

Benign and Pathological Religious Experience

Experiência religiosa benigna e patológica

José Eduardo Porcher¹

¹ Bacharel, mestre e doutor em filosofia pela Universidade Federal do Rio Grande do Sul. Atualmente atua como pesquisador de pós-doutorado do Programa de Pós-Graduação em Filosofia da Universidade Federal de Santa Maria. Foi pesquisador de pós-doutorado na Universidade Federal do Paraná, na Faculdade Jesuíta de Filosofia e Teologia e no Rutgers Center for the Philosophy of Religion. É membro da atual diretoria da Associação Brasileira de Filosofia da Religião. Seu projeto de pesquisa atual, “Expanding the Philosophy of Religion by Engaging with Afro-Brazilian Traditions”, é financiado pela John Templeton Foundation (grant #62101). E-mail: jose.porcher@ufsm.br.

Abstract

In this paper, I draw on phenomenological analyses of religious voice-hearing and related experiences to elucidate the role of phenomenology in discerning benign from pathological religious experience. First, I present phenomenological discontinuities between cases of benign and pathological voice-hearing by drawing on a study of first-person accounts of voice-hearers within the Pentecostal movement which evinces that voice-hearing is not inherently pathological. Second, I introduce the epidemiological continuity of psychotic-like phenomena by drawing on a study of the contextual and responsive differences between clinical and non-clinical voice-hearers which point to the contexts wherein voice-hearing does not lead to pathology. Third, I present a successful case where the meaning of the anomalous experiences is validated and normalized by drawing on studies of mediumistic experience which illuminate its therapeutic benefits. Finally, I argue that failing to take the voice-hearer's lived experience into account in the diagnostic moment can result in the pathologization of benign experiences.

Keywords: religious experience; voice-hearing; phenomenology; medicalization.

Resumo

Neste artigo, baseio-me em análises fenomenológicas da audição de vozes religiosas e experiências relacionadas para elucidar o papel da fenomenologia no discernimento da experiência religiosa benigna da patológica. Em primeiro lugar, apresento descontinuidades fenomenológicas entre casos de audição de voz benigna e patológica, com base em um estudo de relatos em primeira pessoa de ouvidores de vozes dentro do movimento pentecostal que evidencia que a audição de vozes não é inerentemente patológica. Em segundo lugar, apresento a continuidade epidemiológica dos fenômenos psicóticos a partir de um estudo das diferenças contextuais e responsivas entre ouvidores clínicos e não-clínicos que aponta para os contextos em que a audição de vozes não leva à patologia. Em terceiro, apresento um caso de sucesso em que o significado das experiências anômalas é validado e normalizado com base em estudos da experiência mediúnica que iluminam seus benefícios terapêuticos. Por fim, argumento que não levar em conta a experiência vivida do ouvidor no momento diagnóstico pode resultar na patologização de experiências benignas.

Palavras-chave: experiência religiosa; audição de vozes; fenomenologia; medicalização

Introduction

The voice of the Lord is powerful;
the voice of the Lord is full of majesty.
Psalm 29:4 (KJV)

Ezekiel was a priest and a prophet who experienced visions and voices for 22 years during the 6th century BCE, in a period during which several people from the ancient Kingdom of Judah were captives in Babylon. In a glaring case of retrospective medicine, George Stein all but diagnoses Ezekiel with schizophrenia.

Like any prophet, Ezekiel hears the voice of God, and it is his prophetic task to relay God's message onto the people. He hears the voice of God more often (93 times) than any other prophet, and the way God addresses him as "son of man" or "mortal" is also unique. Ezekiel experiences a variety of other auditory phenomena, including command hallucinations which are not described in any other prophet, 3:3 "He said to me; mortal, eat this scroll that I give to you and fill your stomach with it. Then I ate it; and in my mouth it was as sweet as honey." (2010, p. 101)

This is an extreme example of someone's lived experience being ignored in the formation of a pathologizing judgment. However, it is common for voice-hearers to be forbidden to talk about their experiences, which makes it more difficult for them to understand how the voices influence their daily lives (Woods, 2013). In this paper, I will explore anomalous experiences and their religious interpretations to investigate that region which, according to William James, "contains every kind of matter: 'seraph and snake' abide there side by side" (1902, p. 426).

There are many ways to draw out taxonomies of religious experiences. Rodney Stark (1965) usefully categorized them into four families: *confirmatory* (e.g., awe, reverence); *responsive* (e.g., awareness of divinity); *ecstatic* (e.g., bodily excitement); and *revelational* (e.g., visions, voices). I will focus here on the last kind, giving special attention to the phenomenon of hearing voices in the absence of any speaker, which in the clinical literature is also known as Auditory Verbal Hallucination,² a common symptom of psychosis that affects approximately 75% of people with

² I will forgo completely the use of this clinical term because of the pejorative connotation of the term "hallucination". The term "Auditory Verbal Hallucination" has been created by professionals who do not typically have the experience themselves, and which, because it is rejected by service-users and their organizations (such as the Hearing Voices Movement), colonizes the experience of voice-hearers. Cf. Dillon & May (2002).

schizophrenia (Nayani & David, 1996). The phenomenology of voice-hearing is diverse, involving single or multiple voices, which may be known or unknown, speaking sequentially or simultaneously, in the first, second, or third person, and which may give orders, comments, insults, or encouragement (Jones, 2010).

Voice-hearing occurs in many contexts, throughout most cultures, and in possibly every moment in human history, but it is of special interest to this investigation because it is particularly common in the texts and customs of most of the world's major faith traditions, both ancient and contemporary, and certainly in the Abrahamic religions (Cook, 2019). As Ezekiel illustrates, the voice of God is frequently heard in the Old Testament. Although it is generally only implicitly encountered in its prophetic works, in the Pentateuch conversations between God and the Patriarchs, and between God and Moses, are narrated as any other conversation between two people.

The New Testament presents fewer examples of what may be interpreted as voice-hearing, but the identifiable voices are very significant and, as with the Old Testament, many unhesitatingly identify examples of voice-hearing within its pages. For example, Jesus and Paul are listed by John Watkins (2008, p. 30) among "famous voice hearers". Paul's conversion experience certainly features among the most culturally meaningful cases of voice-hearing among foundational religious figures.

And as he journeyed, he came near Damascus: and suddenly there shined round about him a light from heaven: And he fell to the earth, and heard a voice saying unto him, Saul, Saul, why persecutest thou me? And he said, Who art thou, Lord? And the Lord said, I am Jesus whom thou persecutest: it is hard for thee to kick against the pricks. And he trembling and astonished said, Lord, what wilt thou have me to do? And the Lord said unto him, Arise, and go into the city, and it shall be told thee what thou must do. (Acts 9:3-6 KJV)

Finally, Islamic tradition may be said to be founded upon a voice-hearing experience. In the year 610 CE, at the age of 40, Muhammad experienced a vision of the archangel Gabriel and heard a voice which told him that he was God's last prophet. From this time on, he continued to hear a voice that conveyed to him words which were compiled in the Qur'an (literally meaning "recitation"). It is thus usually understood that God was the speaker, and that Gabriel was only a mediator. Within the Qur'an itself it is said that God had previously sent revelations to the

patriarchs and prophets of Hebrew scripture and Jesus: “To Moses God spoke directly” (Surah 4:163-164).

But even if voice-hearing is a normative experience in the scriptures of the Abrahamic religions, in an increasingly medicalized society, anomalous experiences of every kind raise the question of whether, if the experient is sincere, he or she is mentally ill. Thomas Szasz (1973, p. 101) once quipped that “If you talk to God, you are praying; if God talks to you, you have schizophrenia”. This quotation is often taken out of context and quoted by people who take it literally. But it was written in a spirit of criticism to underline the pathologizing tendencies of psychiatry in Szasz’s day. That said, one does not have to agree with sweeping medicalizing generalizations to understand that, as Simon Dein and Roland Littlewood (2007, p. 214) remark, “It is when God replies that the particular issue of pathology in prayer seems most pertinent”.

As Tasia Scrutton (2016) observes, both the general public and psychiatrists can be guilty of pathologizing by attributing or diagnosing a mental disorder purely based on hearing voices. The question, then, is whether and how we may be able to differentiate benign and pathological voices. While this may seem like an entirely academic debate, the label that is attached to a voice-hearer’s experience has a real-world impact on how the voice-hearer is treated and whether they are medicalized (McCarthy-Jones, 2012, p. 334).

In the following sections, I will draw on phenomenological analyses of religious voice-hearing and related experiences to elucidate the epistemic role of phenomenology in discerning benign from pathological religious experience. First, I will present phenomenological discontinuities between cases of benign and pathological voice-hearing by drawing on a study of first-person accounts of voice-hearers within the Pentecostal movement which evinces that voice-hearing is not inherently pathological. Second, I will introduce the epidemiological continuity of psychotic-like phenomena by drawing on a study of the contextual and responsive differences between clinical and non-clinical voice-hearers which point to the contexts wherein voice-hearing does not lead to pathology. Third, I will present a successful case where the meaning of the anomalous experiences is validated and normalized by drawing on studies of mediumistic experience which illuminate its therapeutic benefits. Finally, I will argue that failing to take the voice-hearer’s lived experience into account in the diagnostic moment can result in the pathologization of benign experiences.

Phenomenological discontinuity

James (1902, pp. 31-2) defined religion as “the feelings, acts, and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider divine”. He classified religious states with similar non-religious ones, distinguishing them only with reference to their significance in the lives of those who experienced them (Dein, 2010).³ In the spirit of James, we need detailed phenomenological descriptions of diverse religious experiences and their relationship to culturally-sanctioned states of psychopathology. This research needs to be ethnographically informed, taking into account indigenous conceptualizations of the self and agency.

Dein and Littlewood’s (2007) work on the experience of hearing God’s voice is illustrative of this type of research, most commonly referred to as Interpretive Phenomenological Analysis (IPA). By acknowledging the researcher’s position in the analytic process, the IPA method can detect the two levels of interpretation involved: the participant making sense of their experience, and the researcher, in turn, making sense of that (Smith and Osborne, 2003). In other words, as IPA seeks to explore the lived experience of individuals who make up a homogenous group, rather than making generalizations that apply to all, fewer participants examined in greater depth is considered better than a descriptive analysis of many individuals.

One contemporary group in which hearing God’s voice is relatively common are the members of the Pentecostal movement, with its emphasis on direct personal experience of God (Davies *et al.*, 2001). Much of the literature on divine communication within this group contemplates prophecy (Poloma, 1998) and glossolalia (Spanos *et al.*, 1986), but much less work has focused on direct communication *from* the Divine—although, again, this kind of experience is common among evangelical Christian groups, who rate it more positively than do either psychotic patients or the general population (Dein and Littlewood, 2007, p. 217). To correct this oversight, Dein and Littlewood asked 40 members of an English Pentecostal church of around 110 people in north-East London to complete a questionnaire on prayer. Those who reported that they heard God’s answering voice were then interviewed.

³ Cp. Littlewood (1997, p. 67): “Mental illness and spirituality are not two distinct natural phenomena ‘out there,’ existing independently of human volition. They are both social—cultural if one prefers—ascriptions. Neither has some substantive core whose elucidation through psychophysiological, phenomenological or ultrahuman procedures could enable us to define its essence and thus differentiate it from the other. Neither experience is a self-evident datum.”.

The participants who completed the questionnaire describe diverse ways in which God communicates with them: “through events in the external world, as personal messages through hearing sermons, in reading the Bible, through an internal voice, through an audible external voice, as a compulsion, through interjected thoughts and emotional changes, or as complex imagery including visions and dreams” (2007, p. 218). The authors then focused on the 25 participants who experience hearing God’s voice either internally or externally.

The participants are clear that this voice was not part of their own thoughts. “Diana”, a 26-year-old woman, noted:

It is not like, when say for instance my body is telling me I am thirsty so I think in my mind, I think I will make myself a drink now. It is not like that. It is definitely something outside of me, talking to me. (2007, p. 218)

Dein and Littlewood report that, in the case of the 15 informants who heard voices from outside the head, this is often associated with initial feelings of bewilderment and disbelief, and that for most of these informants the experience of external voices happened only once. One of the participants, a 28-year-old woman, reports an audible voice being heard once in her life after she and her husband prayed fervently for a baby for several months:

I was driving back to work in my car and saying thank you God for the day and singing hymns. It all went quiet and all of a sudden I heard an audible voice. I believed it was in the car and it said, ‘you will have a son and you will name him Isaac’. I turned round and looked behind me because I thought this is crazy: how did someone get in my car? I looked but there was no one so I carried on driving and thought, ‘Is this you God or am I losing my mind. I have finally lost it!’ I wanted a baby so much I thought there was a voice talking to me telling me I am going to have a baby. The voice repeated the same thing, ‘You will have a son, you will name him Isaac.’ At that moment I believed it was the Holy Spirit talking to me. (2007, p. 220)

Regarding this kind of imperative communication, an important finding from the interviews is that, although participants generally state that they would automatically obey God’s voice, Dein and Littlewood report that “in practice, many tell us that they have not: they still have a degree of freedom. They feel themselves clearly responsible for whether they do obey” (2007, p. 224). This element of choice is a flagrant phenomenological discontinuity between God’s voice and most voices arising in mental illness. The testimony of “David” is an excellent example of distinguishing between what the patient himself calls “psychotic voices” and what he calls “the voice of God”,

and it sheds light on the patient's point of view as an *expert by experience* in distinguishing them. David had a psychotic breakdown several years before the interview:

When I was going through my breakdown, I would get quite nasty and aggressive thoughts and voices in my head, which I didn't know how to handle. These were very forceful and pushy... (2007, p. 224)

On being asked how these voices differed from that of God, David notes that the voice of God does not compel:

God says something and doesn't force you, so you do what you like with it. It is much easier to respond than with a negative voice. [By contrast, with the psychotic voices] you can't refuse to do something when you hear them. They are very pushy. (2007, p. 224)

And further comparing the voice of God to the psychotic voices he knew from previous experience:

It is very calm and peaceful and doesn't force you. He tells you what you should do but basically it is up to you... [So if you ask God a direct question] 'Should I go for this job, for instance, or should I do such-and-such?' the only time you will get a no, is when it is for your benefit and it is not good for you. (2007, p. 224)

So far, we have two important phenomenological discontinuities between the participants in the study and patients with schizophrenia who manifest voice-hearing. In Dein and Littlewood's study—as well as other studies, such as that by Tanya Luhrmann (2012) with “third wave”, neo-charismatic evangelicals in the US—the experience of hearing God's voice “out loud” was occasional, not disturbing, and, furthermore, subjects were not compelled to obey God, with the person having complete control over their choices. This is to be contrasted with the voices in schizophrenia, which are usually heard “out loud” and where the individual often feels compelled to obey (Dein and Cook, 2015, p. 99). The latter may properly be described as “command hallucinations” and are often associated with schizophrenic “passivity”, in which an individual experiences their thoughts, emotions or actions as replaced by another power (Wing *et al.*, 1974). So, God's voice—as heard by Dein and Littlewood's as well as Luhrmann's interviewees—leaves the person with a choice as to whether to heed advice or admonishments, while psychotic voices are mostly intrusive and replace individual volition.

Another phenomenological discontinuity between God's voice as experienced by Dein and Littlewood's subjects and psychotic voices is that hearing God's voice is generally associated with

positive affect including feelings of peace, certainty, and well-being, as well as physical changes such as feelings of warmth or lightheadedness (2007, p. 219). The authors also report that participants are often able to have a conversation with the voice and question or clarify what it said—something which, in the recent clinical literature on hearing voices, is widely considered therapeutic (Corstens *et al.*, 2012). Regarding the character of the voice they hear, participants comment:

Yes it is just very gentle, a gentle voice. It is not demanding or controlling it is just a gentle voice.

It always encourages and it always edifies. It brings even a conviction of peace.

I hear God as sharp, crystal clear and very soft. It touches you so deeply. It is so clear you know it is not your own thinking.

I wouldn't describe it as a voice of another human being. It is a voice I came to recognize in the early stages of my Christianity as being quite distinct, quite unique . . . It is soft, not like a male or female voice. I couldn't really put a gender on it. (2007, p. 219)

So, while psychotic voices are variably aggressive and disparaging, God's voice is characteristically gentle and supportive, often associated with peaceful psychic and bodily sensations, even aiding in problem-solving and enhancing psychosocial functioning (2007, 221). However, the first-person perspectives we have seen so far raise the question of whether and how the voice-hearer can pinpoint the source of the voice as being divine (e.g., God, angels, saints) rather than being self-generated or, worse, having a malignant source (e.g., Satan, demons, evil spirits). Indeed, the origin of the voice is often scrutinized both by the voice-hearers themselves and by their pastor, and so they seek confirmation from the Holy Spirit. "David" discusses the voice with God in his mind:

Yes, because the Bible says to test the spirit.⁴ If you have got a voice it could be a spirit. It could be God's spirit, which is good. It could be a negative spirit, which is bad, so the Bible says to test every spirit, which will confess that Jesus Christ is God. If it [doesn't] say He is, then I won't entertain him. (2007, p. 223)

⁴ *Discretio spirituum* has a scriptural basis in the Pauline writings on spiritual gifts in 1 Corinthians 12:8–11 and consists in the practice of discernment to establish if experiences are the result of a divine or demonic encounter, or whether they were variously fraudulent and feigned, or the product of mental and somatic illness.

The informants in Dein and Littlewood's study also emphasize that recognizing God's voice is a process of elimination. They claim that they are able to clearly differentiate God's voice from their own thoughts and from the internal voices that derive from bodily signals such as hunger and thirst. This usually involves a process of learning:

No, you don't learn to hear God's voice, you learn to recognize the voice. It is a bit like a child recognizes its parents' voice and recognizes the voices they are close and attached to. I have learnt to hear and recognize God's voice but nevertheless no matter what I get in terms of inspiration it has to be assessed because I have to be responsible for my actions. (2007, pp. 222-3)

Second, they claim that they are able to clearly differentiate God's voice from that of the enemy or evil spirits. In that respect, they generally hold that God would only speak something from the Bible or something that is positively encouraging.

The only response to that is when I have heard people say 'It was God's will that I went and slaughtered or killed a person' you know it is a mental illness, because God would not have said that.

God does not act outside of his nature or his character. If people were saying things outside his nature and character I would question it.

The only thing I would say to that is if it contradicts anything that I believe God is about I would say it wasn't from God. (2007, p. 223)

Given such phenomenological discontinuities between benign and pathological voice-hearing, Dein and Littlewood conclude that the voice of God cannot be held to be *ipso facto* pathological. Realizing this fact gives us a hint of how profoundly harmful medicalizing tendencies can be and raises the question of why anomalous experiences such as voice-hearing become pathological (or lead to pathology) when they do.

Epidemiological continuity

Even though it is popularly thought that anomalous experiences occur most commonly in the context of a psychiatric disorder such as schizophrenia, it is a growing consensus that voice-hearing and other "psychotic-like phenomena" happen both in clinical and non-clinical populations, existing on a continuum with normal experience (Strauss, 1969). This so-called

“psychosis continuum” has been proposed in multiple forms throughout the history of psychiatry, but efforts to explain it have seen an exponential increase in the last 20 years (van Os *et al.*, 2009). As we have just seen, while many people who have anomalous experiences are distressed by them, being subsequently diagnosed with a psychiatric condition and requiring clinical treatment, there are also people who have anomalous experiences that resemble psychotic symptoms, but who do not experience distress, do not look for medical treatment, and hence do not receive a diagnostic label (Verdoux and van Os, 2002).

Hearing voices *is* a significant symptom of schizophrenia. But consider that while schizophrenia is a severe mental illness that affects around 1% of the population (Johns and van Os, 2001), estimations of the prevalence of voice-hearing put it around 10-15% of the population at large (Tien, 1991). Rachel Pechey and Peter Halligan (2012), for example, found that in a British sample of 1000 individuals 75% reported anomalous experiences, with 15.3% reporting voice-hearing. Consider also that voice-hearing is predictably associated with lower distress in non-clinical than in clinical populations (Lawrence *et al.*, 2010).

What should we conclude? In terms of ontology, epidemiological continuity suggests that the dividing line between benign and pathological voice-hearing is vague. Indeed, as Scrutton (2016, p. 173) points out, “attempts to find a (biological, phenomenological, or other) essence or substantive core of these categories has thus far been unsuccessful, and so to speak of them as natural kinds would seem to be to jump to unsubstantiated essentialist conclusions”. In terms of diagnosis, epidemiological continuity suggests that in the absence of distress, dysfunction, or co-morbidity, attributing psychopathology to voice-hearers is the transformation of experiences into symptoms based on considerations outside the scope of psychiatry. In terms of therapy, epidemiological continuity suggests that, in a significant amount of cases, voices can be successfully coped or dealt with through non-clinical methods, including religious ones.

Where Dein and Littlewood’s study provides evidence for what Scrutton (2016, p. 172) calls the *contextualist* view of psychopathology, which regards anomalous experiences and other mental states as pathologically indeterminate, Charles Heriot-Maitland, Matthew Knight, and Emmanuelle Peters (2012) argue that anomalous experiences do not inevitably lead to psychiatric conditions and that people can experience psychotic-like phenomena while continuing to function effectively. In other words, psychopathology does not emerge out of anomalous experiences alone, but in conjunction with responsive and contextual factors.

To investigate this hypothesis, Heriot-Maitland and colleagues interviewed 12 people who reported having anomalous experiences in the 5 years previous to the study. They analyzed the qualitative data they gathered using IPA. The participants were split into two groups of equal size, one clinical and the other non-clinical, depending on whether they had been involved with mental health services as a result of their experiences. The anomalous experiences reported by the participants in the clinical group were: receiving visions from God; body taken over by spirits; telepathic communication and speaking with God; receiving symbolic messages from other realms; hearing voices, and thoughts of being watched or filmed; and hearing voices when nobody is there. The anomalous experiences reported by the participants in the non-clinical group were: body taken over by spiritual energy; visions of people who have died and religious figures; receiving words directly from God; spiritual calling, and developing intuitive perception; visions and voices of spirits (mediumship skills); and body taken over by an external force.⁵

Heriot-Maitland and colleagues analyzed inter-group similarities in the triggers and subjective nature of experiences, and group differences in the interpersonal and personal contexts, as well as how the experiences were incorporated into their lives. The authors were able to distinguish the factors involved in having an anomalous experience from those involved in it becoming diagnosable as pathological. They found that, while triggers and the initial subjective experience were similar in both clinical and non-clinical groups, having the experience validated was associated with a non-clinical outcome. This difference can be illustrated by the following accounts, the first of which is from a clinical and the second from a non-clinical participant:

[I] relayed this experience to psychiatrists in the [hospital] and was sent for EEG tests, was told that I was hallucinating ... this guy just didn't listen to, just obviously hadn't heard anything really that I'd said... I just felt that this really positive experience was just scrutinized and just not, just liked mocked. I didn't feel offended, I just thought they were being really stupid, and disregarding this kind of, yeah, really important thing. (2012, p. 46)

Somebody came up to me and said "well, you know, we really need to hear from you. That's a very powerful message to people, and they need to hear that message". And that did matter to me. (2012, p. 47)

⁵ Note that, if the two groups were to be mixed up, it would be impossible to identify which participants belonged to the clinical or non-clinical group based on the content of their experiences alone. This, of course, was the intention of Heriot-Maitland *et al.*'s screening: to control for the experiences themselves in order to make phenomenological and contextual comparisons.

As Heriot-Maitland and colleagues note, for the person who is already hesitant about how best to incorporate their experience into their social world, the difference between these two interactions can be substantial. They point out that this seems to be the major difference between the clinical and non-clinical groups, who had generally reported quite similar experiences both in triggers and in subjective nature.

The researchers conclude that it is nothing in the anomalous experience itself that determines its interpretation as a clinical condition, but rather the wider personal and interpersonal contexts through which this experience is subsequently integrated. In other words, there is nothing inherently pathological in such anomalous experiences, since in certain contexts they do not cause distress or dysfunction. Rather, pathology emerges from anomalous experiences “when the meaning of the [anomalous] experience is failed to be acknowledged through a lack of integration with the inter-personal and background personal contexts” (Heriot-Maitland *et al.*, 2012, p. 50). As we saw in the case of hearing the voice of God within the validating context of a Pentecostal church, this correlates with the experience being overwhelmingly positive, with many voice-hearers reporting its utility in situations of doubt or difficulty.

Meaning

While not every voice-hearer would classify their experiences as religious, or even be open to reframing their previous experiences in such a manner, many do describe them in that way—some from the beginning, others through contact with religious subcultures in which their experiences are validated. In these contexts, anomalous experiences such as voice-hearing, but also visions or sensing the presence of the dead may be considered a “gift” that can enrich and enhance one’s life.

One group of individuals that provides such a context are mediums who believe they receive information from spirits in the form of voices and visions that are not available to others. Mediumistic experiences are integral to many religious traditions throughout human history and are arguably part of the Greek, Roman, and Judeo-Christian roots of Western society, which were passed down through oracles and prophets. In the West today, these can be found mostly in Spiritualist churches (or centers, as practitioners of Kardecist Spiritism call them). In their study of British Spiritualist mediums, Elizabeth Roxburgh and Chris Roe (2014) conducted interviews with 10 participants and, using IPA, identified themes that illuminated aspects of the mediumistic

experience that have therapeutic implications for individuals who have similar experiences but become distressed by them. Chief among these was the theme of the search for meaning, or the normalization of mediumship. When Roxburgh and Roe asked their subjects how they became (or rather found out that they were) mediums, most reported experiences that had normalized mediumship for them. Their explanations focused on how mediumship had always been an ordinary occurrence in their lives or how mediumship helped to construct a personal framework for making sense of reality as they experienced it, whereby their “anomalous” experiences were interpreted as “normal”.

Before being normalized within a religious framework, many participants in Roxburgh and Roe’s study spoke about having an overwhelming fear, at the onset of their experiences, that what they were going through was a form of mental illness. This is particularly evident in the account of “Sarah”, who describes her experience in detail:

The first memory that I actually have was hearing voices after my father died (...) one night I went to bed and I woke up and I’d had these voices talking to me saying that my dad was fine, he was living, there wasn’t a problem, he wouldn’t want me to be upset. And I thought I was dreaming, so I thought “pull yourself together”, and as I turned over to go back to sleep the voices were still there, so I thought “sit up in bed, sort myself out” because I really thought this was still all to do with a dream I was having. So I sat up and these voices were still there in my head, still talking to me, so I thought “I’m losing it, I’ll go down and make a cup of tea.” So I went down and all the while I was making this cup of tea these voices were still talking to me, so the next day I said to my husband, “You know, I really must be having a nervous breakdown, I need to go to the Doctor’s.” So I went to the Doctor’s and I told him what had happened. I said I must be having a nervous break-down, so he gave me some pills – as they do – told me to go away for a few days and just try and chill and relax. So my husband at that stage worked away quite often, and he was going to Wales, so I said to him “I’ll come with you and we’ll have a few days.” [I] never took the pills because I don’t take tablets, I don’t believe in that sort of thing, I never even got them but all the while that I was on holiday I’d still got these voices talking to me, so at that stage when I got back I thought, “Right this is me and now I need to cure myself to get better” so I just pulled myself together, blocked absolutely everything out, thought I’ve just really got to get back on track and I did that. I did that probably for about 6–7 years (...) I started to talk to [a Spiritualist she had met] about what happened with my dad and different things and her sister was a medium but not local and I went with her one day to meet her sister who was lovely. And we sat just chatting about things and that is when my interest started because they were explaining things to me because that was my first real knowledge that somebody was talking to me (...) Steph and her sister were starting to explain all these things to me and all the little things that had happened over the years which you just put down as “Oh that must be that and that must be that” so you know, things just started making sense. (2014, p. 647)

Such religious reframing of anomalous experiences through contact with a normalizing framework echoes the early work of Paul Chadwick and Max Birchwood (1994), whose cognitive model theorizes that *beliefs about voices* (e.g., regarding identity, power, intention, and control) are key to understanding distress and maladaptive responding in pathological voice-hearing. Conversely, such a cognitive model explains why mediums are more likely to view their voices as benevolent and engage more with them than do psychiatric voice-hearers (Andrew *et al.*, 2008).⁶ A religious tradition that enables the development of positive feelings towards one's voices can, therefore, be therapeutic. It comes as no surprise, then, that in Lana Jackson, Mark Hayward, and Anne Cooke's (2001) study of 12 people who have positive experiences of hearing voices, only one subject did not belong to a religious group, although this was not the deliberate object of the study:

Most participants felt that their voice-hearing experiences were meaningful and therefore sought alternative understandings (often spiritual) to an illness-based medical view. Those who had received a diagnosis of mental illness tended to view their voices as more than just 'a bunch of symptoms that need fixing' (Rachel). This often conflicted with the medical approach they were offered. (2001, p. 491)

Reframing was transformative of their experience because, as one participant put it, it enabled "understanding what was happening for me, giving it meaning and breaking down the fear that I had around not knowing and thinking that I was a complete freak, really different and ill" (2001, p. 492). As Arthur Frank (1995, p. 6) observes, the postmodern experience of illness "begins when people recognize that more is involved in their experiences than the medical story can tell". Once there are cultural resources available which provide a means of understanding and managing the experience, then, and only then, can a proper judgment of the pathological character of an anomalous experience begin to be made.

A lack of conceptual and intellectual resources by which to make sense of anomalous experiences may result in those experiences being unjustifiably pathologized because positive interpretations or coping strategies have not been exhausted. This gap in collective hermeneutical

⁶ This does not mean that mediums are not subject to hearing and actively engaging with malevolent voices. Mediums are usually trained to choose when to engage with voices rather than attempting to block them and it is considered important for them to share their experiences with others and normalize them as "part of the journey" towards becoming a medium. Cf. Taylor and Murray (2012). Thanks to Rogério Severo for raising this point.

resources must be bridged whenever possible, but it is usually not any one individual's fault. That being said, when experiencers choose to recount their anomalous experiences to laypeople or clinicians and receive negative, pathologizing responses because the latter willfully ignore the positive resources and contexts through which the subject interprets their own experiences, then a wrong has been done to them in their capacity as a knower (Kidd and Carel, 2017). When health services and societies as a whole ignore that patient testimonies and interpretations carry epistemic authority, systematically overlooking the realm of lived experience in carrying out judgments of pathology, then the result is a deep and willful form of hermeneutical marginalization.

Concluding Remarks

Simon McCarthy-Jones (2012, pp. 372-3) observes that 'For most of history, voice-hearers have only had one destiny, and that is silence. The silence of the voices they hear has been the definition of health, and their opinions on the meaning of their voices when in conflict with the prevailing paradigm, be this medical or religious, have been silenced'. In this paper, I have attended to studies which are exemplary in their efforts to correct this harmful attitude. These studies employ the analysis of first-person accounts of benign anomalous experiences, as well as their comparison to their psychiatric counterparts, and demonstrate the primacy of the epistemic role of phenomenology in discerning benign from pathological experiences. Attending to these first-person accounts inevitably leads to the conclusion that anomalous experiences are not inherently pathological—a fact that is corroborated by the epidemiological continuity of “psychotic-like phenomena” (Verdoux and van Os, 2002; Heriot-Maitland *et al.*, 2012).

We have seen that the way an experience is narrated and interpreted is an integral part of the experience. Hasty clinical colonizations of anomalous experiences can transform them into real symptoms, even in the initial absence of distress, dysfunction, or co-morbidity. Profound neglect of the subject's lived experience, coupled with a gap in hermeneutical resources for its interpretation, partially explains how a benign anomalous experience may be considered sufficient for a judgment of pathology. The clinical consequences of this attitude are appalling, not only because they close off potentially therapeutic avenues, but because the framing of a benign experience in medicalized terms risks being a self-fulfilling prophecy.

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