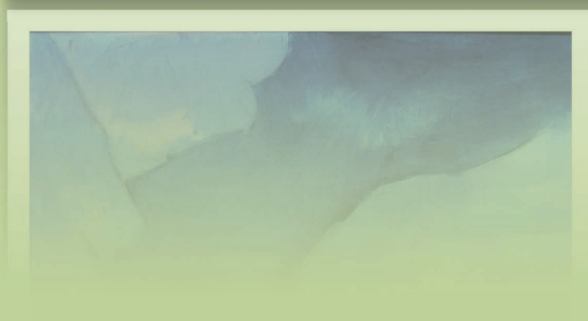


The significance of religiousness in coping with
psychosis

A qualitative study

Dissertation for the degree of philosophiae doctoral (PhD)
University of Oslo, Norway 2016

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1 Preface and acknowledgements

1.1 Acknowledgements

I have been fortunate to be working at Jæren DPS for 16 years. All these years I have found the working environment at Jæren DPS to be encouraging for my personal as well as for my professional development. It is a pleasure to work with so many positive, clever and dedicated colleagues. I am grateful that I have been given many challenges and opportunities in my work at Jæren DPS. The present research project is obviously the most challenging and interesting one so far. It is truly a gift to be given the opportunity to do research, after working for several years in the clinic.

Likewise I am grateful to The Centre for Psychology of Religion in Norway and especially to my supervisors who are all employed there. The Centre for Psychology of Religion offers an inspiring academic environment in Norway and also includes close associates from Sweden and Denmark.

There are some in particular that are to be thanked:

- Thanks to my leaders at Jæren DPS, Bård Bakke and Inger Aareskjold Salte, and the former managing directors Asle Torland and Signe Nijkamp for giving me the economic funding to complete my PhD study.
- Thanks to former the leader of the research department at SUS, Stein Tore Nielsen, for approving the collaboration with the TIPS project.
- Thanks to the leader of the research department at Jæren DPS, Anne Martha Kalhovde, for encouragement and inspiring collaboration.
- Thanks to the former leader of the research department at Jæren DPS, Margrethe Tytlandsvik, for helping me with the interviews in paper 1 and giving me the first introduction to the field of research.

- Thanks to Eva Flodberg for companionship in the groups of expressive art therapy at Jæren DPS, and to Senait Chefena for being my co-therapist in the expressive art therapy group in paper 1.
- Thanks to my supervisors, for optimistic and patient supervision. I would never have completed this thesis without your good help and advice:

Professor Lars Johan Danbolt

Professor Lars Lien

Professor Knut Hestad

- Thanks to my husband, Arne Hanevik, for helping me with philosophical questions and linguistic aid. Without you I could not have succeeded.
- And thanks to my children, Sunniva and Hallvard, and stepchildren, Kaj-Andreas and Ragnhild, for patience and love.
- Thanks to my father, Geir Harald Johannessen for interesting discussions on theological issues.
- Thanks to my mother, Laila Synnøve Johannessen for always taking part in my life and encouraging my research project as well as every other project in my life.
- And, most of all, thanks to all the wonderful patients with psychosis I met during my research project, sharing so much of their thoughts and life stories with me.

1.2 Abstract

Objectives: The aim of this thesis is to bring forward new knowledge as to the significance of religiousness for patients with psychosis in coping with their disorder, and to contribute to a well-founded theoretical understanding of how new knowledge can be utilized to improve therapy in general, and art therapy in particular, for patients with psychosis. At the moment only 15-30 % of the patients with psychosis obtain remission after their first psychotic episode (Hegelstad et al., 2012). This fact highlights the need for more research in order to improve the quality of treatment for psychosis, and also constitutes a challenge for the patient to search for own resources in coping with the disorder. Psychosis is a serious mental disorder, which affects the individual's ability to make adequate decisions in her life, and may potentially be a threat to herself and for people around her. In the process of recovery, finding own recourses is important for the patient. Religiousness may be a personal recourse helping the patient to cope with her life.

Generally, research has shown that an engagement in religious congregations, having a positive religious coping strategy, is associated with better mental health (Pargament, Ano, & Wachholtz, 2005). Religiousness is also thought to be important for patients with psychosis, coping with their disorder. At the same time religiousness can be the cause of struggle and mental health difficulties. As for patients with psychosis, religiousness is often expressed in the patient's disorder, such as the delusion of being Jesus, the experience of being possessed by aliens or evil spirits, or in the hearing of the voice of God. Unfortunately, religious delusions seem to be correlated with a poorer outcome for the patient (Siddle, Haddock, Tarrier, & Faragher, 2002). Often, it is difficult to differentiate between patients' religiousness and religious difficulties, and the psychosis itself. There is an ongoing discussion

about the content of the concept of psychosis, especially when it comes to the phenomenon of hallucination, understanding the hallucination either as a symptom of psychosis, or as a mystical experience, or both (APA, 2013).

My desire to improve treatment strategies for psychosis, resulted in the research questions of this thesis, focusing on getting a better understanding of the significance of religiousness in the process of coping with the disorder. I learned that the guidance found in professional literature, was inconsistent and contradictory, and that there was a need for further research.

Method: This present thesis is a qualitative study. In order to find sufficient answers to the aim of the study, I decided on including three sub-studies in my thesis; a case study design, a phenomenological analysis and a thematic analysis. The PhD study has a cumulative approach. The first sub-study is set in the clinic, focusing on the possibility that art therapy might help the patients cope with their psychosis. Two of the patients stated that an artistic process helped them to reinterpret their psychotic experience and by means of this they managed to cope with their psychosis in a more adequate way. For one of the patients, the exploration process of the psychosis helped her judge between her hallucinations and her mystical experiences. To be better equipped in the therapeutic encounter with patients with psychosis and their religious struggle, I wanted to grasp more fully the significance of religiousness for patients suffering from psychosis in general. Thus, I wanted to examine more closely how religiousness and existential thoughts influenced on patients' ability to cope with their psychosis. Study 2 and 3 are interview studies, examining the participants in a research setting, not in a therapeutic environment.

Main Results: The results from this thesis show that patients' religiousness may be understood as attempts of religious coping. Some patients describe that their religious coping strategies are of great importance for them, for some even life saving. Important for their meaning making process is that their understanding of their hallucinatory experiences to be an encounter with God, ancestors or a Higher Power, and that the experience is given significance as a mystical experience. This may lead to positive as well as negative religious coping strategies. Patients' religious coping strategies are not necessary solely positive, even though judged so by the patients themselves. The patients that find meaning in their religiousness, seem to display ideas of being an omnipotent religious figure, or of having a sacred omnipotent mission. Patients' relationship to the sacred figure is built on hallucinations that may change over time, possibly taking the responsibility away from the patients of caring for themselves and their relations. Even so, for some patients, their religiousness, by offering love and dignity, may serve as positive religious coping, supporting the healthy part of patients' personality, enabling them to work through and to cope with the psychosis. Alas, patients' religiousness may also reinforce their delusional system or even make them dangerous for themselves or to others. Some of the patients showed signs of negative religious coping, and their religiousness functioned as a dysfunctional reinforcement of negative core beliefs. Thus, their religiousness will add to their suffering.

The five patients in sub-study 1 (Linn) described that their participation in the art therapy group had furthered their coping abilities. All the patients met our preposition that they were capable of exploring their psychotic experience through art therapy. Two out of 5 patients described the exploration process to be particularly helpful for their ability to cope with their psychosis, whereas the others reported a

more unspecific improvement of their disorder. Religious and existential issues turned out to be two of the main focuses discussed in the art therapy group, and one of the participants described that the exploratory artistic work had opened a new ability for her to distinguish between what she experienced to be her helpful mystical experiences on the one hand, and her hallucinations and religious delusions connected to her psychotic experience, on the other.

Conclusion/ clinical implications:

On the basis of the findings in my study, I will argue that the patients' religious understanding of their hallucinations, plays a significant role in their meaning making system, and is therefore important to address in therapy. Patients with omnipotent religious delusions, such as the idea of playing an important role in the spiritual world, will often view their religiousness as a functional and positive one. For the therapist, this view may constitute an obstacle to the therapeutic process. Patients may refuse therapy, and their delusional system might be the cause of unwanted behaviour, making the patient dangerous for herself and people around her. Most probably, the function of the religious omnipotent delusion is to protect the last remnants of dignity and self-value of the patient. Therefore, it will be a very risky task for the patient to question her delusions. The challenge in therapy will be to bring the patient in a position where she feels safe enough to question her omnipotent religious convictions, or mystical experiences, not serving her well in the long run. Restoring the patient's trust in her self and her dignity, will open the possibility for her to question her delusions. Her trust will depend on the support from health care professionals as well as from close private relations in family (or congregation).

Both CBT and first-person accounts emphasize the importance of exploring the psychotic experience in order to obtain recovery (Chadwick, 2006; Lampshire,

2012; Lauveng, 2012; Sørensen, 2014). Art therapy may function as an assisted exploration of the psychotic experience, helping the patients in the process of recovery. The benefits of art therapy, is brought about by the focus on patients' recourses. This focus will empower the patient helping her to restore her trust in her self and in her dignity (Killick & Schaverien, 2006). In the exploratory process of psychotic experiences, the patient will herself decide how much of her thoughts and emotions she is willing to share with her therapist. Thus, she can go about exploring her psychotic experience without her defence system being severely threatened. The case of Linn (paper 1), as well as some other case reports (Stålsett, Engedal, & Austad, 2010; Sørensen, 2014), bring hope that therapy focusing on patients' ability to explore their experiences in psychosis, can help the patients master their dysfunctional religiousness / religious delusions: However, further research is needed to verify this.

1.3 List of publications

Paper 1:

Hanevik, H., Hestad, K., Lien, L., Teglbaerg, H. S., & Danbolt, L. J. (2013). Expressive Art Therapy for Psychosis. A multiple case study. *The Arts in Psychotherapy, 40* (3), 312-321.

Paper 2:

Hustoft, H., Hestad, K. A., Lien, L., Møller, P., & Danbolt, L. J. (2013). "If I Didn't Have My Faith I Would Have Killed Myself!": Spiritual Coping in Patients Suffering From Schizophrenia. *The International Journal for the Psychology in Religion, 23* (2), 126-144.

Paper 3:

Hanevik, H., Joa, I., Hestad, K., Lien, L., Larsen, T.K., Danbolt, L.J (2015) "Religiousness in first-episode psychosis". Submitted to the Journal of Nervous and Mental Disease.

1.4 List of abbreviations

TIPS: Early Treatment and Identification of Psychosis Study

ExA: Expressive art therapy

SCID: Structured Clinical Interview for DSM disorders. SCID is a diagnostic tool corresponding to DSM-V diagnostic categories

PANSS: The Positive and negative syndrome scale is a medical scale used for measuring symptom severity of patients with psychosis (Key, Fiszbein, & Opler, 1987).

GAF: The Global Assessment Scale is a numeric scale used in psychiatry to rate subjectively the social, occupational, and psychological functioning of adults (APA, 2000).

CBT: Cognitive behavioural therapy

DSM-V: The Diagnostic and Statistical Manual of Mental Disorders. The fifth Edition is the 2013 update of the classification and diagnostic tools of the American Psychiatric Association's (APA)

ICD-10: The 10th revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification list by the World Health Organization.

REK: The Regional Ethic Committee

DUP: Duration of Untreated Psychosis

FEP: First Episode Psychosis

1.5 Academic anchoring

1.5.1 The Centre for Psychology of Religion

The present study has been supervised by The Centre for Psychology of Religion in Norway, a research centre at Innlandet Hospital Trust, located at Sanderud psychiatric hospital near Hamar in Norway. The centre is the host of conferences and research projects related to the field of the clinical psychology of religion.

1.5.2 TIPS II study

Part 3 of the study is a collaborative work with the Early Treatment and Identification of Psychosis Study (TIPS II study). The TIPS II is a prospective clinical trial conducted in a Norwegian catchment area, investigating the course and outcome of first-episode-psychosis (FEP) (Joa et al., 2008). The study actively uses low-threshold detection teams, which recruit patients through information campaigns and visibility at schools, health centres and doctors' practices. The TIPS is designed to identify and follow, clinically, the epidemiologic sample of FEP patients. TIPS II (2002-ongoing) is a continuation of the early detection TIPS I study (1997–2000) (Larsen et al., 2001; Melle et al., 2004).

1.6 Pre-understanding

In the process of qualitative research, the relation between the researcher and the object of research, is an inter-subjective one. Thus, to judge the quality of the results of a qualitative study, it will be important to know the researcher's pre-understanding. I will therefore start this thesis by introducing myself, and my reasons for conducting this study.

Working as a psychiatrist for more than 15 years, trying to help patients with psychosis, it struck me both how unclear the concept of psychosis is, as well as the great number of explanatory models there are for psychotic disorders. Likewise, I was worried how poor the treatment results in fact are for patients with psychosis (Hegelstad et al., 2012). Traditionally, the medical tradition will focus on finding the biological cause for a medical (or psychological) problem, in order to cure it. By detecting the biological cause of an illness, doctors have succeeded in treating many diseases successfully (i.e. pneumonia cured by penicillin and the eradication of small pox from the earth due to vaccination programs). In the case of psychosis, a biological explanatory model is yet to be found. Even though researchers have succeeded in finding many and diffuse biological disturbances, such as a disturbance of the dopamine system, the explanation for these disturbances is still unknown. The last decades the use of antipsychotic medication has improved the symptoms of psychosis, but medication has only solved part of the problem. As a result of all this, ever since I started my training to become a psychiatrist, I have taken much interest in perfecting my psychotherapeutic skills. The basis of my psychotherapeutic education is psychodynamic therapy. Later I have specialized to become a cognitive behavioural therapist and also an art-therapist (ExA). CBT and ExA are both psychotherapeutic approaches that fit well with the recovery approach, focusing on patients' ability to

cope with their lives (Sheperd, Boardman, & Slade, 2015). CBT and ExA will focus on the patient being the real expert on her life, while the therapist will function as the coach, encouraging the patients to work toward recovery (Beck, Rector, & Stolar, 2011; Chadwick, 2006; Stubbe Teglbjaerg, 2011). I certainly take personal interest in finding better treatment options for patients with psychosis. This strongly encouraged me to fulfil my project. My disappointment with our current treatment strategies in psychiatry has made me be more open-minded towards new ways of constructing the concept of psychosis, e.g. by letting myself be influenced and inspired by first-person accounts of recovery.

As a consequence of my desire to improve treatment options for patients with psychosis, I decided on starting an art therapy treatment program at Jæren DPS. Sub-study 1 of this thesis is my case study of the treatment process of the first art therapy group for psychosis. Being the therapist in this particular group, I felt overwhelmed when having to discuss the issues of religiousness, which became an important topic in the course of the group. I felt I had no right to judge their religious experiences as delusional. I myself found the differentiation of the two phenomena difficult. I was open to the patients that I did not have any clear answer to their questions, but that I held the opinion that these issues might be explored through art. In my work as a therapist, I myself utilize art to explore my emotions. During the process in the art therapy group I made an artistic response to the emotions the encounters with the patients had evoked in me. The painting on the front page of this thesis is my artistic response, showing an ice-covered lake, while humanity is drifting away on an ice flake. My reaction to the painting, was the intense emotions the patients evoked in me, which I interpreted, according to psychoanalytical theory on countertransference, as the patients' deep sense of isolation (Tahka, 1983). I did not share this painting

with the patients, but utilized the information it gave me to explore the patients' experience of being marginalized as a result of their psychosis. The patients worded their sense of isolation by describing themselves as "the crazy ones", expressing that they felt that neither their spouses, nor the society, treated them seriously.

As to the significance of religiousness for patients with psychosis, there are certainly a number of theories available on the market. Some will argue that the psychotic disorder does not exist at all, and that the "psychotic experience" is in fact a religious experience, or part of a psychological evolutionary process. Others, such as in the psychiatric tradition, will more likely see patients' religiousness as part of the psychotic disorder, or alternatively, that religiousness may exist well together with a psychotic disorder, or even that it has been the cause of the psychotic disorder. I myself do believe that the diagnosis of psychosis describes a mental disorder, causing great suffering to the patient. However, I aim at staying open-minded, and I generally believe in the possibility of having mystical experiences, such as seeing angels or hearing sacred voices. I do not have any prefixed opinion of religion as solely positive in the life of an individual, psychotic or not. On the contrary, I have seen many examples from my professional and private life that religion is a burden. Generally, there is no doubt that religiousness has great impact on a person's general psychological life, leaving the possibility open for a positive as well as a negative impact. Being raised as a daughter of a Protestant priest, theological issues have always been important, and for me personally, religiousness is a way of finding meaning in life. Being a psychiatrist, I am of course influenced by the pre-understanding of my discipline (psychiatry), viewing the hearing of voices and the seeing of visions as symptoms of psychosis. However, in my private life I have met with many who have had mystical experiences, such as hearing voices, which they

consider to be a normal part of their religiousness. During the period of research, I also had the pleasure of meeting personally with Debra Lampshire and Jan-Magne Sørensen, who both gave first-person accounts of their psychosis (Lampshire, 2012; Sørensen, 2014). It impressed me how they dealt with their psychosis by normalizing its symptoms. In the case of Sørensen, this was done through his understanding of his symptoms being a part of his shamanistic religiousness.

2 What is this thesis about

The aim of this thesis is to bring forward new knowledge as to the significance of religiousness for patients with psychosis in coping with their disorder, and to contribute to a well-founded theoretical understanding of how new knowledge can be utilized to improve therapy in general, and art therapy in particular, for patients with psychosis.

My interest as a clinician for research, has sprung out of a desire to help the patient with psychosis toward recovery. In the process of recovery, finding own recourses is important for the patient. Religiousness may be such a personal recourse, helping the patient to cope with her life. However, the research on religiousness in coping with psychosis, is limited and contradictory, as described in the “introduction” section of this thesis. In the mental health system, religiousness is the last taboo, and all too many mental health workers will still avoid bringing up this issue in therapy. As to psychosis, in Norway, many mental health workers have been told they should not discuss religiousness with the patients. The reason for this was the idea that such a discussion would worsen patients’ psychosis. In the clinic we often observe that religious delusions are a source of distress for the patient, often causing them to oppose psychiatric treatment. Religiousness is often expressed as a part of the patient’s disorder, such as the delusion of being Jesus, the experience of being possessed by aliens or evil spirits or in the hearing of the voice of God. The hearing of voices or seeing visions may represent symptoms of psychosis, but may also function as a more or less integrated part of a patient’s religiousness (APA, 2013). Likewise, a religiousness, judged by the psychiatry as delusional, might represent, in terms of recovery, a helpful resource for the patient (Brett, 2002; Jacson & Fulford, 1997). These contradictory observations in clinical practice, as well as in the research

literature as to the view of the symptoms of psychosis and the role of religiousness, represent a challenge in the treatment of the patient. A mystical experience, should, out of respect for the integrity of the patient, not be treated as a psychosis. On the other hand, psychiatry might be obliged to treat symptoms, considered by the patient to be helpful mystical experiences, as part of a psychosis. The existent different views of the nature of psychosis, will inevitably affect the choice of treatment options, as well as the manner in which the mental health system will approach patients' religious expressions and needs.

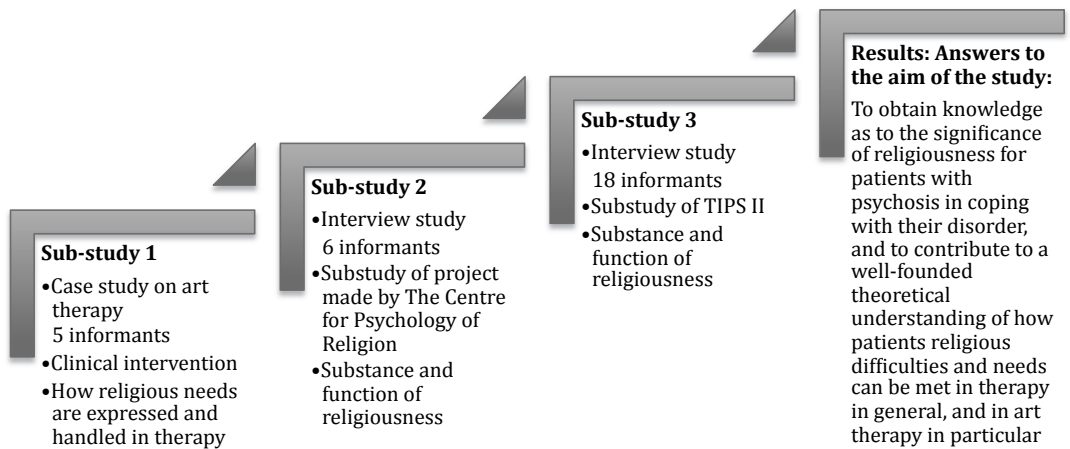
This thesis has a cumulative design. The three sub-studies, applying different sample units and methods, provide answers to the main aim of the thesis. The first sub-study explores the issues of the thesis from a therapeutic point of view, whereas for sub-study 2 and 3 the issues of the thesis are studied by means of an experimental interview situation. All three sub-studies contributed to the final conclusions of the thesis in the following way:

Sub-study 1 investigates an art therapy group, which was conducted by me. The starting point of this PhD study was the fact that I as an art therapist and CBT therapist, wanted to combine the two approaches in therapy. I then conducted an art therapy group for patients with psychosis, drawing on theory from both disciplines. As this was a new therapeutic intervention, I decided on conducting a case study on how / whether the patients had experienced their participation in the art therapy to be helpful for them in coping with their psychosis. This first sub-study provided answers to the research questions of the sub-study, but, in addition, it was revealed that patients in the art therapy group were very concerned about existential themes and religiousness, especially about how they could differentiate between religious experiences and hallucinations. For one of the patients, the exploration process of the

psychosis through artwork helped her judge between her hallucinations and her mystical experiences.

The findings from sub-study 1, corresponded well with the impression from the clinic that religious issues may be important for the patients in coping with their disorder. I started to study the literature in the field of religiousness in psychosis, but I found that the issue was scarcely investigated. I felt a need for more research on the significance of religiousness in coping with psychosis. Therefore, I planned study 2, which is an in-depth study on how patients experienced their religiousness to be help or a burden for them in coping with their disorder. I made the choice to study patients already included in the study of Danbolt et al (2011). This choice would also equip me with a research group from the field of the psychology of religion, which was to be important for the progress of my PhD study. During the process of analysis of sub-study 2, I found that it would have been a benefit for the study to have more information on patients' psychosis, because patients' religiousness and their psychotic disorder seemed to be related. I also found that sub-study 2 only included patients with long-term psychosis, and to understand more fully the significance of religiousness in psychosis, during the course of the disorder, I would also need information in the early stage of the disorder. I therefore decided on conducting a third sub-study in collaboration with the TIPS II project, which had specialized in the study of first episode psychosis. The choice of performing the third sub-study, gave me the opportunity to study the patients at the onset of their psychosis. I also got access to information on the patients' psychotic illness, such as the information available through the PANSS interview and the diagnoses of the patients.

Figure 1. The cumulative design of the thesis



To obtain knowledge as to the aim of the thesis, I found a qualitative research design suitable. I wanted to listen to the voices of the patients; i.e., the patients' subjective experience. Therefore, I wanted to focus on the patients' subjective experience of the significance of their religiousness in psychosis, and how their religiousness was of significance for them in the treatment process. In order to do so, I have included qualitative data from their artwork as well as from interviews with the patients. In addition, my intention with the present PhD study was to theorize new knowledge as to the significance of patients' religiousness in psychosis, learning how patients' religious struggle can be met in therapy. In order to obtain knowledge as to this second part of the aim of the research project, I needed information on patients' psychiatric disorder and their engagement in therapy. I thus have included data on patients' mental disorder as well as on their therapeutic process.

3 Background

In the following section I will introduce and then discuss the main concepts utilized in this thesis.

3.1 The concept of psychosis

In the present thesis I will apply the term *psychosis* according to its common use in contemporary psychiatry, and in accordance with the DSM-5 description (APA, 2013). The key problem of having a psychotic disorder, is that the disorder affects the patient's ability to judge her experiences and the outer world adequately, often making her unable to interact with others in a meaningful way, or by making her potentially dangerous to herself or others. The most common psychotic disorders include schizophrenia, delusional disorders and affective disorders (APA, 2013). Symptoms of psychosis are generally divided into two categories: *positive* and *negative psychotic symptoms*. Negative psychotic symptoms are experienced reductions, e.g. reduced motivation or reduced intensity of emotions during the psychotic stage. Positive psychotic symptoms will be defined as symptoms corresponding to a PANSS score of 4 or more on positive subscale items P1 (delusions), P2 (conceptual disorganization), P3 (hallucinations), P5 (grandiosity), P6 (suspiciousness/persecution), or A9 (unusual thought content). None of these symptoms are viewed as sufficient alone for a diagnosis of psychosis unless accompanied by a B-criterion of social or occupational impairment (APA, 2013). Based on recent research, I have applied a broader definition of the concept of *psychosis* for the present thesis and thus included both the diagnosis of affective psychosis, of schizophrenia spectrum diagnosis as well as drug-induced psychosis. Due to the apparent similarities between the various types of psychosis, researchers

have recently argued, that on a deeper level, there is only one psychotic syndrome and that we should focus on the symptoms described, rather than different diagnostic categories (Bentall, 2013) (This choice will be discussed in the section “discussion of method”).

In the present thesis I have especially focused on two distinct symptoms of psychosis, i.e. *hallucinations* and *delusions*, because they are of special significance as to the discussion of psychosis and religiousness. Moreover, the concept ***delusion*** will be applied in accordance with the DSM V description of a delusion as a *fixed belief that is not amenable to change in light of conflicting evidence* (APA, 2013) p. 87. According to this definition, the distinction between a delusion and a strongly held idea is *the degree of conviction with which the idea is held despite clear and reasonable conflicting evidence* (APA, 2013) p. 87. The cultural and religious context should of course also be taken into account when judging whether a conviction is to be labelled delusional or not (APA, 2013) p. 103, because the concept of delusion is obviously culturally specific. A conviction that an accident is caused by someone casting a spell on you, might be a plausible explanation for people in many non-western communities, but in Norway, this might be regarded by psychiatry as a psychotic delusion. More so, the Christian belief in the crucifixion and resurrection of Jesus, saving us from our sins, might for non-believers bear some resemblance to a religious delusion. According to DSM V, a ***religious delusion***, is a delusion with religious content (APA, 2013). The distinction between normal beliefs and delusions lies on a continuum (Maher & Oltmanns, 1988; Meissner, 1996; Oyebode, 2014). Peters et al (1999) found that members of charismatic groups scored evenly compared to psychotic patients on religious delusion measures, but the former were not so

distressed and preoccupied with their thoughts as the patients with psychosis (Peters, Day, McKenna, & Orbach, 1999).

In this thesis the concept of *hallucination* will be defined as a perception-like experience related to any of the 5 senses: sight, hearing, taste, smell and touch, without an external stimuli (APA, 2013; Oyebode, 2014). A *perception* is the *awareness of the elements of the environment through physical sensation* (Merriam-Webster, 2012). Human perception is based on complex neuronal interpretations of sensory experiences. In the interpretation of sensory impulses, the process of perception is brought forward by existent cognitive schemas in order to create meaning (Teigen, 2012). The hallucinatory experience has no external stimulus, but the patient will all the same consider this to be a “normal” perception. Hallucinations are not pathognomonic for a psychotic disorder (McCarthy-Jones, 2012), and may also be part of normal psychological life and normal religiousness (APA, 2013) p. 103. Even though experiences, such as seeing things, or hearing voices without any external stimuli are key symptoms for the diagnosis of a psychosis, these experiences are also frequently reported in the general society. It is a common fact that religious people report hearing voices or seeing sacred persons, interpreting them as *mystical experiences*. Patients, with first-person accounts of psychosis, will sometimes consider such experiences as “a special gift”.

3.2 Mystical experiences

The results of this thesis point to the fact that patients often understand their experiences of hallucinations as mystical experiences (see the “result” section). In the following, I will give a short introduction on the definition of the concept of mystical

experiences, as well as on the nature of such experiences. In defining mystical experiences, I have applied Geels' (2014) definition based on Robert S. Ellwood:

Mystical experiences are experiences in a religious or profane context that is immediately or subsequently interpreted by the experiencer as a direct, unmediated encounter with a higher or ultimate divine reality. This experience, which for the experiencer is irrational and immediate, engenders a deep sense of unity and suggests that during the experience the experiencer was living on a level or being other than the ordinary. The experience causes a large impact on the lives of the experiencer (Ellwood, 1980; Geels, 2014) p. 218 . Geels suggests that religious visions and auditions, should be included in the concept of mystical experiences (Geels, 2014). I will for this thesis apply the concept of *mystical experience* for experiences as being described by The Exceptional Human Experience Network, which tries to document that mystical experiences are common phenomena in the general population. The network provides a list of possible mystical experiences: After death communication, encounters with aliens, ancestral experience, encounters with angels, aura vision, automatic writing, clairaudience, voice hearing, divination, energy experience, evil entity, fire-immunity, hallucination, human magnets, human-machine interaction, paranormal touch, sacred vision, enlightenment and the sense of presence of dead ones (Network, 2016).

The characteristic state of mind, accompanying the mystical experience, is a feeling of unity, sacredness and a deeply felt positive mood (Geels, 2014). The experience brings forward a mystical consciousness that is felt to be true, and it often culminates in a positive change of attitude (Fenwick, 2010) p 13. However, in the present thesis, the term *mystical experience* will also include experiences causing negative emotions. The reason for this decision is that the experiences reported by the

patients included in this thesis, for example the experience of an encounter with ancestors or with God, is both reported to give positive as well as negative emotions. Likewise, the encounter with an evil power is not necessarily accompanied by negative emotions. Thus, for the sake of functionality and clarity, I found the concept of “mystical experiences” to be adequate.

Mystical experiences have been reported since ancient time. Through the ages, the hearing of voices was often attributed to the hearing of God’s voice (McCarthy-Jones, 2012). From the Bible we meet with several stories describing the hearing of voices, extraordinary bodily sensations and the seeing of visions. When Jesus was baptized, the crowd heard God’s voice (Holy Bible Matthew 3. 16-17), when Paul converted to Christianity to become an apostle, he heard a voice he considered to be Good (Holy Bible. Act 9. 3-5), and when Moses was chosen the leader of Israel, he heard the voice of God (Exodus, 3. 2.). Mystical experiences are extensively described in The Holy Bible, as well as in other religious scripts, such as in the Koran, the Bhagavad Gita, the Rigveda and the Upanishads.

William James was the first to examine the relationship between mystical experiences and mental health (Dein, 2012a). In his famous book “The varieties of religious experience. A study of the human nature” he claimed that the core of personal religion is the mystical state of consciousness (James, 1902). Looking into a number of different studies, Dein (2012) reports that the prevalence in the general population reporting mystical experiences, ranges from 5- 65 %. The variation is probably caused by differing definitions of such phenomena (Dein, 2012a) p. 181. In a Norwegian study, 28 % of adolescents reported to have had mystical experiences. These experiences were nearly as common among atheists as among believers in God (20 versus 36%). As many as 27 % believed in miraculous healing or in the effect of

casting curses on other people (Holmquist, 2007). Alas, in the recent past, we have seen examples of authoritarian leaders claiming to be, by means of mystical experiences, in direct contact with God. These leaders have seduced people to commit suicide collectively, e.g. pastor Jim Jones and his congregation in Guyana. In the religious traditions, such as the Catholic church, there are systems to judge the content of mystical experiences in the light of their religious tradition (Ángel Fuentes, 2016). However, the subjective significance and understanding attached to a mystical experience will often carry more weight for the experiencer than the dogmas of the church (Henriksen & Pabst, 2013).

3.2.1 Psychological understanding of the mystical experience

The psychoanalytic understanding of the mystical experience started out with Freud who described the mystical experience as a regression to the narcissistic symbiosis of mother and child (Freud, 2002/1930). Others have developed this further into a more Jungian understanding of the mystical experience being connected to a regression to the collective unconscious, while others have theorized the possible adaptive function of the mystical experience, leading to change and an answer to existential problems (Geels, 1991, 2014; Jung, 1990). Of special interest is the study of Geels (2001). He describes how religious visions, were connected to a psychological crisis. The visions served as a psychological solution for the experiencers (Geels, 1991).

3.2.2 Biological explanation for the mystical experiences

Generally, the neuropsychological basis of religious mystical experiences is sparsely investigated. However, the deep right temporal lobe and associated limbic structures have been associated with mystical experiences (Hestad, 2014). Studies

have shown that patients suffering from epilepsy and brain tumours in these areas of the brain, report mystical experiences related to their illnesses (Hestad, 2014). Earlier one estimated that 10-70% of patients suffering from temporal lobe epilepsy experienced religious voices and visions, however, research has now concluded that such experiences are extremely rare in this condition (Dein, 2012b; Hestad, 2014). Michael Persinger has shown that electromagnetic stimulation of the temporal lobe in human research objects caused them to have mystical experiences (Persinger, 1987). The findings from neuro-imaginary and neuro-psychological studies indicate that the areas in the brain involved in the hearing of voices are located in the same place as religious experiences caused by electromagnetic stimulation or cerebral pathology (Hugdahl, Løberg, & Nygård, 2009; Persinger, 1987). Other researchers have studied religious active and healthy persons in prayer or engaging in religious meditation. The studies conclude that these experiences are related to many different areas of the brain (Hestad, 2014).

3.3 Spirituality and religiousness

In the vast variety of literature on the psychology of religion, the concepts *spirituality* and *religiousness* are applied in different ways, but often nearly as synonyms (Zinnbauer & Pargament, 2005). In paper 1 and 2 we have applied Pargament's definitions of *spirituality* to describe the patients' religiousness (Pargament, 2007): *Spirituality* signifies the *personal search for the sacred*. The concept of *religiousness* was in paper 1 and 2 defined according to Zinnbauer, as *the larger social, institutional, and cultural context of spirituality*. In our sub-studies 1-2 this context will refer to a Lutheran cultural context. However, as this PhD study has proceeded, we have understood that as for patients with psychosis, their religiousness is an important way of searching for significance and meaning, more than seeking the

sacred. Because of this observation, we have applied the concept *religiousness*, based on Pargament (1997), as the main concept for this thesis as well as for the third paper: *Religiousness* is defined as the *search for significance in ways related to the sacred* (Pargament, 1997) p. 32. The term *significance* is understood as *those things we care about* (Pargament, 1997) p. 31. In defining the concept of the *sacred*, Pargament (2007) highlights *that any aspect of existence can be seen through the sacred lens as a manifestation of God or as the container of sacred qualities* (Pargament, 2007) p. 49. In accordance with the patients' descriptions of their religiousness, we understand God, as well as good and evil supreme powers or spirits, to be possible "containers of such sacred qualities".

3.4 Existential issues

Dealing with existential issues means meeting with the internal conflicts arising from the inevitable confrontation with the realities of life, such as the need for meaning in times of distress, the reality of death, sense of belongingness, the quality of relationships with others and the search for identity (Yalom, 2007).

3.5 Coping and Religious coping

The term *coping* means dealing with life stressors by analysing the threat, choosing appropriate ways of dealing with the threat and finally by acting adequately (Pargament, Koenig, & Perez, 2000; Torbjørnsen, 2014). However the "process of analysis" is not necessarily a cognitive and well-founded one, but may be built on the basis of previous experiences and skills. The final result of the coping strategy will determine the adequacy of the coping process (Torbjørnsen, 2014). A successful coping strategy means dealing with the psychosis adequately, living a meaningful life being integrated in society. The manners in which religion may contribute to coping

with life have been studied systematically, by specifically studying “religious coping” in the context of general studies on “coping with life” (Pargament et al., 2005).

As to the understanding of coping mechanisms, the terms *appraisal* or *reappraisal* in this thesis are used in accordance with the use in literature. In coping literature an appraisal-centred approach to stress means that the manner in which the individual feels and thinks about (appraise) the stress, is considered essential for coping, more than the objective environmental stressor (Lazarus, 1993). The concept *reappraisal* means a reconsideration of the worth or quality of someone or something. An example of this, often seen in times of distress, is the reappraisal of the image of God (Pargament et al., 2000; Torbjørnsen, 2014).

3.6 Recovery

The concept of *recovery* focuses on the individual’s potential for healing, finding a meaningful life, with or without the symptoms of mental disorder (Borg, Karlsson, & Stenhammer, 2013). In this thesis the concept of recovery is used nearly synonymously to the term *coping with psychosis*, referring to the process of recovery (Basset et al., 2014; Borg et al., 2013). The aim for the recovery process, is the gradual empowerment of the patient, so that she will be capable of making her own choices. This will mean taking choices for her life on her way to remission or improvement, being able to live a meaningful life, integrated in society. The focus in recovery is the patient’s ability to take part in social interactions and create a meaningful life, more than the absence of symptoms of psychosis. The emphasis is on ***empowering*** the patient, which means encouraging the patient to make her own choices, setting own goals for her life (Basset et al., 2014). The idea of recovery is nurtured from different psychological approaches to psychosis, such as CBT and the ideas from the antipsychiatry movement (Basset et al., 2014). Antonovsky, the creator

of the concept *salutogenesis*, (1979, 1987) studied what kept people healthy despite of significant stressors in life. He found that a sense of coherence in life as well as sufficient finances and social support was important (Antonovsky, 1979, 1987).

3.7 Remission

In this thesis the term *remission* is applied as: *a score for psychotic symptoms of mild or less (Positive and Negative Syndrome Scale item scores of ≤ 3 ; BPRS (Brief Psychiatric Rating Scale) item scores of ≤ 3 , using the 1–7 range for each item; SAPS (Scale for the Assessment of Positive Symptoms) and SANS (Scale for the Assessment of Negative Symptoms) item scores of ≤ 2) simultaneously on all items as representative of an impairment level consistent with symptomatic remission of illness (Andreasen et al., 2005) p 446-447.*

In short, the concept remission is understood as the total absence of psychotic symptoms and the ability to work full-time or part-time.

4 Therapeutic intervention of art therapy. Sub-study 1

4.1 Theoretical framework

There is growing evidence as to the effectiveness of art therapy for patients suffering from psychosis (Crawford & Patterson, 2007). However, the working mechanisms of art therapy are still sparsely understood. Art as therapy has been used in psychiatry for decades in order to further the patient's recovery process. Traditionally art therapy was based on a psychodynamic understanding of psychotherapy and was practiced as a supplement to this form of therapy (Killick & Schaverien, 2006; Rubin, 1999; Schaverien, 1992). However, during the past decades, a new form of art therapy, coined *Expressive art therapy* (ExA), has emerged from the art studios. Artists, trained as psychotherapists, have developed this new approach. Of course, in every kind of art therapy the artistic expression is the main focus. However, in ExA the very process of artistic expression, by bringing forward normal perceptions, is itself regarded to have a healing potential. Important pioneers in the field of ExA are Knill, Levine and Levine (2005), and McNiff (1981,1992), who all contributed to an enriched conceptualization of expressive art therapy (Knill, Levine, & Levine, 2005; McNiff, 1981, 1992). In addition, Stubbe Teglbjaerg (2011) has put a huge effort into explaining the theoretical framework of ExA in the treatment of psychotic disorders (Stubbe Teglbjaerg, 2011). The artistic expression may provide a new perspective to the experiences or emotions, revealing new abilities or possibilities for a new course in life for the patient. In her PhD thesis Teglbjaerg (2009) concludes that as a result of the strengthening of the primary sense of the self, ExA may contribute to a reduction of psychotic symptoms and anxiety in some patients suffering from schizophrenia (Stubbe Teglbjaerg, 2009).

ExA is rooted in a phenomenological tradition, in which the artistic piece of art is regarded as something new and unknown, being perceived for the first time (Løgstrup, 1995). Expressing emotions by creating a piece of art, makes it possible to perceive the emotion as something new and unknown. This idea opens up the possibility of exploring any emotion, as well as the psychosis itself, through art. In order to deepen the artistic process and the exploration process, ExA utilizes various artistic modalities such as music, poetry, painting or sculpturing. Moving from one modality to another opens the possibility of exploring emotions or bodily experiences from different perspectives, thus improving the artist's understanding of herself and her illness. This process is coined *crystallization* by Knill (Knill et al., 2005).

On the basis of my therapeutical work with patients, inspired by the art therapy tradition, the CBT, as well as by first person accounts of psychosis, I have formulated a theory on the working mechanisms of art therapy, leading to the research questions for sub-study 1. I suggested that artistic expression, in the form of art therapy, is a way of exploring the psychotic experience itself. My intervention, building on the CBT theory of the exploration of the psychotic experience, in combination with the theory of Løgstrup (1995) of the explorative potential of art, presents an alternative method of exploring the psychotic experience (Chadwick, 2006; Løgstrup, 1995).

Originally, CBT had a verbal approach to the exploration of the psychotic experience. In addition, the latest contribution in the field of CBT uses, in order to endure, understand and cope with the psychotic experience, meditation in the exploration of the psychosis (Chadwick, 2006). The intention of sub-study 1 was to investigate whether the creation of art would open up the possibility for the patients to explore and understand their wordless emotions and bodily experiences of psychosis, and

whether they through this exploration would be able to cope with their disorder in a more adequate better way.

4.2 Description of the course of the group

A typical group session. The group met once a week from September 2006 to June 2007. Each session lasted for 2.5 hours. In order to create an atmosphere of safety and predictability, the group had a rigid structure; embedded in the plan for the day. First, the group would listen to a piece of music and then a short poem was read. Second, all the participants were asked to share how their last week had passed, and what they planned to work on during the session. Third, we used some elements of movement therapy for some minutes. The idea behind this was to get the participants started, helping them to connect to their bodies. Finally, after the preparatory work, we started working with various forms of arts, which occupied most of the time spent in the group. Before closing the group for the day, the participants shared with the others their artwork produced and its significance for them. The patients worked with many artistic modalities, such as paint, clay, poetry, fairy tales, body movement, music, and also cautious role reversal, a method from psychodrama (Moreno, 1987).

The structure of the group process. The patients were offered art therapy focusing on the patient's recourses. In addition, they had three sessions in which they explored their psychotic experience through art in three different modalities: such as clay, movement and writing.

1. Before entering the group, the participants had the opportunity of meeting with the group therapists, and to try out the artistic tools. In this separate setting they made a drawing of their life so far, and set a goal for their therapy process.
2. Establishing confidence: The participants explored their recourses by painting or drawing a safe landscape and modelling a figure in clay, living in this landscape.

They were also encouraged to write and draw a fairy tale inspired by this figure.

3. Patients working on an optional theme: The patients chose both the theme and the material. The therapists carefully instructed them in the use of different art materials.

4. Expressing the psychosis using clay and body movement, and writing a letter to the clay figure: The patients were asked to imagine their previous experiences of being psychotic and to express this in clay. Then the patients would explore their psychotic experience in three different art modalities: clay modelling, body movement and by writing a letter. First, the patients created a figure in clay. In the next session they were asked to show what kind of movement this figure embodied. Finally, they would write a letter to their psychotic figure. The letter was supposed to be supportive and comforting, written by a person loving the psychotic figure.

5. Closing the group: During the last sessions in the group, the patients would draw a picture of their future path. What were their hopes and dreams for the future? Finally, we had an end-of-the-term party where we all ate together and the therapists had written a poem as an aesthetic response to the participants, telling them what they had appreciated the most from each. The participants had bought some flowers for the therapists.

6. During the group process the patients engaged in two different group artistry activities. Early in the group process, we asked the participants to model in clay what they wanted to bring into the group to help it become safe and constructive. Later they arranged these figures on a wooden plate, decorating the plate as a garden. About halfway in the group process the patients were asked to produce a joint painting, and then to give the group a name.

5 Introduction

In order to form the background and context for the present PhD project, as well as for the discussion and the analysis, it has been necessary to draw on literature from various fields of research. The present thesis touches upon several academic disciplines, e.g. psychiatry, theology, psychology, philosophy, anthropology and the psychology of religion. Due to my academic anchoring, the main theoretical framework of this project is related to psychiatry and the psychology of religion.

Starting out on my project, I first had to familiarize myself with existing professional literature. I have utilized the Ovid Technologies for searching a variety of databases including MEDLINE, PreMEDLINE, EBM, PSYBASE and EMBASE. My latest literature search was done May 2015. My study of literature in the field has been an important part and support for my analyses. Starting out, I will give a historical background of the concept of psychosis, treatment strategies and the focus on coping and how this focus has influenced some therapeutic approaches, such as the ExA and the CBT. Contemporary psychiatry has a strong focus on recovery, or coping with psychosis, however, it is a sad fact that all too many patients, giving first-person accounts of their psychosis, have reported being maltreated, stigmatized and provoked by psychiatric treatment (Andersen, Hasund, & Larsen, 2012; Andersen & Larsen, 2012; Basset et al., 2014; Larsen & Andersen, 2011). In addition, the religious needs of the patient have traditionally been ignored by psychiatry (K. Loewenthal, 2007; K. M. Loewenthal, 2004; Pargament, 2007).

5.1 The history of psychiatry

In order to explain the different theoretical views of the psychotic disorder, I will give a short review of the history of the treatment of psychosis in Europe. Then I will

continue with a presentation of different contemporary views of psychosis. The understanding of the causes of psychosis will inevitably affect the choice of treatment, as well as the ways the patient herself, and the society, understand the psychotic disorder. If one considers psychosis to be due to a biological dysfunction of the brain, a medical focus will be the best way of treating the patient. If, on the other hand, one considers the psychosis to be caused by psychological or religious difficulties, a psychological or religious approach would be more adequate.

The concept of psychosis was, according to Burgy (2008), first used by Canstatt in 1841, viewing madness as a psychic manifestation of a disease of the nervous system (the *bio-medical* model of madness) (Burgy, 2008). There has, for a very long time, been an ongoing discussion as to the cause or causes of psychosis, presenting biological, psychological as well as religious explanation models (Belin, 1999; Cullberg, 2005; McCarthy-Jones, 2012). The current classification of psychotic disorders, as described in the description of the concept of psychosis, is based on a *phenomenological approach*, i.e., the observation of the symptoms of the patients, and does not verify any causal explanation for the disorders (APA, 2013). Even so, starting with Kraepelin and continuing through the successive Heidelberg school, including Jaspers and Schneider, schizophrenia was assumed to be a brain disease similar to that of senile dementia (Burgy, 2008; Sass, 1992). Jaspers and Schneider continued to create the dichotomization between the “endogen” (biological) cause of psychosis and the “exogen” (psychological) cause of neurosis (Jaspers, 1963/1997). For the pioneer psychiatrists the idea of the phenomenological approach would imply a description and then a classification of the illness. The dichotomy of psychosis and neurosis as totally differentiated concepts was abandoned during the development process of DSM-III and ICD 10, and from that time on it has been absent in the

diagnostic tools (Burgy, 2008). The diagnostic gap between the psychological etiology of neurosis and the biological etiology of psychosis that had been established by Jaspers and Schneider, disappeared, and was replaced by the assumption that psychosis represented a particularly grave form of neurosis, having no proof of biological etiology (Burgy, 2008).

The care and treatment for madness in Europe was not a medical concern until about 1365 AC. Earlier, the mentally ill were taken care of by Christian monasteries or their families. From 1850 on, in Norway, when the first asylums were established, madness was transferred from being considered a social problem, into a medical discipline (Kringlen, 2007). In Norway, the first mental health act was amended in 1848 and regulated the transfer of patients with serious mental illnesses to mandatory treatment in psychiatric hospitals. The mental health act was revised in 1961 and 1999. Still, patients with psychosis will be admitted to treatment at a psychiatric hospital, if necessary mandatory, depending on whether their prospects of cure or considerable improvement otherwise will be lost, or if the patients represent a serious danger to himself or others (Kringlen, 2007).

The fact that the treatment of patients with psychosis was transferred to the medical domain, did not mean that the medical field was able to offer an effective treatment for the disorders. Historically, psychiatric treatment has not at all been as good as one could wish for. Psychiatric biological “treatment” for psychosis, such as lobotomy and insulin shock, is a story of shame when viewed retrospectively. In fact, the “treatment” has in many cases been useless, even harmful, and more like torture than therapy (Kringlen, 2007; Read & Dillon, 2013). As a reaction to biological “treatment”, several alternatives to these treatments were established, such as *moral treatment*, established by the Quakers in the 18th century. This form of treatment

viewed the patient with psychosis as a proper and worthy human being. During the past decades (from 1952 onwards), biological psychiatry has been successful in introducing helpful medication, i.e., the antipsychotic drugs, in the treatment of psychosis (Kringlen, 2007).

After the Second World War American psychiatry was strongly oriented towards the psychotherapeutic approach, whereas German psychiatry tended to focus biologically. The Second World War and the anti-Semitic and genetic focus in the German society were probably the causes for this segregation between German and American psychiatry. The genetic and biological focus were used as excuses for the execution of between 200,000 and 250,000 mentally ill and physically handicapped persons in Germany from 1939 to 1945 (Read & Dillon, 2013).

During the 1960s, *The anti psychiatry movement* emerged (Haugsgjerd, 1972). The anti-psychiatry challenged the "bio-medical" view of psychiatric treatment, including the genetic and the neurochemical focus. In general, the anti-psychiatry movement took a very critical view of official psychiatry, considering it to be harmful to the patient. The representatives of the movement argued that official psychiatry was an oppressive and coercive instrument of society by which society could set the standards of "normality". Important psychiatrists associated with anti-psychiatry were Ronald Laing and Silvano Arieti, who both contributed to the psychological understanding of psychosis (Arieti, 1976; Laing, 1967). They considered the definitions of "normality" and "abnormality" given by society to be oppressive, giving legality to involuntary treatment of patients.

It should be kept in mind, that today, despite helpful medication and new psychological treatment strategies, optimal treatment and early intervention only lead to a rate of 15-30 % remission from first episode psychosis (Hegelstad et al., 2012).

5.1.1 The biological explanatory model of psychosis

Research has shown diffuse biological disturbances, such as a disturbance of the dopamine system for patients with schizophrenia. In addition, these patients display neurocognitive disturbances. Neuropsychological studies of individuals with schizophrenia show that the patients seem to experience a diminished sense of agency of thoughts and sensory stimuli, and that they will misattribute self generated thoughts and actions to be originating from others (Frith, 2005; Hestad, 2014; Pacharie, Green, & Bayne, 2006). From a biologically oriented point of view, it can be argued that hearing voices is associated with malfunctioned neurons in left temporal lobe, causing patients to misattribute their thoughts (Hugdahl et al., 2009). This malfunction can be explained from various points of view, not necessarily contradicting each other: a) as neuro-cognitive disturbances b) to originate from special personality traits or c) caused by psychological trauma and dissociation (Beck et al., 2011; Bentall, 2013; Chadwick, 2006). Genetic research has shown an increased risk of schizophrenia and bipolar disorders in some families, nurturing the assumption of a biological genetic cause of psychosis. However, finding the exact “psychotic” gen has proved difficult. Lately, genetics has concluded that there is an interaction between environment and genetics. This field of research states that there is a general inherited vulnerability to many different psychiatric problems e.g., schizophrenia, ADHD and autism (Van Os & Kapur, 2009; Van Os, Rutten, & Poulton, 2008).

The stress vulnerability model is often used as an explanation why some develop psychosis (Zubin & Spring, 1977). In short, this theory concludes that every individual has a possibility of developing psychosis, but the level of stress necessary to evolve the disease differs from individual to individual. Heredity, drug abuse, childhood neglect and unresolved traumatic experiences may cause a greater

vulnerability for a psychosis to develop (Cullberg, 2005; J. O. Johannessen, Martindale, & Cullberg, 2006).

Researchers have succeeded in finding successful medication that will normalize some of the biological disturbances found in patients with schizophrenia. There is strong evidence that antipsychotic medications can improve the outcome of psychosis and help the patient toward recovery (NICE & Guidelines, 2009). Research has proved that long duration of untreated psychosis is correlated to poor outcome (Marshall et al., 2009).

5.1.2 The phenomenological approach of psychosis

The phenomenological approach to psychosis has developed into a description of subjective experiences, from the perspective of the experiencer (Burgoyne, 2008). The key explanatory concept, coined *basic symptoms*, was first interpreted as the underlying biological neuronal disturbance of schizophrenia. The basic symptoms were considered to represent a permanent modification of the entire personality caused by neuropsychological disturbances. These basic symptoms can be explored by means of the phenomenological method (Burgoyne, 2008). In the phenomenological tradition delusions and hallucinations are seen as temporary and unspecific, deriving from basic symptoms. Patients with schizophrenia often report a sense of being external to the rest of the world. They report feeling profoundly different from others; unreal, dead, separated, changed and with a lack of emotions. Moreover, patients suffering from schizophrenia describe their experience of psychosis as an alienation from themselves and the world, a wordless experience, which in psychiatric terms is described as a seriously disturbed *perception of the self* (Moller & Husby, 2000; Sass, 1992). Often the patients experience that their perceptions are altered in such a way that some aspects of their environment are felt to gain importance, whereas other

aspects of their environment are perceived as fragmented or with less importance (Sass, 1992). In recent years, the phenomenological approach has led to an attempt to detect basic symptoms at an early stage, wanting to prevent the development of psychosis before the psychosis is evident (Parnas, Handest, Jansson, & Saebye, 2005; Parnas, Moller, et al., 2005).

The understanding that the psychosis by the experiencer is perceived as a seriously disturbed perception of the self and of the environment, is important for the understanding why the patients experience their psychosis as a mystical experience.

5.1.3 Psychodynamic understanding of psychosis

In the psychodynamic tradition of understanding the psychosis, there are different explanatory models as to the causes of the disorder. A number of these agree in the understanding of psychosis as a regression to a childlike archaic mode of experience, dominated by non-rational thinking, similar to that of dreams (Bleuler, 1950; Cullberg, 2005; Sass, 1992). The main psychodynamic conceptualization of psychosis is that psychotic symptoms often function as a defence against unbearable aspects of reality. Consequently, the psychotic symptoms will contain meaningful personal information, including elements of the avoided reality (Hingley, 2006; Martindale & Summers, 2013). The fundamental concept in the psychodynamic understanding of psychosis is the concept of the *self*, and the understanding of the difficulties related to the development of the self (Trop, 1984). I will define the *self* as the conscious and unconscious experience of oneself as a cognitive and affective human being (Cullberg, 2005; Karterud & Monsen, 1997). In the first stages of the psychological evolution, the child learns to differentiate itself from the others. The self is built on integrated constructs of object-representations (the individual's image of important others) and of self-representations (the individual's image of itself). The

way the child is treated by its first caregivers, will strongly affect how the child views other people (as harmful or caring), and will also affect the child's self image (lovable or not lovable). These important others will be integrated in the self as *object-representations*, building an emotionally charged memory of the attachment figure. These object-representations are images of the important others, but are not identical to the real person. The representations are rather constructs from various inputs of the interjected object such as important meetings with the person in interaction with the child's personality, as well as the child's other relations and social environment. The ability of the caregivers to "tune in to" the child and to give the child appropriate emotional response, is essential for the evolution of a safe object representation. The basic notion of the attachment theory is that the attachment style during the first years of life, will function as a template for all further relationships in life. Experiencing a secure relationship to important others early in life, will increase the ability of an individual to acquire secure relationships in adulthood as well (Ainsworth, 1985; Bowlby, 1988). In psychosis the experience of the self becomes disrupted and fragmented (Cullberg, 2005). In addition, the boundaries between the self and others may become less clear (Sass, 1992). This experience of discontinuity of the self results in great anxiety, and the individual will try to re-establish continuity and coherence by a reinterpretation of the outer world (Cullberg, 2005).

The trauma model of psychosis maintains that there is strong evidence that psychological traumas affect a person's way of thinking (Arieti, 1976; Ross, 2008). Several researchers argue that the content of the delusion is understandable as a *dissociation* of some of the psychological experiences (Arieti, 1976; Ross, 2008). The phenomena of *dissociation* implies that psychological experiences are separated from the main stream of consciousness because they are felt to be too painful (Evans,

1996). Research strongly supports the presumption that traumatic experiences are associated with the evolvement of psychosis (Laudar & Thomas, 2000). A childhood trauma may affect the fundamental experience of safety, which is related to the experienced unity with the first caregivers. This experience of safety is important for the child's development process and the development of the self, as described above. The stage of unity with a safe and omnipotent caregiver, is the narcissistic state of the child's developmental process, in which the child feels almighty, possessing magical abilities caused by the unity with the first caregiver. In order to repair the need for security, psychosis may be understood as a return to this narcissistic stage of development. According to Cullberg (2005) (and psychodynamic theory), this phenomenon is understood as "a regression in the service of the ego"(Cullberg, 2005).

For my research on the significance of religiousness in psychosis, I have especially found the psychodynamic attachment theory useful. Especially for patients with omnipotent delusions, the psychosis, can, as stated above, be understood as a return to the narcissistic stage of the development of the self, establishing a state of safety in a psychotic universe in which she feels powerful and almighty.

Today, the psychodynamic understanding of psychosis still influences many of the treatment strategies for patients with psychosis. The psychodynamic tradition will for patients with psychosis first and foremost focus on establishing a safe relation to the caregivers in order to repair childhood traumas and facilitate psychological growth (Belin, 1999; Cullberg, 2005). In the following section I will focus on CBT, which together with ExA form the foundation of the therapeutic intervention in sub-study 1 of this thesis.

5.1.4 The CBT understanding of psychosis

During the past decades Cognitive Behavioral Therapy (CBT) has shown promising results in the treatment of psychosis (Beck et al., 2011; Chadwick, 2006). CBT will have its focus on the exploration of the psychotic experience and the aspects of the disease which the patient experiences to be troublesome (Beck et al., 2011; Chadwick, 2006). The fundamental idea of CBT is that our thoughts, our emotions and our behaviour are strongly dependent on one another. As to psychosis, CBT agrees with the understanding that psychotic symptoms lie on a continuum from the normal way of thinking to the experience of psychosis (Beck et al., 2011; Bentall, 2013; Chadwick, 2006; Johns & van Os, 2001). More precisely, CBT considers delusional thoughts to be similar to negative *schemas* or compensation for such schemas, but being more fixated and incorrigible ones. Jean Piaget introduced the concept *schema* as a mental framework enabling the individual to organize new experiences and perceptions (Piaget, 1952). The schema will be constructed as a process of learning through experience, and the acquired schema builds on all previous experience in life (Piaget, 1952). In CBT the concept of schema is understood as the basic or core beliefs acquired early in childhood, simply as the ways we think about the world and ourselves (Beck et al., 2011). The concept of schema is related to the psychodynamic model that early relations in life are crucial for the ways one is to feel and think about oneself and the world. The schema evolves into a cognitive map that will affect the information to which the individual will pay attention, and also the interpretations of this information (her attributions) (Beck et al., 2011). The content of patients' schemas is important for the ability to cope with the stressors in life.

The phenomenon of cognitive schemas is a common human property, containing patterns of thoughts and emotions as to potential, personal skills and worthiness. A characteristic example of a negative schema is: “I am unworthy of love”. The negative schemas constitute a cognitive foundation for low self-esteem or the sense of being vulnerable. According to Beck, in psychosis, these negative schemas later develop into delusions (Beck et al., 2011). CBT considers hallucinations to stem from a person’s tendency of imaginary hearing or the misattribution of her inner thoughts. More than paying attention to the causes of the symptoms, the CBT will focus on the patient’s subjective experience of discomfort, for example the hearing of voices, aiming at reducing this discomfort more than finding the reason for the disturbed perception (Beck et al., 2011; Chadwick, 2006). Important questions are: How and when started the delusional thinking? What happened and what is the objective evidence for the delusion? Which consequences does the delusion have? According to CBT, it is important to explore the emotions accompanying the delusion or hallucination, and how these may lead to unwanted behaviour, such as avoidance, or excessive energy used on assurance seeking or neutralizing strategies. Events and experiences that are taken as evidence for the delusional belief are examined. The treatment focuses on reducing the conviction, pervasiveness and distress that are associated with delusional beliefs (Beck et al., 2011). An example of this exploratory therapeutic approach is the questioning of the omnipotence of the patient’s hallucinations. Beck highlights the importance of uncovering the patient’s underlying schemas such as those of worthlessness and vulnerability. If possible, *behaviour experiments*, (trying to do something in a different way), questioning the negative beliefs and the safety strategies, are important in reducing the belief in a delusion. The overall goal of CBT is to reduce

the negative effects of the delusions on the quality of life (Beck et al., 2011; Chadwick, 2006).

For the purpose of my PhD study, I have found the CBT understanding of delusions and hallucinations to be of special importance. The CBT considers hallucinations as a perceptualization of patients' own thoughts; i.e. that the patient "create" a hallucination originated from their own thoughts. The delusion may be understood as patients' own negative schemas, or a compensation of such schemas. For example, the conviction of being Jesus could be understood as a compensation for a negative schema of being a human being without dignity and purpose.

5.1.5 First-person accounts and recovery from serious mental disorders

Throughout my work with this thesis, it has been important for me that the voice of the patient shall be heard, i.e., both how the patients experience their participation in the art therapy group, and whether they experience their religiousness to be of significance for them. In order to interpret the findings, I needed to learn more from the literature as to patients' own descriptions of religiousness in psychosis, and what they said made them recover. During the past decades, the voice of the patients themselves has been more strongly emphasized in the mental health system. Thanks to patients' influence on psychiatry, the discipline has faced some fundamental challenges as to the definition of normality. Firstly, patients with first-person accounts argue for a normalization of the phenomenon of hallucinations, sometimes by interpreting them in religious terms. Secondly, they argue for the right to be "different". From the 1980s and onwards, patients who had experienced the treatment of psychiatry to be labelling and derogatory, engaged more visibly in the discussion on psychiatric treatment. "The hearing voices community", is one of these organizations carrying weight (Laudar & Thomas, 2000). Recovery oriented

therapists argue that the patient's narrative of her difficulties determines how she will interpret her hearing of voices (Laudar & Thomas, 2000). It is argued that hearing voices is a symptom that can be observed in the general non-clinical population as well. In one study more than half of the general population described to have heard inner voices (Posey & Losch, 1983). 10 % of the population report to have experienced comforting voices that are not perceived to be their own thoughts (Barret & Etheridge, 1992). Commonly, hallucinatory experiences occur after bereavement. The past decades, numerous publications have pointed to the normality of such experiences (Steffen & Coyle, 2012). The experience of the sense of presence of loved ones, has been reported in approximately 50% of the bereaved ones in UK (Rees, 1971). In their book "Voices of reason, voices of insanity", Lauder and Thomas (2000) reviewed the research on the phenomenon of hearing voices and concluded that there is evidence that hearing voices is strongly associated with significant life events such as bereavement, sexual abuse and a variety of other emotional traumas (Laudar & Thomas, 2000). Some patients with first person experience of psychosis will often argue that they have a more vivid fantasy life than others and will thus more easily "hear" voices originating from external objects (Lampshire, 2012). Others will understand their voices as an extraordinary gift, like the ability of hearing music for a composer, or for a believer the religious gift of hearing God's voice (Sørensen, 2014).

5.1.6 Religious explanation of psychosis

Jung (1936) was the first one to argue that psychosis might be a result of a fragmentation due to the ignorance of the spiritual aspect in life (Jung, 1936). Researchers at the Religious Experience Research Centre at Lampeter, Wales University, support this idea of a religious explanation of psychosis (Dein, 2012a).

Some researchers point out that both religion and psychosis are universal ways of getting to know a non-ordinary reality (Clarke, 2010). Other researchers underline the fact that religious themes are common in schizophrenia (Clarke, 2010; Siddle et al., 2002). Some health professionals, naming themselves “transpersonal psychologists”, go further in their emphasis on the importance of the religious aspect in the treatment of psychosis (Lukoff, 2012). They consider religiousness to be an integral part of working through the psychosis, as well as for the ability of recovery, and maintain that psychosis is a natural developmental process with both spiritual and psychological components (Lukoff, 2012). Clarke (2010) introduces the concept “transliminal experience”, meaning an experience that is different from normal consciousness, comprising both the psychotic experience, dreams, religiousness and meditative states (Clarke, 2010). She understands psychosis as a state where the patients are unable to return to the normal state of consciousness, being stuck in the transliminal space, unable to escape. This view of the psychotic experience corresponds to the theories of Laing and the anti-psychiatry movement (Laing, 1967). A number of first-person accounts support the idea of a religious explanatory model, as an alternative, or supplementary model to the biomedical model of psychiatry (Chadwick 2010; Lee, 2005; Lukoff, 2012; Sørensen, 2014). Some case reports have been published where the religious hallucinatory experience, diagnosed to be psychotic, seem to function as a way of coping with a difficult life situation (Brett, Johns, Peters, & McGuire, 2009; Jacson & Fulford, 1997). An example of this phenomenon is Sørensen (2014), who argues that his hallucinations, for which he has been hospitalized several times, are part of a normal religiousness, believing he is a shaman. He has suffered 8 episodes of psychosis, the latest one 10 years ago. Now, being recovered, he still argues that his psychotic experiences are part of his normal

religiousness and a stage in his developmental process as a human being (Sørensen, 2014).

Jackson and Fulford (1997) argue that psychosis and mystical experiences can be distinguished by the manner in which the mystical experience is integrated in the values and beliefs of the person concerned (Jackson & Fulford, 1997). A contrasting approach comes from Lukoff (1985), who argues for a diagnostic category, which he terms *mystical experiences with psychotic features*. He argues that this phenomenon should be distinguished from a psychotic disorder, and should be treated by means of religious counselling (Lukoff, 1985). Underhill (1911), influenced by William James, maintained that religious voices could be distinguished from pathological voices by their life-enhancing quality (Underhill, 1911) p. 323 in (McCarthy-Jones, 2012). McCarthy-Jones (2012) argues that the voice-hearer herself must have the right to judge for herself how to understand her voices (McCarthy-Jones, 2012) p. 335. In my opinion the idea that the patients herself should judge her voices, is an appealing idea, but problematic when the voice hearing is part of a psychotic disorder. As described, the key problem with the psychotic disorder is that the patients are not necessarily able to judge adequately, but this should all the same be the goal for the future recovery process.

5.2 The psychology of religion

The research field of the psychology of religion assumes that religiousness and thoughts about existential issues are integrated elements of an individual's life, and studies how religious and existential questions influence psychological as well as physical health (Pargament, 2007). During the past decades there has been a growing amount of epidemiological publications on religiousness (Koenig, King, & Carlson, 2012). There have also been studies on the psychological effect of religion and how

religious and existential topics may be integrated in psychotherapy (Pargament, 2007).

The psychology of religion is at times criticized for its allegedly reductionist attitude of reducing the sacred dimension of religiousness to psychological theory (“nothing else than...”) (Geels & Wikström, 2012). To study a phenomenon such as religiousness, we will rather have a need for a “methodological reductionism”: It is necessary to reduce the complex reality to some specific elements to enable the researcher to conduct research on the phenomena. But by reducing religiousness to something researchable, one should be aware that studying a phenomenon from a particular viewpoint, such as psychological theory, will by no means tell everything (Geels & Wikström, 2012). Applying this to the present research project, we should be aware of the fact that the religiousness studied, is patients’ religiousness at the time of encountering the psychosis. In other phases of patients’ life their religiousness may have other expressions.

Studying religiousness, a distinction between two different aspects of the concept can be helpful, i.e., the substance and the function of religiousness (Geels & Wikström, 2012). The study of the *substance of religion* is concerned with the content of religiousness, the belief in God or a Supreme Power, the sacred places, dogmas, rituals, social interactions, religious institutions and symbolic acts. My thesis focuses on how the substance of religiousness has changed when encountering a psychosis and how/ whether the disorder seems to interact with patients’ religiousness. *The function of patients’ religiousness*, on the other hand, highlights the positive and negative effects of religiousness on the life of the individual, possibly helping them cope with their disorder (Danbolt, 2014; Geels & Wikström, 2012).

Both aspects, the substance and function of religiousness among patients with

psychosis, will be discussed in this thesis. However, in accordance with the overall aim of my thesis, my main focus will be on the function of religiousness.

5.2.1 The substance of religiousness in a Norwegian cultural setting

In order to study religiousness for patients with psychosis, it will be important to have an idea of the significance of religiousness in the general population.

Epidemiological research of relevance for this study, confirms the obvious fact that religion, in particular Protestantism, is still very influential in Norway. Today 77% of the population belongs to the Norwegian Church, whereas 2 % belongs to other religions than Christianity, and 13% (0,5 in 1960) are not members of any religious congregation (Stifoss-Hanssen, 2014; Taule, 2014). Even though about 68% in 2008 (78% in 1991) of the general population in Norway believes in a God or some sort of Supreme Power, the number reporting a personal relationship to God is relatively sparse (about 32% of the population in 1991, falling to 26 % in 2008) (Botvar & Schmidt, 2010). There is also an increase in the number considering themselves to be atheists (10% in 1991-18% in 2008) (Taule, 2014). Studies on spirituality, religiousness and thoughts about existential issues among young adults (13-16) in Norway, found that 59% reported a belief in God. Often their belief was a mix or a light syncretism of several religions and beliefs, such as Christianity, Buddhism, New Age and spiritualism (Brunstad, 1998; Holmquist, 2007). The adolescents reported that their belief in God was of little importance in their everyday life. Another finding was that the adolescents feared and disliked people that were too preoccupied with religion or showed signs of fundamentalism (Brunstad, 1998). Moreover, research has shown that when encountering a life-threatening disease, there is an increased preoccupation, especially among the young generation, with existential and religious

issues and an increase in the use of religious practices, such as prayers, (la Cour, 2014b).

5.2.2 The function of religiousness on mental health

Throughout the history of modern psychology and psychiatry, there has been little focus on the religious domain in the treatment of patients. Freud, the founder of psychotherapy and an outspoken atheist, introduced scepticism to religion, an attitude which has influenced psychiatry and psychology since then (Freud, 1913/1985). Freud (1913) considered religious faith to be a psychological defence against the experienced helplessness in childhood and the harsh reality of death and loneliness (Freud, 1913/1985). Freud claimed religion to be an illusion and a regressive defence mechanism against the fear of death as well as the fear of living. He understood the belief in God as an extension of the omnipotent father figure in whom you could trust, and that would protect you. According to Freud, a belief in God is an avoidance of psychological pain and anxiety, a condition which is necessary to accept and endure in order to achieve psychological growth (Freud, 1913/1985). Religion was long viewed as a subsiding phenomenon in the modern civilized society and regarded contradictory to modern science (K. M. Loewenthal, 2004). Since Freud (Freud, 1913/1985, 2002/1930) religion was suspected to be the cause of several mental health problems. Schaetzing (1955) introduced the term *Ecclesiogenic Neurosis* to describe mental disturbances caused by destructive aspects of religious traditions, and several others have documented the negative influences of religious congregations (G. H. Johannessen, 1991; Klosinski, 1990; Rignes & Ulland, 2014; Schaetzing, 1955; Wikström, 2004). Later, research has documented a strong association between religious struggle and psychological distress, negative religious coping and mental health problems (Ellison & Lee, 2010; Koenig et al., 2012; Pargament, 2007). Even

so, research has failed to show any association on a numeric level between religious faith itself and psychopathology, but that there is an association between neuroticism and anxiety concerning sexuality, super-ego conflicts and childhood fears of God (Agorastos et al., 2012; Pfeifer, 1994; Pfeifer & Waelty, 1999). The scepticism toward religion still dominates modern psychiatry. Shafranske (2001) found that 90% of all US citizens believed in God, but only 24 % of the clinical psychologists did so (Shafranske, 2001). In Norway as many as 93% of the psychology students experienced that there were no focus on religious faith during their education to become a psychologist, and that 27 % of the students experienced the psychology discipline to be degrading to religious people. 15 % said that religious people had been made fun of during lectures (Endresen Reme, Berggraf, Anderssen, & Backer Johnsen, 2009).

Later theorists have rejected Freud's (1913) perspective, considering it to be a reductionist attitude, arguing that a "God illusion" in the terms of Freud is not necessarily negative and pathological (Freud, 1913/1985; Meissner, 1996; Rizzuto, 1979). These theorists understood the term *illusion* not as a primitive need for wishes to come true, but rather as an important part of a normal psychological growth (Erikson, 1959; Rizzuto, 1979; Winnicott, 1953, 1971). Psychodynamic theories, such as the *object-relation theory and the theory of self psychology and attachment*, all focus more on the importance of the relationship to others, and that it furthers psychological growth and the development of the self (Ainsworth, 1985; Bowlby, 1988; Karterud & Monsen, 1997; Stålsett, 2014; Winnicott, 1953, 1971). The relationship to a sacred figure may play a positive as well as a negative role as to psychological growth, a fact which will be elaborated upon in the part of this thesis dealing with religious coping mechanisms.

Generally speaking, research has shown that engagement in a religious congregation and positive religious coping are related to better physical and mental health (Levin & Chatters, 1998; Pargament et al., 2005; Plante & Sharma, 2001; Sørensen, Danbolt, Lien, Koenig, & Holmen, 2011).

5.2.3 The substance and function of religiousness for patients with psychosis

There are few studies on the substance of religiousness for patients with psychosis. Often patients' religiousness is described in the terms of the psychotic illness. Characteristic examples of this phenomenon are the depressive patients claiming to have sinned against the Holy Spirit or the delusion of being a Sacred Figure (Wikström, 1980). It is a fact that patients suffering from severe mental disorders report a high "rate" of religiousness (Bellamy et al., 2007; Corrigan, McCorkle, Schnell, & Kidder, 2003; Danbolt, Møller, Lien, & Hestad, 2011). In a Scandinavian study based on written autobiographies of patients with psychosis, it was found that the majority of the authors utilized religious terms in their description of their experience of psychosis (Andersen et al., 2012; Andersen & Larsen, 2012).

As to the function of religiousness, several studies point to the positive effects of religion on mental health also when encountering severe mental health problems (Fallot, 1998, 2007; Tepper, Rogers, Coleman, & Malony, 2001). Fallot's (2007) review of literature in this field concluded that both first-person accounts as well as scientific research point to the fact that religiousness serve as important resources for recovery (Fallot, 2007). Religiousness may also install hope, purpose and meaning and give social support (Fallot, 2007; Mohr, Brandt, Borrás, Gillieron, & Huguelet, 2006). The studies on how religiousness foster recovery, also point to the fact that meditation may serve as an important tool helping the patients distract from their symptoms. A study from Mohr et al (2006) showed that 51 % reported that religion

lessened psychotic symptoms (Mohr et al., 2006). Tepper et al. (2001) found that patients with severe mental health problems reported their religiousness to be helpful for them in coping with their symptoms, and 48% of the patients reported that their religiousness became increasingly important to them as their symptoms worsened (Tepper et al., 2001). Corrigan et al. (2003) showed a positive correlation between religiousness and psychological well-being or reduced psychiatric symptoms for people with serious mental illnesses (Corrigan et al., 2003). Sullivan (1993) stated that religion could serve as a social support for seriously mental ill patients, because in their isolation, they could still trust God (Sullivan, 1993). Similarly, Mitchell and Romans (2003) showed that religiousness was important in coping with bipolar disorder and would affect the way the patients thought about their illness (Mitchell & Romans, 2003). Phillips and Stern (2007) found that benign religious reappraisal of the illness reduced stress and improved psychosocial wellbeing in patients suffering from psychosis (Phillips & Stein, 2007). After a 3 year follow up study, Mohr et al (2011) stated that for patients suffering from schizophrenia and schizoaffective disorder, having a helpful religion at baseline, the importance attached to religiousness was predictive of fewer negative symptoms, better clinical global impression, social functioning and quality of life (Mohr et al., 2011). When studying young adults suffering from mental disorders, Phillips and Stein (2007) found that these patients generally reported the same coping strategies as did healthy individuals (Phillips & Stein, 2007). Rieben et al. (2013) have published a thematic analysis on religious delusions (Rieben et al., 2013). They state that for 45% of patients with current religious delusions, religiousness was described as helpful in coping with their illness, whereas for 55% of patients, religiousness was described as harmful. They also concluded that religiousness generally assigned meaning to the suffering or to

specific symptoms, such as hallucinations (Rieben et al., 2013). Danbolt et al (2011) found that a majority of the patients reported that religiousness served a vital and positive influence on their ability to cope with their disorder (68%), whereas only a minority reported their religiousness to be a burden (6%). However, patients with more negative psychotic symptoms showed less support from their religiousness (Danbolt et al., 2011).

Although most studies indicate a positive effect of religiousness on mental health, there are studies pointing to the negative effects of religiousness on mental health for patients with psychosis (Borras et al., 2007; Miller & Kelley, 2005; Siddle et al., 2002). Some studies connect religious conviction to psychopathology (Miller & Kelley, 2005). Borras et al. (2007) showed that half of the patients had religious convictions (for example, their disorder is a punishment from God) something which influenced their attitude to disorder and treatment (Borras et al., 2007). Likewise, Borras et al. (2007) found that religious representations of the illness, e.g., that the disorder is a punishment from God, were prominent in patients who were non-adherent to medication. These patients often had no religious group activity (Borras et al., 2007). Fallot (2007) describes the possible danger that a religious belief representing strict moral standards, may cause the feeling of being sinful or rejected by God or one's community (Fallot, 2007). Siddle et al (2002) pointed out that patients suffering from religious delusions had higher symptom scores (PANSS, Positive and Negative Symptoms Scale), lower overall function (GAF, General Assessment Scale) and that they were prescribed more medication compared to patients with other types of delusions (Siddle et al., 2002). Furthermore, they found that the most common religious delusions are of secondary nature. These are delusions being evolved from hearing voices or experiencing other hallucinations, and

then attributed to manifestations of God or the Devil (Siddle et al., 2002).

These partly opposed findings, summarized above, indicate that there is a need for further investigation on the possible positive and negative effects of religiousness in the recovery process for patients suffering from severe mental disorders, such as psychosis. Furthermore, most of the studies have a quantitative design, unable to provide a deeper understanding of the substance and function of religiousness for patients suffering from psychosis. The apparent need for further research was the incentive for the research questions in paper 2 and 3.

5.3 Religious coping

In order to improve the understanding of how religion may be positive or negative for mental health, research has focused on the phenomenon of religious coping strategies. Nolan et al. (2012) found a significant positive correlation between positive religious coping and psychological health and a significant negative correlation between negative religious coping and reported quality of life (Nolan et al., 2012). Pargament et al (2005) studied religious coping strategies and found 5 key religious functions of religiousness: the search for meaning, the search for mastery and control, the search for comfort and closeness to God and the search for intimacy and closeness to God, and finally the search for a life transformation (Pargament et al., 2005). According to Pargament's (2005) theory on the strategy of religious coping, (and in accordance with general theories dealing with coping), religious coping may be considered harmful as well as helpful. Pargament (2005) applies the method of process evaluation in his discussion of religious coping, stating that the final outcome of a coping strategy decides whether it is to be considered positive or negative (Pargament et al., 2005).

5.3.1 Positive and negative religious coping

Positive religious coping strategies reflect a secure relationship with God and a sense of spiritual connectedness, benevolent religious reappraisals and collaborative religiousness. Likewise, a positive religious coping strategy, might, if necessary, imply seeking spiritual support from clergy or members of the congregation (Pargament et al., 2005). A benevolent religious appraisal, such as the belief that God has a plan for one's suffering, or that He uses one's suffering for something enriching in life or in eternity, will have positive effects on mental health (Pargament et al., 2000).

Negative religious coping, in contrast, reflects an insecure relationship with God and may in addition bring forward insecurity and tension between congregation members (Pargament et al., 2005). These negative factors will possibly result in a negative appraisal of one's suffering being a punishment from God or reappraisals of God's power, which are shown to have a negative effect on mental health (Fallot, 2007; Pargament et al., 2000). Negative religious coping is related to greater anxiety and depression and low self-esteem and also more PTSD (posttraumatic stress disorder) symptoms for those who have experienced traumas earlier (Exline, Yali, & Lobel, 1999; Fallot, 2007; Pargament, Smith, Koenig, & Perez, 1998). Generally, religious strain has been shown to be associated with a larger degree of depression and suicidality (Exline, Yali, & Sanderson, 2000).

5.4 Religious coping in psychosis

The following section is an attempt to theorize, from the perspective of religious coping strategies, the function of patients' religiousness when suffering from a psychosis. Generally, religiousness may constitute a challenge when exposed to suffering, because it is then hard to view God as loving and all mighty (Trevino &

Pargament, 2008). Research has shown that major life events affect people religiously as well as socially, physically and emotionally. Often when people encounter crises, religiousness comes more to the foreground (la Cour, 2014a; Pargament et al., 2005). When facing hardships in life, like an illness or the loss of a loved one, the substance and function of religiousness is put under stress. Pargament (2007) describes two different religious coping styles in times of stress, distinguishing between the *conservatory* and *the transitional* way of coping. The individual, coping in a conservatory way, will try to keep everything as normal by encompassing his suffering in his existent religiousness. In contrast, the person coping in a transitional way, will be unable to find a satisfactory reappraisal within her present belief system. She will therefore need to go through the process of a religious conversion, coined by Pargament (2007) as a transitional religious coping strategy (Pargament, 2007). A three-year follow up study shows how religiousness seems to be unstable over time for patients with chronic schizophrenia and that these changes are associated with reduced subjective self-esteem and quality of life. The salience of their religion changed for 37 % of the patients, either increasing or decreasing, or it transformed from a negative religiousness to a positive one, or vice versa (Mohr et al., 2010).

5.4.1 A relationship with God or a spiritual figure

According to Pargament, the relationship with a spiritual figure is one of the five key categories of religious coping (Pargament et al., 2005). The relationship with God, according to Rizzuto (1979), depends on the inner representations of God (Rizzuto, 1979). The manner in which the individual relates to others will also affect their relationship to God, because the image of God will evolve in accordance with the general attachment style of the child (Granqvist, 2014; Rizzuto, 1979; Stålsett, 2014). The key issue of Rizzuto's theory is that our image of and relationship to God,

like other relationships in life, is strongly influenced by our relation to our first caregivers, such as our father or mother. Rizzuto (1979) understands the image of God as an object-representation of God (Rizzuto, 1979). The image of God is coloured by our other object-representations, however, the image of God is experienced as a *personalized representational transitional object*. According to Rizzuto (1979), this means that we create our image of God from our other object-representations, but at the same time the image of God has the characteristics of a *transitional object*. A transitional object is an object the child utilizes as a container for its emotions and fantasies, always being available, like the teddy bear, for love or hatred or any human emotion. As a consequence, the representation of God is created from both the child's important object-representations but also bears important features of the transitional object. Because of this double origin, the image of God, unlike the teddy bear, continues to bear influence through life, like other object-representations. Rizzuto (1979) continues like this at p. 179: *This psychic usefulness (of the transitional object) is the service of protecting the minimum amount of relatedness to primary objects and a baseline of self-respect and obscure hope through common (or at times paradoxical or even psychotic) maneuvers* (Rizzuto, 1979). Rizzuto (1979) concludes that the formation of the image of God is extremely complex and is influenced by a multitude of "cultural, social, familial, individual phenomena" (Rizzuto, 1979) p. 182. The representation of God may be given similar abilities as the first caregivers, or can be given the opposite characteristics as a compensation for dysfunctional parents. According to Rizzuto (1979) the representation of God fulfils the needs of the child, serving as a an excuse for the child's badness and negative impulses, as a comforting figure for the lonely or

rejected child, and as a auxiliary superego helping the child to behave well, or serving as a omnipotent figure for the child to maintain control (Rizzuto, 1979).

Many patients suffering from serious mental disorders have problems in their relations with their first caregivers and may have rigid representations of their parents and God (Granqvist, 2014; Rieben, Huguelet, Lopes, Mohr, & Brandt, 2014; Rizzuto, 1979). This may lead to an unsecure relationship to God and an appraisal of God as punishing or weak, which adds to the suffering and increases the likelihood of mental problems. We may therefore assume that patients suffering from psychosis will need therapeutic help with religious questions as well as other difficulties in life.

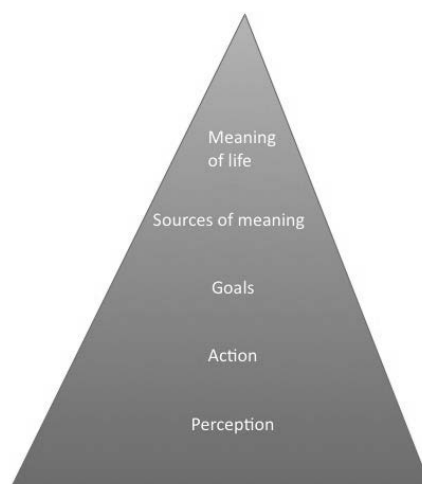
Taking a different (and more positive) perspective, it can be argued that the inner representation of God functions as a compensation for the abusive or neglectful caregiver. The relationship to God or a spiritual figure may compensate for the lack of care during childhood, giving the believer the experience of being fully loved and cared for (Halstensen, 2014; Henriksen, 2013; Stålsett, 2014). The creation of a trustful relation with a spiritual figure, as well as secure relations to other people, may cure the psychological problems caused by the lack of a secure attachment in childhood (Halstensen, 2014; Henriksen, 2013; Karterud & Monsen, 1997; Stålsett, 2014).

To sum up this section, we may say that patients' relation to God will be coloured by their attachment style they have adopted in childhood. When suffering from mental disorders, patients often have problems with the relation to others and these problems may influence their relation to God or Higher Powers as well. However, the relation to a Spiritual Figure may also represent a possibility of engaging in a positive and healing relationship to a loving God.

5.4.2 The search for meaning / making sense

The search for meaning is, according to Pargament (2005), one of the five key functions of religious coping (Pargament et al., 2005). I will in this thesis focus on the process of meaning making, which in the context of the present thesis refers to a process of working towards restoring meaning in life (Park, 2005). Victor Frankl, together with other existentialist psychologists, have pointed to the fact that a sense of meaning and direction in one's life is associated with better psychological well-being (Antonovsky, 1979, 1987; Frankl, 1959; Yalom, 1980). Most people, in order to create meaning, need something "more than them selves". However, according to Schnell (2010), about 35% claims to live a good life without needing a higher meaning other than what they find in everyday life. According to Schnell, the existential indifferent personality was more predominant among younger individuals, but was not associated with a higher vulnerability to psychopathology (Schnell, 2010).

Figure 2. The hierarchic model of meaning making (Schnell, 2009)



Schnell (2009) describes how the search for meaning may manifest itself on various levels, from that of making sense of one's perceptions (*cognitive significance of sensory stimuli*), to that of seeking a higher level of meaning, such as self-actualization or finding a higher purpose of life (existential meaning) (Frankl, 1959; Schnell, 2009; Spilka, Hood, Hunsberger, & Gorsuch, 2003) (see figure 2).

Considering perception to be the basic building block of meaning making we see that for patients with psychosis, that the system of meaning making may be affected by the disorder (Schnell, 2009). The psychosis causes the patients perceptual system to be altered, and this will affect the meaning making system of the patient as well. The patients struggle to find an explanation for, and significance in, their new reality. As mentioned above, the experience of psychosis, with its hallucinations, is described by the patients as an alienation from the self and the world, a wordless experience, which in psychiatric terms can be described as a "seriously disturbed perception of the self" (APA, 2013; Moller & Husby, 2000; Sass, 1992).

Both scientific research and first-person accounts agree that patients seem to have a need to make sense of their psychotic experience (Geekie & Read, 2009; Larsen., 2004). Geekie and Read (2009) studied FEP in an outpatient setting. The main findings of this study were that participants attempted to make sense of their experience by seeking explanations for them. Geekie and Read (2009) pointed in their study to the fact that religious explanations were quite common among the patients (Geekie & Read, 2009). The study also underlines the importance of being given the opportunity to tell a congruent story of one's life. Larsen (2004) presented an anthropological longitudinal study of FEP in Denmark (Larsen., 2004). He documented the need for the patients to make sense of their experience in psychosis. Larsen found that the understanding of psychosis to be an illness was not in itself a

satisfactory explanation for the patients, and that the patients engaged in a constant process of negotiation between various systems of explanation. The patients' explanations for the psychosis shifted over time, and the different explanatory systems seemed to function in a parallel manner, more than being contradictions (Larsen., 2004). Similar results are found in studies in Brazil, India and in the US and (Geekie & Read, 2009).

5.5 Psychotherapy addressing existential and religious issues and psychosis

The last century has widened the gap between the fields of psychology and religion. As a result of this, professionals working at the crossroads of religion and mental health, recommend a dialogical approach to close this gap between the two disciplines (Richards & Bergin, 2002). Literature on this topic encourages mental health professionals to become more literate as to religious and philosophical issues and for theologians and philosophers to widen their knowledge about psychotherapy (Richards & Bergin, 2002). Furthermore, it is recommended to encourage clergy from the religious community to take part in the treatment of mental disorders (Richards & Bergin, 2002). Religiously integrated psychotherapy aims at integrating religious matters in regular psychotherapy (Pargament, 2007). In contrast to traditional religious counselling, religiously integrated psychotherapy does not recommend that the therapist prays with the patients or offers other spiritual services (Pargament, 2007; Stålsett, 2014). This form of therapy will focus on the religious side of life, addressing religious needs and theological questions (Stålsett, 2014). In accordance with the established practice of religiously integrated psychotherapy, the focus will be on how religiousness affects mental health (Pargament, 2007).

In order to address religiousness in psychotherapy adequately, we will have to understand the nature of the patients' religiousness. Patients may feel that their religiousness contains personal and sensitive information. Their willingness to reveal their inner thoughts will depend on, as is always the case in psychotherapy, the therapist's ability to build trust (Pargament, 2007). Pargament (2007) recommends setting a stage for the religious dialogue. This does not only mean asking the patients about their religiousness, but also that the therapist shares her thoughts why religiousness might be an important topic in therapy. Pargament (2007) advises the therapist to be willing to share personal information about her values and her religiousness. This transparency will help the patient in her decision to build a therapeutic alliance with the therapist. It is commonly agreed upon that the therapist's values, whether being articulated or not, will influence the therapeutic setting (Pargament, 2007). One may argue that religiously integrated psychotherapy, in some respects, is more a matter of attitude than a specific therapeutic intervention. It means openness towards the possibility that religious issues can be important recourses of healing as well as constituting part of the problem. Psychotherapy addressing the religious aspects of life is not a separate kind of therapy, rather an additional dimension and possibility in all forms of therapy.

Psychodynamic therapy addressing religiousness mainly draws on Rizzuto's theory on the creation of the image of God as described above (Rizzuto, 1979). The paper, "The Case of Olav and the Transformation of His Pathological Self-Image", was published by Stålsett (2010). The case describes in detail the therapy process of a man suffering from long time depression, also having psychotic symptoms. He recovered after receiving treatment based on principles drawn from a number of therapeutic theories, i.e., existential therapy, narrative therapy, object relation theory

and affect and script theory. The focus in therapy was on enabling him to reconstruct his inner representations of himself and others, helping him to be less critical and more accepting towards himself. The therapy also focused on his representation of God, which was central in his pathology. By the help of therapy he was able to change his inner representation of God from a condemning God to a caring God (Stålsett et al., 2010). The Vita program at Modum Bad, where "Olav" received his treatment, is as far as I know the only religiously integrated therapy program in Norway. However, the Vita program does not normally treat patients with psychosis.

As to CBT, Beck (2011) advises the CBT-therapist to address religious delusions in cooperation with a senior in the particular congregation, if possible and so wanted. This is important in order to prevent the patient from being alienated from her congregation. The patient and the therapist will work together by questioning her religious delusions, just like any other delusions (Beck et al., 2011). CBT research literature provides some examples of the inclusion of the issue of religiousness in CBT treatment programs (Rosmarin, Auerbach, Bigda-Peyton, Björgvinsson, & Levendusky, 2011). As to religiousness, Riben et al. (2013) conclude that the most important difference between a healthy religiousness and a delusional religious belief system, is not the substance of the belief system, but whether the belief system is to be considered open and dynamic. An open and dynamic belief system will be reconstructed constantly in the interaction with the world in general, and with other people, in particular. Contrastingly, the properties of a delusional belief system are rigidity and fixedness (Rieben et al., 2013). Other researchers, such as Brett et al (2007), showed that the appraisal of the mystical experience, more than the attribution of such experiences, seems to separate patients suffering from psychosis from healthy individuals. The healthy individual attributed her experiences to positive and benign

normal psychological experiences. The patients diagnosed with psychosis, on the other hand, tended to appraise their experiences to be caused by some outer agencies, and their experiences were often accompanied by negative emotions. There were no differences in the tendency of making religious appraisal between the two groups (Brett et al., 2007).

Summing up the research literature on therapeutic interventions, it is fair to say that there is a lack of precisely formulated therapy strategies as for religious difficulties in psychosis, and that there is a need for more research. The interventions are, as far as I can see, generally directed toward religious delusions, being handled as other types of delusions. It seems that the religious aspect of patients' life are often more or less separated from the general psychological life of the patient, being the domain of the clergy. Patients with first-person accounts express a wish to integrate the religious aspect in life, when seeking help in the mental health service. The aim of the present thesis has sprung out from a wish to contribute to bridging the gap between the mental health service and the religious domain.

6 Aim of the thesis

The aim of this thesis is to bring forward new knowledge as to the significance of religiousness for patients with psychosis in coping with their disorder, and to contribute to a well-founded theoretical understanding of how new knowledge can be utilized to improve therapy in general, and art therapy in particular, for patients with psychosis. This aim of the study resulted in following main research questions:

Sub-study 1

1. How do participants in an art therapy group, suffering from psychosis, explore their psychotic phenomena through arts?
2. In which ways do the participants in an ExA group consider art therapy to be helpful in coping with their disorder?

Sub-study 2

3. What characterizes religiousness in patients suffering from schizophrenia spectrum disorder?
4. In which ways is religiousness reported to be a support or a burden for patients suffering from schizophrenia spectrum disorder when coping with their daily lives?

Sub-study 3

- 5: What characterizes the religiousness of patients suffering from first- episode psychosis (FEP)?
- 6: In what ways, if any, do patients with FEP consider their religiousness to be of value to themselves?

7 Method

The present PhD thesis is a *qualitative study*. The design has been chosen in order to provide answers to the research questions on the significance of religiousness for patients with psychosis in coping with their disorder. A qualitative research design provides information on patients' subjective experiences; i.e. the voice of the patient, which is the central topic of interest of this thesis. A qualitative methodology is also suitable when studying symptoms of a psychotic disorder as well as a therapeutic process, which are the other main topics of interest in this thesis. Generally, qualitative research is suitable for obtaining information about human experiences, thoughts, expectations, intentions or beliefs, and may produce information, as in my research, about meaning making or significance of life events. A qualitative design is thus well adjusted when studying the dynamic interplay between different phenomena, such as the interplay between religiousness and psychosis (*Denzin & Lincoln, 2011; Kvale & Brinkmann, 2015; Malterud, 2011*).

An important intention has been to pay respect and attention to the patient's voice, and much precaution has been made to achieve this. In the present thesis I have included three different sub-studies and various types of qualitative data in order to secure the voices of the informants to be heard. I have also focused on studying the interplay between psychosis and religiousness both from the patients' point of view as well as from a psychiatric perspective, and also how religiousness is expressed, and handled, in a therapeutic setting (see "data collection" below). It can be argued, because of the inclusion of quantitative data in the present thesis, that the design is rather the *mixed method or the multiple method design*. However, due to the relatively small amount of participants, no statistical analysis is possible. Hence, the

quantitative data included are utilized as descriptive information and the study has a therefore qualitative design (Denzin & Lincoln, 2011; Malterud, 2011).

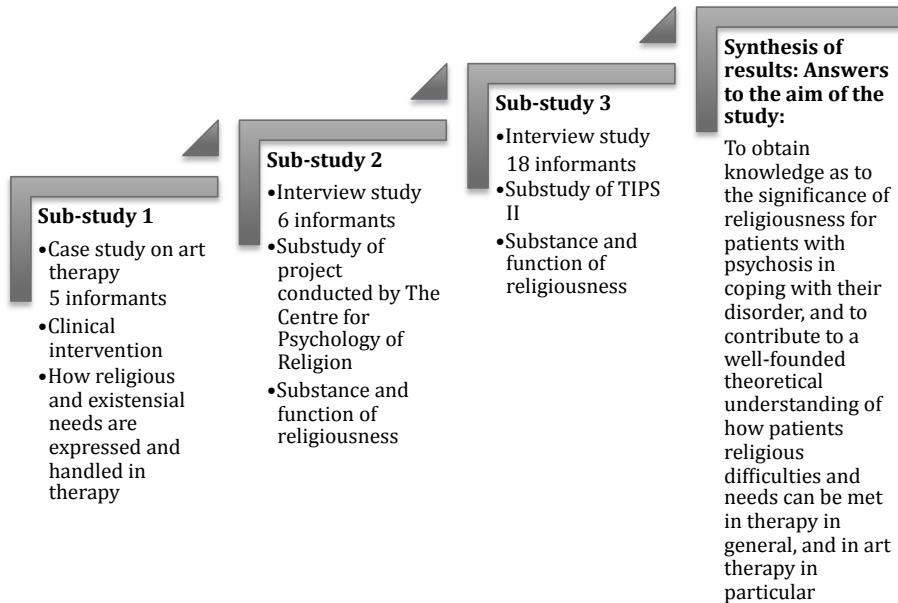
The thesis has both a *phenomenological* and as well a *hermeneutical approach*. A phenomenological design implies that the knowledge obtained from subjective experiences is considered meaningful and valuable, and that these experiences have a meaningful structure that can be detected through a careful and empathic study of the empirical material (Denzin & Lincoln, 2011; Kvale & Brinkmann, 2015; Malterud, 2011). However, all levels of analysis of human experiences will require the use of elements from the hermeneutic tradition focusing on the interpretation of meaning in human expressions (Denzin & Lincoln, 2011; Kvale & Brinkmann, 2015; Malterud, 2011). All qualitative research methodology emphasizes that the researcher should attempt at setting her own pre-understanding aside. This will mean that the researcher aims at engaging open-mindedly in the interview situation and in the early phases of the data analysis. The open-mindedness represents, in order to acquire new knowledge, an attitude of readiness to let oneself be surprised by the data. One of the techniques utilized in this thesis, in order to improve the quality of the data, and as far as possible to avoid the researchers pre-understanding to bias the interpretation, is the technique of triangulation. The technique of observing a phenomenon from different angles, coined *triangulation*, will provide different perspectives of a specific theme (Malterud, 2011). In the present thesis I have applied triangulation of observers (different researchers in a research team), of theories as well as of data. However, the researcher's pre-understanding, or schemas, will inevitably influence the process of analysis, even though undesirable. The construction of meaning is dependent on the former schemas of meaning for the interviewer as well as for the participants (Piaget, 1952).

Expanding on this, Antonovsky (1979, 1987) argued that the human nature strives to make meaning and coherence in life (Antonovsky, 1979, 1987), often presuming a higher degree of order and equality than it really finds (Flyvbjerg, 2003) p 309. In the qualitative research tradition, the concept of hermeneutics means the interpretation of data through a careful circular movement. The interpretation starts with the detailed coding and de-contextualization of a text, to find the smallest meaningful units. Then the analysis continues with a re-contextualization to the original informant, or by the introduction of theory from different points of view. By drawing on a variety of data, the researcher will introduce different perspectives to a study, furthering the process of analysis. Throughout the research process, we will have to confront ourselves with questions of an epistemological nature (Kvale & Brinkmann, 2015). According to a postmodern understanding of epistemology, to which I will lean in this thesis, the interpretation of an interview, as well as of a therapeutic story or of an artwork, will inevitably involve the researcher as well as the object of research. From the point of view of postmodern epistemology, information from the qualitative data in this thesis has been brought forward through a meeting between the interviewer/ therapist and the interviewees. Thus, the final knowledge is constructed from human interaction in that particular setting and the knowledge arising from this context, is inter-subjective and contextual. Even so, from a scientific point of view, the results are to be considered valuable and valid, and may contribute to new knowledge on human experiences (Kvale & Brinkmann, 2015). Kvale (2015), metaphorically speaking, takes the view that the researcher is more like “a traveller than a miner”, suggesting that new knowledge is produced inter-subjectively in the encounter between people, more than it is a pre-existent truth “to be dug out of a gold mine”.

Bearing this in mind, in order to obtain transparency of the research context (Denzin & Lincoln, 2011; Kvale & Brinkmann, 2015; Malterud, 2011), I have focused on the following: 1. To give an accurate description of the aim of the study. 2. To explain how the research questions were developed (see the “aim”, “what is this thesis about” and “introduction” section). 3. To describe the inclusion process of the informants (see “sample”). 4. To make clear the contextual setting of the interviews (see “collection of data”). 5: To explain the choice of data included (see ”collection of data”). 6. To describe the process of analysis of the transcribed texts (see “analysis”). In the introductory part of my thesis I have presented the reader with my personal pre-understanding of the subject matter, as well as the theoretical framework used in my analyses.

The thesis has a cumulative design and the three sub-studies jointly, from different perspectives, provide answers to the main aim of the thesis. The three sub-studies have contributed to the final conclusions of the thesis in the following way: The first sub-study explores the issues of the thesis from a therapeutic point of view, whereas for sub-study 2 and 3 the issues of the thesis are studied from the point of view of an experimental interview situation (see figure 3).

Figure 3 The cumulative design of the thesis



The three sub-studies are all a collaborative work, but I am the first author of all three papers (paper 1,2 and 3), and the presenter of the results. The final thesis is my synthesis of the results from the three sub-studies.

The first level of the overall analysis of this thesis comprises a résumé of the results for each of the three sub-studies. The first sub-study describes how patients with psychosis engage in therapy, and how their questions as to religiousness are brought into the therapy room. Sub-studies 2 and 3, on the other hand, supplies the thesis with information as to the significance of religiousness for patients with psychosis and how this relates to the patients psychiatric disorder.

The next step was to analyse the results from the three sub-studies in conjunction. First, in conjunction, I summarised the findings from sub-study 2 and 3. In order to interpret and to describe the results, I have compared the findings from the two interview sub-studies on religiousness, analysing what they have in common. In addition, the results are discussed in accordance with relevant theory. For my purpose,

I have utilized literature from three different theoretical perspectives: first-person account of psychosis, the field of psychology of religion, and from the perspective of psychiatry. The results from each sub-study have been brought forward by an inductive process, but are discussed and interpreted in the light of important theory, taking the analysis in a more abductive direction.

The third level of analysis, is an attempt to contribute to a well-founded theoretical understanding of how new knowledge on religiousness for patients with psychosis can be utilized to improve therapy in general, and art therapy in particular, for patients with psychosis. At this level, the results from sub-study 2 and 3 are seen in conjunction with the findings in sub-study 1.

7.1.1 Methodology sub-study 1

Sub-study 1 is a multiple single case study of an art therapy group I have conducted. In this sub-study, the group process, the artwork produced and the semi-structured interviews of the patients were analysed by using a qualitative research method. The method of the case study is inspired by the methodology of Yin (Yin, 2009). The choice of this case study design was based on the following considerations: We wanted to study a few cases, the 5 patients included, both in detail, and also from different angles. We hoped this would provide answers to the research questions, both on how the patients explored their psychotic experience, and how/whether they experienced help from their participation in the art therapy group. The case study design may provide, through the application of multiple qualitative and/or quantitative research methods, a nuanced and empirically rich holistic account of a specific phenomenon. This may be particularly appropriate for the building of a new theoretical understanding. Patients with psychosis may find it difficult, as demonstrated in my thesis, to explain how they benefit from therapy. However, the

production of a *condensed therapeutic story*, i.e. my summary of the patients therapeutic story presented in a narrative form, in addition to in-depth interviews, will provide a broader description of the patients and their therapeutic story. To allow for the voice of the patient to be heard in the condensed therapeutic stories, I have also included the patients' artwork. I have, in addition, utilized the method of *member checking*, asking the patient to read the case report, as well as the paper, as a whole, before publishing. Later in this method section I have described how we applied the case study methodology in practice.

7.1.2 Methodology sub-study 2:

Sub-study 2 is a qualitative exploratory study on religiousness for patients suffering from schizophrenia spectrum disorders and is a collaborative work with The Centre for Psychology of Religion in Norway. The methodology of the study is a phenomenological analysis of in-depth interviews with the patients. The interview study design is chosen to answer the research questions on patients' religiousness. Danbolt and al (2011) had previously published the results of a quantitative study, utilizing semi-structured interviews (Danbolt et al., 2011). The 6 selected cases for our sub-study 2 were recruited from the study of Danbolt et al (2011), thus providing my sub-study 2 with additional information on the patients religiousness and also on the diagnoses of the patients (Danbolt et al., 2011). The method of data analysis is inspired by phenomenological analysis in the tradition of Giorgi and modified by Malterud (Denzin & Lincoln, 2003; Giorgi, 1985; Malterud, 2011). The methodology will be described in more detail later in the method section.

7.1.3 Methodology sub-study 3:

Sub-study 3 is an interview study on patients' subjective experience of religiousness in (FEP) and is a collaborative work with the TIPS II project. The study is a thematic analysis focusing on the process of making meaning (Boyatzis, 1998; Braun & Clarke, 2006). The patients were interviewed utilizing in-depth interviews and semi-structured interviews, obtaining information on their religiousness from their subjective point of view. The choice of including patients from the TIPS II project, provided the sub-study with detailed information on the patients' diagnoses as well as on their psychiatric history and symptoms of psychosis. The advantage of including the information given by the TIPS project is the possibility to study patients' religiousness, from a psychiatric point of view, in the light of their described symptoms of psychosis, enabling a triangulation of the data. In the light of the main aim of the thesis, knowledge both on patients experience and their psychiatric symptoms, is of importance in order to contribute to a better theoretical understanding of how religiousness for patients with psychosis can be met in therapy. The detailed description on how we utilized the method of thematic analysis in practice, is described later in the method section.

7.2 Sample

To secure the aimed cumulative effect of the three sub-studies, I have focused on providing ample diversity as to the sample of patients. The sample consists of three different strategically inclusions of patients with psychosis. Achieving a *purposive sampling* is an important quality criterion in qualitative research. This means that the sample must be adequate in securing enough information on the phenomena of interest (Malterud, 2011). To achieve this, I have included informants from a therapeutic setting (sub-study 1), giving in depth information of the patients and how

they engaged in therapy, as well as how religious issues emerged during the therapeutic process. Additionally, I also needed in depth information on the religiousness for patients with psychosis, and I therefore included two interview studies focusing on religiousness (sub-study 2 and 3). I included different diagnoses of psychosis, because I, in agreement with newer theory on the field of psychosis, regard the different types of psychosis to be related (Bentall, 2013). I have also included patients with a psychosis persisting for several years (sub-study 2) and patients with first-episode psychosis (sub-study 3). In sub-study 1 and 3, the sample included came from Rogaland, whereas the sample included in sub-study 2 was from Hedmark, which are two different counties in Norway. Traditionally, Rogaland has a higher degree of religiously active inhabitants, compared with Hedmark (Vaage, 2012).

7.2.1 Inclusion of sub-study 1

The aim of sub-study 1 was simply to study how the participants of the first art therapy group for patients with psychosis at Jæren DPS, experienced their participation. Thus, I was the one to include all the patients in the art therapy group. The patients were informed about the study by the research assistant that were to conduct the in-depth interviews, one of the last sessions of the art therapy group. The inclusion for sub-study 1 took place about 8 months afterwards, when permission from REK (committee for medical ethics) was given. The study sample consists of 5 patients. All participants in the art therapy group agreed to participate in the study, and they all gave written informed consent (see table 1).

Table 1. The participants in sub-study 1

Participant	Age	Diagnosis	Short presentation
Cindy	37	Bipolar	Cindy is a married woman living together with her family. She suffered her first psychotic breakdown

		disorder	about 10 years ago and has since then engaged in different forms of therapy. Despite this, she has never told anybody about the content of her psychotic experience before entering this group.
Hanna	31	Schizophrenia	Hanna suffered her first psychotic episode when she was a student. She has a child, for whom her ex-husband is the caregiver, due to her inability to do so because of her disorder. Continually, she has the experience of being able to read other people's thoughts.
Jean	31	Schizo-affective Disorder	Jean suffered her first psychotic episode when she still was in her adolescence. She is unmarried and has no children, but she yearns to have her own family. She continuously has a feeling that other can read her thoughts and she struggles with a lot of anxiety.
Linn	35	Bipolar disorder	Linn moved to Norway from another European country some years ago and married a Norwegian. She suffered her first psychotic episode after she lost her new-born baby who had a severe inborn disease. She has been seeing angels ever since she was a child, and she is very preoccupied with her thoughts about having supernatural abilities.
Rita	58	Paranoid psychosis	Rita is divorced and has six children and many grandchildren. She has experienced many traumas in her life, and is struggling with paranoid ideas, which are kept under control by means of antipsychotic medication.

The patients were diagnosed by their clinicians to suffer from various forms of psychotic disorders: (e.g., bipolar disorders, schizoaffective disorders, schizophrenia and paranoid psychosis), all diagnoses in accordance with the ICD-10 diagnostic system (WHO, 2010). At the time of inclusion most of the patients had residual symptoms of psychosis in the form of hallucinations or abnormal thought content (see Table 1). Ages varied from 31-58 and they had all been ill for several years. One participant decided to quit after the second group session because he found it difficult to be the only man in the group, and was then replaced by a woman (Rita). He has not been included in the research sample.

7.2.2 *Inclusion sub-study 2*

The first interview study, sub-study 2, recruited patients that provided the PhD study with information as to the significance of religiousness for patients suffering from long term schizophrenia spectrum disorders. The study sample consists of 6 patients. They were all selected from the original sample of 31 patients in the study of Danbolt (Danbolt et al., 2011). The recruitment of the 6 patients was made by two of my co-researchers, Danbolt and Hestad. The patients were recruited at the rehabilitation ward where they were hospitalized or were outpatients. The patients' therapists asked the 6 patients if they wanted to participate in the sub-study, and all agreed, giving written informed consent. In this sub-study the informants were selected in order to examine characteristics and differences as to their religiousness, as presented in table 2. In the original study of Danbolt et al. (2011), the religious profiles of the patients differ as to their images of God or Supreme Powers, spiritual activities, beliefs, and experiences, their ways of existential rumination, and the subjective understanding of their religiousness being a support or a burden (Danbolt et al., 2011). We selected three informants who expressed a belief in God, and three who were more likely to believe in a Supreme Power. Furthermore, we wanted diversity within the group of patients as to their experienced spiritual support or burden. In accordance with these criteria, the included informants consisted of two informants who reported either strong support and or no burden from their religiousness, and three who reported different combinations of experiencing both support and burden, and finally one who reported her religiousness to be neither a support nor a burden (table 2).

Table 2. The participants in sub-study 2

Participant	Age	Diagnosis	Belief in God or Supreme Powers	Belief - a help or a burden?
Agate	32	F20.0 Paranoid schizophrenia	God	Much support, no burden
Elmer	42	F25.1 Unspecified schizoaffective disorder	God	Much support, no burden
Dennis	38	F 20.0 Paranoid schizophrenia	God	Most support, some burden
Cecilie	19	F 25.1 Schizoaffective disorder, depressive type	Higher Power/ life	Some support, no burden
Fredrik	54	F 20.0 Paranoid Schizophrenia	Higher Power/ God	Little support, little burden
Beate	44	Paranoid Schizophrenia	Higher Power	No support, no burden

The patients were diagnosed by their clinicians according to the criteria of ICD 10 (WHO, 2010), applying the phenomenological oriented diagnostic tool, named “Diagnostic Workflow Chart” (DWC)¹(Danbolt et al., 2011). The 6 patients were diagnosed to have broad schizophrenia spectrum disorders (WHO, 2010). The group of patients consisted of three women and three men.

7.2.3 Inclusion sub-study 3:

The second interview study, sub-study 3, recruited patients that were expected to provide the PhD study with information as to the significance of religiousness for patients suffering from first episode non-affective psychosis. The study sample consists of 18 patients (see table 3).

¹ Developed by Paul Møller and in use in several mental health clinics in Norway. In Norwegian it is called Diagnostisk arbeidsdiagram

Table 3. The participants in sub-study 3

Main diagnosis and age		Frequency
Diagnosis DSM IV	292,11 Drug-induced psychotic disorder	2
	295,30 Schizoaffective disorder paranoid type	4
	295,70 Schizoaffective disorder	2
	296,34 Major depressive disorder, recurrent, severe with psychotic features	1
	297,10 Delusional disorder	2
	298,80 Brief psychotic disorder	1
	298,90 Psychotic disorder NOS	6
Age	<u>>=26 years</u>	7
	<u><=25 years old</u>	11

For the recruitment to sub-study 3, I was informed about the twenty patients most recently included in the TIPS II project. I contacted the patients by telephone and asked them to participate in an interview study. Two patients refused on the telephone, the other 18 agreed. There were no significant differences between the consenters in this sub-study on religiousness (n=18) and the remaining sample of included patients in TIPS II (n=241), as to age, gender, PANSS positive and total symptoms, GAF symptoms and functioning, and DUP (Duration of Untreated Psychosis) (see paper 3). We aimed at including informants with different religious convictions, believers as well as non-believers.

Patients were diagnosed using a SCID diagnostic interview form as well as the PANSS medical scale.

7.3 The collection of data

In the following section I will briefly summarize the methodology of the collection of data. As described above, to answer the research questions of the thesis it was necessary to obtain information on patients' subjective experience as well as on their psychiatric disorder and therapeutic process, and thus I have included a variety of data.

Table 4. Collection of data

Collection of data		
Sub-study 1	Sub-study 2	Sub-study 3
In-depth interviews	In depth interviews	In-depth interviews
Condensed therapeutic stories	Semi-structured interviews on religiousness from the study (Danbolt et al., 2011)	Semi-structured interviews on religiousness
Patients' artwork from the art therapy group	Information on diagnosis from (Danbolt et al., 2011)	Patients' drawings on their relationship with God or Higher Power, if any
		PANSS interview in full text from the TIPS II project
		Quantitative data from TIPS II on patients' psychiatric disorder

The data material includes in-depth interviews, pictures, condensed therapeutic stories, PANSS interviews in full text and descriptive quantitative data, such as SCID, PANSS numeric scale, DUP and results from the semi-structured interviews on religiousness (see table 4)

In order to obtain **knowledge from the patients' subjective experience**, which was our main intention, the main research tool of this thesis has been the **in-depth interview**. The validity of all qualitative research interviews depends on the ability of the researcher to engage in an explorative approach throughout the interview. In this study, the interviewers (co-researchers in study 1 and 2, and I in study 3), focused on engaging in an active listening process where the main focus was to pay the interviewee as much attention as possible during the interview. We focused on following the lead of the patient, and when important for our understanding, we would mirror the statements of the interviewee (member checking). Thus, we hoped to explore and understand the patients' experiences and attitudes more in depth. In order to grasp the participant's personal story, their reasoning and their attribution of meaning as fully as possible, we offered the patient ample time for the interview (Kvale & Brinkmann, 2015). The interview guide used in the individual in-depth interviews was tentative and contained only general themes, no specific questions, giving the researcher the possibility of asking additional questions, following up the story and the reasoning of the patients. The interview template functioned as a guide to secure that the interviewer discussed the issues of interest with each patient, according to the research questions of the study. The interviews had a duration of approximately 1-1.5 hours, a period of time which is regarded to be a standard for such interviews (Malterud, 2011). All informants were interviewed only once (except for Elmer in sub-study 2, who was interviewed twice).

For sub-study 1 and 2, I did not conduct the in-depth interviews. For sub-study 1, an independent research assistant conducted the in-depth interviews, whereas I functioned as one of the therapists of the art therapy group. For sub-study 2, the informants were interviewed by two of my co-researchers, Lars Danbolt and Knut

Hestad. (See “discussion of material and method” for a further discussion on the choice as to interviewers).

For sub-study 1, the individual in-depth interviews took place in the ward where the patients had their treatment. The interviews focused on patients’ experiences in their participation in the group and if/how they had experienced the therapy to be of any help. For sub-study 2, the appointments with the informants were arranged by the patients’ main contact in the ward, and most of the interviews took place at the treatment unit, except for one, which was held in the patient’s home. These in-depth interviews focused on whether and how the patients experienced their religiousness to be help or a burden for them when suffering a psychosis. For sub-study 3, I gave the participants the option of meeting with me in the psychiatric ward or in an outpatient setting, with which they were familiar, or at the TIPS headquarters at Stavanger University Hospital. The patients were asked if they wanted to conduct the interview with their therapist, but they all wanted to meet with me alone. These in-depth interviews focused on the religious history of the patients, their current religiousness as well as their experiences in encountering their psychosis.

In the tradition of qualitative research, data collected from in-depth interviews are achieved in the form of sound records, which in turn are transcribed into written texts. For sub-study 1 and 2, a secretary performed the transcriptions, but for sub-study 3 I myself transcribed all the interviews.

For sub-studies 2 and 3 we utilized **semi-structured interviews** to gain information on patients’ religiousness, their thoughts about existential questions as well as their religious practice. For sub-study 2, the data were based on a semi-structured interview on the function and content of patients’ religiousness, consisting of a 68-items’ questionnaire (Danbolt et al., 2011). The validation of the questionnaire

and the collection of data are described in the paper of Danbolt et al (2011). The semi-structured interview included partly predetermined questions and alternatives for answers, thus providing quantitative descriptive data, whereas in some other parts it contained open-ended questions. For sub-study 3, the questionnaire was a slightly reviewed version of the interview form used in the publication of (Danbolt et al., 2011). We had added questions about changes in religiousness during the course of the illness. The advantage of using a semi-structured interview guide is the possibility of getting a comprehensive overview of patients' subjectively experienced religiousness (see appendix). In sub-study 2, the in-depth interviews were conducted about 6 months after the semi-structured interviews. As for sub-study 3, the in-depth interview was conducted the same day, just after the semi-structured interview had finished.

All pieces of **artwork** were collected and photographed by me. The art objects studied in sub-study 1 of this thesis are the patients' own expressions of the therapeutic process. Hence, the art objects were analysed in conjunction with the therapeutic story of each participant. In sub-study 3, the artwork was utilized in a triangulation of data in order to verify the verbal statements given in the interviews as to the patients' relations, (if any), to God or Supreme Powers. At the end of the interview situation, all participants were asked to choose one coloured crayon and to make a drawing of themselves and their relationship to God or a Higher Power (see below). The drawings are enclosed after paper 3.

Since the second part of the aim of this thesis is to contribute to a **theoretical understanding of how new knowledge can be utilized in therapy**, it has been important to include other sources of information than the interviews and the artwork. We have therefore included data such as condensed therapeutic stories and

information on patients' psychotic symptoms from a psychiatric point of view. To achieve information on patients' psychosis, sub-study 3 has included **quantitative descriptive data from the TIPS II project**, where a TIPS-II researcher was responsible for the data collection. These data have been utilized in several other publications (Hegelstad et al., 2012; Joa et al., 2008; Larsen et al., 2011). The data from the TIPS II project include the PANSS interview, which contains a measure of patients' symptoms of psychosis on a numeric level. In addition, the data from TIPS II include measures of the duration of untreated psychosis (DUP), age and employment of the patients. The strategy of the TIPS study is to assess the participant at baseline (inclusion), after 3 months, and then after 1, 2, 5, and 10 years. In the present thesis the data from baseline are utilized. We also included the **PANSS interviews** in full text, about 4 pages for each patient including the numeric score. These interviews were conducted in the initial phase of the patients' psychosis and contain descriptions of patients' symptoms of psychosis, as well as their medical history presented in a narrative form (Hegelstad et al., 2012; Joa et al., 2008; Larsen et al., 2011).

To answer the research questions of sub-study 1, we needed sufficient information about the therapeutic process. For sub-study 1, I produced a **condensed therapeutic story** for all patients, using my personal notes from the therapy sessions, filling in with patients' artwork to illustrate and to verify their therapeutic process. I also summed up of the therapy process in the group. To verify the presentation, given in the condensed therapeutic story of the group, I drew on my notes from therapy sessions, using the patients' collaborative artwork as illustrations of the group process. I have, in accordance with theoretical recommendations, focused on providing details about the treatment context, the patients, the reasons why they

sought therapy, their psychosocial history, including family history, psychiatric history and the course of the therapy (Malterud, 2011) (see below for a closer description of the process of producing the condensed therapeutic stories.

7.4 The analysis of the data

The analyses of the three separate sub-studies in this thesis are described in detail below (and in the papers I-III). I have applied different methods of analysis for each of the three sub-studies (see table 5)

Table 5. The analysis of data

Analysis of data		
Sub-study 1	Sub-study 2	Sub-study 3
Case study design	Phenomenological analysis	Thematic analysis
In-depth interviews: Systematic text condensation in the tradition of Giorgi and modified by Malterud (Giorgi, 1985; Malterud, 2011)	In-depth interviews: Systematic text condensation in the tradition of Giorgi and modified by Malterud (Giorgi, 1985; Malterud, 2011)	In-depth interviews: Thematic analysis (Boyatzis, 1998; Braun & Clarke, 2006):
Art work Utilized as patients' voice in the condensed therapeutic stories		Art Work Utilized in the interview situation as a triangulation of the patients' statements of their relationship to God or a Supreme Power

In the first steps of our analysis, we have aimed at an inductive approach. First, we wanted to get acquainted with the patients' subjective experience. This will constitute the first level of analysis. It is essential to establish an understanding of the subjects' own experiences and self-understanding, not allowing the analysis of the material to be controlled by preconceived opinions and theories.

Then, in the later steps of analysis, we continued with an abductive approach where the information as to patients experiences are viewed from different theoretical perspectives, aiming at contributing to a theoretical understanding of how the new knowledge can be useful for therapy.

Due to the requirements of confidentiality, it is not possible to share all raw data of a qualitative study. However, I have focused on presenting a broad description of the patients, making a case summary of each patient in paper 1 and 2, and of the example cases in paper 3. In addition, I have made a table presenting an overview of the informants for sub-study 3. This detailed description will help the reader to judge the validity of the knowledge that has been produced. There was limited room available in the papers to give examples of the patients' statements, as well as of the inductive development of the categories, and because of that I will give some examples of the patient's voice and how it was categorized.

7.4.1 Analysis of the artwork

Both for sub-study 1 and 3, the data, in the form of artistic expressions, were of importance. However, the analyses of the artwork in the two sub-studies differ from each other. In sub-study 1, the artwork was analysed in conjunction with the condensed therapeutic stories. The therapeutic story of the group as a whole, and the stories of the individual participants, are presented in a narrative form, in which the artwork function as direct expressions from the patients, supporting my presentation of their therapeutic story. As an example, I will present one painting from one of the participants in the sub-study 1. In the tradition of Expressive Arts therapy the artwork is dealt with "on the surface". This means that the therapist functions as the observer and facilitator of the patient's creation of art, engaging emotionally in the artwork by an *aesthetic response*, i.e. the sense or the feeling, evoked in the therapist by the piece

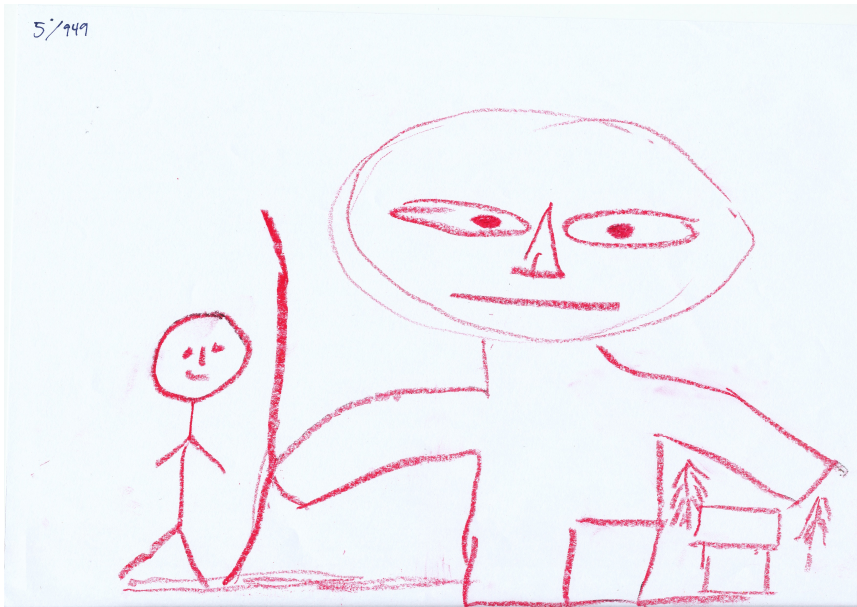
of art. This will be utilized as a piece of information for the therapist in the therapeutic process. The main intervention of the therapist is, by asking questions, to bring back her aesthetic response to the artist. The therapist does not interpret the artwork for the patient, but rather utilizes the information from her aesthetic response to ask the patient questions as to her piece of art. By this, the therapist will want the patient to go on exploring her artwork in new pieces of art, improving the patient's understanding of the emotion or bodily experience she is trying to express (Knill et al., 2005). The aesthetic response to a piece of art is the therapist's *compositional analysis* of the artwork (Rose, 2005). A compositional analysis will mean to "feel" the artwork, depending on several aspects of the artwork, such as colour, the spatial organization, the focus, the light and the expressive content. To give an example of a compositional analysis or aesthetic response to a piece of artistic expression, I will utilize Jean's painting of her existential fear:



Artwork 1 Jean's existential fear

My immediate impression of Jeans' painting was the expressive content of a great danger approaching. The painting is expressing a frightening situation of a mother standing on the very edge of a cliff, holding her baby. Towards them soldiers with weapons are approaching. The scene of the painting, reminds me of the famous Pulpit Rock in Rogaland, where the abyss underneath is a fall of 600 meters. The painting evokes in me a "feeling" (the expressive content) of fear, that dangerous forces are trying to destroy the mother. As to the colours of the painting, the mother and her child and the sun behind are strongly coloured in red, possibly the colour of blood and suffering. In contrast, the soldiers take the colour gray, like the cliff and the abyss underneath. The spatial organization is one of very little sky, just a small stripe at the upper part of the painting. This spatial organization of towering mountains with a tiny skyline, might evoke fear in the observer. In the therapy session I would not explicitly express my aesthetic response to her painting, but instead ask Jean, what she sees and senses. She told me she was afraid of never being able to live a normal life, and that she was afraid, if she ever had a baby, that the authorities would take it away from her because of her psychotic illness.

For sub-study 3, I utilized the drawings as a supplement, or a triangulation, to the patients' statement of their relationship to God or a Higher Power. An example from sub-study 3 is the drawing made by Edward:



Artwork: 2 Edwards' relation to God

At the end of the in-depth interview, Edward drew his relation to God. I chose not engage in any aesthetic response to his painting, but rather ask him to explain his drawing verbally. When being asked to explain his drawing, he told me that he had made a drawing of himself on his way to a happy life, being illustrated as a cottage behind to the right in the drawing. The giant figure in the focus of the drawing he told me was a giant troll, blocking his way to happiness. This troll, he explained, was an expression of a God that wanted him to fail. My understanding of the drawing was much the same. I could see the giant holding something to block the person to the left. I also noticed that the drawing is in red, a powerful colour, and that the troll/God and the person seemingly had no communication.

7.4.2 Phenomenological analysis according to Malterud, Sub-study 2

We, the research group, have utilized a modified version of systematic text condensation in sub-study 1 and 2 of this thesis. The use of systematic text

condensation for sub-study 1 will be described under “Case study”. Malterud states that systematic text condensation is inspired from phenomenological analysis in the tradition of Giorgi and modified by Malterud (Denzin & Lincoln, 2003; Giorgi, 1985; Malterud, 2011), bearing resemblance to Grounded Theory. However, Grounded Theory, in its full version, requires that analyses are driven toward the development of theory (Braun & Clarke, 2006), a prerequisite not necessary in Malterud’s version of the systematic text condensation method. Giorgi points out that the aim of his method is to acquire knowledge of the informants lived experience, viewing the subjective description of human experiences as valid knowledge. In the modified version, we did not find it necessary to transcribe and analyse the first interview before interviewing the next participant (Malterud, 2011). Consequently, all the interviews were conducted before we went on analysing.

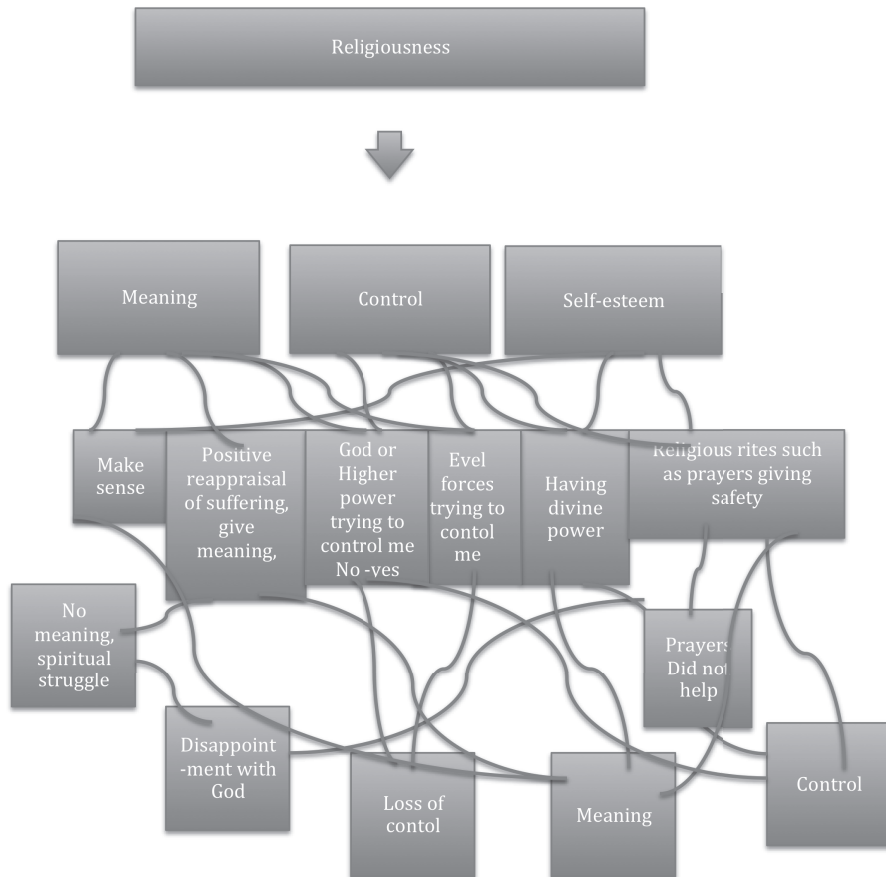
The use of systematic text condensation according to Malterud, in sub-study 2, can be described as follows: The data from the in-depth interviews consisted of 81 pages 35341 words of transcribed text. The first step of the analysis was getting an overview of the data. To secure different approaches in the interpretation process, the research team was made up of professionals within the field of general psychiatry, clinical psychology, cognitive theory, neuropsychology, theology and the psychology of religion. Jointly, the research team conducted a qualitative analysis of the transcribed in-depth interviews. This would mean that the research team read and re-read the transcriptions separately to get an overview of the material.

The next step was to identify the main themes or *codes*. The intention of the collaborative analysis was that all authors; the research team, should give their own perspective on the texts so that it could be viewed from different angles. This is recommended by Malterud (2011) as a way of producing a more nuanced analysis

(Malterud, 2011). The codes were discussed in the research group, and a consensus was obtained that the three main codes were the following: 1. control 2. self-esteem and 3. meaning making

All the texts from the interviews were coded systematically according to these initial codes, and the part of the text relevant to each code was extracted. The codes were discussed in the research group in telephone meetings several times. The idea of agreeing upon main themes reduced the data even more and was helpful for the further process. Then, in the next step of analysis, the text for each code was grouped in potentially new sub-themes by me (see figure 4). Through the process of coding, the text was divided into small meaningful units, and these text units are then collected, and de-contextualized from the initial interview. This de-contextualization of the text units made it possible to observe the text units, separated from their original context (patient).

Figure 4. Analysis sub-study 2



I will give some examples of patients' statements and the resulting identification of the codes/ categories:

Category 1: Religiousness as a positive reappraisal of suffering (Meaning)

Elmer describes how his religiousness helped him understand his suffering:

Jeg tror ikke jeg er dømt til å skulle være her, sitte her alene resten av livet. Jeg håper da ikke det.

I don't think I am doomed to sit here alone the rest of my life. I really hope not!

Jeg tror lidelsen bare var noe jeg var pålagt å komme gjennom for å bli den jeg er i dag (Jesus). Jeg er veldig nær Gud, i prøvelser, og man kommer vel ikke stort nærmere Gud enn å være Jesus.

I feel my suffering is required to become who I am today (Jesus). God feels very close, when suffering, and the closest one could be to God is to be Jesus.

Category 2: Disappointment with God (spiritual struggle)

Beate and Cecilie describe how they are disappointed with God:

Cecilie:

Hvis Gud finnes, har han vært veldig stille.

If God exists, he is very quiet.

Beate:

Jeg har snudd meg til Satan i stedet. Jeg har bedt mye og trod at Gud ville hjelpe meg, men det gjorde han ikke. Det plagde meg at Gud ikke ville hjelpe meg.

I have turned to Satan instead.

It has really bothered me that God would not help. I have prayed a lot, believing that God would help, but he did not.

Category 3: Being governed by God or higher powers is experienced either as a help and a burden

Agate and Elmer describe how they feel governed by God:

Agate: (Da jeg var på et religiøst møte) opplevde jeg at noe skjedde med øynene mine. Jeg følte meg styrt av Gud. Det var ubehagelig. Jeg liker å styre meg selv.

Attending a religious meeting, something happened to my eyes. I felt governed by God. It was unpleasant, because I want to control myself.

Elmer:

Jeg mener ikke at mennesket har fri vilje, .. jeg tror at alt er Guds vilje. Hva med de som sulter, hva med de som blir drept, hva med

de som blir drept i krig, og alle lider som nød? Ja, men de har evig liv, alle har evig liv.

My opinion is that humans don't have a free will,I think that everything that happens is God's will. But what about starvation, people being killed, wars and all the suffering? Yes, but they will all have an eternal life.

Category 4: Religious rites as a support

Agate describes help from prayers:

Agate:

Min svigermor ba for meg og jeg kjente at det skjedde noe, at jeg ble letta på en slags måte.

My mother in law prayed for me. I felt a sense of relief and that something happened.

Category 5: Evil forces trying to take control

Dennis describes how evil forces is trying to control him:

Dennis:

Den onde stemmen/kraften prøver å ta over. Jeg blir helt "vill", jeg føler jeg mister kontroll. ...Det er som å bli utsatt for tortur.

The evil voice/forces are trying to govern me, and I feel I lose control and become completely crazy. ... It's like being subjected to torture.

The next step in the process of analysis was to go from the condensed meaning of the patients' statement, the codes or categories, to the descriptions and the concepts, summarizing the content of each code and validating the results by again relating the central content of the codes to the original text material. During this step of analysis, we would describe the subgroups of codes, rereading and reconsidering the initial data to be sure the themes found, in fact constituted a condensed meaning of the data. In this phase of the interpretation of data, it is important to maintain the focus on the

patients' original statements, preventing that their "voices" are overshadowed by theory and unsound reasoning (Malterud, 2011). We found that patients' descriptions of the effect of their religiousness differed strongly from patients to patient. It was therefore important to regroup the codes according to patient' statements as to how they experienced their religiousness to be a help or a burden in their process of coping with their disorder. Furthermore, we found it helpful for the presentation of the results to link the results to the earlier published paper (on the quantitative data of the same patients) by Danbolt et al (Danbolt et al., 2011) (see paper 2).

To give an example of the further analysis process, I will use the case of Elmer as an illustration of patients that experienced their religiousness to be a help in coping with their psychosis. As to Elmer, we applied the following subcategories for **meaning making** "": 1. making sense, 2. the influence of a higher power and 3. a positive reappraisal of suffering. Through his story of possessing divine powers, we learned that Elmer in his belief that he is Jesus Christ, often feels affirmed by God:

Concept 1: Having divine power (Elmer)

Da tok jeg fyr på ... ja, sånn sengelaken som lå over dyna tror jeg, men det begynte å brenne noe fryktelig, vet du. Da tok jeg hånda mi og så bare la jeg oppå og det svei som pokker, vet du, men jeg bare holdt den der helt til alle flammene var slukket og så bare så jeg på hånda etterpå – ikke et merke! Forklar det, du! Det er umulig å forklare.

When I put fire on ... my bed linen it started to burn terribly. Then I just put my hand on the flames, it hurt as hell, but I just held it there until all the flames were gone ...and when I watched my hand afterwards - there were no marks on it! Explain it if you can! It is impossible to explain.

Elmer's belief in being Jesus is strengthened by his logical reasoning (making sense). He argues that he has suffered much, just like Jesus. He also informs us that his father is a carpenter, the same occupation as Josef had; the father of Jesus. In addition, he states that the "signs" from God, such as the feeling of possessing divine power, is important for his belief system;

Concept 2: "Signs from God"

Jeg kan jo ikke gå rundt og tro at jeg er Jesus uten å få tegn. Jeg vet ikke hva Jesus gjorde, jeg har aldri hatt en bibel.

I would not walk around believing I am Jesus Jesus without having these divine tokens. I do not know who Jesus was or what he acted like, because I never had a bible.

In the first example given above, Elmer describes, (being restrained in belts), how he can stop a fire with his bare hands. Elmer experiences having supernatural powers, and this strengthens his opinion that he is Jesus. In fact, he knows little about what is written in the Bible, but the limited information he has of Jesus' life, such as the occupation of Josef and Jesus' suffering, he interprets as a support for his belief system. His psychotic experiences become "tokens", strengthening his belief. Generally, we see that Elmer's belief system is closely related to his psychosis, and functions as ways of making meaning in a world of altered perception.

The last step of the analysis was to compare the findings with existent theory relevant to the results of the study. During the interpretation process, it became clear that Pargament's (2007) theory on religious coping might shed light on our findings as described in the "result section". Applying his theory of religious coping, we found that, from a certain perspective, one may say that Elmer displayed a "successful" religious conversion. He succeeded in creating a new religiousness that he found helpful when coping with his disorder. This process of switching from sources of data to professional literature, and back again, in order to gain a deeper understanding of a phenomenon, is the last step of the phenomenological analysis described by Malterud (Malterud, 2011).

7.4.3 Thematic analysis

Sub-study 3 is a thematic analysis, even though it bears much resemblance to the phenomenological method described by Malterud (2011) (Boyatzis, 1998; Braun

& Clarke, 2006; Malterud, 2011). The difference is that, as for sub-study 3, due to its relatively large amount of data, we chose to focus on the main theme found in the initial analysis of data: e.g., the patients' *search for meaning*. To start with, the thematic analysis was data driven, but eventually Schnell's (2009) theory on meaning making was applied, directing the analysis in a more theoretical and abductive direction (Braun & Clarke, 2006; Schnell, 2009). The motivation behind this choice was our interest in examining how religiousness influenced the patients' search for meaning in their present life situation. We conducted a qualitative analysis of the transcribed interviews following the stepwise model of thematic analysis (Boyatzis, 1998; Braun & Clarke, 2006):

(1) The data from the in-depth interviews consisted of 313 pages, 106285 words of written text. In order to get an overview, I, the first author, reduced and summarized the raw data to make a case summary for each of the patients. The case summary was written just after finishing the interview with the patients, and was based on what I (the interviewer) considered to be the main themes discussed during the interview. In addition, the case summary included a summary of the patients' medical history, from the PANSS interview. These case summaries are based on the interviewer's first impressions, and contain important information as to the main themes as well as the interviewers' emotional response emerging from the interaction with the interviewee (see discussion of method).

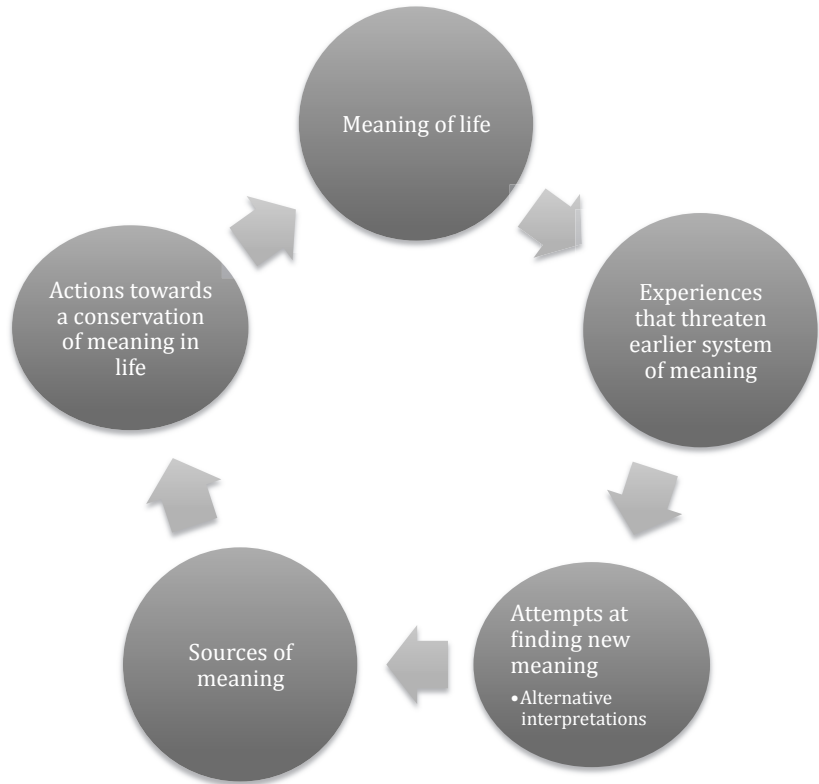
(2) To secure that the interpretation process would benefit from the use of different perspectives, a research team contributed to the analysis process. The research team consisted of professionals within the field of general psychiatry, clinical psychology, cognitive theory, neuropsychology, theology and the psychology of religion. It consisted of religious researchers as well as atheists. Jointly, the

research team conducted a qualitative analysis of the transcribed in-depth interviews in the following way: All the researchers would read the case summaries. Then, working together, the research team discussed and extracted the main themes of the case summaries. In addition, we co-analysed one of the interviews in full text. We made an effort to find a wide range of interpretations and possible themes, from the patients' statements. During the following weeks the members of the research team, individually, would read and analyse two more interviews in full text. There was consensus in the research group that the main topic of the interviews, was the patients' attempts to make meaning in a difficult life situation.

(3) In accordance with our finding of "making meaning" as a central theme, the research group decided for the forthcoming analyses to apply Schnell's model of the construction of meaning in life (Schnell, 2009). In her works, Schnell (2009) has introduced a five step hierarchic model of "meaning making" (Schnell, 2009). Each step represents an increasing complexity as to the degree of abstract thinking, from the level of perception to the highest level of experienced meaning in life (see the "introduction" section).

The full text of all the interviews on religiousness was analysed applying the following initial codes from Schnell's model: *perception, sources of meaning, goals, actions toward meaning, and meaning in life* (Schnell, 2009). (4) The first author (me), in cooperation with the last author (Danbolt), conducted the further analyses. All the texts from the interviews were coded systematically, and the part of the text relevant to each code was extracted. Then the text for each code was broken down in potential new sub-themes (Figure 5).

Figure 5. Codes study 3

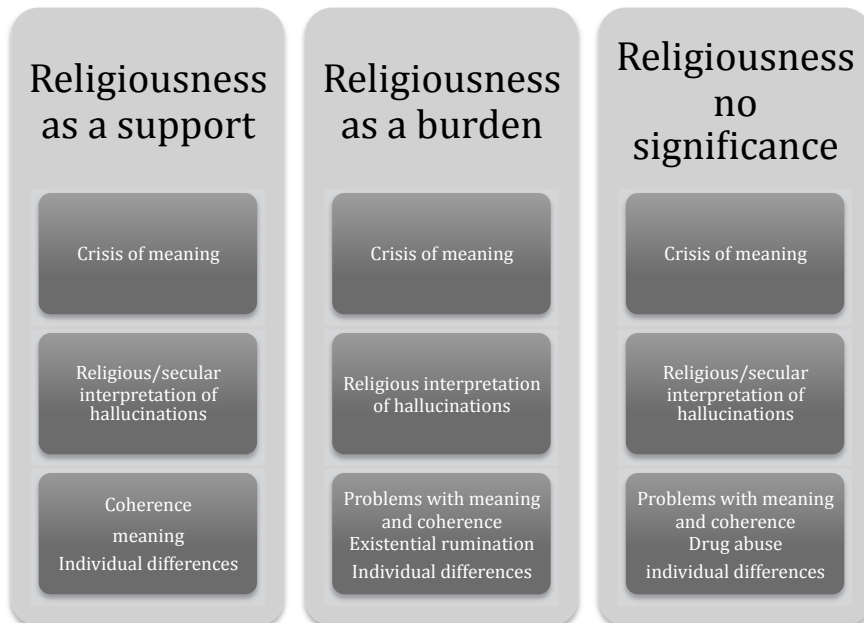


The new sub-themes, which were revised or different ones compared to the original themes of (Schnell, 2009), seemed to demonstrate an interaction described as follows: Patients' experiences in psychosis, such as hallucinations, disrupted their previous system of meaning. The patients needed to make sense of their hallucinatory experiences in psychosis, and as a result of this, a new system of meaning emerged. The stepwise process of meaning making found in the new sub-themes, is above illustrated as a circular movement.

(5) All text, for each sub-theme, were analysed utilizing systematic text condensation (Malterud, 2011). The analysis, conducted by me, was done with feedback, on several occasions, from the research team.

6) The final themes from the analysis on religiousness and meaning making, were then analysed in conjunction with the other sources of qualitative data and the stories of the patients given in the PANSS interview. The results from the coded and de-contextualized data seemed of little importance alone when being de-contextualized from the patient that gave her story, because the patients would display important individual differences. We wanted to understand the interplay between patients' religiousness and their psychosis. Thus, we decided on collecting all possible information for each patient, and the findings from the in-depth interview, the main issues from the PANSS interview and the summary of the patient's spiritual story on the basis of the semi-structured interview was gathered for each participant. The patients were grouped in three categories: 1. those who experienced their religiousness to be a support, 2. a burden or 3. of no significance (figure 6).

Figure 6. Final themes of sub-study 3



In the following, I will present some examples of patients' statements and the resulting codes/categories 1. *religious interpretation of hallucinations*, and 2. *meaning and coherence* or 3. *problems with meaning and coherence*:

Category 1: Religious interpretation of hallucinations

Hans: An example of his religious interpretation of his hallucinations.

Jeg ser jo at jeg har blitt trukket av mørke krefter.. Jeg tror jo så sterkt på at det er noen krefter utfor, og så har jeg jo hørt stemmer, sånn gode og onde og så sett noen slags skikkelser.

Det er mye som er så heftig .. Ja og sånne tegn som jeg kan også få (pentagrams etc)

I understand that evil forces have led me... I really believe that there must be external forces, I have heard voices, good and evil ones, and seen some creatures too.

The experiences are so forceful, ... and I have had other signs as well (pentagrams etc)

Berit: Hears the voice of God advising her what to do.

(Jeg hørte Guds stemme) at jeg skulle sende en melding til bestevenninna min fordi foreldrene hennes holdt på å skille seg og hun var helt ute av seg. Også sendte jeg en melding med en eller annen tekst på, jeg husker ikke helt hva det var for noe nå, og så ble hun kjempeglad ..

(I heard the voice of God) asking me to send a message to my best friend because her parents were divorcing and she was very unhappy. I sent her a text message with a bible verse, I do not remember which one, and she was so happy.

Berit considers her religiousness to be helpful and an example of this is given below.

When she experiences depression, sleep difficulties and troublesome hallucinations, she finds comfort in imaging that she is resting in the arms of God: The statement below was coded in the category of “coherence and meaning”:

Category 2: Coherence and meaning

Jeg medarbeider på en leir og da sov jeg ingen ting de tre første nettene og så sov jeg lite den fjerde dagen og da blir du ganske dårlig... Da var det en som sa til meg at "du vet at du kan hvile i Guds armer", og jeg ,bare JA, og da bare følte jeg at jeg bare la meg i armene til Gud og bare hvilte, og så var det godt og trygt der og så fikk jeg sove.

I worked as an assistant at a summer camp, but I could not sleep. The first three nights I slept very little and the fourth day I felt pretty bad... Then a friend said to me that "you know that you can rest in God's arms", and I just YES, and then I just felt that I just could leave myself in the arms of God and just rest. It felt well and safe and I could sleep again.

In the case of Danny, his expression of his relationship to God was coded as a problem with meaning and coherence. Danny experiences a vision of Jesus as an astronaut, giving him hope that God will rescue him (physically) from suicide. He tells me that he hopes that in the case of him jumping from a large bridge, in order to commit suicide, Jesus will pick him up before he is crushed against the surface of the water: This is well illustrated by his drawing of his relationship with God.



Artwork 3: Danny's drawing

7) Analysing the subgroups (religiousness as a burden, help or no significance), we found that they, above all, had one theme in common: The patients understood their hallucination as an encounter with God or a Supreme Power. Because of that I re-labelled this code as **mystical experiences**. The findings from the semi-structured interviews were utilized to get an overview of patients' statement as to their religiousness. It turned out that the patients that had mystical experiences also had experienced changes as to the content or function of their religiousness. The final presentation of the results will include an analysis as to the function, and also the substance of patients' religiousness.

8) The last step of the analysis was the interpretation of the results in the light of professional literature. Especially, the theories on religious coping and the evolvement of the image of God, were found important for the further analysis process (see the “discussion” section) (Pargament 2009; Rizzuto, 1979).

7.4.4 Case study

We decided that a multiple single case study design was the most appropriate methodology for sub-study 1 (Yin, 2009). The design of the case study is the logical sequence that connects the empirical data to a study’s initial research questions. According to Yin the research design is the “action plan” for getting from “here to there” (Yin, 2009). Sub-study 1 aimed at studying our initial proposition for the case study in a clinical context, in order to analyse and modify theory according to empirical findings. The data were analysed using a modification of the method recommended by Yin for single case studies (Yin, 2009).

The case study model described by Yin (2009) applies a 5-step procedure functioning as an “action plan”. Yin (2009) maintains that these 5 steps will encourage the researcher to start the building of a preliminary theory related to the topic of study (Yin, 2009). Yin (2009) proposes that as for the case study the researcher will simply start by asking a research question.

Then, Yin (2009) suggests that the researcher produces a *proposition* i.e., the presumed final result of the intervention. In sub-study 1 of this thesis, this proposition, built on existing theory in the field; is in the of form of an presumption, foreseeing the effect of a given intervention (Beck et al., 2011; Chadwick, 2006). As for Sub-study 1, we worked from the following proposition: *Considering artistic expression as a way of exploration, and through this, understanding emotions and bodily sensations, opens up the possibility of exploring the psychotic experience itself*

through art therapy. CBT focuses on the exploration of the psychotic experience by using words, in order to help the patient to master her symptoms. Originally CBT had a verbal approach, but later contributions to the field also utilize meditation to explore the psychotic experience in order to endure, understand and cope with the psychotic experience (Chadwick, 2006). The therapy study builds on this theory, but will utilize artistic expressions instead of meditation in the exploration process (Paper 1 p. 313).

In order to analyse and modify theory according to empirical findings, the case study examined our initial proposition in a clinical context. We wanted to explore how patients experienced their participation in the art therapy group and in which ways their experiences would fit with our initial proposition. The steps of analysis were conducted in the following order:

7.4.4.1 The first step of analysis

The first step of analysis was to organize the data and then to analyse the different sources of information separately.

7.4.4.1.1 Condensed therapeutic stories

The artworks of the participants were, according to ExA theory, analysed in conjunction with the notes of the therapists from the therapy sessions in order to create a condensed therapeutic story. The artwork of the patients verify the understanding of the therapist and functions as the “patients’ voice”. The main focus was to investigate how the patients went about exploring their psychosis and how this work was presented in the therapeutic group.

As to the condensed therapeutic story of the group process, I would carefully observe and analyse the themes emerging during the therapeutic process, and also the

interaction between the participants, therapists and the artwork produced.

To give a broader description of how the condensed therapeutic story of the group process was created, I will give some examples of the results presented in paper 1:

1. The patients were able to create a safe group, interacting in a supportive way.

In paper 1 this finding is verified by a description of the group process from the therapist's point of view:

The group was evolving into a group in which all participants seemed to feel rather confident. They brought private issues into the discussion both at the start and at the end of the group sessions. Several of the participants stated they feared being stigmatized as crazy ones, which they feared would lead to an exclusion from the social community. They described how their disorder affected their relationships to others. In fact, they were embarrassed about having a diagnosis of psychosis and they often felt that other people treated them as "the crazy ones". In particular, they were preoccupied with thoughts about how this would affect their close relationships.

To illustrate how the patients' joint artwork provided sources of data, supporting the condensed therapeutic story on the group process, I will present the reader with the drawing of the rainbow (see below), supplied with the patients' own words on how they experienced their participation in the group. The task of this particular group session was to make a drawing of how they experienced the group, and to give the group a name. In describing how they felt about the group, the adjectives and nouns being used were: *hope, self-consciousness, engagement, belief, happiness, friendship, joy, creation, belief, forgiveness*. They told me the drawing of the rainbow symbolized them all in all their colourfulness, and that each of them was to compare to a treasure chest. In the process of producing the drawing, they were cheerful making jokes about how they had renamed the group "The Rainbow", now

changing the nickname of the group into “The colourful ones”, instead of the “the crazy ones”. Once, during the break, with the door left open, the custodian passed by, spontaneously and jokingly asking them for permission to join the group because he found it so joyful/ cheerful. The atmosphere of confidence and light-heartedness, together with the impressions of the patients’ interaction in the group in general, are indicators that the patients experienced the group as safe place. In the in-depth interview the patients gave the following statements as to the group process:

Jean

Vi hadde en fortrolighet til hverandre at vi snakket om problemer... vi åpnet oss for hverandre og lærte av det.

We took confidence in each other and talked about our problems.. we opened up to each other and learned from each other.

Cindy

*Jeg følte meg 100 % sikker på gruppelederne.. Det er så store følelser at hvis de slipper ut, så er jeg trygg på at de to vil håndtere det, det var en enorm trygghet
Det var en deltager som jeg reagerte litt på, men det ble tatt opp og blei også utrolig flott.*

I felt 100 % safe with the group leaders.. We have such intense emotions and if they are set free I feel secure the group leaders will handle it. For me it is a huge feeling of safety. I was a bit puzzled by one of the members of the group, however, this was discussed in the group and turned into a wonderful experience as well.

Linn

Det var veldig bra å treffe folk som hadde opplevd det same... at andre også hadde opplevd, følte seg merkelige som jeg.

For me it was a very good thing meeting with people that had some of the same experiences and felt strange like me.



Artwork. 4 The rainbow

2. Existential and religious issues were one of the main themes in the group

The findings that existential and religious issues were one of the main themes in the group, are supported by the therapist's (me) notes from the sessions, as well as by the artwork produced and the semi-structured interviews. The artwork showed a variety of religious, mythical and existential themes, such as, e.g., angels, the rainbow, unicorn, the motherhood, aliens, doomsday and the snake (see paper 1 and appendix to paper 1). The collaborative drawing of the rainbow is described above, Jeans painting of existential fear/motherhood is described under the section of analysis of the artwork produced. Additionally, I will below present the artwork on angels. Two of the participants, Linn and Cindy, made guardian angles in clay to protect them and the group:



Artwork 5. Cindy's angel



Artwork 6. Linn's angel

As described in paper 1, Linn had experienced the loss of a child, and her angel protected its grave. She had been seeing angels even since she was a child, and she still found this comforting. For Cindy, her angel inhabits her safe landscape, functioning as guidance in her life.

In the in-depth interviews the patients underline how religious and existential themes are important to them:

Table 6

	The statements of the participants	Crystallized meaning	Codes
Jean	<p><i>Noen av de andre hadde liknende mine visjoner, eller psykoser, jeg mener psykoser, ikke visjoner</i></p> <p><i>Some of the others had similar experiences of visions, or psychosis, I meant to say psychosis, not visions.</i></p>	<p>It seems that Jean has understood that her experiences of seeing things is part of the psychosis, not religious visions.</p>	<p>Share with others</p> <p>Religious struggle</p> <p>Share her experiences with others</p> <p>Religious struggle</p>
Linn	<p><i>Når vi laget psykosen i leire hjalp det meg å se at jeg var veldig syk, at det ikke var magiske evner. Men det hjalp meg også å se at jeg er frisk nå. At jeg lever i den friske verden, ikke den psykotiske</i></p> <p><i>When I expressed the psychosis in clay, it helped me to understand that I was very sick and that there were no magical powers. But it also helped me to realize that I am healthy now. I live in the healthy world now, not the psychotic one.</i></p>	<p>It helped her differentiate between spiritual experiences and her psychosis.</p>	<p>Coping</p> <p>Religious struggle</p>

7.4.4.1.2 The in-depth interviews

The in-depth interviews consist of 66 pages single spaced text, 17388 words.

The transcripts of the interviews were analysed applying a phenomenological analysis, inspired from Giorgi and modified by Malterud, as described above (Denzin & Lincoln, 2011; Giorgi, 1985; Malterud, 2011). The interviews of the patients were first analysed by me by means of systematic text condensation (Malterud, 2011). The process of systematic text condensation requires a de-contextualization from the interview text of the original informant, in order to extract the themes and the condensed meaning of the patients' statements about their therapy.

In the course of the process, four themes crystallized as to the patients' subjective experience of the helpfulness of art therapy: 1. Generally coping with their psychosis,

2. understanding their experiences 3. feeling more alive. Examples of the patients' statements and how they were coded, are presented in tables 6 and 7.

Table 7

	The statements of the participants	Crystallized meaning	Codes
Cindy	<p><i>Det var viktig for meg å uttrykke meg kreativt, og særlig muligheten å uttrykke psykosen. Det var første gang jeg begynte å snakke om det (psykosen). Tidligere var det bare noe massivt som kom over meg, som jeg ikke hadde kontroll med og jeg fikk medisiner for å justere det voldsomme trykket. Men nå merker jeg veldig godt når det kommer, så at jeg kan bremse ned og ta meg inn igjen.</i></p> <p><i>It was important for me to express myself creatively, and especially the ability to express my psychosis. It was the first time I started talking about it (her psychosis). Previously, there was just "something massive" that came over me, over which I had no control. I was given medication to adjust the pressure it caused. However, now I notice more easily when it appears, so that I can slow down, and take better care of myself.</i></p> <p><i>Det var først nå, det siste året (når jeg deltok i kunstgruppen) at jeg forsto at jeg har en psykose, jeg visste ikke det før. Jeg har ikke vært psykotisk siden april for et år siden, og årene før det var jeg psykotisk i alle fall en gang i halvåret.</i></p> <p><i>It is only during this past year (while participating in this group) that I realized that I suffer from psychosis, I did not know before. Earlier I went psychotic at least once a season. But the past year I have not been psychotic.</i></p>	<p>Art-therapy helped her to recognize her psychotic experience and by means of this she can cope with her disorder in a better way.</p>	<p>Understand experiences</p> <p>Coping</p>
Hanna	<p><i>Det var en modning slik at jeg fikk bearbeidet ting, og ryddet ting på plass i livet.</i></p> <p><i>I think participating in art-therapy was like a maturation process. Things got cleared out in a way.</i></p> <p><i>Jeg har kanskje ikke klart å sette ord på det, og det er litt vanskelig å sette ord på kunst- og uttrykk. Men jeg syntes det var veldig positivt, det var veldig kjekt og jeg fikk veldig mye ut av det uten at jeg konkret klarer å sette ord på det. Det var liksom noe som ble satt i gang i meg selv.</i></p> <p><i>For me it is difficult to express in words how I experienced ExA. But I experienced ExA as very positive... I benefitted much from therapy even though I am unable to specify or to articulate it. It was like something "got started" inside myself.</i></p>	<p>Art-therapy helped her to sort things out and something "got started" inside her.</p>	<p>More alive</p>

Rita	<p><i>Noe hadde stoppet opp inni meg, for jeg trodde ikke jeg kunne gjøre mer verken for meg selv eller andre. Det at jeg kunne være til hjelp for andre ved å fortelle noe som andre hadde kunne ha nytte av, det var godt. Det gav meg et lite vink om at jeg ikke var død.</i></p> <p><i>Entering this group, I felt that everything had stopped inside me, and that I was unable to do anything for others or myself. But the experience that I could help others by sharing some of my experiences, gave me an indication that I was not dead.</i></p>	<p>It was possible to express herself and help others. This gave her an indication that she was not psychologically dead.</p>	Felt alive
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Tables 6 and 7 show how the original text, the patients’ statements, have been condensed, and then coded. Because our intention was to conduct the analysis on the level of the single case study, the statements were re-contextualized to represent each of the original informants. In order to make valid conclusions, we analysed patients’ statements from the in-depth interviews in combination with their condensed therapeutic stories.

At this step, the research team entered into the further process of analysis. The research team consisted of professionals within the field of general psychiatry, clinical psychology, cognitive theory, neuropsychology, art therapy, theology and the psychology of religion. Jointly, the research team conducted the further qualitative analysis of the case study in the following way:

7.4.4.2 The second step of analysis

We applied what Yin call “time-series analysis” by observing the patients during the course of their therapy, comparing their situation before, under and after the intervention (the therapy) (Yin, 2009). The concept “time-series analysis” is often used in a quantitative research setting to mean an analysis of a sequence of data points, typically consisting of successive measurements made over a time interval (Yin, 2009). In sub-study 1, the concept is applied for the analysis of the observations of the patients during the therapeutic process in conjunction with the interview 8

months after the conclusion of the therapy.

7.4.4.3 The third step of analysis

We, the research group, analysed the different sources of data as an entity in order to deepen our understanding of the therapeutic process. The patients' statements from the interviews were then analysed in conjunction with the patients' condensed therapeutic stories. We analysed patients' statements from the interviews on whether/how they found the therapy helpful in coping with their psychosis together with the information from the condensed therapeutic stories. By analysing these sources of data in combination, we aimed at understanding more fully how the patients went about exploring their psychosis and also how they engaged in the therapy group. I, the first author of paper 1, summed up the different sources of data then asked the research group for feedback. In the presentation of the findings in paper 1, we have made an effort to give a broad description of the cases, telling the story of the patient in its diversity, rather than summarizing them in neat formulas or theory.

An example of how we conducted the analysis can be described by using the case of Linn. It explains how she went about exploring her psychotic experience of being in contact with alien: The main doubt she addressed in therapy (see her therapeutic story in paper 1), was whether her experiences of seeing aliens and her experience of a supernatural power resting in her body, really was part of her psychosis. In her psychosis she felt she was given the powers and responsibility to save the world through magic. She experienced her magic world to be real, seeing aliens outside her house. She expressed in clay her encounters with the aliens:



Artwork 7. Aliens

After the psychotic episode disappeared by means of antipsychotic medication, she experienced a loss of her magical powers as well. This loss she found very unpleasant, and it led to non-adherence to medication. Ever since she was a child, Linn had been familiar with a transcendent reality. Being a child, she experienced seeing angels, which she believed protected and guarded her. Thus, her spiritual interpretation of her hallucinatory experiences during the psychosis was in accordance with her already established belief in a transcendent reality. By means of her artistic work, however, she was able to explore and analyse her experiences, and she understood that the experiences of aliens were part of her psychotic experience, not her healthy religiousness. The artistic process enabled her to reinterpret her psychotic experiences and by means of this she gained control over her religious delusion (see her statement of her process above).

7.4.4.4 The fourth step of analysis

We analyzed whether the total sources of data from each participant met our initial proposition. This procedure is described by Yin as *pattern matching*. As to this study, we first analyzed whether the patients met our presumption that the patients

would be able to explore their psychotic experience, and they all did. Second: Two research questions had to be analysed: Did the statements of the patients confirm that the artistic exploration had led them to a cognitive understanding of their experience? And: Did they express, and in case how, that they were able to cope with their psychosis in a more adequate way?

7.4.4.5 The fifth step of analysis

In the final step of the analysis process, I consulted the informants (member checking). The draft article was presented to each of the five patients, asking for response as to whether the description of their therapeutic process was in accordance with their own experience. They all agreed to the content.

8 Results

The main findings of this study can be summarized as follows in eight points:

Answers to the research questions of sub-study 2 and 3:

The substance of religiousness:

1. Patients with psychosis seem to mirror the general state of religiousness in Norway. Patients believe in a variety of phenomena, e.g., the relationship to a sacred figure, reincarnation, encounters with ancestors, angels, good and evil forces. However, patients' religiousness often contains religious omnipotent delusions of being a spiritual omnipotent figure, having a sacred omnipotent mission in life, or experiences of being possessed by divine evil powers.
2. Patients understand their hallucinations as mystical experiences, encompassing them in their belief system.
3. Patients that understand their hallucinatory experiences as mystical experiences, changed the substance of their religiousness.

The function of religiousness:

4. Patients' religiousness may be understood as attempts of religious coping.
5. For some patients, their religiousness served, in their own judgment, as a positive religious coping strategy, offering meaning and a relationship with spiritual figure. However, their religiousness included religious omnipotent delusions, and/ or displayed an unsecure relationship to the sacred figure, all built on hallucinations.
6. Some patients engaged in negative religious coping. In these cases, the patients' religiousness functions as a reinforcement of negative core beliefs.

Answers to the research questions of sub-study 1

Therapeutic implications:

7. Art therapy may help some patients to an improved cognitive understanding of their psychosis, enabling them to cope with their disorder in a more adequate way. For other of the patients, art therapy seems to improve the awareness of the self.
8. Art therapy may be a feasible way of helping patients with religious struggle.

The substance of patients' religiousness discussed in this thesis, such as the belief in reincarnation, angels, good and evil forces, encounters with ancestors and the relationship to a sacred figure, also mirrors some of the general religiousness in Norway. However, patients' religiousness contains religious omnipotent delusions, e.g., having a sacred mission in life, or they experience the intrusion of evil forces. The patients, who give their religiousness significance, will understand some of their hallucinations as mystical experiences. The attribution of the symptoms of psychosis to a Supreme Power or God, seems to be the result of the patients' need to make sense of their altered perceptions in psychosis, as well as the need for making a higher meaning of life. Their understanding of hallucinations as mystical experiences, led to a change in the substance of patients' religiousness. The results from this thesis show that patients' religiousness may be understood as attempts of religious coping. Some patients describe their religious coping strategies to be of great importance for them, for some even life saving. Only one patient utilizes religious coping strategies without any understanding of his hallucinations as mystical experiences. We also see examples of patients utilizing, simultaneously, more than one system of meaning making for their psychotic experiences, both a religious, and a bio-medical one.

Patients' religious coping strategies are complex and by far not solely positive, even though judged so by the patients themselves. Their religiousness may reinforce their delusional system and even make them dangerous for themselves or to others. The relationship to the sacred figure is not a secure one, since it builds on hallucinations, which may change over time. For some of the patients their religiousness adds to their suffering, because they are preoccupied with thought patterns leading to an appraisal of God as persecutory or weak.

Art therapy is demonstrated as a way of helping patients with psychosis to explore their psychotic experience and for some patients their exploration process leads to a cognitive reconstruction of the experience, improving their coping abilities. For one patient the exploration process helped her to distinguish between what she experienced to be her helpful mystical experiences on the one hand, and her hallucinations and religious delusions connected to her psychotic experience, on the other.

8.1 Synopsis of paper 1

This paper describes the course of an art therapy group for five women suffering from psychotic disorder and their statements of the usefulness of the therapy. The focus of the group was, as in all forms of art therapy, to help the patient to find her recourses in order to cope with the psychosis. In addition, the group leaders would encourage the patient to explore her psychotic experience through art. The theoretical proposition of the case study can be summarised as follows: 1. According to the CBT theory, the exploration of the psychotic experience will improve patients' ability to cope with their psychosis. This is brought about by a better cognitive understanding of the psychotic experience, and 2. The ExA theory maintains that experiences and emotions can be explored by means of artistic

expression.

Results: The five patients described that their participation in the art therapy group furthered their coping abilities. All the patients met our proposition that they were capable of exploring their psychotic experience through art. Two out of 5 patients described their exploration process to be particularly helpful for their ability to cope with their psychosis, whereas the rest reported a more unspecific improvement of their disorder. Religious and existential issues turned out to be two of the main focuses discussed in the art therapy group, and one of the participants described that her exploratory artistic work had opened a new ability for her to distinguish between what she experienced to be her helpful mystical experiences on the one hand, and her hallucinations and religious delusions connected to her psychotic experience, on the other.

Conclusion: Our initial proposition is strengthened: Artistic exploration of the psychotic experience may contribute to the patients' cognitive understanding of their disorder, thus helping the patient to control her psychosis. This result leaves us with a modified proposition: Art therapy may help some patients to an improved cognitive understanding of their psychosis, enabling them to cope with their disorder in a more adequate way. For others, art therapy may improve the awareness of their own emotions and the self. Art therapy may also be a feasible way of helping patients with religious struggle.

8.2 Synopsis of paper 2

Sub-study 2 is an interview study on patients suffering from schizophrenia spectrum disorder. The focus of this sub-study was to study what characterizes religiousness for patients suffering from schizophrenia spectrum disorder, and

whether the patients reported their religiousness to be a support or a burden in coping with their everyday life.

Results:

What are the characteristic of their Religious Stories?

The stories are all very different with regard to their religious content, ways of expression, and the attached significance. However, some common features are observable:

1. The informants who felt their religiousness to be solely a support had displayed coherent religious belief systems, which they regarded as very important in their lives. However, the clinician would diagnose these belief systems as religious delusions.

The informants, who felt their religiousness to be a support, had a more or less coherent religious belief system, encompassing a hope for the future. Such belief systems displayed an integrated religiousness, meeting the new challenges of their disorder. Acting in the role as an omnipotent figure, the informants themselves played an important part in their religious narratives. The stories generated a sense of meaning and control. Elmer even describes that he would have killed himself if he did not have his faith.

2. Religiousness, hallucinations, and delusional systems were closely woven together.

The phenomenon of religiousness presented in these six interviews, display the development of a personal belief system, closely woven together with the informants' changed perceptions of the world. The content of the belief system differed from that of being close to God, to be given special religious gifts, being in dialog with the Devil or that of being Jesus. Their belief systems seemed closely related to their

psychoses and functioned as ways of meaning- making in a world of altered perception.

3. The experience of having supernatural powers.

The two informants, Agate and Elmer, who experienced their religiousness to be helpful, reported to have supernatural powers, understanding them as divine tokens. Their interpretation of their hallucinatory experiences, provided a suitable explanation and a sense of control.

4. Experiences of being controlled by evil forces.

Dennis who experienced his religiousness both as a support and a burden, and Beathe and Fredrik, who reported their religiousness to be neither a support nor a burden, all experienced their hallucinations as evil forces trying to control them.

5. Religious struggle.

All our informants had changed their ways of relating to God or the sacred in the course of their lifespan. The patients, who reported their religiousness to be a support, displayed a positive religious coping style. All informants struggled with religious issues, especially those who reported that their religiousness was neither a support nor a burden. For these, their religiousness had changed from being important, to becoming of little importance or even a burden. All the same, their religiousness seemed to be a source of struggle and rumination.

6. One of the patients that displayed a helpful religiousness, demonstrated that he was able to live a relatively normal life and to receive psychiatric treatment, despite the fact that he had the conviction that he was Jesus.

The religious delusion of being Jesus did not interfere with his compliance to medical treatment. The other patient who reported a helpful religiousness, however, was potentially dangerous to herself. As a result of her religious conviction that she was

able to fly together with the spirit of her spouse, she jumped from the first floor, hurting herself severely.

Conclusion: All informants displayed signs of religious struggle and attempts of religious coping. They interpreted their hallucinatory experiences as divine or supernatural tokens, and their religiousness was interwoven with these experiences. These findings indicate how patients with schizophrenia spectrum disorder adopt religious coping strategies in interpreting their psychotic experiences in order to create meaning and coherence in a difficult life situation. The interplay between hallucinations and how evolving delusional systems may give relief of anxiety is well known, but how religious coping strategies may be involved in this process, has as far as we know not been shown before. The results underline the patients need for the shaping of meaning, and that a stronger focus in therapy on the process of making meaning, may help the patients in their struggle to find a meaningful life in spite of their disorder.

8.3 Synopsis of paper 3

Many patients with psychosis report that their religiousness is of great importance for them in coping with their psychosis. To fully understand the significance of religiousness in psychosis, I decided on conducting a third sub-study, where I had the opportunity to focus on the patients at the onset of their psychosis. The aim of sub-study 3 was to explore the religiousness of patients suffering from first-episode psychosis (FEP) and how they experienced their religiousness to be a help or a burden in coping with their lives.

Results: The predominant feature of patients' religiousness was that they understood some of their hallucinations as mystical experiences. In presenting the results, we

divided the findings in two categories: The substance and function of patients' religiousness:

Substance' of religiousness:

1. Most of the patients demonstrate some sort of religiousness at the time of the interview, and / or in their past lives. Their religiousness comprises a variety of notions and aspects related to religion, e.g.: The belief in a Holy war, in apocalypse, crop circles, reincarnation, angels, good and evil forces, encounters with ancestors and the relationship with a sacred figure (see table 1 paper 3).
2. Eleven out of 18, gave a religious explanation for some of their hallucinations. These patients highlighted the experiential dimension of religiousness, understanding their hallucinatory experiences as mystical experiences. The patients attribute their hallucinations to a direct encounter with God, or to the influence of God, of ancestors or of a Supreme Power.
4. The patients that attributed their symptoms of psychosis to supernatural powers, reported changes as to their religiousness. These reported changes imply changes as to the subjective importance as well as to the substance of their religiousness (see table 2, paper 3).
5. Seven out of 18, gave no religious explanation for their hallucinations (table 1) Most of these patients had adopted a biomedical model to explain their hallucinatory experiences. They understand their voices to stem from their disorder or from the abuse of drugs.

Function of religiousness for the patients that understood some of their hallucinations as mystical experiences:

For the patients that understood some of their hallucinations as mystical experiences, their coping strategies may be divided into positive and negative religious coping

strategies, using Pargament's key functions of positive and negative religious coping strategies as a guidance:

Positive Religious coping:

For some patients, their religiousness served, in their own judgment, as a positive religious coping strategy, offering meaning and a relationship with spiritual figure. However, their religiousness included religious omnipotent delusions, and displayed an unsecure relationship to the sacred figure, all built on hallucinations.

Negative religious coping:

Some of the patients, experienced their "mystical experience" to be negative for them and these patients struggled to order their experience in a system of meaning and coherence. Such mystical experiences seem to reinforce the crisis of meaning, introducing a persecutory or "weak" God.

Function of religiousness for the patients that did not understand any of their hallucinations as mystical experience

One of the patients (Ole), expresses support from his religious belief without exposing any religious attribution to his hallucinatory experiences. During his psychosis he once expected to be arrested by the CIA because he had lost a memory stick at work. This expectation of an out-of-the-proportion punishment for his small failure at work seemingly have similarities to his fear of eternal punishment in hell for his sins. He is convinced that his religious fostering with a focus on strict moral standards is the cause of his psychotic illness. Paradoxically, at the time of the interview, he regards God as a sun who gives him love and comfort.

The other patients reported their religiousness was of no importance. Two of the patients (Leo and Per), had earlier in life utilized their religiousness as a means of coming to terms with all their problems, culminating in a psychotic breakdown. They

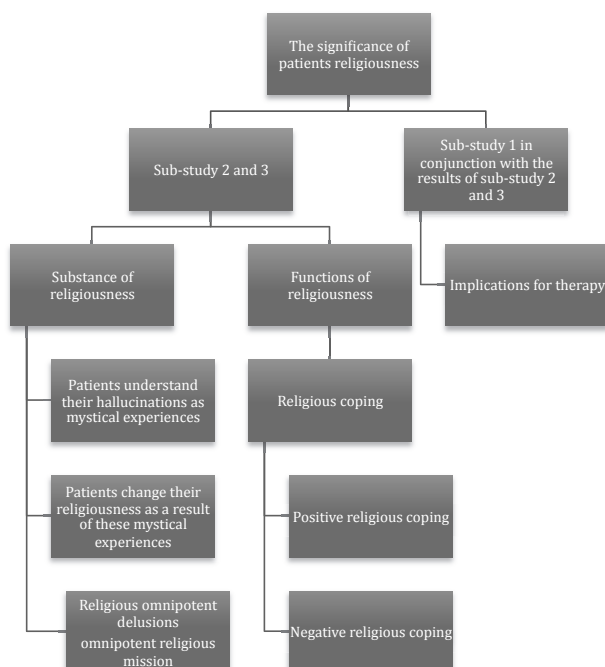
experienced their religiousness to be useless in coping with their lives, and they learnt that God had let them down.

Conclusion: The present study points to the fact that patients understand some of their hallucinations as religious experiences, encompassing them in their religiousness as well as in their meaning making system. For some patients, religiousness served as positive religious coping, despite the fact that their religiousness encompassed religious omnipotent thoughts and hallucinations. Others displayed the characteristics of negative religious coping, and their religiousness functioned as a reinforcement of negative core beliefs. These findings points to the importance of taking religiousness seriously into account in psychotherapy for patients with psychosis.

9 Discussion of the results

The aim of this thesis is to bring forward new knowledge as to the significance of religiousness for patients with psychosis in coping with their disorder, and to contribute to a well-founded theoretical understanding of how new knowledge can be utilized to improve therapy in general, and art therapy in particular for patients with psychosis. The PhD-study has been conducted by introducing three different sub-studies: two interview-studies (paper 2 and 3), and one case study on art therapy (paper 1). The main results, as described in the result section, will be presented applying the following categories: 1. the substance, and, 2. the function of patients' religiousness and 3. implications for therapy (figure 7):

Figure 7 Presentation of results



As described in figure 7, the results from sub-study 2 and 3 will first be analysed in conjunction. Then, in order to discuss the implications for therapy, the

knowledge obtained from the interview studies will be analysed in combination with sub-study 1. Based on theory in the field, I have chosen to present the phenomena of religiousness from two perspectives, i.e., the substance and the function of patients' religiousness (Danbolt, 2014; Geels & Wikström, 2012).

9.1 The substance of patients religiousness

One of the main characteristics of patients' religiousness is that the patients understand their hallucinations to be mystical experiences. The phenomenon of "hallucination", as clarified in the introduction, may include religious visions and auditions and a sense of presence of dead ones. These experiences are also a part of a normal religiousness. Consequently, the introductory statement of this paragraph do not itself judge between a psychosis and a possible mystical experience. Manifestations of mystical experiences and psychotic experiences are, according to literature, described in some cases to be apparently similar to each other (Geels, 2014; James, 1902; McCarthy-Jones, 2012; Sass, 1992). The fact that the experience of hallucinations is described in the terms of mystical experiences, will raise important questions in need of discussion. Are patients' experiences in psychosis in fact religious ones and an encounter with a Higher Ultimate Reality? And: Is the "religiousness" discussed in this thesis no "religiousness" at all, but rather the features of the psychosis itself?

9.1.1 Mystical experiences

The question whether there exist a Higher Ultimate Reality, to be encountered in mystical experiences, is a theological and philosophical question and impossible to answer through research. The belief in God or a Supreme Power is a common human feature, and as stated in the introductory part of the thesis, in Norway more than half

of the population believes in a Higher Reality (Botvar & Schmidt, 2010). The substance of patients' religiousness discussed in this thesis, such as the belief in reincarnation, angels, good and evil forces, encounters with ancestors and the relationship to a sacred figure, also mirrors the state of general religiousness in Norway, today. Often religious belief in Norway is a mix or a light syncretism of several religions and beliefs, such as Christianity, Buddhism, New Age and spiritualism (Brunstad, 1998; Holmquist, 2007; Nordeng & Princess, 2009). As to the mystical dimension of religiousness, it is still an important issue in many charismatic congregations in the more industrialized countries, and there is also a focus in the Norwegian society on spiritualism, e.g., in the ability to get in contact with ancestors or angels (Brunstad, 1998; Holmquist, 2007; Nordeng & Princess, 2009). In many countries, there is an ongoing discussion as to this distinction between mystical experiences and psychotic experiences, however, so far no conclusions have been made (Greenberg, Witztum, & Buchbinder, 1992; Jacson & Fulford, 1997; Lukoff, 1985; Maher & Oltmanns, 1988; Meissner, 1996; Oyebode, 2014; Saver & Rabin, 1997; Wikström, 1980). Henriksen and Pabst (2013) have interviewed persons with mystical experiences in Norway. The authors refer to the Exceptional Human Experience Network that tries to document such experiences to be common phenomena. The network provides a list of possible mystical experiences as described in the "introduction" section. The list of extraordinary human experiences offered by the EHE network includes all of the mystical/ hallucinatory experiences reported by the patients of the present study, with the exception of the experience of catatonia (Edward, sub-study 3). The patients in my material attribute their hallucinations to a direct encounter with God, or to the influence of God, of ancestors or of a Supreme

Power. They claim their experiences to be mystical ones, and not the symptoms of their psychosis.

A distinguishing factor between psychosis and the mystical experience, may be the fact that the patients seem attach such a great importance to their mystical experiences, probably more significantly so, than the importance given to mystical experiences among religious people without a psychosis (Brunstad, 1998; Holmquist, 2007). The patients seem to describe that their mystical experiences are crucial for their religious belief and relationship to the sacred figure. In comparison, the general population in Norway, belonging to a Christian Church, will instead base, and express, their Christian faith by means of rites, the scripture and the Christian fellowship (Luther, 1529/2014). It can be argued, however, that patients' religiousness share traits with modern religiousness in Norway, such as the belief in spiritism, as well as the belief in the reality of encounters with angels and ancestors (Brunstad, 1998; Henriksen & Pabst, 2013; Holmquist, 2007). The informants with paranormal experiences in the study of Henriksen and Pabst (2013), attached great significance to their mystical experiences, trusting these experiences more than the dogmas of the church. This reaction is in accordance with the patients' appraisal of their mystical experiences in my sample.

Laing and the anti-psychiatry movement view the psychosis as a mystical experience (Laing, 1967). The fact that patients' hallucinations bear resemblance to mystical experiences found in the general population, strengthens the argument that "psychosis" is in fact a mystical state of mind. Jung (1936) was the first one to argue that psychosis might be the result of a fragmentation due to the ignorance of the religious aspect in life (Jung, 1936). Several contemporary researchers support his idea of a religious explanation of psychosis, arguing that some, or all symptoms of

psychosis, such as hallucinations, may be understood in religious terms (Clarke, 2010; Dein, 2012a). As described in the introductory section, these researchers consider religiousness to be an integral part of the ability for recovery. They maintain that psychosis can be seen as a natural developmental process with both religious and psychological components (Clarke, 2010; Lukoff, 2012). I find this an interesting perspective to take into account. As we know, around the world the supernatural explanatory model of psychosis, is an important alternative to modern psychiatry. The Catholic church in Latin-America, for example, offers guidance to how one may distinguish a possession from a psychosis (Ángel Fuentes, 2016).

9.1.2 Delusion or Religiousness?

We will have to ask; is “religiousness” demonstrated in this thesis religiousness at all, or delusions based on hallucinations and thus a symptom of the psychosis? In the following I will try to contribute somewhat to this problematic question. Patients’ religiousness demonstrated in this thesis seems to be a belief system, which also encompasses hallucinations. The patients interpret these hallucinations as mystical experiences. According to the DSM V, the experience of having hallucinations corresponds to the description of positive psychotic symptoms (APA, 2013). However, a diagnosis of psychosis is only justified if the patient has additional social or occupational impairment. The patients included in this thesis are all diagnosed with psychosis, displaying social or occupational impairment. Consequently, from a psychiatric point of view, one could explain patients’ hallucinations and their attribution of their experiences to a Supreme Power or God, as symptoms of a psychotic disorder, and as the development of a religious delusional system.

Patients’ religiousness show differences from the religiousness of the general

population, both when it comes to the substance and the function. Patients' interpretations of their mystical experience show differences from those of the healthy population. Most strikingly, some of the patients display thoughts and actions of being an omnipotent figure, e.g., Jesus (Elmer, sub-study 2), an angel (Agate, sub-study 2), the possession or intrusion of divine evil powers (Hans, sub-study 3, Fredrik, Dennis, sub-study 2) or having a sacred omnipotent mission (Anna, Simon, sub-study 3). These thoughts are not commonplace interpretations in the general population, and in psychiatric terms, they can be understood to represent a religious delusion (Brunstad, 1998; Holmquist, 2007).

Sidle et al. (2002) found that the most common religious delusions were of secondary nature, being evolved from the hearing of voices or from experiencing other hallucinations, which in turn are attributed to manifestations of God or the Devil (Siddle et al., 2002). Expanding on this, one can argue the “religiousness” demonstrated in this study has nothing to do with faith and “real” religiousness, but is rather a symptom of psychosis. From a psychiatric point of view, a religious interpretation of hallucinatory experiences may be understood as demonstrations of how the basic symptoms of psychosis result in a religious and existential preoccupation and attribution of symptoms (Møller & Husby, 2000; Sass, 1992). One may also explain patients' tendency of attributing their psychotic experiences to God or a Supreme Power to be caused by a diminished sense of agency of thoughts and senses, and a tendency of misattribution of self generated thoughts and actions to be originated from an external force, such as God or a Higher Power (Beck et al., 2011; Chadwick, 2006; Frith, 2005; Garety, Freeman, Kuipers, & Fowler, 1999; Hestad, 2014; Pacharie et al., 2006). From a neuropsychological point of view, as stated in the introduction of this thesis, the phenomenon of hearing voices is associated with

malfunctioned neurons in left temporal lobe causing patients to misattribute their thoughts to an external source (Hugdahl et al., 2009). This area is located in the same area of the brain as the one associated with mystical experiences (Hestad, 2014; Persinger, 1987). This fact may explain patients' choice of a religious attribution for their hallucinatory experiences. Moreover, from a psychological point of view, we may explain psychosis, and the resulting religious preoccupation, to be the long-term effects of childhood traumas. Studies have shown a large overrepresentation of early traumas in patients suffering from psychosis, seemingly causing an increased tendency of religious preoccupation in adult life (Arieti, 1976; Laudar & Thomas, 2000; Lawrence, Edwards, Barraclough, Church, & Hetherington, 1995; Ross, 2008). The "religiousness" displayed in the present thesis may be understood as a "regression in the service of the ego" to an early narcissistic stage of the development of the self in order to repair the developmental difficulties produced by childhood traumas (Belin, 1999; Cullberg, 2005; Martindale & Summers, 2013; Wikström, 2007). The early phase of psychological development in life is characterized by a high degree of egocentricity; that everything is triggered by the child, and a tendency of magic thinking (Cullberg, 2005).

9.1.3 Conclusions as to the substance of patients' religiousness

If the patients "religiousness" was nothing else but a delusion built on hallucinations, the needed intervention should be medication and therapy to cure the psychosis. The results from the present study, however, give several indications that this is not necessarily sufficient in order to help the patient with their religious struggle, at least not with the present treatment outcome for psychosis. Paper 3 demonstrates that a majority of the patients still displayed a religiousness with psychotic content at the time of the interviews (conducted 5-12 months after the first

admission to treatment). Unfortunately, with the contemporary treatment-strategies in psychiatry, only 15-30 % of patients with psychosis will obtain a status of remission (Hegelstad et al., 2012). Therefore, many patients will have to cope with persistent psychotic experiences, and consequently, there is a possibility that some of the experiences of hallucinations will consistently be understood as magical experiences. From professional literature we know that some patients with first person account, even when recovered, will continue to experience or interpret some of their hallucinatory experiences as mystical ones (Chadwick 2010; Lee, 2005; Sørensen, 2014).

The DSM-V diagnostic tool leaves the possibility open that the symptoms of hallucinations, understood as mystical experiences, can be viewed as a healthy religiousness. According to the DSM V, the differentiation between a hallucinatory experience considered to be mystical or psychotic, is to be judged by the functionality of the patient. The symptoms of hallucinations alone are not viewed as sufficient for a diagnosis of psychosis, unless, as stated before, they are accompanied by a B-criterion of social or occupational impairment (APA, 2013). Seemingly, this brings us a step forward in our discussion on mystical experiences as part of a normal religiousness. However, the definition, for patients already diagnosed with a psychosis, is not necessarily helpful in distinguishing a healthy religiousness from an unhealthy one. The DSM V offers no tool for this differentiation. In my opinion, we should accept and respect, that a patient with psychosis, can still display a healthy religiousness, containing mystical experiences.

The religious attributions of hallucinations may bear strong influence on patients' lives, and may be part of a religious delusion. Linn (paper 1), is an illustration of this. She described that when medicated she would feel sorry for not

having supernatural abilities anymore, and this had caused her to be non-adherent to medication before the exploration of the psychosis had taken place in the art therapy group. Several patients with first-person account, as well as some researchers, will argue that the patients' hallucinations are indeed mystical experiences (Clarke, 2010; Jung, 1936; Lukoff, 2012; Sørensen, 2014). Patients often will fight for their natural right to give meaning to their experience, as well as the right to have a religiousness despite a psychiatric diagnosis. The problem, from a psychiatric point of view, is that unfortunately, the disorder of psychosis causes the patient to misjudge situations, and to take decisions that may be potentially dangerous to herself or others. This fact is well described in the stories of the patients included in this thesis. In order to approach a differentiation between a healthy religiousness, furthering the recovery process on the one hand, and a religious delusion in the need of treatment on the other hand, a closer investigation of the function of patients' religiousness will be required.

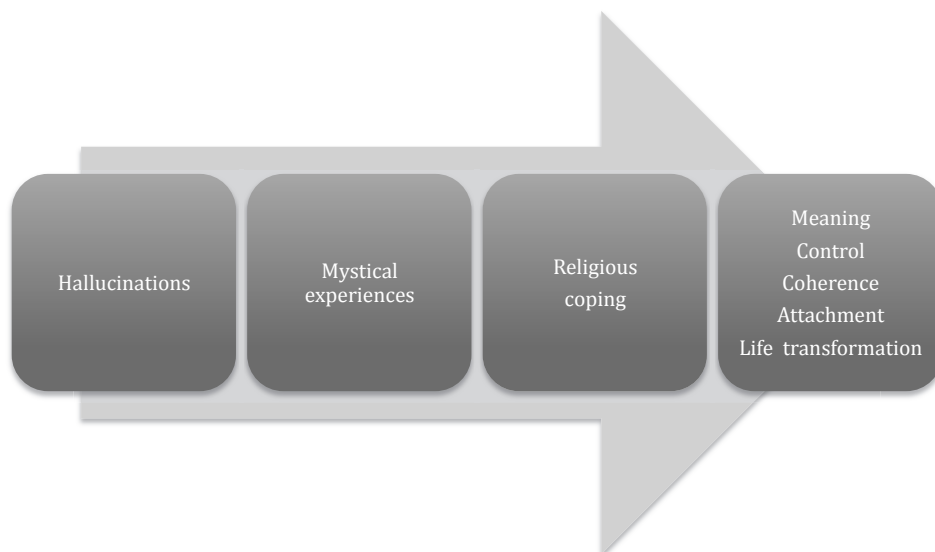
9.2 The function of religiousness

To differentiate between religiousness and psychosis is not necessarily an easy task. Even so, both a religious congregation and the mental health system will meet with the challenge of differentiating between the two types of experiences, and in psychiatry the differentiation will be important for the choice of therapy. Brett and al (2007) states that for individuals reporting mystical experiences, the appraisal more than the attribution of such experiences seems to separate patients suffering from psychosis from the "healthy ones" (Brett et al., 2007). This fact leads us to the discussion of the function of patients' religiousness, i.e.: How does it influence their psychological life? The results from this thesis as to the function of religiousness, will be discussed in the light of the theory of religious coping strategies.

9.2.1 Religious coping

On our way to an understanding of religiousness in psychosis, the research team introduced Pargament's theory on religious coping (Pargament et al., 2005; Pargament & Raiya 2007). The analyses of sub-study 2 and 3 show how patients with psychosis adopt religious coping strategies in an attempt to cope with the psychosis. Pargament et al (2005) list the key functions of religious coping as follows: the finding of meaning, the sense of a life transformation, the experience of mastery and control and the intimate relationship with a sacred figure (Pargament et al., 2005). Figure 8 describes the process of religious coping for the informants in sub-study 2 and 3. As described, the first step is the experience of hallucinations, which the patients understand as mystical experiences. Second, the patients change the substance of their religiousness in order to encompass their mystical experience in their belief-system. Patients' attempts of coping will for some of the patients result in a positive, and for others in a negative religious coping style.

Figur 8. Religious coping



The informants in sub-study 2 and 3 showed attempts of religious coping. First, my focus will be on patients that displayed signs of positive religious coping, yielding meaning, mastery and control, an attachment to a spiritual figure or life transformation. Second, the topic of interest will be the patients that displayed negative religious coping strategies, leading to an appraisal of God as persecutory or weak (Pargament et al., 2005).

9.2.1.1 Positive religious coping strategies

In paper 2 and 3, many of the informants reported that they experienced help from their religiousness, thus displaying several of the characteristics of a positive religious coping style. Summing up the two studies, the function of the religiousness, for some of patients, correspond well with Pargament's (2005) main categories of positive religious coping (Pargament et al., 2005). From a theological and/or humanistic point of view, positive religious coping, even a delusional one, may be important for the recovery process, even life saving, in the lived reality of being severely ill (Rizzuto, 1979). Unfortunately, it is a sad reality that patients suffering from psychosis are at high risk of suicide. In fact, about 5% of patients with schizophrenia do take their own lives (Haug et al., 2012).

9.2.1.1.1 Meaning

Positive religious coping offers a higher meaning in life, giving life a purpose and a direction. My focus is how religiousness may contribute in the process of meaning making for patients with psychosis. From the results of this thesis, religiousness seems to be involved in the process of making meaning on to levels: making sense of altered perceptions/ hallucinations and by finding of a higher meaning in life. Schnell (2009) has produced a model for the construction of meaning,

where perceptions are considered to be the basic building block in the system of the creation of meaning in life (Schnell, 2009). As described in the introduction, scientific research, as well as first-person accounts, point to the fact that patients with psychosis have a need to make sense of their psychotic experiences (Geekie & Read, 2009; Larsen., 2004). In the result section of this thesis, as well as in the discussion regarding the substance of religiousness, I have argued that the patients understand their hallucinations as mystical experiences, which will alter the substance of their religiousness, serving to create a higher meaning in their lives.

Our analysis in paper 2 points out that the religiousness of Elmer and Agate, can, from the perspective of the patients, be regarded as helpful, and in the case of Elmer, even as life saving. These patients found *purpose and meaning* in a difficult life situation of being severely mentally ill. Both Elmer and Agate had been mentally ill for several years, suffering from hospitalization, the side effects of medication, and the illness itself. For both patients, their religiousness had altered from that of being of little importance to becoming an important part of their coping system. Their “mystical experiences”, (diagnosed by psychiatry as hallucinations), had become part of their belief system and were given religious significance. In their universe they, respectively, experienced possessing divine powers of being Jesus or an angel.

In paper 3, our analysis of the statements of the patients, in combination with their psychiatric history, concluded that for Hans, Anna, and Simon, their religious coping strategies resulted in a new religiousness that they describe to give meaning to their psychotic experiences and helped them to regain control, giving them a sense of coherence in their lives. Despite the fact that their religiousness (also) contained delusions of divinity and omnipotence, the positive function of their religiousness is apparent. The case of Hans tells us about a difficult childhood where he felt powerless

and was bullied. Being younger, he had no personal religiousness, but when starting to experience various forms of hallucinations, he attributed those to an Evil Power pulling him towards doing evil acts. His obedience to this Evil Power resulted in the experience of a divine power inhabiting him, giving his life a purpose and meaning and a feeling of power and control, letting him escape from his experienced inferiority as a bullied child. The negative consequence of his new religiousness, however, is that he is potentially dangerous to others. Anna and Simon, like Hans, engage in a sacred mission. Anna is addicted to drugs, and because of that, her child has been taken care of by the authorities. Her religious conviction that she is fighting a Holy War, is clearly built on a religious explanation of hallucinations, giving her a purpose in life and letting her escape psychologically from her failure as a mother. By incorporating the symptoms of psychosis in a coherent religious belief system, her psychosis is given meaning and purpose. Simon, presented in table 1, experiences to have a sacred mission of saving the world from an approaching supernova. He experiences hearing voices, which he interprets as his “bacteria” talking to him as a result of an imbalance in gravitation caused by the supernova. He also reports seeing formulas written on the wall, which he considers is evidence that God will help him to construct an airplane stopping this supernova from destroying the world (see table 1). All these patients have clearly developed a sense of omnipotency in their psychotic universe, most probably as a compensation for their dysfunctional real life.

9.2.1.1.2 Delusional positive religious coping strategies

Patients, who display a positive religious coping style, offering meaning and coherence, also demonstrate a delusional omnipotent system. The hallucinations, understood as mystical experiences, function as evidence for their delusional system. From a therapeutic point of view, we will have to ask: What are the dangers of having

a delusional omnipotent religious coping system that offers meaning, control and a sense of coherence? There is no doubt that omnipotent beliefs can have serious consequences. In the case of Hans (Paper 3), the negative consequence of his new religiousness, being obedient to a Dark Lord, is that he becomes dangerous to others. For Simon (paper 3) and Agate (paper 2), their psychosis is potentially dangerous for themselves. As we learned, Agate jumped from the first floor, hurting herself severely (see paper 2) and Simon boiled his hair in a penicillin solution and tried to set fire to his hair in order to get rid of his bacteria (see table 1 paper 3). In the case of Simon, there is no clear indication that his religious delusions itself, or his religiousness in psychosis, caused him to set fire to his hair. Agate, on the other hand, seems to have acted on her religious conviction that she could fly together with the spirit of her spouse.

Another of the grave consequences of being delusional, is that this condition separates the patient from human contact. As described in the definition of the concept of delusion, patients become fixated in their thought patterns and hold them to be true despite conflicting evidence. Since a delusional religiousness finds its legitimacy in a supernatural domain, the patients will probably be even more reluctant to discuss, and question, the content of such a delusional system. The delusional religiousness in its very nature may therefore constitute an obstacle in itself for the therapeutic process (Beck et al., 2011; Chadwick, 2006). Other research supports the above mentioned assumption, showing that religious delusions seem correlated to non adherence to medication and that the patients tended not to take part in any religious congregation (Borras et al., 2007). Furthermore, patients suffering from religious delusions have been found to be more severely ill than other patients with psychosis,

and less than half of the patients with religious delusions displayed a helpful religious coping system (Rieben et al., 2013; Siddle et al., 2002).

My sample demonstrates that a delusional religious coping strategy may represent a danger for the patients themselves or to others. So, paradoxically, even though some of these patients consider their religiousness to be helpful for them, they are at a risk of self-inflicted bodily harm and also of constituting a danger of hurting others. The potential grave consequences of psychosis, has in Norway led to the legal right to, and duty of, compulsory treatment in severe cases (Lovdata, 2015).

All these patients, demonstrating a delusional omnipotent religiousness, exhibit the phenomenon of omnipotence often observed in psychosis, compensating for a deep sense of being unworthy and powerless (Chadwick, 2006). Or, described in terms of a psychoanalytic language, as a “regression to the omnipotent stage of the child’s developmental process” (Rizzuto, 1979). My suggestion for the interpretation of this result, building on the theory of the CBT, is that patients need a delusional omnipotent system to survive their psychosis, and that a religious delusion of omnipotent character is the perfect solution for this need. Behind the omnipotent delusion we find a severe lack of self- esteem that severely threatens the patient’s ability to live with dignity (Beck et al., 2011; Chadwick, 2006). The religious experience serves as a guarantee for the patient that they are valued by God or a Higher Power and therefore their belief-system is crucial in order to survive, or as Elmer put it: “If I didn’t have this my faith (of being Jesus), I would have killed myself”.

9.2.1.1.3 Intimate relationship to a sacred figure

Another key feature of religious coping is the relationship with a sacred figure. Establishing such a relation will provide the patient with love and companionship,

which may be very important for a patient that feels alienated from the world. However, the patients' relationship to the spiritual figure is built on hallucinations, which may change over time. Rachel, Berit, Danny (paper 3) report an encounter with, and a relationship to, a spiritual figure as the most important part of their religiousness. Rachel has just rejected her mother because she has experienced her to be offensive. She believes that her rejection of her mother has caused her parents to divorce, and she feels guilty. The comforting sense of the presence of her ancestor functions as an escape from her experienced guilt giving her support for her decision to exclude her mother from her life. Berit, hears the voice of God advising her what to do. In addition, when she experiences depression, sleep difficulties and troublesome hallucinations, she finds comfort in imaging that she is resting in His arms. Danny experiences his vision of Jesus as an astronaut giving him hope that God will rescue him (physically) from suicide. He hopes that in the case of him jumping from a large bridge in order to commit suicide, Jesus will pick him up before he is crushed against the surface of the water.

One of the characteristics of a positive religious coping strategy is the ability to establish a **safe** relationship/ attachment with a religious figure. Since Berit's and Rachel's relationships with a religious figure are built on hallucinations, the content of the spiritual figure will change in accordance with the hallucinations; for example into a condemning or persecutory figure (described below in the case of Ingrid). Building decisions on hallucinations will also be problematic since this will take the responsibility away from the patient to take care of herself and her relations. In the case of Danny, we see that his belief that Jesus will rescue him from suicide is potentially life threatening. In his case the relationship to a sacred figure, by asking for miracles to happen, may be understood as a quest for, and a wish for confirmation

of love.

According to Rizzuto (1979), the image of God (or a Supreme Power) is often given the same qualities as the first caregivers, or God will be given the opposite characteristics compensating for dysfunctional parents, instead offering love and care (Rizzuto, 1979). For Berit and Danny, we may view their image of God as a caring father, as a replacement of their biological father who died/ disappeared when they were children. In the case of Rachel her dead ancestor displays the opposite qualities compared to those of her offensive mother. At the moment the compensatory religiousness of Rachel and Berit functions well, offering love and companionship. For Danny, in contrast, it may be dangerous.

9.2.1.1.4 Life transformation

Niels is the only one who directly describes how he has been able to change his life because of his religiousness. However, several of the other patients, such as Simon and Anna, display a religiousness with an omnipotent content that seems to have changed their life. In the case of Niels, we learn that he subscribes to Bible verses, which he receives on his cell phone. These Bible verses give him direct guidance in life. He describes a religious conversion from his former life as a drug addict. His goal is to do well to others. His religious belief supports him in his process of changing his life, and is strengthened by the fact that he senses energy waves in the room, which he refers to as God or a Higher Power trying to contact him.

Again we observe a religiousness built on hallucinations, possibly subject to change over time, but at the moment Niels' religiousness serves him well.

9.2.1.2 Negative religious coping

Some of the patients engaged in negative religious coping strategies, and, as we have seen in several of the cases in studies 2 and 3, their new religiousness or apostasy, adds to their suffering. The patients experience their hallucinations, which they understand as mystical experiences, to be negative for them and these patients struggle to order their experience in a system of meaning and coherence. Such mystical experiences seem to reinforce the crisis of meaning. The negative religious coping strategies may be understood in light of attachment theory, which maintains that the image and the attachment to God will correspond to the relation to the first caregivers, as described above (Granqvist, 2014; Rizzuto, 1979). The case of Ingrid (paper 3), illustrates how her religious explanation of her unpleasant voice changed God from being a loving and caring spiritual figure, to a critical and condemning one. Her image of God being evil and persecutory is seemingly correspondent to her first caregivers, who could not protect her from being assaulted sexually as a child. Ingrid had experienced a very difficult life and her religious life was an important source of meaning for her until the voice she considered to be God, changed into a condemning one. Thus, God changed to be as little trustworthy as her other social relations.

Edward, (paper 3), adopted an understanding of God as a figure that wants him to fail. Edward experiences that his religious conviction that God is against him, is stronger when he is severely ill. He has always felt being treated badly by other people, and has the conviction that he is a victim of other people and of God's malice. His experience of catatonia and his explanation of this to be caused by God, corresponds well with his experience of being badly treated by others. Unlike Ingrid, Edward is unable to choose apostasy, because he finds that there is too much evidence

of someone causing all his suffering. His religiousness thus adds to his suffering and seems to strengthen his core belief that the world is against him.

Some of the patients describe a disappointment with God. An example of this is Kristina, who experiences a sense of presence around her, a presence to which she attributes the existence of ghosts. She feels threatened by this and it causes her trouble falling asleep. Earlier in life Kristina shared a Christian belief and turned to God in her prayers when she was bullied. She was disappointed to find that God did not help her, and as a consequence she has stopped believing in Him as someone in whom she can take comfort. We meet with the same phenomenon in the cases of Leo and Per in study 3, and Fredrik and Beate in study 2, who have all rejected God in some way or another. Earlier in their lives they have used their religiousness as a means of coming to terms with all their problems, but it had culminated in a psychotic breakdown. Their religiousness was useless in coping with their lives, and they learnt that God would let them down.

9.2.1.3 Patients' ability of religious coping

Summing up, we see that some patients describe their religious coping strategies to be of great importance for them, for some even life saving. Patients' religiousness contains elements that psychiatry diagnoses as hallucinations or delusions. Patients' religious coping strategies are not solely positive, even though judged so by the patients themselves. Patients that find meaning in their religiousness, are convinced they are an omnipotent religious figure or have a sacred omnipotent mission. Patients' relationship to a sacred figure is built on hallucinations that may change over time or it may take the responsibility away from the patient of taking care of themselves and their relations. Even so, for some patients, religiousness, by

offering love and dignity, may serve as positive religious coping, supporting the healthy part of patients' personality and enabling them to work through and cope with the psychosis. Alas, patients' religiousness may also reinforce their delusional system or even make them dangerous for themselves or to others. Some of the patients showed signs of negative religious coping, and their religiousness functioned as a dysfunctional reinforcement of negative core beliefs. Such a religiousness adds to their suffering.

9.2.2 Does patients' religiousness cause the psychosis?

Another question to be discussed is whether the psychosis is caused by, or in any way related to, patients' religiousness earlier in life. Research has documented a strong association between religious struggle and psychological distress, and negative religious coping and mental health problems in general, (as described in the introduction section of this thesis) (Ellison & Lee, 2010; Koenig et al., 2012; Pargament, 2007). There is no association on a numeric level between religious faith itself and psychopathology, but that there is an association between neuroticism and anxiety concerning sexuality, super-ego conflicts and childhood fears of God (Agorastos et al., 2012; Pfeifer, 1994; Pfeifer & Waelty, 1999). As to psychosis, Wikström (1980) conducted a meta-analysis of some former handbooks, as well as of contemporary handbooks of psychiatry. He concluded that there was little evidence that religion causes the psychosis, but rather that culture and the religion help the patient articulate the new and unknown experience of psychosis. According to Wikströms (1980) theory on religiousness in psychosis, patients' religiousness *should be understood as an interactional process between the individual patients psychodynamic organization (or biologically determined experience of the self and*

the world) and the cognitive subculture he belongs to (my translation) (Wikström, 1980) p. 119-20.

In the present study there are some indications that patients' former religiousness may have contributed to the evolvement of their psychosis. However, this is a complicated subject, and further in-depth studies, based on the individual therapeutic stories of the patients, are needed. There are quite a few examples in the present thesis of patients struggling religiously, either because of disappointment with God, or due to intrusive and troublesome hallucinations, which are interpreted as God's voice or lead. The struggle of these patients may be rooted in their former religiousness, and I will give some examples: Several of the patients seemed to have had, earlier in life, a belief in God as a kind of Santa Clause, fulfilling all their wishes. As the patients encountered the realities of life, such a belief would surely lead to disappointment with God. Some of the patients had experiences of a persecuting God, which seems to be related to superego conflicts associated with a strict religious fostering (see Ingrid and Edward paper 3, Jean paper 1) (Stålsett et al., 2010). Some patients in my sample have suffered sexual abuse inside a religious family or congregation, and these experiences will most likely bear an influence on their religiousness and their relation to God (Ingrid paper 3 and Beate paper 2). Ole (study 3), is the only one who directly expresses that he is convinced that his religious fostering, with a focus on strict moral standards, is the cause of his psychotic illness. During his psychosis he once expected to be arrested by the CIA because he had lost a memory stick at work. This expectation of an out-of-the-proportion punishment for his small failure at work may have resemblance to his fear of eternal punishment in hell for his sins.

However, according to the analysis in the present study, the language of religiousness serves as a means to express patients' new and wordless experiences of the psychosis. The patients' stories about their lives and their disorders, show that the hallucinatory experience is the first step towards the construction of a delusional/religious system (see paper 1-3). Patients' interpretation of their hallucinatory experiences as mystical ones, can be understood as a "normal" reaction to the uncommon experience of having a hallucination. The subjective understanding of their hallucinations as mystical experiences, leads to a change in the belief of God or a Supreme Power. Illustrative examples of this are the cases of Linn in paper 1, and of Agate, Elmer and Fredrik in paper 2, as well as several of the patients in paper 3 (see paper 3 table 1). The observation that most of these patients, triggered by their "mystical experiences", change the substance of their religiousness when encountering the psychosis, strengthens the conclusion that the hallucinatory experiences are the first step in the construction of their religious/ delusional system. Since manifestations of mystical experiences and hallucinatory experiences are described similarly to each other, the interpretation of the psychotic experience as a mystical experience is in accordance with the theory of social/ cultural schema, giving words, in religious terms, to a wordless/new experience of hallucinations (la Cour, 2014a; Piaget, 1952; Wikström, 1980). The schema theory maintains that new experiences, such as a hallucination or a "seriously disturbed perception of the self" (Frith, 2005; Hestad, 2014; Moller & Husby, 2000; Pacharie et al., 2006; Sass, 1992), will be categorized in existing schemas of the mind (Piaget, 1952). This provides the theoretical background why the patient's religious and cultural setting influence the attributions of the hallucinations and that an experience, such as hearing voices, will be understood in accordance with the view of mystical experiences in the general

population, or, in the subgroup of society, or the particular family, to which the patients belong. The normality, as to the manner in which the patients handle their experiences, is confirmed in the study of Henriksen and Pabst (2013) of healthy individuals that had experienced mystical experiences. The authors describe that the mystical experiences will naturally bring forward a need to reformulate ones pre-knowledge. The informants in the study of Henriksen and Pabst (2013) seemed to pay much attention to all their mystical experiences and in none of the cases the mystical experience was ignored. However, in their new religiousness, their previous cultural/religious framework of understanding was not totally abandoned. The informants in the study of Henriksen and Pabst (2013) did not experience that their congregation, a part of the Protestant Church of Norway, was capable of giving trustworthy interpretations of their mystical experiences. The informants reported that their own interpretations of their experiences, based on what felt correct, were done intuitively, and that they respected their own experiences more than the spiritual wisdom inherited through religious tradition. Apparently, their experiences give plausibility to the construction of their new belief system, and vice versa (Henriksen & Pabst, 2013).

9.3 Implications for therapy

In the following section I will first discuss the results from the art therapy (sub-study 1) and then continue with a discussion on how the findings of sub-study 2 and 3 on religiousness may contribute to a theoretical understanding in order to improve therapy in general, and art therapy in particular, for patients with psychosis.

9.3.1 Art therapy may improve coping abilities

The five patients described that their participation in the art therapy group furthered, to various degrees, their coping abilities (paper 1). This effect may be understood in various ways, but I will highlight two explanatory possibilities which both may be working together: a) The psychotic experience being explored through art, helps the patient to explore his/her *experiences in psychosis* at a psychological distance. Or, b) art therapy will further *normal perceptions* and by means of this process, it will help the patients to find alternative and healthier meaning making systems in order to make sense of their hallucinatory experiences.

9.3.2 Exploring the psychotic experience

Starting out on my exploratory art therapy group, I was warned by colleagues that my intervention might have undesired effects on the patients. However, they were proved wrong. As described in paper 1, all patients were able to explore their psychosis through art and none of them reported this exploration process to be harmful for them. On the contrary, the art therapy study demonstrates the importance of addressing the patients' subjective experience of psychosis in therapy. This finding is in accordance with research, namely that various forms of therapy exploring the psychotic experience, are found to be helpful for patients (Chadwick, 2006; Greenberg 1964/2009; Stålsett et al., 2010). Viewing artistic expression as an act of exploring emotions and bodily sensations, opens up the possibility of exploring the psychotic experience itself through art therapy. As I see it, ExA presents us with an alternative and promising method of exploring psychosis.

As described in paper 1, Linn and Cindy coped with their psychosis through a cognitive reinterpretation of their psychotic experience. They themselves relate their improvement to the artistic exploratory work with their psychosis. Their exploratory

artistic work improved their self-awareness enabling them to understand their symptoms and to cope with their disorder. The statements of Linn and Cindy are illustrated and documented by the individual therapeutic stories as well as by the in-depth interviews of these two participants (paper 1). These findings strengthen the initial proposition of paper 1, namely that ExA is a tool by which the patient can explore her psychotic experience in order to understand and cope with it. It should be underlined that these two participants attribute their increased mastery of the psychosis directly to their artistic expression, in particular to the exploration of their psychotic experiences. By objectifying the psychosis in a piece of art, the patient can explore her psychosis at a psychological distance, without getting overwhelmed by emotions. The patient will research and reinterpret the phenomena of her psychosis, enabling her to take more control over her disorder (Chadwick, 2006; Killick & Schaverien, 2006; Løgstup, 1995)

9.3.3 Bringing forward normal perceptions and emotions

The other 3 patients in the art therapy group differed as to their ability to formulate whether the exploration of the psychotic experience had helped them or not. All the same, they reported improvement that may be understood as an improved sense of the self, improved social self-awareness and reduced negative symptoms. It remains unclear, however, whether this is to be linked to the exploration process of the psychosis, the group process itself, the ExA therapy in general, or a productive combination between two or more of these variables. Hanna and Rita described more diffusely that they “felt more alive” through the participation in the ExA group and did not link this improvement directly to the exploration of the psychotic experience. Their statement: “felt more alive”, can be interpreted as a reduction of negative symptoms. Furthermore, their statements might be understood as an increased sense

of the self (Stubbe Teglbjaerg, 2011). The same two women reported that through their artistic work they felt more pleasure in their lives, and they also felt they were capable of connecting to their inner selves in new and constructive way. Both Linn and Cindy reported an improved ability to understand the symptoms of their psychosis. This may have been brought about by their artistic work, strengthening the awareness of the self and of normal perception. According to ExA theorists, the work of art may be considered as a way of strengthening the primary sense of the self (Stubbe Teglbjaerg, 2011). In his studies of early psychosis, Møller (2000) described how the emerging psychotic disorder disturbs the perception of the self (Moller & Husby, 2000). ExA may be seen as a tool to open up to new and healthy perception. According to Løgstrup (1995), the artistic process engages the artist in an immediate sensory experience of the art created (Løgstrup, 1995). The findings in the art therapy study suggest that ExA may help patients suffering from psychosis improve their perception and the awareness of the self, even though no cognitive reinterpretation has occurred as to the psychotic experience. Further research, such as a follow up study of these patients, will reveal whether these patients will be able to verbalize a cognitive reinterpretation of their psychotic experience, or whether the patients simply benefitted from the intervention, without any cognitive reconstruction taking place.

9.3.4 Addressing religious omnipotent delusions and a persecuting God in art therapy

As dealt with in sub-study 1, Linn demonstrates the negative sides of her delusional religious coping strategy. Believing she possessed supernatural powers and staying in contact with aliens, she was unable to take care of herself and her child. In the in-depth interview she maintained that her exploratory artistic work had opened a new ability for her to distinguish between her healthy religious experiences and

religious delusions with omnipotent content. Her new insight was that her hallucinations of aliens were connected to her psychotic experience. In the case of Linn, the main problem she addressed in therapy was her experiences of seeing aliens and her experience of a supernatural power resting in her body, giving her the powers and responsibility to save the world through magic. After the psychotic episode disappeared by means of antipsychotic medication, she experienced a loss of her magical powers as well. This loss she found very unpleasant, and it led to non-adherence to medication. Ever since she was a child, Linn had been familiar with a transcendent reality. Being a child, she experienced seeing angels, which she believed protected and guarded her. Thus, her religious interpretation of her hallucinatory experiences during the psychosis was in accordance with her already established belief in a transcendent reality. Through her artistic work, however, she was able to analyse her experience, and she understood that the experiences of aliens were part of her psychotic experience, not her healthy religiousness. The artistic process enabled her to reinterpret her psychotic experiences and by means of this she gained control over her religious delusions. This corresponds well to the CBT-theory; namely that an exploration of the hallucinatory experience may help the patient to cope with her psychosis (Chadwick, 2006).

Jean (paper 1) experienced in her psychosis that Doomsday had come. She modelled the psychosis as a clock with a snake coiled around it, and the hand of the clock showed five minutes to twelve. Her emotion connected to the psychosis, was one of great anxiety. She also feared do her exploratory work with the psychosis, in fact she hesitated to do so until she saw that the others were doing fine. In the in-depth interview (paper 1), she describes her experience of exploring her psychosis in the following way:

It was hard to remember the experience of being psychotic, I would rather avoid it, but it felt good to share the experience with others in the group and to learn that they had similar visions ..., I meant to say psychosis, not visions...

Jean's experience in psychosis was clearly connected to her religiousness, and fear of Doomsday, and possibly an image of a prosecuting God. She did not share more of her thoughts connected to the content of her experienced Doomsday, nor how art therapy helped her. Even so, Jean expresses that her exploration, and the sharing of her experience of psychosis, was helpful for her. After the art therapy had concluded, she is coping with her psychosis in a more adequate way. During the group process Jean decided to move back to her extended family instead of living in a care home for young people suffering from psychosis. Working part time in her family business, and also being part of her extended family, turned out to be important for her in coping with her psychosis.

9.3.5 The results of study 1 in the light of study 2 and 3

From the results of the interview studies (Sub-study 2 and 3), we may conclude that the evolving religiousness of the patients plays an important role in the patients' meaning making system, and that it is closely related to the patients' general psychological life. As to religiousness, the function, more than the substance is important for coping. Exploration of the psychotic/ religious experience will be important for a dysfunctional religiousness (Chadwick, 2006; Lampshire, 2012; Lauveng, 2012; Sørensen, 2014). In judging the function of patients' religiousness, we will have to evaluate the influence of their religiousness on their overall psychological system.

The aim of therapy is the recovery of the patient, more than the total absence of symptoms. As to the religious domain, this means reaching a religiousness or

apostasy, which furthers the patients' recovery. As demonstrated in this thesis, the patient may, through their religiousness, even a delusional one, experience to be loved, to be valued and to feel powerful. These emotions are important for psychological growth, as they stimulate patients' self-healing potential. Such a religiousness may therefore offer a tool for psychological growth (Chadwick 2010; Cullberg, 2005; Laudar & Thomas, 2000; Rieben et al., 2013; Rizzuto, 1979).

However, in order to recover, the patient need to engage in a type "religiousness" that does not make them dangerous for themselves or others, and that will function well in their struggle to establish relations with other people, finding their place in society. A key factor on the road to recovery, is the development of the patients' own ability to explore their experiences in psychosis, arriving at a belief system which is functional for their rehabilitation (Chadwick, 2006).

9.3.5.1 Addressing a omnipotent delusional religiousness in therapy

Several of the patients in the present thesis display a delusional omnipotent religiousness, believing they play an important role in the spiritual world. These will often judge their religiousness as positive and functional, no matter whether they constitute a danger to themselves or others. Such religiousness might also make the patient opposed to therapy. Much professional literature in the field points to the fact that acute psychosis is characterized by the tendency of "jumping to conclusions" as well as a rigidity of thought (Beck et al., 2011; Chadwick, 2006). From this rigid state of mind the patient will not be in position to discuss or explore her religiousness or delusional system. To be able to help these patients, the therapist will need, to understand and value the function of the patients' delusional religiousness. Probably, the function of the religious omnipotent delusion is just to protect the last remnants of dignity and self-value of the patient, and thus it would be very risky for the patients to

question their delusion (Beck et al., 2011). The challenge is to bring the patient in a position where she feels safe enough to question her omnipotent religious convictions or mystical experiences not serving her well in the long run. Restoring the patient's trust in her self and her dignity, will open the possibility for her to question her delusions (Beck et al., 2011; Belin, 1999; Chadwick, 2006). Her trust will depend on the support from health care professionals as well as from close private relations in her family (or congregation).

Using Elmer (sub-study 2) as an example, we see that Elmer's belief of being Christ protects him from committing suicide because it provides a purpose in life, offering meaning to his suffering. In therapy, it would therefore be very unwise trying to remove or deconstruct his belief system (see paper 2). A more fruitful intervention is help him going an alternative way, encouraging him to find additional sources of meaning in his life, and by this reducing the importance of his delusion. At the time of the interview Elmer describes that he experiences being both Jesus and Elmer at the same time. In spite of his omnipotent belief of being Jesus, he continues his everyday life and takes his medication. He understands that others will find it strange if he were to proclaim publicly that he is the returning Christ, so he rather keeps this to himself. This shows that the patients with delusional psychosis may be able to live their lives in two dimensions; one dimension in which they make sense of their psychotic experiences in a religious way, and the other dimension where they receive treatment for their disorder. In the case of Elmer, it seems like he is able to live a relatively normal life without acting on his delusional ideas. The ability of the patient to cope with a difficult life situation in two separate dimensions or meaning making systems, has also been described elsewhere in literature (Chadwick 2010; HviteØrn, 2014; Larsen., 2004; Lee, 2005).

The benefits of art therapy as to religious delusions, is the focus on patients' recourses. This focus will empower the patient and help her to restore her trust in her self and in her dignity (Killick & Schaverien, 2006). Art therapy will open a safer room in therapy for the patients since the main focus will be the expression of art, not the patient's psychological problems. Art therapy takes the focus away from patients' problems and offers a playground for the patient to express herself in clay, paint or movements. Generally, art therapy offers the patient more control in the therapeutic setting. Art therapy stands out from other kinds of therapy in that it introduces a third party or object in the therapy room, i.e, the piece of art created by the patient (Killick & Schaverien, 2006; Rubin, 1999; Schaverien, 1992). In the interaction between therapist and patient, the focus will be on the art object, so that the relation to the therapist will be less threatening. In the exploratory process of psychotic experiences in sub-study 1, the patient will herself decide how much of her thoughts and emotions she will share with her therapist. Thus, she can go about exploring her psychotic experience without her defence system being severely threatened. As demonstrated above, Linn managed to question her religious omnipotent delusion by means of this form of therapy.

9.3.5.2 The persecuting God

For other of the patients in my study, such as for Ingrid, Edward (sub-study 3) and Jean (sub-study 1), their religiousness adds to their burden by introducing a persecuting God in their lives. Ingrid's experienced change of the character of the voice she considered to be God, resulted in the rejection of her religiousness. Ingrid then adopted a bio-medical understanding of her hallucinations being symptoms of a psychosis. After questioning its omnipotence, she took an atheist's view of life, and now she reports that the voice she considered to be God, does not bother her anymore.

Ingrid's decision to fight her destructive inner voice by actively questioning its omnipotence, bears much resemblance to a well-known technique in CBT, and is described by several patients with first-person accounts of psychosis (Beck et al., 2011; Chadwick, 2006; Lampshire, 2012). In therapy, Ingrid's self-made technique may serve as a model showing her how she can cope with her other voices as well. However, it is not necessarily that simple to reject a condemning God. One should be aware of the fact that even though a patient outwardly seems to have rejected God, because of disappointment with Him, for example being persecutory, the disappointment and loss of faith may still constitute an important inner psychological force causing distress, and should be addressed in therapy (Rizzuto, 1979; Stålsett et al., 2010; Wikström, 2007).

The image of a persecuting God or a God that would let them down, is demonstrated by several of the patients of this thesis. Within the therapeutic tradition of the CBT, for example, it would be important, in order to assist recovery from psychosis, to address such a core belief if they bother the patient (Beck et al., 2011). The art therapy study (sub-study 1), demonstrates that Jean in some way was helped with her troublesome religious/ psychotic experience. Jean's experience in psychosis was clearly connected to a fear of Doomsday, and possibly the prosecuting God. She did not share much of how the art therapy helped her, only that she experienced help in the sharing of her experience with others.

9.3.6 Patients with first person account of psychosis differentiate between psychosis and religiousness when recovered

According to research literature, several patients, even after having recovered from psychosis, will persistently go on explaining some of their experiences religiously. Some case reports have been published where the religious hallucinatory

experience, diagnosed to be psychotic, is demonstrated as a way of coping with a difficult life situation (as described in the introduction section of this thesis) (Brett et al., 2009; Jacson & Fulford, 1997). I have also studied several first-person accounts during my literature research to write this thesis. Several of these patients, who are documented being recovered and integrated in society, still report mystical experiences of extraordinary nature (hearing voices or having experiences of being able to foresee the future), many of which they consider important and helpful for them (Chadwick 2010; Lee, 2005; Lukoff, 2012; Sørensen, 2014). From literature we know that many of the patients with first-person accounts, will agree that they have suffered a psychosis, but they will argue that their mystical experiences are different from what they will consider to be psychotic experiences (Chadwick 2010; Lee, 2005; Lukoff, 2012; McCarthy-Jones, Waegelic, & Watkinsd, 2013; Reina, 2014; Sørensen, 2014). They describe their psychotic experience as something terrible and overwhelming, and by no means as a positive spiritual experience. Even so, they highlight that their religiousness and their mystical experiences, which they consider different from the experience of psychosis, helped them to recover.

Linn (study 1), is an example of a successful differentiation between the psychosis and a mystical experience. Through her participation in the art therapy group she herself was able to differentiate between her experiences, and to agree to receive treatment for her psychosis.

9.4 Summing up the results.

Differentiating patients' religiousness from their symptoms of psychosis, will in some cases be difficult. First person accounts, as well as the case of Linn (sub-study 1), may demonstrate that patients in a therapeutic setting may themselves be

capable of distinguishing between their hallucinatory experiences, considering them to be part either of a psychosis, or a possibly helpful mystical experience. In the process of obtaining this insight, they will need some help. Several patients with first person account of psychosis highlight the importance of having a helpful religiousness in order to cope with life and the psychosis, and they emphasize that patients with psychosis have the same spiritual needs as every other human being (Chadwick 2010; Sørensen, 2014). It will therefore be important not to judge all religiousness for patients' with psychosis as delusional, even though it may include unusual content.

The results from this thesis show that patients with psychosis display attempts of religious coping. Some patients describe their religious coping strategies to be of great importance for them, for some even life saving. Important for their meaning making process is that they understand their hallucinatory experiences as mystical experiences. This may lead to a positive as well as a negative religious coping. Patients' religious coping strategies are not necessary solely positive, even though judged so by the patients themselves. The patients that find meaning in their religiousness, have thoughts of being an omnipotent religious figure. Patients' relationship to the sacred figure is built on hallucinations that may change over time or it may take the responsibility away from the patient of taking care of themselves and their relations. Even so, for some patients, religiousness may serve as positive religious coping, by offering love and dignity, supporting the healthy part of patients' personality, enabling them to work through and cope with the psychosis. Alas, patients' religiousness may also reinforce their delusional system or even make them dangerous for themselves or to others. Some of the patients showed signs of negative religious coping, and their religiousness functioned as a reinforcement of

dysfunctional or negative core beliefs and such a religiousness will add to their suffering.

9.5 Summing up the implications for therapy.

From the findings of my study, I will argue that the patients religious understanding of their hallucinations, undoubtedly plays an important role in their meaning making system and will be important to address in therapy. Well demonstrated in the case of Linn, the questioning of the reality of such religious beliefs, in her case of having magical power, resulted in her new ability to cope with her psychosis in a more adequate way. Her improved judgement resulted in her choice to go on taking her antipsychotic medicine, in order to stay healthy.

Several of the other patients of this thesis display a religiousness that potentially will cause trouble for them/ and or the mental health service in the treatment of their psychosis. To help the patient with their religious struggle or dysfunctional religious beliefs, psychiatry need to be more literate about religiousness. It will be important for the therapist to understand the function of patients' religiousness in order to give them adequate therapy.

In my opinion, being a therapist, the aim of all therapy for patients suffering from psychosis, is that the patients themselves shall be able to judge their own experiences in an adequate way. However, as the present thesis describe, the disorder of a psychosis is not a dispute between interesting possible explanatory models. The disorder of psychosis is in many occasions a terrifying, and a possibly dangerous condition that affects the patients' ability to judge their experiences adequately. The real pain both for the patient and the therapist, working with psychosis, is the sad reality that the patient in acute psychosis is incapable of distinguishing reality from

her psychotic universe. She is incapable of knowing her own good, and may be dangerous for herself or others. Several of the patients describe that they are shameful being the “crazy ones” (Paper 1), and they feel ashamed of what they say or do during their psychotic episode (Chadwick 2010). Working as a therapist, trying to help these patients, it is painful being accused by the patients that you ruin their lives, or that the spirits of the universe will destroy the world if you give her medicine. In our modern world we want to empower the patient and worship the right of every human to be responsible for her life. However, in acute psychosis the patient is unable to take care of herself and to judge her experiences adequately.

Based on my research, it would be advisable to question the religiousness displayed during the psychotic episode. The therapist should question religious beliefs as well as any other belief, helping the patient to explore her beliefs in order to evaluate whether they are helpful and trustworthy (Chadwick, 2006). Finding herself in a more stabilized phase of her psychosis, the patient will need to be empowered, and to take responsibility, making choices for her life. She will need to trust her own recourses to stay healthy. But she will also have to understand her psychotic episode, why it has come, what it means and what it takes to stay healthy. In this phase of treatment the patient will gradually be able to explore her experiences, making her own judgement about her disease.

Art therapy may function as an assisted exploration of the psychotic experience, helping the patients in the process of recovery. The case of Linn, and several other case reports, bring hope that therapy focusing on patients’ ability to explore their experiences in psychosis can help the patients master their religious delusions (Stålsett et al., 2010; Sørensen, 2014). I will give Rufus May, a clinical psychologist, himself suffering a psychosis at the age of 18, the final word of the

discussion section: *Traditionally the problem with being seen to be psychotic is that one is isolated with this experience, set aside as fundamentally different and inferior. The way to combat this isolation is to create safe spaces where unusual experiences can be shared and made sense of (May, 2014).*

10 Discussion of material and method

The purpose of research is to obtain knowledge that may have implications for a broader area than just the sample studied. In a qualitative design, when the results provide knowledge relevant for a larger population, we will apply the term *transferability* (Malterud, 2011). The concept of *validity* will be utilized as to the correctness or credibility of the conclusions (Maxwell, 2005), while the concept of *reliability* signifies whether the study follows the standards of good scientific research traditions (Kvale & Brinkmann, 2015). In concluding this section, I will also discuss the ethical considerations given to my research.

Even though my study has its limitations, as described below, I will maintain that the validity and reliability of my thesis meet the standards of good qualitative research. The research team has as far as possible conducted all three sub-studies according to the standards of widely accepted qualitative methodology (Denzin & Lincoln, 2011; Kvale & Brinkmann, 2015; Malterud, 2011).

The requirements of the reliability, the validity and the reflexivity of the study, have been paid much attention throughout the research process. My thesis starts out with a presentation of my pre-understanding and the intention of the study and how the aim and research questions relate to literature in this field of research. The method section describes the process of sampling, data collection and analysis. As described in the method section, various strategies have been utilized to strengthen the validity, reliability and transferability of the study.

10.1 Validity

The *validity* of a study refers to the quality of what have been found out referring to the initial intention of the study; depending on the planning of the study,

the sample, how the sources of data have been collected, the transcription of the interview data, the analysis process and the reporting of the results.

The reliability of a study is important for the validity and refers to which extent the results are found to be consistent over time, and whether the results of a study can be reproduced using an identical methodology (Kvale & Brinkmann, 2015). The question of reliability concerns the trustworthiness of the researcher. How did the researcher conduct her interviews? How is the transcription brought forward? And, how are the categories produced in the analysis process?

Throughout the research process I/ we have utilized various procedures to improve the reliability and the validity of the study (see method section). First, to avoid that my pre-understanding would bias the project, I have utilized **triangulation** of researchers, theory and data. Second, I have utilized **methodology in accordance with the aim of the study**. Third, the informants of the study are chosen to give a **purposive sample**. Fourth, the **methods for the collection of data** are chosen to give information as to the research questions of the study. Fifth, the **interviewers have focused on engaging in an open-minded discussion** with the patient on the subject matter. Sixthly, I have aimed at **transparency and reflexivity** of the research process. The concept of *transparency* means giving an accurate and open description of the research process, whereas the concept of *reflexivity*, refers, in the search for other plausible explanations of the results, to an attitude of open-mindedness and willingness to question ones' findings (see below).

10.1.1 Triangulation

The technique of observing a phenomenon from different angles, coined triangulation, will provide different perspectives of a specific theme (Malterud, 2011). In the present thesis I have applied triangulation of observers (different researchers in

a research team), the triangulation of relevant theories, as well as of data. Since the phenomenon of interest will be viewed from different perspectives, this technique will improve the reliability of the research, securing a truer picture. The triangulation of data will give information on the patients from different perspectives, such as patients' subjective experiences, as well from a therapeutic/psychiatric point of view. Patient's subjective experiences range from their experience of religiousness to their experience with the therapy situation, and are collected in the form of interviews and artwork. From the therapeutic/ psychiatric point of view, data range from descriptions of diagnoses and symptoms of psychosis, to condensed therapeutic stories.

The triangulation of the researchers provided us with different perspectives, religiously and professionally, during the analysis process. Conducting research in collaboration with others, is an important way of challenging one's pre-understanding, improving one's reflexivity. Different researchers will have different pre-understanding, and will as a consequence, focus on different aspects of the data. Collaboration with others will thus improve the analysis of data; securing a variety of possible interpretations of the patients' statement. For the three sub-studies the research teams have contributed in different ways in the analyses. For sub-study 1, I conducted the analysis of the interviews and produced the therapeutic condensed stories, alone. However, the further analysis of the different sources of information and the conclusion of the case study, were conducted in collaboration with the research team. In retrospect, I would have preferred the involvement of the research team at an earlier stage. However, this will not mean that I was totally alone in my judgments. I discussed my study with colleagues at the psychiatric ward and with the research team at Stavanger University Hospital, and as I have described in the method section, I utilized the procedure of member checking. As described in the method

section, for sub-study 2 and 3, the research team was involved on several occasions during the analysis process.

In addition, the research team was involved in the writing process of all three papers: The draft of the paper was sent to all the co-writers, to secure that they agreed in the presentation of the results. For sub-study 1 and 2, there was little disagreement as to the draft paper. For sub-study 3, however, we had some disagreements as to the findings for the subgroups of patients, experiencing support, a burden or no importance of their religiousness. This disagreement opened for a deeper analysis of the findings, leading to the final product of paper 3. The final version focused on the common features of religiousness, i.e. the patients' understanding of their hallucinations as mystical experiences.

As to the triangulation of theory, I have discussed my results in accordance with different theoretic frameworks in the “discussion” section of this thesis. Different theoretical theories will shed light on the data from various perspectives, and open for a deeper understanding of what has been found out (see the “discussion of the results” section).

10.1.2 Methodology in accordance with the aim of the study

How the aim of the study led to the research questions of the study, is described in the sections “what is this thesis about” and in the “introduction” section, as well as in the “method” section of this thesis. The aim of this study is twofold. First, to obtain knowledge on the significance of religiousness for patients with psychosis, and second, to learn how patients' religious struggle can be met in therapy. The qualitative design of this thesis has been chosen in order to provide answers to the research questions on patients' subjective experience as well as on patients' therapeutic process. To find answers as to the aim of the study, I have chosen to

include both a case study (sub-study 1), and two interview studies (sub-study 2 and 3). The case study provides information on patients with psychosis in a therapeutic setting, whereas the interview studies give general in-depth information on religiousness for patients with psychosis. Cumulatively, the 3 sub-studies provide the basis for addressing the overall aim of the thesis.

It can be argued that research on few cases, or just, one case, may be of little value, but in fact many of the new advances in medicine, such as the vaccine against smallpox and the discovery of the HIV virus have come from single case studies or study of a few cases (Malterud, 2011).

It could also be argued that the aim of the study is too wide, and that a design of only case studies or only interview studies would have been better. Admittedly, using one or the other, might have set me an easier task. However, since the aim of the thesis was to produce knowledge that might turn out be useful in a therapeutic setting, I will argue that the present design is the more suitable one. My choice of design opens up for a theoretical understanding of the significance of patients' religiousness in coping with psychosis, and in addition, it produces knowledge as to how religiousness might influence the therapeutic process for patients with psychosis. Drawing on both the findings on the significance of religiousness in psychosis, as well on the obtained knowledge on the therapeutic process, enables, addressing the aim of the study, a cumulative effect to take place.

10.1.2.1 The validity of case study research

Through history, medical case studies have been important for obtaining new knowledge about disorders and forms of therapy (Malterud, 2011). The advantage of the clinical case study is that it may study a phenomenon under *naturalistic*

conditions, providing the possibility of in-depth knowledge, for example of a therapeutic process (Flyvbjerg, 2003; Yin, 2009). A naturalistic condition means studying the intended phenomena in a real life situation, for example in a regular therapeutic setting. The benefits of the choice of methodology in sub-study 1, was that the case study design is a structured way of studying psychological treatment, enabling us to follow the therapeutic process of the patients in the art therapy group in detail (Yin, 2009). One of the drawbacks of conducting research under naturalistic conditions, is that a strict purposive sample of informants is not guaranteed. In sub-study 1, only women, on their own initiative, were included (as discussed under “sample”).

Usually a case study design is utilized as a tool for building new theory (Yin, 2009). Yin (2009) argues for a stringent methodology of the case study, by giving a hypothesis for the expected finding prior to the research, and by utilizing the case study to verify or disapprove of the initial presumption. The present case study resulted in a modified hypothesis as to art therapy for patients with psychosis.

10.1.2.2 The validity of interview studies

Questions have been raised whether it is possible to obtain valid knowledge from an interview or a story being told. There will always be the danger that the researcher’s own construct of meaning will overshadow the real content of the statements of the participant (Kvale & Brinkmann, 2015; Malterud, 2011; Piaget, 1952). The qualitative design will allow more room for the researcher’s own judgment than the quantitative design and the researcher must therefore pay special attention to secure reliability during the research process (Flyvbjerg, 2003; Maxwell, 2005).

10.1.2.3 The sample

As to the sample of this study, the critical questions to be asked are: 1. Does the sample of patients included in this thesis really represent the broader group of patients with psychosis? 2. Does the sample of participants give answers as to the research questions and the aim of the study? I will conclude that the purposive sampling of my study has provided valid information as to the aim of the study, even though there are some limitations as described below. The number of informants in the three sub-studies are 5, 6 and 18, respectively. This constitutes a limited number, but does not deviate from the standards of most qualitative research (Denzin & Lincoln, 2011; Kvale & Brinkmann, 2015; Malterud, 2011). As described in the methodology section, the informants were selected to provide a purposive sample, addressing the intention of the study. In a qualitative design, the diversity of the participants, rather than the number of participants are important. A *purposive sampling* means to be aiming at giving sufficient diversity as to the phenomena of interest (see the “method” section). We have included patients with psychosis according to the following criteria:

- with different views on religiousness; religious as well as atheist ones
- male and female
- different age groups
- different diagnoses of psychosis
- FEP
- patients that have been ill for several years
- patients in a naturalistic therapeutic setting
- patients that experience help from their religiousness
- patients that experience their religiousness to be a burden

10.1.2.3.1 The diagnoses of psychosis

I have included a number of diagnoses of psychosis in this study. In the first two sub-studies, clinicians would set the diagnoses. There were no mandatory assessment tools for the diagnoses, other than the normal way of diagnosing in Norway, which is the ICD-10 diagnostic classification (WHO, 2010). However, as for sub-study 2, the “Diagnostic Workflow Chart” (DWC) was applied as a diagnostic tool, corresponding to both the ICD-10 and the DSM–IV diagnostics (APA, 1994; WHO, 2010). This diagnostic instrument has been developed by Paul Møller and is in use in several mental health clinics in Norway. In Norwegian it is called “Diagnostisk arbeidsdiagram”. The third study was a sub-study of the TIPS II project, which offered specific procedures as to diagnoses and symptom scores, such as the PANSS and SCID interviews.

The lack of a specific diagnostic manual in sub-study 1 of this project can be seen as a weakness. On the other hand, it is a fact that a psychiatrist and a clinical psychologist have much experience in judging whether a patient really suffers from a psychosis. In order to describe and verify the psychotic symptoms, I have included a presentation of each of the patients in the papers (see paper 1-3).

As to the discussion of the homogeneity of the sample diagnoses, it should be mentioned that sub-studies 2 and 3 include only non-affective psychosis, whereas for sub-study 1 (the art therapy study), two patients are diagnosed with bipolar disorder. These two patients are the ones who experienced help, in terms of a cognitive understanding of the psychosis, from the art therapy group. This could be an indication that only patients with affective psychosis had the desired effect of art therapy. It can be argued that the affective psychosis is a type of psychosis other than schizophrenia, and that a patient with affective psychosis is more likely to profit from

psychotherapy. However, it is relevant, to discuss the diagnoses given to these two patients: Linn obtained the diagnosis of paranoid schizophrenia when she first was admitted to the hospital, but the diagnosis was later (as she improved) changed to bipolar psychosis. However, as described in the method section and paper 1, Linn continued to believe in the reality of her magic abilities between her affective episodes, which may indicate that her correct diagnosis should have been schizoaffective disorder. As to Cindy, her diagnosis was set before she admitted to have psychotic symptoms. In the course of the art therapy group, she explained that she often saw small worms in her house, probably also when not having the symptoms of depression or mania. Displaying psychotic symptoms without having a simultaneous affective episode, would give her the diagnosis of a schizoaffective disorder.

For the present thesis, as to the differentiation between different types of psychoses, I have applied a broader definition of the concept of psychosis (described in the introduction). Due to apparent similarities between the various types of psychosis, researchers have recently argued, that on a deeper level, there is in fact only one psychotic syndrome, and that the focus, for therapeutic purposes should be on the symptoms described, rather than the different diagnostic categories (Bentall, 2013). For my purpose, addressing the aim of my thesis, I have therefore avoided any differentiation as to various psychotic diagnoses, having viewed the patients in studies 1, 2 and 3 as a homogeneous group of patients suffering from a psychotic disorder.

10.1.2.3.2 Gender and age of the participants

In sub-study 1, only women participated in the group. So, strictly speaking, I have studied the course a women's therapy group in sub-study 1. However, I find it unlikely that the findings are specific to gender. The other sub-studies included

approximately an equal number of female and male participants. All sub-studies included only adult informants, except from one girl (Kristina), at the age of 17 (sub-study 3).

10.1.3 The collection of data

In the method section I have described in detail the reason for the inclusion of the data of this thesis as well as how the different sources of data contributed to giving answers to the research questions of the study. In my view, the quality of the collected data meets the standards recommended for qualitative research. All the same, there have been some methodological challenges, which will be discussed in the following section.

10.1.3.1 The in- depth interviews

For this PhD study, the data of patients' subjective experience are mainly collected through in-depth interviews, which is the most common method of collecting data in the tradition of qualitative research (Kvale & Brinkmann, 2015; Malterud, 2011). Traditionally, until the present day, the interview has been considered an important source of knowledge. In the history of medicine, the medical story has often been more important in deciding the correct diagnosis and treatment for a patient, than a blood test or the x-ray results (Malterud, 2011). However, the interview, as a systematical research method, has only been utilized during the past decades (Kvale & Brinkmann, 2015). As described in the method section, the interview situation is inter-subjective, which means that both the researcher and the informant will bear influence on the knowledge that is given voice during the interview. The pitfall of the interview as research method is that the researcher might, on the basis of her theoretical and personal background, focus one-sidedly on certain

questions and topics, (Maxwell, 2005). In the sub-studies of this thesis, all the interviewers were trained in qualitative research, and they were fully aware of the pitfalls of asking leading questions. Consequently, the interviewer would focus on open-ended questions, following the lead of the patients, as well as asking for confirmation as to the researcher's understanding of the informants' statements (member checking) (Malterud, 2011). The aim of the qualitative research interview is to obtain knowledge of the lives of the informants, as seen from the perspective of the informant (Kvale & Brinkmann, 2015). However, this will nonetheless challenge the researcher to interpret what "really is being said". Bearing this in mind, (in order to grasp the meaning making process and the perspectives of the interviewee), the interviewers in the 3 sub-studies have taken care not to jump to conclusions during the interview. They have spent the time necessary and have repeatedly checked out the meaning of the statements of the interviewee.

All the informants in this thesis have been interviewed only once, except from Elmer (sub-study 2). It can be argued that the lack of repetitive interviews is a limitation of the study, because more interviews may provide more information, possibly leading towards more specific questions giving additional in-depth information. With the exception of the interview with Elmer, at the end of the interviews, the informants did not seem to have more to tell about their religiousness. Thus, it was decided to make a follow-up interview only with Elmer.

To improve the internal validity of the sub-study 1, for which I was the therapist, I decided to let an independent research assistant, Margrethe Tytlandsvik, trained as a psychiatric nurse and a researcher, conduct the interviews. Playing a double role, being a therapist and a researcher at the same time, may constitute a problem since the patients, facing their therapist, may have a tendency to over-report

the positive effects of the treatment. In addition, the involvement of the therapist in the project may constitute a challenge to the researcher's objectivity. As for sub-study 1, the procedure of having an independent interviewer conduct the interviews aimed at creating more distance to the interviewee. My intention was that this procedure would help the patients speak more freely. However, I was already acquainted with the independent research assistant, and the patients were informed that I was going to read the interviews afterwards, so the effect of this procedure was probably limited. Generally, it should be argued that replacing the therapist researcher for the sake of objectivity has its drawbacks, because the therapist researcher herself will not have the opportunity of spontaneously adding follow up questions in order to clarify and deepen her understanding of the patients and their therapeutic process. In addition, data collected from second party in the form of transcribed texts, may constitute a methodological problem because the written language loses some of the subtleties found in oral speech. To adjust for some of these disadvantages, I have tried to strengthen the validity of patients' statements given to the independent researcher by conducting "member checking" in retrospect. By asking the patients to read the final draft of the paper, I had the opportunity to check with them that I had understood their statements about their therapeutic process correctly.

As for sub-study 2, my co-researchers conducted the in-depth interviews. Even though some of the same methodological challenges apply to sub-study 2, I found that the use of data collected by second party was less problematic for this sub-study. As for this sub-study, my co-researchers contributed in the process of analysis, limiting the possibility of misunderstanding the content of the written text.

Another aspect to be taken into account, is the possibility that the interviewee will vary her responses according to the profession of the interviewer (psychiatrist or

theologian). Possibly, the patient will address religious issues more easily, or differently, being faced with a theologian (one of the interviewers of sub-study 2). A patient would probably expect to meet a different attitude from a theologian, than from a psychiatrist, as to the patients' relation to God and religious experiences. The choice of interviewer may thus affect the qualities of the interviews and likewise the repeatability of the study (Malterud, 2011). In sub-study 3 I learned that some of the patients would avoid answering some types of questions to their psychiatrist. Berit, for example, revealed that she feared that her religiousness would be diagnosed as a psychotic delusion among psychiatrists. The fact that the interviewer is a psychiatrist, not a theologian, may therefore have affected the content of the patients' replies as well as how the questions were formulated (see discussion of reflexivity below). When starting out on sub-study 3, I was worried that the patients would reveal little information to me, being a stranger. I assumed that religious matters and information on their psychiatric disorder were highly private issues for the patients, but in this I was mistaken. The patients would take me into their confidence, willingly sharing their thoughts.

10.1.3.1.1 Audio recording and transcribing

To improve the reliability of the interviews, all qualitative interviews included in this study are audio recorded and then transcribed. Even though the process of going from the audio record to the written text has its limitations, this procedure will nonetheless improve the possibility of recalling the exact statements of the participants (Malterud, 2011). In the written text some of the emotional content may get lost, as well as the hesitations and the tone of voice. This may partly be counterbalanced by the use of case summaries, which were utilized for sub-study 3. For the other two studies we

utilized member checking in retrospect (sub-study 1), and the participation of the interviewers in the process of analysis (sub-study 2).

10.1.3.2 The semi structured interviews

The semi structured interviews have been validated in the study of (Danbolt et al., 2011). After having discussed the findings for sub-study 2 in the research team, we found it useful as to sub-study 3, to add questions about the changes in religiousness that had taken place in the course of the disorder. The answers from the patients were plotted in the interview form, and some notes were written as to the open-ended questions. We used the data from the semi-structured interviews as descriptive quantitative data, giving an overview of patients' religiousness.

10.1.3.3 The patients' artwork

The patients' artworks represent the patients' non-verbal expressions of their subjective experiences. A piece of art is an act of self expression and is considered to be as valid, as any other human expression (Knill et al., 2005; Løgstrup, 1995). Expressing emotions or bodily experiences, such as the psychosis or the mystical experience, by means of an artistic non-verbal expression, are often felt to be the easier for the patient. This will improve the likelihood of getting real information from the subjective experienced reality of the patients. The analysis of the artwork is described in detail in the method section of this thesis.

10.1.3.4 The case summary in sub-study 3

In sub-study 3 I have, for the sake of getting an overview of data, created case summaries. These case summaries describe the researcher's first impressions of the interviewee as well as the researcher's emotional impression (described in the "method" section). However, the researchers pre-understanding may also colour these

case summaries. To avoid this possible bias to overflow the analysis, the research team would analyse some of the in-depth interviews in full text.

10.1.3.5 Condensed therapeutic stories

For sub-study 1 of this thesis, the art therapy group, we have utilized the condensed therapeutic stories of the patients as the basic data for research. Being their therapist, I had earned the patients' trust, and this provided me with in-depth information. A patient will most likely be less trustful to strangers than to her therapist. Because I was given the opportunity to conduct research on the patients' therapeutic process in retrospect, I was provided with a rich source of information from patients' journals and their artwork, in addition to the interviews. It could be argued that condensed therapeutic stories made by the therapist, presents the patients' process from the therapist point of view, and may therefore be biased. However, to improve the validity of the case study and to secure the patient's voice to be heard, the patients' subjective artistic expression is an important part of the condensed therapeutic stories. In addition, the in-depth-interviews also provide information of the patients view of their therapeutic process, and, additionally, I have also utilized member checking (Malterud, 2011).

10.1.3.6 Analysis of data

As described in the method section, the process of analysis was conducted in accordance with qualitative methodology such as systematic text condensation, case study design and thematic analysis (Braun & Clarke, 2006; Malterud, 2011; Yin, 2009). The use of stringent methodology lessens the possibility of the researchers pre-understanding to overrun the informants' statement. In addition we utilized the method of triangulation, as described above.

10.1.4 Reflexivity and transparency

An attitude of reflexivity means taking an active approach by questioning every procedure and finding of the study in order to secure that the findings are not driven by the researcher's own pre understanding. All our pre knowledge, personal skills and professional training, constitute our pre-understanding. A researcher's background and position will affect her choice of subject matter for investigation, the angle of investigation, the methods judged most adequately for addressing the aim of the study, the findings considered most interesting and the framing and the communication of conclusions (Malterud, 2011). The ideal, in a qualitative design, will refer to an attitude of open-mindedness and willingness to question ones' findings, allowing for other plausible explanations of the results (Malterud, 2011). To improve the reflexivity of the thesis, I have aimed at describing the research process transparently (Denzin & Lincoln, 2011; Kvale & Brinkmann, 2015; Malterud, 2011), by: 1. Giving an accurate description of the planning of the project and the aim of the study. 2. Explaining how the research questions were developed 3. Describing the inclusion process of the informants. 4. Making clear the contextual setting of the interviews. 5: Explaining the choice of data included. 6. Describing the process of analysis of the transcribed texts, presenting the research team of each sub-study as well as the theoretical framework used in my analyses. 7. By critical evaluation of alternative explanations of the results of this thesis (See the "discussion" section). Concluding the discussion on reflexivity, I will describe in more detail the **planning of the project**. I will also give a **critical evaluation of my pre-understanding**, and how this may have influenced the research process.

10.1.4.1 Planning the project

As described in the section “what is this thesis about”, I started the PhD project by planning research on the art therapy group. This decision arose from a wish as a clinician to contribute to improving the therapeutic approach for patients with psychosis. Changing the role from being a clinician to a researcher, one is challenged to qualify theoretically to be able to conduct such research. The PhD education offered theoretical knowledge, but I also found the collaboration with the skilled research team important.

On the basis of the initial findings of sub-study 1, I decided, in my forthcoming PhD project, to focus on the theme “religiousness for patients with psychosis”. Since I am raised as a daughter of a Protestant priest, I was not illiterate as to the field of religion and religiousness. However, to do research in the field of psychology of religion, I needed more expertise, and I found the help I needed through collaboration with the research team specialized on the field (The Centre for Psychology of Religion). To secure that my knowledge as to the research field of psychology of religion was sufficient, it was important for me to have supervisors specialized in this subject. The research team also helped me plan the further project.

When planning sub-study 1 (alone), I first received permission from REK to collect data from the in-depth interviews of the 5 participants in the art therapy group. However, the data collected were not very useful unaccompanied, because they did not contain any information on the therapeutic process of the patients. The advice from my supervisors was, in order to strengthen the validity of the study, to include material from the therapeutic process. REK approved this change of the project, and the patients all agreed to participate in the extension of the study.

Finally, as the research proceeded, as we planned sub-study 3, I also found it necessary to collaborate with the research team specialized on the study of first episode psychosis, the TIPS II.

10.1.4.2 How my pre-understanding may have influenced the research process

Being a psychiatrist by profession, doing therapy, means taking the role as a helper. Becoming a researcher, on the other hand, means changing your perspective. As a psychiatrist I am used to focusing on patients' symptoms of psychosis, trying to understand their way of thinking. The therapeutic approach may constitute an asset for research in this field, because it means that I am used to talking with patients with psychosis, being attentive in order to understand their stories. In my opinion, it is important for the clinicians to contribute to research, because their clinical experience represents important knowledge as to the challenges in the therapeutic setting. On the other hand, my cultural understanding of mental disorders, (being a psychiatrist in a psychiatric ward), may be an obstacle as to open-mindedness unless I succeed in setting aside my pre-understanding during the interview situation. In this study I have tried as far as possible to take the role as a researcher, emphasizing on asking the question as to psychosis and religiousness with an attitude of open-mindedness.

10.1.4.3 Summing up the validity of the present thesis

The results of the present thesis describe the diversity of religiousness and its function and content for patients with psychosis, also showing contradictions and paradoxical findings. In general, I will argue that the present thesis will contribute to a broader picture of the interaction of religiousness and psychosis. In addition, the sample provides us with information of a therapeutic process (sub-study 1), which

opens up for the discussion of therapeutic interventions as to religiousness for patients with psychosis.

10.2 Transferability

The concept of transferability, or external validity, refers to the degree that the results are valid for a larger population. In comparison to quantitative studies, the term *transferability* is understood differently as to qualitative research. While the quantitative research tradition speaks of *statistic generalization*, qualitative research will speak of transferability or of *analytic transferability* (Kvale & Brinkmann, 2015). This will mean that the researcher will have to argue for the transferability of the results, but also the reader, or the independent researcher, will have to judge for herself whether the results are transferable to her situation or context. In this study I have argued for transferability of the results by including a broad description of the patients involved and by describing in detail the research context. In addition, I have utilized findings from other researchers and established theories (triangulation of theories), in order to argue for the validity and transferability of the results. This will provide the reader, or independent researcher, with a broad base of information (Kvale & Brinkmann, 2015; Malterud, 2011).

I will conclude that the fact that many of the same features are found as to religiousness in psychosis in the three separate sub-studies of this thesis, and also the fact that similar results are found elsewhere in research literature, strengthens the probability that the results of the present thesis represent a valid description of the significance of religiousness in psychosis (Denzin & Lincoln, 2011; Malterud, 2011; Yin, 2009). The case study (sub-study 1) may be a supplement to the research field for the further development of therapy for patients with psychosis. Flyvbjerg (2003), as well as Yin (2009), argue for the possibility of the transferability of case studies,

when several cases describe more or less the same phenomena (Flyvbjerg, 2003; Yin, 2009). As for future research, a natural continuation of the present thesis, could well be conducting more art therapy studies for patients with psychosis as described under the section “further research”.

10.3 Ethics

In my opinion, I have paid respectful attention to ethical issues throughout the research process. The project was conducted using the standard of the World Medical Association’s Declaration of Helsinki. The Norwegian Regional Committee of ethics in medical research gave approval to my project: Grant number: 2011/384-2 (185.07), 588-07333a 1.2007.2767 and 2011/1198.

10.3.1 Participation must be voluntary and informed

All participants gave written informed consent. As for sub-study 3, I decided to pay the participants 200, - Norwegian kroner. This payment was offered in order to pay for the expenses of transportation and to compensate for the patients’ use of time. I decided that they should not suffer economically for participating. Of course one may see this payment as a way of encouraging patients’ participation, but the small amount of payment would not lead anyone to accept participating in the study against their will. As for study 1 and 2, no payment was offered to the participants.

10.3.2 Participation should not affect the health of the participants in any negative way

Will the focus on delusions and religiousness worsen the psychosis? This has been a topic of discussion in psychiatry, and for many decades psychiatry thought that focusing on patients’ religiousness or the content of their psychosis, would worsen the symptoms of their illness. However, as described in the “introduction” section, recent

research in the field of CBT and the Recovery movement, have pointed to the fact that patients rather seem to gain control over their symptoms by exploring and discussing their experiences in psychosis with someone they trust.

The vulnerability of a patient with psychosis, finding herself in a severe crisis, is an important aspect to bear in mind when studying these patients. However, all over the world a lot of research is conducted on patients with psychosis. In Norway, both the TIPS project and the Center for the Psychology of Religion, conduct research on patients with psychosis, and have found it ethically acceptable. As described in the World Medical Association's Declaration of Helsinki, one should always consider the need of a research project in relation to the risk that the patients will find it stressing or unpleasant. In addition, there should be a reason to believe that the patients investigated will benefit from the results of the research. My deliberation as to the present study was that the need for more knowledge regarding religiousness for patients with psychosis, was larger than the cost for the patients participating. My hope is that patients with psychosis will benefit from my research. As to the "cost" for the patients taking part, most patients thanked me after the interview, and told me they had found it rewarding and helpful to give me their stories about these issues.

11 Further research

I have the following suggestions for further research:

11.1 Case study research on explorative ExA therapy for patients with psychosis

a) A follow up study of the patients in sub-study 1 may reveal more details about how the patients in the art group function today. However, quite many years have passed, and the patients have attended other therapies and many other factors may contribute to their improvement other than the participation in the art therapy study. Even so, it would be interesting, both from a personal as well as a scientific point of view, to examine how they have been coping with their illnesses after the conclusion of my study.

b) An additional, and possibly better alternative, in order to verify the external validity of sub-study 1, would be the conduct of new case studies. Before starting a new case study, it will be important to formulate a modified proposition built on the first proposition of sub-study 1 and the new findings obtained in paper 1.

A new proposition might be formulated like this:

“Patients suffering from religious delusions, in a therapeutic setting, will be capable of exploring their hallucinations/ mystical experiences, and through this exploration, they will find a helpful religiousness/ apostasy”. Or:

“Patients will be capable of exploring their psychotic experience, improving their ability to make sense of their perceptions, thus gaining control of their psychotic symptoms. The process of making sense of their experience is brought about as a result of a cognitive process, or, alternatively, through a non-verbal bodily experience.”

Yin argues for the idea of building up a database of case studies. He concludes that while a single and separate case study is insufficient, a larger number would justify the testing of a hypothesis.

11.2 Follow-up study on the patients in paper 3.

In cases where religiousness clearly can be understood as part of a delusional system, we may raise the question whether this form of religious coping is helpful or harmful for the patient. A hypothesis will be that patients succeeding in building a helpful religiousness, will have a more positive outcome of their disorder (Pargament, 2007).

An alternative hypothesis is that the patients, as a consequence of the occurrence of new hallucinatory experiences, will have to change their religiousness accordingly. If these hallucinatory experiences do not fit well with the present belief-system, the patient will have to transform her religiousness to encompass the new challenges of her disorder. As the illness is worsening, we may assume that the patients no longer will be able to create a coherent belief system, and their religiousness will no longer be helpful. Research pointing to such a hypothesis, are the studies of Danbolt et al. (2011) and Mohr et al. (2010) (Danbolt et al., 2011; Mohr et al., 2010). Danbolt et al. showed that the majority of patients with schizophrenia reported their religiousness to serve a vital role in coping with their disorder. However, there was less support from religiousness for patients having more negative symptoms. These negative symptoms indicate a more serious course of the illness. The findings of Mohr et al. (2010) showed how changes in religiousness were associated with reduced self-esteem and quality of life. These findings indicate that changes in religiousness are associated with the deterioration of the illness.

In order to investigate how religiousness is influenced by the course of the illness and vice versa, follow up studies are necessary, for example in the form of a second interview of the patients in paper 3, 4-5 years after the initial one.

12 Conclusion

The results from this thesis show that patients' religiousness may be understood as attempts of religious coping. Some patients describe that their religious coping strategies are of great importance for them, for some even life saving. Important for their meaning making process is that their understanding of their hallucinatory experiences to be an encounter with God, ancestors or a Higher Power, and that the experience is given significance as a mystical experience. This may lead to positive as well as negative religious coping strategies. Patients' religious coping strategies are not necessary solely positive, even though judged so by the patients themselves. The patients that find meaning in their religiousness, seem to display ideas of being an omnipotent religious figure, or of having a sacred omnipotent mission. Patients' relationship to the sacred figure is built on hallucinations that may change over time, possibly taking the responsibility away from the patients of caring for themselves and their relations. Even so, for some patients, their religiousness, by offering love and dignity, may serve as positive religious coping, supporting the healthy part of patients' personality, enabling them to work through and to cope with the psychosis. Alas, patients' religiousness may also reinforce their delusional system or even make them dangerous for themselves or to others. Some of the patients showed signs of negative religious coping, and their religiousness functioned as a dysfunctional reinforcement of negative core beliefs. Thus, their religiousness will add to their suffering.

The five patients in sub-study 1 (Linn) described that their participation in the art therapy group had furthered their coping abilities. All the patients met our preposition that they were capable of exploring their psychotic experience through art therapy. Two out of 5 patients described the exploration process to be particularly

helpful for their ability to cope with their psychosis, whereas the others reported a more unspecific improvement of their disorder. Religious and existential issues turned out to be two of the main focuses discussed in the art therapy group, and one of the participants described that the exploratory artistic work had opened a new ability for her to distinguish between what she experienced to be her helpful mystical experiences on the one hand, and her hallucinations and religious delusions connected to her psychotic experience, on the other.

On the basis of the findings in my study, I will argue that the patients' religious understanding of their hallucinations, plays a significant role in their meaning making system, and is therefore important to address in therapy. Patients with omnipotent religious delusions, such as the idea of playing an important role in the spiritual world, will often view their religiousness as a functional and positive one. For the therapist, this view may constitute an obstacle to the therapeutic process. Patients may refuse therapy, and their delusional system might be the cause of unwanted behaviour, making the patient dangerous for herself and people around her. Most probably, the function of the religious omnipotent delusion is to protect the last remnants of dignity and self-value of the patient. Therefore, it will be a very risky task for the patient to question her delusions. The challenge in therapy will be to bring the patient in a position where she feels safe enough to question her omnipotent religious convictions, or mystical experiences, not serving her well in the long run. Restoring the patient's trust in her self and her dignity, will open the possibility for her to question her delusions. Her trust will depend on the support from health care professionals as well as from close private relations in family (or congregation).

Both CBT and first-person accounts emphasize the importance of exploring the psychotic experience in order to obtain recovery (Chadwick, 2006; Lampshire,

2012; Lauveng, 2012; Sørensen, 2014). Art therapy may function as an assisted exploration of the psychotic experience, helping the patients in the process of recovery. The benefits of art therapy, is brought about by the focus on patients' recourses. This focus will empower the patient helping her to restore her trust in her self and in her dignity (Killick & Schaverien, 2006). In the exploratory process of psychotic experiences, the patient will herself decide how much of her thoughts and emotions she is willing to share with her therapist. Thus, she can go about exploring her psychotic experience without her defence system being severely threatened. The case of Linn (paper 1), as well as some other case reports (Stålsett et al., 2010; Sørensen, 2014), bring hope that therapy focusing on patients' ability to explore their experiences in psychosis, can help the patients master their dysfunctional religiousness / religious delusions: However, further research is needed to verify this.

I will conclude that the fact that many of the same features are found as to religiousness in psychosis in the three separate sub-studies of this thesis, and also the fact that similar results are found elsewhere in research literature, strengthens the probability that the results of the present thesis represent a valid description of the significance of religiousness in psychosis (Denzin & Lincoln, 2011; Malterud, 2011; Yin, 2009). The case study (sub-study 1) may be a supplement to the research field for the further development of therapy for patients with psychosis. Flyvbjerg (2003), as well as Yin (2009), argue for the possibility of the transferability of case studies, when several cases describe more or less the same phenomena (Flyvbjerg, 2003; Yin, 2009). As for future research, a natural continuation of the present thesis, could well be conducting more art therapy studies for patients with psychosis as described under the section "further research".

13 References

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