Article:
Scrutton, T. orcid.org/0000-0002-8335-7464 (2024) Psychopathology AND religious experience?: Towards a both-and view. Philosophy, Psychiatry and Psychology, 31 (3). pp. 243-256. ISSN 1086-3303

https://doi.org/10.1353/ppp.2024.a937768

Psychopathology AND religious experience?: Towards a both-and view

Abstract

Psychiatric literature about when instances of voice hearing should be regarded as religiously-inflected psychopathology and when they should be regarded as religious experiences sometimes presupposes that a person's experience can only be *either* psychopathological, *or else* a genuine religious experience. In this paper I will consider an alternative: the possibility of a both-and account. A both-and account might involve the idea that a religious experience causes psychopathology, or is psychopathology, or that people open to religious experiences may also be susceptible to psychopathology. After arguing that these are either problematic or under-evidenced, I will argue for another version of a both-and account: that genuine religious experience can arise out of situations involving psychopathology. I will also point to some of the clinical and pastoral implications of my view.

Key words:

Hearing voices; visions; theology; Christianity; psychosis; mental illness

Psychopathology AND religious experience?: Towards a both-and view

Introduction

Mohammed Rashed describes the following case of one of his psychiatric patients (Rashed, 2019, 154 – 155). Abeo was a 29 year-old woman originally from West Africa who had lived in the UK with her father for the past 15 years. She had always been religious, and attended a Pentecostal church in London, which her father also attended.

Two months prior to her admission to a mental health unit, she became disillusioned with her usual church, describing the sermons as 'empty' and 'uninspiring'. Instead of attending that church, she made contact with a church in her birth-country, which emphasised personal experience of God. She stopped going to work, instead going for long walks and spending hours reading the Bible and listening to sermons.

Two months prior to admission she began isolating herself from her friends, and reported having intense experiences, which involved seeming to hear God talk to her. At times she would feel that the Holy Spirit was taking over her body. Her father became worried and appealed to the pastor in the London church, who made it clear that he regarded the practices as harmful and excessive and did not endorse them. A few days prior to admission she began to fast for prolonged periods in order to 'further cleanse her soul'. The fasting challenged her physically and she was found confused and disorientated in a public place; an ambulance was called and she was referred to the mental health services.

Once admitted, Abeo told the psychiatrist and social worker that she had no doubt that she had been in direct communication with God. She felt she had come to understand what God was, and that she felt on to something significant in her life. She was sectioned under the mental health act, on the grounds that she was presenting with second-person hallucinations ('hearing' the voice of God) and command hallucinations, volitional passivity, and was a significant risk to herself (due to social and occupational deterioration and fasting). A further reason for the decision to section her was that her father and the London church pastor did not endorse the idea that her experiences came from God (Rashed, 2019, 155).

Abeo resisted treatment, and regarded her incarceration as a test from God. A week after admission, she was diagnosed as having an acute psychotic episode. Treatment was then forced on her. After a couple of days of treatment she accepted medication. Two weeks after that she acknowledged that she might have been ill, and no longer reported hearing the voice of God. However, the case does not have an entirely happy ending: by the end of her

treatment she 'no longer felt the expectancy of a major change in her life, and was transformed into an unmotivated and indifferent young woman' (Rashed 2019, 154 - 155).

Medical professionals face a problem when responding to cases like Abeo's. If they diagnose someone with an illness and treat them for it, then it is possible that the meaning-making aspects of the experience will be lost. The person may well cease to have experiences such as voice-hearing that they regard as significant, and the effect of being told their experience is the result of an illness may also diminish their belief that their experience has spiritual meaning. If, on the other hand, the person is not diagnosed and treated, the dysfunctional elements of their condition may significantly worsen, and a severe condition develop that is far more difficult to treat at a later stage. Abeo's case highlights this conundrum, since it is clear that she accorded meaning and significance to her life before treatment, yet it is also clear that her condition included dysfunctional or pathological elements such as being confused, disorientated, physically challenged and isolated that were sufficient for an ambulance to be called and for her to be considered a risk to herself. Her psychosis therefore does not seem to be of the purely benign, non-pathological kind.[1]

A parallel problem can be faced by clergy and other people with pastoral roles in churches and other religious communities. In these contexts, someone might be struck by the similarities between Abeo and certain saints, and wonder whether they should encourage the person to trust the experience or to seek the help of a doctor.

The first problem (the problem for medical professionals) has given rise to studies in which psychiatrists and psychologists seek to provide criteria differentiating psychopathology from religious experience. These studies tend to assume that someone who has an experience

[1] Elsewhere I have written about how, perhaps at an earlier stage, some religious contexts and beliefs (alongside, e.g. the person's existing psychological resources) may be conducive to experiences of psychosis becoming benign rather than pathological. This is because they may provide support, a positive interpretation and role for the experience, and (in some cases) ways of controlling certain experiences so that the person gains agency in relation to them (X, 2016; 2018). My presupposition in this paper is that, by the time the ambulance is called, Abeo's condition is already pathological (because characterised by suffering and dysfunction over time). I regard 'benign' and 'pathological' as mutually exclusive in that, if something is benign, it is not causing the suffering and dysfunction that characterise pathology.
My understanding of psychosis is compatible with, though does not entail, Mike Jackson's understanding of the aetiology of psychosis, according to which psychosis is a form of adaptive problem-solving, with some cases being or becoming benign (perhaps in part on account of psychological and contextual factors), and other cases being or becoming pathological (again, perhaps in part on account of psychological and contextual factors) (Jackson, 2007). By 'benign' I mean merely that the experience is not characterised by significant levels of suffering/dysfunction, and so does not stand in need of medical attention. Epistemically, psychosis (if defined as a distorted perception of reality) is, in itself, flawed, but this is not sufficient to warrant medical attention or make it non-benign if significant suffering and dysfunction are not present. I also recognise that, even if epistemically flawed in itself, psychosis can sometimes give rise to epistemic goods (Bortolotti, 2020).

such as Abeo's could only be *either* an instance of psychopathology, *or* else a religious/spiritual experience (Hopkins and Battin, 2004). In this paper I am interested in exploring the possibility that someone might experience *both* a religious experience *and* psychopathology.

Why might a both-and view be plausible and worth considering? There may be practical (clinical and pastoral) benefits to considering such a view. If a both-and view is correct, then it may be that in cases like Abeo both diagnosis/treatment and spiritual encouragement/guidance are appropriate. In other words, it is at least possible that, if Abeo's (religious and medical) context had not presupposed that something could only be either an illness or a religious experience, then the end result might have been quite different. We do not know for sure, of course, but it is at least possible that combining treatment with spiritual guidance and encouragement could have left Abeo without the dysfunctional aspects of her experience, but with the sense that God was communicating with her through the experience, and that her life did indeed have meaning and significance (a belief that the Christian tradition would endorse [see Matthew 10.29 – 31]).

In addition to practical motivations, there are also philosophical and theological reasons for considering such a view. Philosophy (at least in the analytic tradition) is typically concerned with conceptual analysis and with discovering and questioning assumptions. In the clinical and pastoral conundrums outlined above we have two concepts (mental disorder, and religious experience) which are assumed to be mutually exclusive of one another. Philosophers might reasonably be interested in analysing these concepts, and questioning whether the (non-obvious) assumption that they are mutually exclusive is correct. Theologians, too, may be interested in considering a both-and view. A significant strand of the Christian tradition holds that 'grace perfects nature' rather than the two being opposed (Aquinas, *STh* Ia, q1, a8, ad.2). In other words, according to this view, divine action in the world takes place within and builds on natural phenomena, including human psychology. Consequently, much Christian theology will favour conjunctive causal explanations which posit the presence of both divine and natural causes. Thus, for example, discussing whether Julian of Norwich's 'visions' should be regarded as illness-induced hallucinations or as from God, theologian and philosopher Grace Jantzen notes that 'it would be a mistake to attribute to God only that for which no causal explanation is yet available' (Jantzen, 1987, 79; see also May, 2004; Cook, 2023). The emphasis on the idea that God works in and through

natural phenomena naturally makes many Christian theologians sympathetic to the possibility of a both-and account in the context of psychopathology as in other contexts.

In order to consider the possibility of a both-and view, I will consider the plausibility of four models, all of which are possible versions of a 'both-and' view.

Model 1 is the *mysterium tremendum* view, according to which an encounter with the divine might be so awe-ful that it results in psychopathology. On this view, encountering God is psychologically dangerous: someone like Abeo may be having a genuine religious experience that is sufficiently disruptive that they experience mental disorder as a result.

Model 2 is the 'identity' view, according to which mental disorder and religious experience are ways of describing the same thing from different perspectives. On this account, something that is caused by God is also, from a human perspective, disordered.

Model 3 is the 'mental openness' view, according to which (at least some) people who are susceptible to psychological instability and mental disorder are also more able to apprehend communication from God (and, potentially, other non-physical beings). On this view the psychological trait of mental openness gives rise to the possibility (and even likelihood) of both mental disorder and also religious experience.

Model 4 is the 'honeysuckle on a broken fence' view, according to which someone might encounter psychopathology (for natural, biopsychosocial reasons), and God might use this to draw the person closer to Godself. I call this the 'honeysuckle on a broken fence' view because the image I want to conjure up is of something beautiful and good – the person drawing closer to God – being somehow supported or (at one level of causation) coming about as a result of something dysfunctional and undesirable, such as a *broken* fence or an instance of psychopathology.

Model 4 is the opposite of Model 1 in terms of causal direction: for Model 1, a genuine religious experience can result in a mental disorder; for Model 4, a mental disorder can become an occasion for a genuine religious experience. Model 2 and 3 both posit that mental disorder and religious experience have a shared cause. According to Model 2 this is because mental disorder and religious experience are identical (and so must share the same causes).

According to Model 3 it is because something that gives rise to one (namely, mental openness) may (at a different moment) also give rise to the other.

I will argue that Models 1 and 2 should be rejected, and that there is an absence of evidence for Model 3. However, I will argue that there are good reasons to affirm Model 4. Before I begin, something needs to be said about methodology and terminology, and (in particular) about what I mean when I talk about 'religious experience' and 'mental illness'.

Methodology and terminology

In order to evaluate the four models, I will use a combination of psychological, psychiatric, philosophical and, in particular, theological, criteria. The theological criteria I will use and the examples I will draw on come from the Christian tradition (since this is the tradition I belong to). Concomitantly with this theological approach, I will use the term 'religious experience' in a realist sense, as an experience that comes from God, and not merely in a constructivist sense, as a cultural way of making sense of an experience that does not point to anything outside the world (Rashed, unpublished paper).[2] If something is a religious experience, on this understanding, then it is an instance of special divine action. In other words, something is a religious experience if it comes from God, not only in the sense that everything comes from God by virtue of God creating and holding all things in being ('general divine action'), but also in the sense of God acting in particular ways in creation (for example, through miracles or providence) (see McCabe, 1987). The theological tradition I am drawing on is inclusivist and so holds that people in non-Christian religious traditions can also know and experience God. In the conclusion I will point to the implications of my having taken a Christian theological approach for non-Christian religious traditions, and for a secular practice such as psychiatry.

In addition to explaining what I mean by the term 'religious experience', some explanation is also needed of my understanding of the term 'mental illness'. Like 'religious experience', 'mental illness' could be understood in a realist or in a constructivist way. I regard it as somewhere between these two. On the one hand, I think that the experiences picked out by the term are out there in the world, in people's experiences of reality. In other words, if we did not have the concept of 'mental illness', it would still be the case that people

[2] I am indebted to Reviewer 1 for drawing attention to these issues.

would experience forms of mental distress that involve both significant suffering and dysfunction as a result of, say, multiple losses over time or genetic factors or the interplay between these. While the phenomenology and expression of mental distress is likely to vary to some extent across cultures and times, and within cultures and times across demographic factors such as gender/sex and socio-economic status, I think we find common features (and common causes) across cultures and time as well.

On the other hand, those experiences could have been grouped differently, and may well have been had they been categorised by a different culture or society. For example, perhaps rather than being seen as 'illnesses' (and so as belonging to the medical domain) a culture could have categorised what we call 'mental illness' as something else (such as a failure of moral virtue, or else a non-pathological human variation, like being left-handed or homosexual). Alternatively, had our culture inherited less dualistic ways of thinking, perhaps we would not have the category of 'mental' illness, because that kind of illness would not be distinguished from (what we call) physical or somatic illness.

That said, I am not value-neutral about which of those options we adopt. In particular, I think our culture has made a good decision in deciding to think of the experiences such as those experienced by Abeo[3] as illnesses rather than as failures of moral virtue or as non-pathological human variations. This is because there are good reasons to think that mental illness is not especially connected to moral failure but (like other illnesses) happens to good and bad people alike (see Scrutton, 2020), and because these experiences involve suffering and dysfunction and thus stand in need of healing (and so, unlike left-handedness or homosexuality, are not merely non-pathological human variations). In addition, categorising certain experiences as illnesses can be helpful, for example in giving people access to helpful treatments, therapies and benefits such as sick leave, and a way of making sense of their experiences that does not involve self-blame.[4] The correct question to ask about whether we

[3] Abeo's psychosis led her to become isolated and physically challenged and thus were not instances of the 'benign' psychosis which some other people experience, for example in the context of grief, which are rightly not pathologised. If psychosis is to be understood as a break with reality, then even benign psychosis involves something 'going wrong' in an epistemic sense, but this is not sufficient to make it clinically relevant.

[4] Reasons for rejecting experiences such as depression as mental illnesses include the role of social injustice (poverty, racist and other oppression) in the emergence and development of these experiences. However, this is to overlook the role of social injustice in physical and somatic illnesses. A person is more likely to develop

have categorised certain experiences as 'illnesses' is not 'does this carve nature at the joints?', any more than this is the right question to ask about how we have ordered a library. Rather, the correct question to ask is 'Is this a helpful way to categorise these experiences and states at this culture and in this time?'. My sense is that, by and large, it is.

The issue of whether experiences such as Abeo's should be counted as *mental* illness is more complex, especially because of our increasing awareness of the somatic aspects of mental illness. However, on balance the term seems apt because it points to the characteristically emotional, cognitive and perceptual emphasis of mental illnesses (see Chappell, forthcoming). While it may have dualistic origins, we have learned how to use the term in a way that is not especially dualistic. For example, if my friend tells me she has a mental illness, I know how to respond well – perhaps by asking about her thoughts and feelings, rather than by asking if there is a pain in her leg or elsewhere. The term is 'in order', to adopt Ludwig Wittgenstein's phrase, because 'we know how to go on' (Wittgenstein, 1986/1953, 72 – 73). My understanding of the term 'mental illness' therefore has constructivist as well as realist dimensions, but not in a way that makes me doubt its aptness or usefulness in relation to the experiences being discussed in this paper.

Having clarified these terms, I will now turn to the models I wish to evaluate.

Model 1: The *mysterium trememdum view*

The term *mysterium tremendum* means 'fearful mystery' and denotes the idea that experiencing God can include not only fascination and wonder (a *mysterium fascinans),* but also experiencing a terrifying, overwhelming power (Otto, 1950 [1923]). In the background of this idea is the thought that there is something dangerous from a human perspective about encountering God: it carries something of the idea, sometimes expressed in the Hebrew Bible, that a person cannot see the face of God and live (Exodus 33.20; Isaiah 6.5). In the context of this paper, the *mysterium tremendum* view posits (more specifically) that an encounter with God might be so awe-ful that it disorders the recipient's mind.

---

severe asthma if they live in poor accommodation and in a polluted, typically low-income, area. A person with HIV can live a full and ordinary life if they live in the UK and have access to antiretroviral medications, whereas an HIV diagnosis in Nigeria, where these medications are only available to a few, remains devastating.

One objection to this *mysterium tremendum* view can be drawn from a meta-study by Alexander Moreira-Almeida and Adair de Menezes Júnior. This meta-study points to a significant consensus among psychiatrists and psychologists that salutary religious experience can be clearly distinguished from psychopathology using various criteria. Unlike psychopathology, they argue, salutary religious experience is characterised by the following:

i) An absence of suffering and functional impairment over time;
ii) The experience of voice hearing has only a short duration and happens sporadically rather than being invasive;
iii) The person initially has a critical attitude regarding the reality of the object of the experience, and is able to perceive its unusual nature;
iv) The experience is compatible with the person's background;
v) There is an absence of co-morbidities;
vi) The experience promotes personal growth over time;
vii) The experience is other-directed rather than ego-centric, and does not result in the person becoming isolated (Moreira-Almeida and Menezes, 2009).

Menezes and Moreira-Almeida indicate that psychotic disorders and non-psychopathological religious experience seem to have different characteristics; for this reason they cannot be identical. On this view, far from an encounter with God causing psychological problems, genuine religious experience would be distinguished from psychopathology by increased human flourishing (such as growth over time and other-directedness), and would not be characterised by a decline in aspects of flourishing typical of psychopathology (such as suffering, social and occupational dysfunction, and loss of control).

A potential objection to this line of argument is that some of these criteria seem to assume just what the *mysterium tremendum* view denies - that genuine religious experience is 'good' for a person in ways that significantly align with secular understandings of human well-being: that it will be characterised by an absence of suffering and by being non-invasive, not disrupting the person's relationships and normal activities. Even if we take into account the ways in which Menezes and Moreira-Almeida qualify the distinctive characteristics by appealing to the question of whether the phenomenon causes suffering *over time,* these criteria may seem at odds with significant hagiographical narratives within the Christian tradition.

For example, many Christian saints' experiences of God seem to have involved longer-term suffering, and been invasive, causing serious disruption in the person's personal and occupational life. St Paul the Apostle's conversion experience led him to give up his social status and stable life in order to face instability, persecution, and ultimately martyrdom. St Francis of Assisi's vision led him to sell his family wealth, renounce his parents, and give up his career to care for the poor and for lepers. The Gospels set up the expectation that, in following Jesus, Christians may have to leave their families, and face persecution (Luke 6: 22; Matt. 5: 10–11; Mark 10: 29–30; John 15:18; see Cook, 2019, 23).

Far from the absence of suffering being a marker of genuine religious experience, in the Christian tradition often the converse is the case. Given this, perhaps we may think that the *mysterium tremendum* view is correct in suggesting that encountering God, including hearing God's voice, can indeed be dangerous and compromise a person's equilibrium, and lead to ongoing instability and suffering. To overlook this fact, it could be argued, would be to flatten some of the more distinctive and challenging aspects of the Christian tradition (and perhaps of other religious traditions too). This may call into question criteria such as suffering and non-invasiveness, two of Moreira-Almeida and Menezes' distinguishing criteria for which there is most support in the psychiatric/psychological literature.

However, I want to defend Moreira-Almeida and Menezes' distinguishing criteria from this objection to some extent, on the basis that the Christian tradition is not undiscerning about the kinds of challenges a Christian might face, or why they might face them. Saints may undergo suffering for the sake of the Gospel – for example, because they face persecution and martyrdom on account of their faith or because they give up their worldly goods in order to devote their lives wholly to the poor (Matt. 5.10 - 11; John 15.18; Luke 6.22; 2 Tim. 3.12). They may experience significant mental distress in the context of contemplative prayer and the associated breakdown of images of self and of God in order to become closer to God (see for example writings by St John of the Cross and Thomas Merton). However, they do not undergo suffering pointlessly – or, if they do (for example, if they happen to be unlucky enough to suffer significant illness), this is not *because* they are Christians but just because they are human – and then their saintliness may lie rather in the way they respond to it than in the fact they have it in the first place (St Terese of Liseux and St Alphonsa are examples of saints for whom this was the case).

To assert that God would communicate in such a way as to cause someone schizophrenia seems to be inattentive to the ways saints suffered and the reasons they

suffered. Perhaps we might modify Menezes and Moreira-Almeida's first criterion, then, and say that, in order to be considered non-pathological, the religiously-inflected experience should not involve suffering over time that does not further the person's spiritual life, where that includes the interpersonal aspect of their spiritual life (for example, their mission to care for the poor and/or sick). In addition, we should keep in mind that the criteria are to be taken collectively; one criterion alone is not a necessary and sufficient condition for something being either psychopathological or a religious experience. While there is scope for nuancing some of Menezes and Moreira-Almeida's criteria, then, and while they need to be taken in conjunction with the other criteria, we should not, I suggest, take these criteria off the table completely when we come to consider whether something is psychopathological or might instead be a genuine religious experience.

Moreira-Almeida and Menezes' study speaks against the *mysterium tremendum* view, because it indicates that people experiencing mental illness on the one hand, and people encountering God on the other, will typically have very different qualities to their experience. This does not seem like conclusive proof against the *mysterium tremendum* view since there clearly are still people such as Abeo who constitute sufficiently complex cases to faze psychiatrists – nevertheless, these do seem to be the exception rather than the rule.

This conclusion is supported by some theological criteria for discerning when a religious experience is genuine, which centres around what the 'fruits' of the experience are, and whether they are characterised by love, hope and joy (on the one hand) or dysfunction and suffering (on the other). For example, one spiritual director at a Christian (Ignatian) retreat centre I spoke to says that an apparent religious experience:

> … needs to be tested in terms of its context and its fruits. Does it lead to greater holiness? Increases of faith, hope and love? How 'grounded' is this person in the rest of their life – can they […] love well and work well? And importantly is there a practical love of neighbour? (Roger Dawson SJ, personal correspondence, Nov 2020).

The psychological and psychiatric criteria discussed above point to the ways in which clinicians can distinguish psychopathology from salutary religious experience. The Ignatian criteria supplement and partially complement this by pointing to the relationship between an experience being salutary in particular ways, and it being genuine. The psychiatric/psychological and the theological criteria agree, against Model 1, that

psychopathology such as that experienced by Abeo is not a sign of God working in the person's life.

Model 2: the identity view

While Model 1 suggests that an encounter with God causes (or can cause) mental disorder, Model 2 suggests that an encounter with God just *is* the mental disorder: the two are identical.[5] In the case of Abeo, hearing God's voice would be an encounter with God and pathological psychosis; fasting and becoming physically challenged would be obeying God's will and a diagnosable absence of self-care; being confused and disorientated would reflect closeness to God while being properly regarded by medical professionals (*qua* medical professionals) as a cause of concern.

In order to get a handle on the identity view we might bring to mind Ludwig Wittgenstein's duck-rabbit. The duck-rabbit can be seen as a duck, or as a rabbit, and neither is more correct than the other. Likewise, on an identity view an experience such as Abeo's might be seen either as a psychiatric disorder, or else as an experience of God – neither is wrong, and neither is more correct than the other. In the context of discussing whether Mother Teresa's experience of mental distress could have been both a Dark Night of the Soul and depression, psychiatrist S. Taylor Williams seems to be putting forward an identity kind of both-and view when she says: 'There are many paradigms through which the human condition can be viewed – the Catholic Church's theology and the DSM's medical model are but two [….] no paradigm is necessarily objectively preferably to another' (Williams, 2014, 296, my parentheses).

Model 2 is subject to the same criticisms as Model 1. If the identity view obtained, we should not expect to be able to distinguish between psychopathological psychosis and religious experience in the majority of cases. Furthermore, much if not most of the Christian tradition posits a close relationship between an experience being salutary, and it being genuine (see Dawson cited above). St Teresa of Avila and others talk about how the 'fruits' of the experience can tell us where the experience came from: if the experience does not result in a lasting sense of joy and peace then it cannot be from God (e.g. St Teresa, *IC* 6.3). St Teresa is not unusual in this respect: similar ideas are found across the Christian tradition from the Catholic Ignatian and Carmelite traditions to Charismatic and Pentecostal churches

[5] Thanks to Robin Le Poidevin for prompting me to consider this option.

(see Luhrmann, 2012; Underhill, 2020). In these traditions and communities, the salutariness of an experience, characterised in terms of peace and joy, is a necessary condition of the experience having come from God. And while spiritual and secular values do not always align, a lasting sense of peace and joy are likely to be considered goods by medical as well as religious communities. Model 2 therefore seems implausible.

Williams states that 'no paradigm is objectively preferable to another'. In this I think she is reflecting a constructivist understanding of both 'religious experience' and 'mental illness'. Indeed, I think would be impossible or very difficult coherently to hold an identity view unless one has a constructivist understanding of these (and related) concepts. This reflects a further problem with an identity view from a theological perspective. The problem is that if 'religious experience' if merely a cultural way of making sense of an experience that does not point to anything outside the world (as a constructivist holds), then the reality of divine grace is denied. It can no longer be said that God works through human prayer (for example) to bring about the person's spiritual growth, but just that the person and their community makes sense of certain experiences (such as change following prayer) by speaking of divine grace. This is an unacceptable conclusion from a Christian theological perspective.

Model 3: the mental openness view

William James, the grandfather of current philosophical debates about psychopathology and religious experience, seems to me to suggest a mental openness account in his *Varieties of Religious Experience*. James recounts the case of George Fox, the founder of the Quakers, who, visiting Lichfield, hears the word of the Lord telling him to cry out in the streets, 'Woe to the bloody city of Lichfield'. At the same time, it seemed to Fox as though there were channels of blood running down the street in Lichfield, and that the market-place was a pool of blood. Following this episode, Fox learned of the martyrdoms that took place in Lichfield following the Diocletian persecution, and interpreted what he saw and heard as referring to these (2004, 20 – 21).

James seeks to find a middle ground between writing Fox off merely as psychopathological, and simply dismissing the obvious parallels to aspects of psychopathology such as hallucinations. In order to do this, James suggests that Fox was both

a great spiritual figure (where this includes genuine religious and spiritual insight), and also that he was also psychopathological. He says:

> No one can pretend for a moment that in point of spiritual sagacity and capacity, Fox's mind was unsound.[….] Yet from the point of view of his nervous constitution, Fox was a psychopath or *détraqué* of the deepest dye' (2004, 19 – 20).

This theme – that great spiritual figures are particularly prone to the mental instability that we find in psychopathology, is something we find throughout *The Varieties;* later on James writes:

> The whole array of Christian saints and heresiarchs, including the greatest […] had their visions, voices, rapt conditions, guiding impressions, and 'openings'. They had these things because they had exalted sensibility, and to such things persons of exalted sensibility are liable. (2004, 412)

To be a great spiritual figure, then, according to James, involves (or usually involves) having a certain kind of sensibility that gives rise to mental instability, including the mental instability we find in psychopathology. Furthermore, great spiritual figures may themselves be psychopathological – but this fact does not detract from the fact that they are great spiritual figures, where this includes having genuine religious experiences and spiritual insight. James finds support for his view in the contemporary literature on the relationship between genius and psychopathology, according to which, 'as a general rule, the greater the genius, the greater the unsoundness' (James, 2004, 27, citing Nisbet, 1893, xxiv), and extends this thought to include the idea of the (mad) 'religious genius'. While it is tempting to regard mental instability as a sign that the person's religious experience is not genuine, James argues instead that the key factor in whether someone is a religious genius (who has genuine religious experience and insight) lies in the theology their experiences give rise to. For example, of St Teresa of Avila he writes:

> *Immediate luminousness,* in short, *philosophical reasonableness,* and *moral helpfulness* are the only available criteria. Saint Teresa might have had the nervous system of the placidest cow, and it would not now save her theology, if the trial of the theology by these other tests should show it to be contemptible. And conversely if her theology can stand these other tests, it will make no difference how hysterical or nervously off balance Saint Teresa may have been when she was with us here below' (James, 2004, 28).

What should we make of the mental openness view? One criticism of it is that, if it were true, we would expect there to be evidence for it but there is less evidence for it than we might think from reading James. In particular, I suggest, certain famous figures in the Christian tradition have become associated with hallucination-like experiences (for example, with having sensory visions and voice-hearing) where this association is unwarranted. This is due in part to a hasty and ahistorical reading of historical texts. I will take as my example here the (just-mentioned) case of St Teresa of Avila, though I think it highly likely that other historical figures (such as George Fox) have also been misread and misrepresented in this way.[6]

When we come to read St Teresa, it turns out that she is clear that the experiences of visions and voices she describes are not sensory: she does not hear voices auditorally, or hear see visions in a corporeal way. In relation to visions, she explicitly says ''The words are very explicit but are not heard with the bodily ears' (*Life* 25.1). In relation to her visions, she says, 'I never saw this vision – nor any other – with my bodily eyes' (*Life* 28.4). In other words, St Teresa distinguishes her visions and locutions from those we would now regard as hallucinatory or hallucination-like, since (she emphasises) they are not experienced as though they are sensory.

For modern readers, this raises the obvious question, what does she mean by 'voices' and 'visions' if she does not mean the hallucinatory (or hallucination-like) experiences associated with psychosis and psychopathology? To understand why St Teresa uses (to us) misleading terms like 'voices' and 'visions' we need to go back to the fourth century St Augustine of Hippo, whose taxonomy of visions influenced how later religious people (including St Teresa) used the language of visions, and also voices. Of seeing visions, St Augustine says:

> One way is through the eyes by which the letters are seen; the second is through the human spirit by which we think about our neighbour, even when absent; the third is through a mental gaze by means of which love is beheld in an intellectual way. (*Gn. litt.* 12.6.15).

Visions, then, might be corporeal (experienced in a sensory way), or else they might be spiritual (in today's language, imaginative in the sense of involving mental images), or else they might be intellectual (in our language, conceptual). Each of these kinds of language might be caused by God ('supernatural'), or else come from our own minds ('natural'). Thus,

[6] Thanks to Rachel Muers for a discussion about this.

a natural spiritual vision, for example, might be one in which someone imagines, perhaps for devotional purposes, being visible at the crucifixion, including the sights and sounds that that might include. A supernatural spiritual vision, on the other hand, is one in which this image is given in the person's mind by God, rather than produced by the person's imagination. The experiences St Teresa describes are thought to be supernatural (they come from God) but they are not corporeal: they are spiritual and intellectual in nature.

In addition, Teresa is cautious of corporeal visions and locutions, and suspicious of reports of them. For instance, in her *Life,* in addition to emphasising that she did herself not experience corporeal locutions and visions, Teresa advises caution when people claim to have corporeal locutions, since she thinks people who want to claim falsely (to themselves and/or to others) to have had divine communications will claim this kind of locution *(Life* 25.9). In *The Interior Castle,* Teresa raises the possibility that a locution could be illusory, and that the illusion may be connected to (what we would now call) mental illness: 'Sometimes, and often, the locution can be an illusion, especially in persons with a weak imagination or in those who are melancholic, I mean who suffer noticeably from melancholy' (*IC* 6.3.1).

Teresa advocates a compassionate approach to people who suffer from melancholy and claim to have supernatural locutions: the spiritual advisor should not do anything 'that is distressing or disturbing to a soul, because truly the soul can't help it if these locutions come' (*IC* 6.3.3). This compassionate approach includes not putting too much emphasis on the experiences or making a big deal about them. In one intriguing and important passage, she writes:

> In my opinion no attention should be paid to these […] persons [who claim corporeal locutions] even if they say they see and hear and understand. But neither should one disturb these persons by telling them their locutions come from the devil; one must listen to them as sick persons. The prioress or confessor to whom they relate their locutions should tell them to pay no attention to such experiences, that these locutions are not essential to the service of God, and that the devil has deceived many by such means, even though this particular person, perhaps, may not be suffering such deception. This counsel should be given so as not to aggravate the melancholy, for if they tell her the locution is due to melancholy, there will be no end of the matter; she will swear that she sees and hears, for it seems to her that she does. (*IC* 6.3.2)

Even if the locutions are in fact from God, this cautious approach is to be preferred, since 'a person even grows when tested' (*IC* 6.3.3). Therefore, whether they are from God or not, it is best to put little emphasis on extraordinary experiences such as corporeal locutions. This is partly because extraordinary experiences such as corporeal locutions (and visions) can be an aspect of mental disorder, and partly because they can result in pride, which is deleterious to the spiritual life.

In this section I have tried to show that the idea that the Christian tradition is full of 'mad religious geniuses' who have dramatic, hallucination-like visions and who hear voices, is based on a misreading of some historical texts, taking as my case study the case of St Teresa of Avila. Showing this in relation to other important spiritual figures is beyond the scope of this paper but I think there is at least some evidence that a similar case could be made in relation to other figures (see Cook, 2019; 2023). What I hope I have shown is that the evidence base for the 'mental openness' view is not as solid as James and others think. This does not mean it should be rejected as a possibility, but rather than there is not yet enough evidence for it to affirm it.

Model 4: the honeysuckle on a broken fence view

According to the 'honeysuckle on a broken fence' view, an experience of mental illness could give rise to a genuine religious experience, even if the religiously-inflected aspects of the experience (such as religiously-inflected hallucinations) are not themselves genuine religious experiences. This has at least some support in psychology in that according to post-traumatic growth literature, there is some reason to think that 'brokenness' itself can constitute fertile ground for personal, including spiritual, growth. Thus, for example, psychologists Tedeschi and Calhoun evaluate whether and to what extent someone has undergone growth after trauma on the basis of five criteria: their appreciation of life; relationship with others; new possibilities in life; personal strength; and, importantly for this discussion, spiritual change (Tedeschi and Calhoun, 1996). Experience of severe mental illness involving psychosis is a significant cause of trauma, and preliminary studies suggest that people who have experienced severe mental illness involving psychosis can experience post-traumatic growth, and that post-traumatic growth is mediated in part by meaning-making (Mazor, Gelkopf and Roe, 2018).

The psychological literature on post-traumatic growth therefore indicates spiritual change is possible as a result of severe mental illness such as psychosis. However, it does not tell us whether a person's religious experience is *genuine* – something beyond the remit of psychology – but only whether it is spiritually *salutary.* We need to turn to theology to consider whether such an experience might also be genuine.

While Model 1 and 2 rely on the theologically-problematic idea that either suffering is good or else that God creates or causes evil, Model 4 appeals to idea that God brings good out of evil, which is central to the Christian tradition. For example, the ancient Christian theme of *felix culpa* holds that sin is both an evil in itself, and also something through which God works in order to bring about an even greater good (namely, the incarnation). Rather than conflating good and evil, this motif shows that God is ultimately victorious over evil, and that God also uses evil precisely to bring that victory about (see Augustine, *Enchiridion* 3.11). Another example of this is Christ's crucifixion and resurrection. The crucifixion is rightly regarded as an evil: the torture and execution of a human being which (furthermore) was the result of political expediency and concern to preserve the status of the powerful – in short, as a result of human sin. The resurrection both brings about and also shows us God's victory over the forces of evil. As the theologian Edward Schillebeeckx puts it, 'Human beings, not God, prepared the cross for Jesus – though God did not allow himself to be checkmated by this' (Schillebeeckx, 2014, 32). Evil, then, remains evil, but (according to the Christian tradition) God uses it to bring about a greater good.

Proponents of Model 4 view would regard psychopathology, something that involves suffering and dysfunction, as an evil, rather than something caused or created by God. Nevertheless, they might think that God can bring something good out of it. Indeed, drawing on the post-traumatic growth literature, they may think there is something about brokenness itself that is particularly conducive to spiritual growth, which includes genuine experience of God. This is a theme that is found in Christian spiritual autobiographies of mental disorder. For example, Catholic priest and psychologist Henri Nouwen talks about how a period of depression ultimately became 'fertile ground for greater trust, stronger hope, and deeper love' (Nouwen, 2009, x – xi; see Scrutton, 2020, 133 - 158).

This analysis suggests that there are weak scientific reasons, and strong theological reasons, for preferring Model 4. In so doing, it affirms one version of a both-and account of psychopathology and religious experience. The narrative Model 4 suggests for cases like

Abeo's is that a period of mental disorder involving psychosis should not be understood as resulting from an extraordinary encounter with God. However, it might be that Abeo's experience of illness could go on to bring her closer to God – and thus may become part of a genuine religious experience. Abeo believed her religious experience lay in genuinely hearing the voice of God, and it is tempting to make this the focus of discussions about this topic. However, according to Model 4, Abeo was probably mistaken about this, though she wasn't mistaken about the fact that God was indeed communicating with her.

A couple of characteristics of Model 4 are worth noting. First, Model 4 is applied here to mental illness, but it could be applied just as much to other events in life that involve suffering, such as a significant physical illness or a relationship break-up or the loss of one's job. According to Model 4, religious experience is related to psychopathology, but it is not especially related to it. That this is the case does not seem to me to suggest that Model 4 is merely an account of how a person with the right sort of inclination will draw spiritual meaning from their experience, since divine grace as well as a cooperative human response to that grace is a core part of the theological account being given here.[7] Furthermore, that Model 4 does not relate exclusively to experiences of psychopathology seems like a strength of the model to me, because it avoids the exoticisation of mental illness as somehow especially related to a 'spiritual realm'.

Second, Model 4 affirms that a person's experience may be both a mental illness and also a religious experience in a diachronic and holistic sense: the experience of God happens amid the storm of the illness itself, and also in the process of healing and reflection. In this Model 4 contrasts with Model 2 in particular, where the focus is on a specific part of the person's experience (such as their perception that they are hearing God's voice) and at a particular point in time. It does not seem that this negates Model 4's place among both-and accounts, though it does seem that, if we hold Model 4, we need to consider human experiences 'in the round'.[8] Again, this seems like an advantage to me, since humans are holistic and diachronic (different aspects of our lives relate to one another, at any given moment and also over time), and Model 4 reflects this.

Conclusion

[7] Thanks to an anonymous peer reviewer for this question.
[8] Again, thanks to a peer reviewer for this point.

I have argued that a both-and account is plausible, and that there is reason to prefer Model 4 to Models 1, 2 and 3. In so doing, I have affirmed a both-and approach to psychopathology and religious experience, but quite a cautious and understated one: I have argued against the idea that psychopathology is an offshoot of, identical with, or a side effect of genuine religious experience, and argued only that a person can come to know and experience God through the experience of psychopathology. This, I suggest, is not because there is anything especially religiously significant about psychopathology, but just because God communicates through human experience, including human experiences of suffering (see Scrutton, 2020).

From a pastoral perspective, my argument suggests that, while we might initially think the religiously significant aspect of a person like Abeo's experience lies in the voices they report hearing, in fact it may lie in less striking aspects of their experience (such as their sense that their life, perhaps in spite of not being conventionally successful, has meaning and significance in the eyes of God). From a clinical perspective, my argument suggests that psychiatrists need not choose between something being psychopathological or a religious experience; both may be the case. As a result, both medication and also spiritual guidance (by someone with a pastoral role) may be appropriate. To this, it might be pointed out that some people might not want medication because they fear they would lose experiences they regard as highly religiously significant. It is a matter of practical wisdom to know when medicalising someone involuntarily is necessary, given that submitting someone to something involuntarily can itself can be injurious. While the question of involuntary treatment lies outside the scope of this paper, two points are worth noting, which might incline a patient to accept voluntary treatment. First, the person would still have the memory of these experiences. If these experiences were genuinely from God, they would (according to the tradition I have been considering) continue to bear fruit if reflected upon with humility and spiritual wisdom. Second, while the dilemma is not one that St Teresa (who lived before the existence of anti-psychotic medicines) considers, she counselled strongly against people relying too heavily on extraordinary experiences (whether or not these are from God), at the expense of cultivating more ordinary, deeply valuable spiritual virtues and practices. Medical treatment, then, may, on this view, help people to discern whether their experiences are indeed from God, reap the spiritual benefits from them, and provide them with the space to cultivate the virtues and practices that are at least equally a part of the spiritual life.

A final pair of questions, which I can only touch on here, relates to what the relevance of my argument, which relies heavily on Christian theology, is for i) a secular practice such

as psychiatry, and ii) for people within religious traditions other than Christianity. Regarding i), my view is that theological criteria properly have no authority for psychiatry. However, it may be that the practical dimension of the view I have put forward is worth considering for psychiatrists (and also psychologists) for non-theological reasons. In other words, it may be that considering the possibility of both treating someone medically and also giving them access to religious and spiritual forms of support is beneficial, even if the theological underpinnings (e.g. the existence of a God) do not in fact obtain.

Regarding ii), it is likewise the case that Christian theological criteria are not authoritative for non-Christian traditions, and there may also be resources within other traditions that suggest a different (or perhaps a similar) view. In my view, an ideal way forward would be for religious traditions – and especially the Abrahamic traditions, which share belief in the same God – to consider the question of what the relationship between psychopathology and religious experience looks like with reference to their own traditions, and then in respectful dialogue with one another. Religious traditions are not hermetically sealed but have historically learned much from one another; my suspicion is that they could do so again in relation to this question.

Bibliography

Augustine of Hippo. (2006). *Literal Commentary on Genesis.* In B. McGinn (ed. And trans.), *The Essential Writings of Christian Mysticism.* New York: Random House, 321 – 323

Augustine of Hippo. (1955). *Enchiridion on Faith, Hope and Love.* Trans. and ed. A.C.Outler. Available at St. Augustine, Enchiridion: On Faith, Hope, and Love (1955). English translation (tertullian.org). Accessed on 19th December 2022

Aquinas, T. (2016). *Summa Theologiae.* Trans. By Fathers of the English Dominican Province. Cambridge: Cambridge University Press. (STh)

Bortolotti, Lisa. (2020). *The Epistemic Innocence of Irrational Beliefs.* Oxford: Oxford University Press

Chappell, Zsuzsanna. (Forthcoming). In defence of the concept of mental illness. In *Lived Experience and Co-production in Philosophy of Psychiatry, Clinical Practice and Mental Health Research. Royal Institute of Philosophy Supplement.* Vol. 94. Ed. Anna Bergqvist, David Crepaz-Keay, Alana Wilde

Cook, C.C.H. (2019). *Hearing Voices, Demonic and Divine: Scientific and Theological Perspectives.* London: Routledge

Cook, C.C.H. (2023). *Hearing Spiritual Voices: Medieval Mystics, Meaning, and Psychiatry.* London: T&T Clark

Hopkins, B., and Battin, M.P. (2004). Religion. In J. Radden, (ed.), *The Philosophy of Psychiatry: A Companion.* Oxford: Oxford University Press, 312 – 326

Jackson, M. (2007). The clinician's illusion and benign psychosis. *Reconceiving Schizophrenia.* Ed. Chung, Man Cheung, Fulford, K.W.M., and Graham, George. Oxford: Oxford University Press

James, W. (2004). *The Varieties of Religious Experience.* New York: Barnes and Nobel Classics

Luhrmann, T.M. (2012). *When God Talks Back.* New York: Knopf

May, G. (2004). *The Dark Night of the Soul: A Psychiatrist Explores the Connection between Darkness and Spiritual Growth.* New York: Harper Collins

Mazor, Y., Gelkopf M., Roe D. (2018). Posttraumatic growth among people with serious mental illness, psychosis and posttraumatic stress symptoms. *Comprehensive Psychiatry* 81, 1-9

McCabe, H. (1987). *God Matters.* London: Geoffrey Chapman

Menezes, A. and Almeida-Moreira, A. (2009.) Differential diagnosis between spiritual experiences and mental disorders of religious content. *Archives of Clinical Psychiatry* 36, 75–82

Nouwen, H. (2009). *The Inner Voice of Love: A Journey through Anguish to Freedom.* London: Darton, Longman and Todd.

Otto, R. (1950/1923). *The Idea of the Holy (Das Heilige).* Trans. J. W. Harvey. Oxford: Oxford University Press

Rashed, M.A. 2019. *Madness and the Demand for Recognition: A Philosophical Inquiry into Identity and Mental Health Activism.* Oxford: Oxford University Press

Rashed, M.A. Unpublished paper. What is the distinction between religious experience and psychopathology really about, and does it matter who is trying to make it? Presented at the University of Leeds, 28th July 2023

Schillebeeckx, E. (2014). *The Collected Works of Edward Schillebeeckx, Vol. 10: Church. The Human Story of God.* London: Bloomsbury T&T Clark

Scrutton, T. (2020). *Christianity and Depression: Interpretation, Meaning, and the Shaping of Experience.* London: SCM Press

Tedeschi, R.G. and Calhoun, L. (2004.) Posttraumatic growth: a new perspective on psychotraumatology. *Psychiatric Times* 2, 58–60

Teresa of Avila. (2020). *The Interior Castle,* trans. K. Kavanaugh OCD and O. Rodriguez OCD. (2nd ed.). Washington DC: ICS Publications

Teresa of Avila. (1987). *The Book of Her Life,* in *The Collected Works of Saint Teresa of Avila Volume One.* Trans. K. Kavanaugh OCD and O. Rodriguez OCD. (2nd ed.). Washington DC: ICS Publications

Underhill, E. (2020). *Mysticism: A Study in Nature and Development of Spiritual Consciousness.* Digireads

Williams, S.T. (2014). Illness narrative, depression and sainthood: An analysis of the writings of Mother Teresa. *Journal of Religion and Health* 53, 290 – 297.

Wittgenstein, Ludwig. (1986 [1953]). *Philosophical Investigations.* Trans. G.E.M. Anscombe. Oxford: Basil Blackwell, available at https://static1.squarespace.com/static/54889e73e4b0a2c1f9891289/t/564b61a4e4b04eca59c4d232/1447780772744/Ludwig.Wittgenstein.-.Philosophical.Investigations.pdf

X, 2016, details omitted to retain author anonymity

X, 2018, details omitted to retain author anonymity