstruction, minimal self-reference, temporal structure, and metacognition. As mentioned above, our narratives were constructed to highlight features of the narrators' experiences of mental disorder including its multidimensional nature, its potentially positive spiritual meaning, and its role in identity. These features may have impacted participants by drawing attention to elements of their own experiences and by shaping their interpretation and integration (or in some cases re-interpretation and re-integration) of previous experiences. This may have potentially counteracted the effects of predominant narratives of mental disorder and religion and/or spirituality which often fail to address the elements above or present a picture counter to it.

For example, if a participant with bipolar disorder had adopted (or unintentionally absorbed) an over-spiritualizing narrative about her disorder this may lead her to pay more attention to and perhaps even ruminate on spiritual (or seemingly spiritual) elements of it (e.g. viewing mania as religious experience, depression as caused by one's sin, etc.). This may in turn obscure the importance of non-spiritual dimensions of her disorder and associated treatments (e.g. neurobiological causes, medication, non-spiritual therapy) and it may also increase self-blame for her disorder. Similarly, adopting a narrative according to which her mental disorder is inherently negative and devoid of any spiritual meaning may also cause her to focus on and perhaps even exacerbate or amplify the negative effects of her disorder, automatically interpreting things as the result of a breakdown or malfunction, and obscuring any potentially positive meaning or effects, including those that are spiritual/religious.

In contrast, reading one of our narratives which highlighted the narrator's experience with bipolar disorder as multidimensional as well as the positive role of spiritual meaning-making may (to some extent) counteract the aforementioned narrative and shift how the participant experiences and interprets her disorder. Reading the narrator's spiritual meaning-making highlighting positive spiritual effects of her bipolar disorder—experiencing God's presence and increases in empathy—may similarly shift her *attention* toward similar elements in her own experience. And reading about the narrator's understanding of the importance of non-spiritual causes of her bipolar disorder (e.g. neurobiology, upbringing) and corresponding treatment (e.g. medication, therapy) may draw her attention to new kinds of '*causal* connections' which may in turn shift the participant away from an over-spiritualized understanding of her bipolar disorder. If she was previously told that her (spiritual) shortcomings were the cause of her bipolar disorder, the narrative may help shift her towards seeing the potentially important role played by her neurobiology and/or traumatic past experiences in bringing about her disorder. The narrative may also have provided new '*thematic* connections'—insofar as the narrator engaged in spiritual meaning-making, this may have provided additional 'themes' such as viewing their bipolar disorder as an important part of her spiritual identity and as playing an important role in her understanding of and relationship with God.

Thus, we can see the ways in which this narrative may have impacted her self-narrative. First, it may have impacted *memory reconstruction* processes in that, previously, while she may have more narrowly focused on the spiritual (or seemingly spiritual) and negative elements of her experience of bipolar disorder—with these changes in her conceptual framework she may, in a sense, 'recover' elements of her past experiences tied to her disorder's non-spiritual dimensions and/or spiritual meaning. Relatedly, this shift in meaning-making may also engage her *metacognitive* processes—perhaps increasing the saliency of those connected to the positive effects noted above and/or those tied to the biological underpinnings of her bipolar disorder. This may also impact the *temporal structure* of her self-narrative in that those more salient past experiences may feel 'closer in subjective time' to her because of their increased relevance.[14] Thus, our knowledge of how narratives impact people can help make sense of why the narratives we presented participants with may have led to our results—namely, statistically significant increases in participants' MD ID, a shift away from over-spiritualization of mental disorder, and towards spiritual meaning-making.

Additional narrative features

Finally, in addition to the more distinctive elements of the contents of our narratives mentioned above (i.e. that they were focused on the multidimensional nature of mental disorder, the role of mental disorder in identity, and its potential spiritual meaning)—there are additional relevant features of our narratives that were highlighted by our participants which may have further contributed to the degree to which partici-

[14] Again, recall that these processes often operate fairly automatically and below the level of one's conscious awareness.

pants were receptive to them, and hence the degree to which they were impacted by them. These features are those often found in narratives more generally and speak to their power in these and similar contexts. First, our narratives communicated *details* (often intimate ones) of the thoughts and experiences of the narrator. This contrasts with the ways in which many participants reported hearing mental disorder addressed (when it was addressed) in their religious communities—namely, as focused more on generalizable meaning that might be drawn from such experience. For example, one participant attests to this contrast explaining,

> I've seen the preaching of religion [on mental disorders], as like a 'catch all', kind of like everyone's testimonies [are] like, 'yay, God saves'. And I'm like, OK, didn't work for me. Like, that's just not how that works. But I see now with these readings of people's testimonies how religion has actually helped them through their mental health and because they are more into detail about how that specifically worked for them.

In this quote, the participant notes the more general and archetypal narratives that are often presented (when narratives about experiences with mental disorder are presented at all)—namely, those that are largely triumphant and end with the person being 'saved from' or having 'cured' their mental disorder. In contrast, the more detailed, personal stories we used fit less neatly into a generalizable narrative arc and often ended very much in the midst of the narrator's struggle. This focus on the intimate and often vulnerable aspects of individual experiences also enabled the narratives to evoke a *sense of connection* in participants—for example, one explained,

> I spent a lot of time with [the narratives] and there are so many things I could relate to and anytime you can read something that you can relate to, I think it gives you a sense of you're not the only one out there. There are people that are experiencing, even if your situation is really different, they're still that similarity and that commonality.

Relatedly, our narratives were *descriptive* rather than prescriptive—in other words, focused more on the narrator simply articulating their story than on conveying a particular 'lesson' to persuade readers. Participants noted that they appreciated how our narratives "simply featured people being honest about their stories" rather than "trying to push a certain perspective" onto them. For example, one explained that

> …seeing everybody else's stories and what they've gone through sort of helped me understand my story a little more concretely. I can't put it into words, but I just had a better understanding. But then at the same time, I felt like, like I couldn't fully like, trying to put it to words. Because yeah…I thought there were some ways in which I gained understanding of myself.

This participant—along with many others—clearly indicates that they sensed they were impacted by the narratives that they read, but they weren't sure how to express the specific nature of this impact. This speaks to the lack of an easily accessible,

explicit, prescriptive message in these narratives—and points to the importance of the description provided by narratives in which they 'showed' rather than 'told' participants how they engaged in meaning-making surrounding their mental disorder. It may also speak to a general lack of appreciation for the formative role of narratives, specifically individual narratives. Again, this contrasts with how participants reported that mental disorder was often addressed in their religious communities—by someone (prescriptively) telling them how they ought to view their mental disorder (e.g. as something they need to repent for or 'offer up' to God).

Finally, perhaps as a result of the aforementioned features, our narratives were *immersive*—they drew the reader in, often triggering emotions in response to or even on behalf of the narrator. The immersiveness of our narratives was likely due at least in part to the features highlighted above: that they were firsthand narratives focused on authentically describing intimate and often emotional details of vulnerable experiences. Many of our participants spoke to this feature, including one who explained that some of the narratives "were hard to read insofar that in some narratives, I remember which ones, I could feel my anxiety, like, my chest getting tight, like, in reading." And another explained,

> I found the stories really moving…overall, I felt compassion for the people and their experience. I definitely felt some anger and frustration when I heard their stories of how they experienced the church in the midst of that. Yeah, so there was kind of a whole range of emotions...

Here, we see participants recount not only understanding or sympathy towards the narrators, but additionally, a deeper kind of empathy in which they (in some sense) shared some of the emotions of the narrator. Although the above features are not unique to narratives—many of them, especially altogether, more frequently occur in narratives, thus it is unsurprising that research in psychology attests to the fact that first-person narratives are particularly persuasive (Brunyé, et al., 2009; Zhuang & Guidry, 2022). Similarly, work in philosophy and theology focused on understanding and dealing with suffering, cites narrative knowledge and means of communication as uniquely well-suited to address this topic (Stump, 2010; Swinton, 2012). More specifically, the immersive effects of narratives are well-documented—although much of this research focuses on the effects of fictional and/or non-written narratives—as is the role of emotional content in this immersion (Green, 2021; Keer, et al., 2013; Martinez, 2014; Wojciehowski and Gallese, 2022).

Implications

Interestingly, while narratives are well-known to play a key role in meaning-making (Singer, 2004; Stapleton & Wilson, 2017), mental disorder (Freedman & Combs, 1996; Tekin, 2011), and many facets of spirituality and religion (Finley & Seachris, 2021; Schnitker, 2019)—the role of narratives in religious meaning-making about mental disorder—especially that which goes beyond religious *coping* - is underexplored. This is an important area of research because, as addressed above, narratives play a central (often underappreciated) role in shaping our understanding and expe-

rience of suffering—for good or for ill; and again as addressed above, a significant portion of the population experiences mental disorder, many from a spiritual and/or religious perspective. This is especially relevant for the topic of mental disorder as over-spiritualizing accounts of them have had much more staying power than have had similar accounts of other disabilities or sources of suffering (Lloyd & Waller, 2020; Scrutton, 2015b; Stanford, 2007).

Our study provides preliminary evidence that firsthand narratives of personal experiences with mental disorder and their complex connections with spirituality/religion, may play a role in changing and shaping how people understand their own mental disorder and its connection to their spiritual and/or religious identity. Additionally, our study indicates that the kinds of changes these narratives brought about—namely increases in identification with one's mental disorder, shifts away from an over-spiritualizing view of mental disorder, and towards one that is open to spiritual meaning-making, may have positive (at least in the short-term) effects on people. This highlights the need not just for more *discussion* of the role and importance of narratives in the relevant academic literatures, but also for increased *availability* of such narratives, especially within spiritual/religious communities.

This is because such narratives provide conceptual frameworks that shape our experiences and interpretations of our experiences and there is a relative lack of such conceptual resources concerning the intersections between mental disorder and religion and spirituality. This is especially clear when contrasting the conceptual resources and narratives available which address other kinds of disabilities (e.g. physical and intellectual) and other kinds of suffering (e.g. grief/loss, physical pain, and disease) from a spiritual perspective. Although in many ways resources are still sparse in these areas as well, those addressing mental disorder are particularly lacking. This unique dearth of conceptual resources is coupled with a particularly strong need for such resources—specifically those that are nuanced enough to avoid over-spiritualizing mental disorder while providing a conceptual framework for spiritual meaning-making (Finley, 2023; Scrutton, 2015). This study helps to lay the foundation for this work by testing the impact of such conceptual resources, specifically communicated through narrative. In closing, it is worth noting that the narratives used to communicate these conceptual resources are not merely 'attractive packaging'—making their contents more engaging, memorable, etc. Instead, the kind of conceptual resources in these narratives constitute a kind of 'narrative knowledge' that is best (and perhaps only fully) communicated through narrative (Stump, 2010).

Worries

Before concluding I will briefly introduce and address a set of worries relevant to the account and empirical work presented here. The worries concern the fact that these narratives and meaning-making processes play a crucial role in shaping our experiences and understanding of mental disorder and its relationship to spirituality/religion—and that these processes are often so malleable that this ought to give us pause about their deliverables. One version of this worry is that the kinds of 'meaning-making effects' addressed above may in fact merely be the result of (overzealous) *'pattern-recognition' capacities*. We are naturally inclined to find patterns in

and propose teleological explanations for our experiences—a phenomenon known as 'pareidolia'—thus, what if the meaning-making capacities operating based on these narratives are in fact engaging in fabrication rather than true meaning-making? Another version of this worry is that these 'meaning-making effects' may be the result of *adaptive, potentially self-deceptive, coping processes*. We are driven to diminish our suffering by finding (or creating) positive meaning out of these experiences—thus, what if (again) our narrativizing capacities are engaging in fabrication rather than meaning-making? These pattern recognition capacities often operate through narratives that we construct to help make our experiences meaningful and integrate them into our self-narratives. So the question is—what if these narratives engaging in spiritual meaning-making are simply the result of adaptive strategies employed by those experiencing mental disorder to make themselves feel better? This question is even further complicated by the fact that spiritual/religious content is common in certain symptoms of mental disorder (e.g., hallucinations that God is communicating with you, delusions that one is a messiah) (Johnson 2018; Winters & Neale, 1983). Thus, how can we maintain that certain instances of spiritual meaning-making do not merely result from coping processes and/or from the disorder itself?

First, note that this worry does not directly challenge my proposal regarding the centrality of narrative nor my empirical results supporting this—instead, it points to and challenges an assumption undergirding the kind of value or meaning we might ascribe to these results. Namely, that in order for our results to be meaningful, the spiritual meaning-making participants engage in would need to be at least somewhat truth-tracking. One would of course want it to be the case that the spiritual meaning drawn from an experience of mental disorder is, to some extent, grounded in reality. To be clear, I do not address such concerns in my study or discussion of it—nor do my results offer resources to disprove such possibilities. However, note that similar worries are often brought up in conversations about cognitive science of religion (CSR)—roughly, whether insight into the cognitive processes underlying religious engagement might undermine their legitimacy (e.g., should our belief in God be shaken by our discovery of the neurological correlates of religious experiences?) (Barrett, 2007a, b).

In response to both kinds of cases cited above, further insight into the processes at work in these scenarios ought not, without further argument, lessen our confidence in their deliverables. In response to the CSR example above, *all* elements of our mental lives have neurological correlates, and the latter is not typically taken to undermine the meaning of the former. Thus we ought to be careful not to apply a uniquely stringent (and unrealistic) standard to religious beliefs and experiences. And in response to the worry as applied to meaning-making and narrativizing processes, similarly, *many* elements of our mental lives and experiences are underpinned by these same processes—indeed, according to some, the vast majority of our experiences of ourselves *as ourselves* depends on them. Merely gaining insight into the operations of and even the goals of such processes does not challenge the trustworthiness of their output. The meaning-making processes we have addressed may be both truth-tracking *and* motivated by pareidolia and/or coping. In fact, they could even also be both truth-tracking *and* emerge (to some extent) because of one's mental disorder.

Relatedly, another potential concern is whether the kinds of spiritual meaning-making advocated for might fuel a kind of *vicious epistemological circle*. Someone is pre-disposed (say because of their spiritual/religious beliefs, past experiences) to suspect that there are certain kinds of spiritual dimensions or meaning in one's experience of mental disorder, so, she allocates more attention to the elements of her experience that might align with these expectations. As a result, she then is more likely to notice and amplify such elements, and then in turn, integrate them into her understanding of her mental disorder, and her self-narrative—and then is more likely to notice something similar about her experience in the future. Thus this 'counterfeit meaning-making' may fuel further erroneous interpretations of experience. Again, in lieu of a more thorough response, it is important to note that while this is a legitimate worry, it is not unique to this discussion of spiritual meaning-making, or indeed to talk of meaning-making at all. Whenever we engage in a kind of meaning-making there is inevitably a back-and-forth process of 'drawing something' out of our experience—as mentioned above, meaning-making must go beyond 'pure discovery' but it also needs to steer clear of 'fabrication'. It would be difficult to give a hard and fast rule or approach for cutting a path between the two, but, this issue is common when addressing many kinds of meaning-making—not just that involving specifically spiritual meaning-making about mental disorder.

While the above responses and distinctions are helpful, these responses likely do not fully allay such concerns, I suspect because of the unique nature of both mental disorder and spirituality/religion and the role they play in the lives of many. A strengthened version of the above objections might be 'even if insight into the operations and motivations or goals of such processes doesn't justify dismissing their truth-tracking potential, doesn't it justify increased skepticism towards them in these kinds of contexts because of the (for many) severity of the suffering in play and/or the deeply rooted nature of spiritual/religious beliefs?' In other words, aren't worries about these (spiritual) meaning-making processes being either *adaptive, potentially self-deceptive, coping processes* or *participants in a vicious epistemological circle* justifiably heightened because in situations of severe psychological and/or emotional pain, the need for coping (and perhaps self-deception) is even higher *and* the influence of deeply rooted spiritual/religious beliefs and experiences even stronger? While a full response to such worries lies outside the scope of this paper, I acknowledge that a heightened skepticism on the part of the individual and their community is likely advisable in many cases. These cases further highlight the importance of external sources of narratives and meaning-making (e.g., spiritual/religious community, spiritual/religious tradition, etc.) to sometimes provide a helpful counterbalance and check on one's own self-narrative and individual meaning-making. Additionally, they also highlight the importance of further research on this topic—specifically on the nature of narratives and their role in meaning-making in such contexts.

Conclusion

Our study speaks to the importance of narratives in spiritual meaning-making about mental disorder. Specifically, reading our narratives (1) decreased the extent to which participants embraced an over-spiritualizing view of their mental disorder, and increased (2) the extent to which participants positively identified with their mental disorder, and (3) engaged in spiritual meaning-making. This study also highlights important features of narratives at the level of content (e.g. their emphasis on the often multidimensional nature of mental disorder) and structure (e.g. their descriptive rather than prescriptive nature) that may have counteracted features in predominant narratives about mental disorder and spirituality/religion and contributed to their impact on participants. Lastly, it also addresses implications of and potential worries about these findings. Overall, it helps to lay groundwork for further study of the interactions between mental disorder and spirituality/religion as well as for practical means of addressing those who experience these interactions.

Declarations

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