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DOSSIER

Can jinn be a tonic? The therapeutic value of spirit-related beliefs, practices and experiences

O jinn pode ser um tônico? O valor terapêutico das crenças, práticas e experiências relacionadas ao espírito

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ABSTRACT

Religion and spirituality are increasingly associated with mental health, yet spirit-related practices, beliefs and experiences (SPBEs) are regarded with more suspicion. This suspicion is misplaced, and worryingly so, since, I argue, it shuts down a potentially therapeutic avenue in relation to anomalous experiences such as hearing voices and sensing the presence of the dead. A presupposition of this argument is that anomalous experiences are not inherently pathological but can become so as a result of the way they are interpreted and reacted to. While this claim is not new in itself, I will provide a philosophical foundation for it by defending a 'contextualist' view of pathology in the context of anomalous experiences against 'inherentist' alternatives, according to which some or all instances of anomalous experiences are inherently pathological.

Keywords: religion, spirituality, auditory hallucinations, psychosis, pathology, mediumship, schizophrenia, hearing voices, mediumship, spirit possession, healing rituals.

RESUMO

A religião e a espiritualidade são cada vez mais associadas a ganhos em saúde mental. No entanto, práticas, crenças e experiências espirituais são vistas com suspeita. Esta suspeita é preocupantemente errônea visto que ela interrompe uma via potencialmente terapêutica com relação a experiências anômalas, como ouvir vozes e sentir a presença dos mortos. Uma pressuposição do meu argumento é que experiências anômalas não são inerentemente patológicas mas podem tornar-se patológicas como resultado do modo como são interpretadas e como se reage a elas. Apesar de essa reivindicação não ser inovadora em si, forneço uma fundação filosófica para ela ao defender uma visão "contextualista" da patologia no contexto de experiências anômalas contra alternativas "inerentistas" de acordo com as quais há instâncias de experiências anômalas que são inerentemente patológicas.

Palavras-chave: religião, espiritualidade, alucinações auditivas, psicose, patologia, mediunidade, esquizofrenia, audição de vozes, mediunidade, posse de espírito, rituais de cura.

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Introduction

While psychiatry has historically been antithetical to religion, numerous empirical studies over the last two decades have suggested that religion and spirituality are positively associated with mental health. While separating cause from correlation is fraught with difficulties, there are indications that the relationship is in part causal: that religion and spirituality act as buffers during times of crisis and promote adaptive coping behaviours, giving rise to better mental health outcomes (Koenig *et al.*, 2013).

Against this general trend, spirit-related practices, beliefs and experiences (henceforth SPBEs) are often regarded less positively, both in this literature, and by western society more generally. Relatedly, anomalous experiences such as hearing voices without an external physical stimulus, or sensing the presence of the dead, have historically and in other cultures been made sense of in relation to SPBEs (e.g. mediumship, ancestor veneration, and communication with spirit-guides). These are now instead frequently described in terms of psychosis and regarded as symptoms of pathology.

This paper will argue that the tendency to regard SPBEs negatively is problematic for both intellectual and practical reasons. It is *intellectually* problematic because it treats as homogenous a broad range of beliefs, practices and experiences. This has a range of causes including absence of familiarity, suspicion born of one-sided media portrayals, and cultural assumptions about what kinds of beliefs are intellectually acceptable, the roots of which include colonial and Enlightenment supremacist myths.

The tendency to regard SPBEs negatively is *practically* problematic because some SPBEs are therapeutic in relation to anomalous experiences, and so, by discouraging people from making sense of their experiences in these terms, negative assumptions shut down potentially therapeutic avenues. That some SPBEs can be therapeutic is indicated in part by recent psychological studies which pinpoint responsive and contextual factors associated with whether or not an anomalous experience is interpreted as pathological (and treated in a clinical context). The responsive and contextual factors associated with non-pathological outcomes are common characteristics of some SPBEs, and so there is reason to suppose that some SPBEs are therapeutic in relation to anomalous experiences.

A presupposition of my use of these psychological studies (and, in some cases, of these studies themselves) is a 'contextualist' view of pathology in the context of anomalous experiences – that is, that anomalous experiences are pathologically indeterminate, and that pathology is something that can emerge during the process of reception and interpretation of an anomalous experience, rather than being inherent in and necessary to the anomalous experience itself. Having given an overview of the psychological studies, I will support the contextualist view by arguing against two alternative inherentist explanations of the findings: (i) that the responsive and contextual factors mean the person remains undiagnosed, as distinct from non-pathological; and (ii) that the responsive and contextual factors are correlates, rather than causes, of inherently pathological and inherently non-pathological states. The former more commonly involves the idea that all anomalous experiences are inherently pathological, while the latter often involves the idea that some anomalous experiences are inherently pathological, and others inherently spiritual or mystical. In arguing against these inherentist explanations for the similarities and differences between pathological and non-pathological anomalous experiences, I will provide a philosophical basis for the contextualist claims found in my own and other discussions of anomalous experiences.

Terms and methodology

SPBEs is the term I will give to a broad range of practices, beliefs and experiences in which the concept of spirits plays a central part. These include spirit possession, both as this occurs voluntarily, as in the cases of mediumship, and involuntarily, as when a cure is sought through a healing ritual. In addition to possession, SPBEs include a broader range of beliefs and practices, such as conversations and receiving help from spirit-guides. 'Spirits' may refer to a range of entities including the earth, animals and trees, where these are related to in particular ways (as in some forms of animism), essentially spiritual non-physical entities (such as orixas and angels), biological and spiritual ancestors (as in the cases of ancestor veneration and the cult of saints), and family and friends who have died but who continue to interact with the human world.

As these examples show, both 'SPBEs' and 'spirits' are broad terms. They are also vague – for example, we could ponder whether Sue's assertion that she believes in ghosts, or Fred's claim to have been filled with the Holy Spirit, constitute SPBEs or have spirits as their objects. Concerns might reasonably be voiced about whether, given this, 'SPBE' and 'spirits' are in fact helpful terms (see Harvey, 2010, p. 28). I think they are, partly because 'spirits' is a term in common usage, and changing the connotations of words is usually more effective than creating new ones, but also because broadness and vagueness are advantages as well as disadvantages since they enable discussion of a wide-range of beliefs, practices and experiences. While using broad terms could tempt us generalise about these, recognising that they are broad is a crucial antidote to this because it encourages us to analyse individual practices, beliefs and experiences on a case-by-case basis, and not to extrapolate from one form of SPBE to another – one of the concerns at the heart of the paper.

'Anomalous experience' is also both broad and vague. It is an attempt to give a name to experiences described in psychiatry in terms of hallucination and psychosis, and in some religious traditions in terms of mystical or spiritual experience, without presupposing either pathology (on the one hand) or spiritual value (on the other). Of particular relevance to this

paper are hearing voices without external stimuli (henceforth just 'hearing voices'), and sensing the presence of the dead. The latter may involve hearing, seeing, smelling or feeling the touch of someone who has died, or may simply involve a feeling that they are present without any physical sensory experience. Other terms attempting to be neutral that are sometimes given to these experiences in the context of discussions of spirituality and psychosis include 'psychotic-like experiences' and 'out of the ordinary experiences'. I prefer 'anomalous experiences' because 'psychotic-like' suggests that they are similar to psychosis but may in fact be inherently different in origin and potential, which is a conclusion I want to resist. 'Out of the ordinary' is better, but cumbersome, and it can also obscure the fact that some people, communities and cultures regard the experiences as quite ordinary. 'Anomalous' is far from ideal, since it seems to indicate that the experience doesn't fit easily into our worldview, and this prioritises worldviews in which spirits do not play a significant part over those in which they do. However, I haven't yet found a better alternative. Not all people involved in SPBEs have anomalous experiences, and not all people who have anomalous experiences interpret them in terms of SPBEs. It is sufficient for this paper that some people, communities and cultures who have anomalous experiences make sense of them in terms of anomalous experiences, and that anomalous experiences are given a radically different interpretation and reception in these communities and cultures than they are by mainstream western society.

While there is no necessary relationship between contextualism and the idea that religious categories (e.g. SPBEs, spirit possession, religious experience, religion and spirituality) and psychiatric categories (e.g. pathology, psychosis, schizophrenia, mental disorder) are social kinds, it is difficult to speak of such categories without implying that they are either social or else (essentialist) natural kinds, and I will presuppose that they are social ones. This is because 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 some unsubstantiated essentialist conclusions (see Littlewood, 1997, p. 67; Dein, 2010). I will also presuppose that, far from entailing truth relativism, we can undertake both descriptive and analytical projects with respect to social kinds (see Haslanger, 2012, p. 222-224). In the context of this paper, the central descriptive project involves inquiring into whether pathology is contextual or inherent – in other words, whether the language of pathology tracks characteristics that are essential to certain experiences, or develop as a result of responsive and contextual factors. The central analytical project involves an evaluation of both religious and psychiatric ways of making sense of certain experiences, not in terms of an absolute culturally and historically objective truth, but in terms of intellectual and practical merit; or in Haslanger's terms, by whether they serve cognitive and practical purposes (2012, p. 223). Intellectual or cognitive merits relevant to this discussion include coherence, fidelity to experience, simplicity, and intuitive plausibility, while practical ones include helpfulness and therapeutic potential.

Negative perceptions of SPBEs in the West

In the West, SPBEs are fraught with a variety of negative associations. For example, they are sometimes associated with the exploitation of the vulnerable by fraudulent practitioners (Loewenthal, 2007, p. 28). Because of their association with anomalous experiences and therefore psychosis, engaging in spirit practices is also sometimes seen as a symptom of pathology. As Stanley Krippner remarks, "It should come as no surprise that professional 'mediums' and 'channelers' in western societies often disguise or hide their activities for fear that the wider public will brand them as mentally ill" (Krippner, 2007, p. 24). It is also usually presupposed that the experience of spirit possession is negative in the sense of distressing and undesirable, as in the depiction in *The Exorcist*. As Bettina Schmidt and Lucy Huskinson put it, "More often than not western interpretations of spirit possession have focused on those instances that imply pain and torment [...] and not on those instances that imply joy and healing, or [...] creativity and comedy" (Schmidt and Huskinson, 2010, p. 7-8). Media portrayals tend to emphasise cases in which spirit-related practices do serious harm to those being practiced upon, as in the case of the Romanian nun Irena Cornici whose alleged 'exorcism' involved her torture and subsequent death by her religious community (BBC, 2005). Such cases are highlighted in the News, while positive experiences remain relatively unknown. In addition to these, while speculation about, for example, ghosts and the paranormal are often the object of informal conversations, belief in spirits is often regarded as not really intellectually respectable or inappropriate in the context of formal academic discourse.

Various genealogies of negative perceptions of SPBEs could be traced. One includes the perspectives of early anthropologists who set the groundwork for later views of SPBEs (see Schmidt and Huskinson, 2010, p. 1-15). For example, in 1692, the Dutch explorer Nicolaes Witsen published the earliest known depiction of a Siberian shaman, which he entitled 'Priest of the Devil' (Harvey, 2010, p. 24-26). This depiction is typical of historical modern western mainstream perceptions of SPBEs in (at least) three respects. Coming from a certain kind of Christian context, it assumes (in this case erroneously) that spirits are evil, and associates spirit-related practices with the demonic. Taking place against the backdrop of European colonialism and, in particular, a slave trade European culture was keen to justify, beliefs of other cultures are portrayed as, at best, primitive and inferior, and at worst pathogenic and exploitative, if not (as here) wholeheartedly diabolical. To remove someone from such a context is not, after all, to do them a disservice (see Johnson, 2011). In addi-

tion to Christian and white supremacist beliefs, the Enlightenment belief that 'objectivity' is the only authoritative perspective led to a dismissal of subjective or 'emic' perspectives about the nature of the experience, both at the expense of the phenomenology of the experience itself, and its meaning within the wider context of the experient's life.

These perspectives have had an abiding influence on mainstream interpretations of SPBEs. For example, the 'objective' perspective of the Enlightenment is evident in psychiatry's ongoing attempt to objectively assess and treat mental illness, which renders the perspectives and, in particular, religious and spiritual beliefs of patients, of secondary importance (Durà-Vilà *et al.*, 2011; Frank, 1997; Charon, 2008). In terms of persistent colonial attitudes, we might note the 1996 example of the seventy-year-old Native American woman who was diagnosed with, and hospitalised for, schizophrenia, on account of the fact that she answered affirmatively when a psychiatrist asked whether she heard voices when she was alone (Krippner, 2007). In fact, the woman was a Native American healer whose vocation involved listening to the earth's messages; had this been properly taken into account, such a diagnosis should not (by DSM-IV's own criteria) have been made. That an otherwise sane-seeming person might be diagnosed on the basis of this may seem surprising, but is less so once one takes into account the cognitive bias by which, as experiments suggest, the fact of voice hearing having been revealed, other aspects of a person's psychological history are judged (Rosenhan, 1973). This cognitive bias can ramify with pathologising presuppositions about certain forms of religious beliefs, and it is interesting for our discussion of SPBEs that studies suggest that it is unfamiliar religions, rather than familiar and mainstream but stigmatised religions (such as Islamic groups), that are most pathologised both within psychiatry and by the public (Judd and Vandenberg, 2014). Such factors can also intersect with sex and age biases to produce forms of epistemic injustice in relation to particular experiences (consider the diminutive connotations of the phrase 'little old lady'). Conscious or unconscious race, class, education and accent prejudices are also common (Fricker, 2007; Carel and Kidd, 2014), and it is not difficult to imagine these playing a part in such cases.

In addition to Enlightenment and colonial perspectives, due to unfamiliarity, mainstream Jewish and Christian beliefs are often projected onto other religious systems. Consider the following case:

> *Imebet is an Ethiopian immigrant to Israel with low mood. She had been given some antidepressants, but then frequently needed hospitalisation for severe head and abdominal pains. She said that these pains were caused by failing to receive her Zar and carry out his worship rituals appropriately. When she was able to do this, she felt euphoric, wonderful. […] Her children were being cared for in foster day care, since she was (according to the social worker) spending most of her time 'performing devil worship ceremonies and turning her apartment into a temple'* (in Loewenthal, 2007, p. 31).

In fact, while sometimes causing illness, Zar (a kind of jinn or spirit) are not considered diabolical, and Zar possession differs from other possession beliefs because the perceived solution is not to free the possessed person from the Zar, but to create an equilibrium such that the possessed person can live at peace with the possessor (Bilu, 2003, p. 353). Lack of familiarity with these beliefs means that SPBEs like Imebet's tend to have mainstream religious categories such as devil worship falsely imposed upon them.

Why negative perceptions of SPBEs are intellectually problematic

Negative perceptions of SPBEs are problematic for intellectual reasons, simply because they treat as homogeneous a diverse set of beliefs and practices. This homogenisation occurs in academic and mental health as well as popular discourse, often because of what is not said, rather than because of what is. This arises partly because empirical studies have a Christian (and Jewish), USA (and western Europe) bias in relation to mental health and religion. This is well-recognised by the researchers themselves; as Koenig *et al.* write:

> *More cross-sectional studies of the R/S [religion and spirituality] relationship are probably not needed. We now have hundreds of such studies, and resources should not be expended on discovering over and over again what is already known. This, however, does not apply to research in non-U.S. populations or in non-Christian populations where such studies are few in number or not yet done. Cross-sectional and qualitative studies are still needed in Jews, Muslims, Buddhists, Hindus, Chinese religions and New Age spiritual believers living in areas of the world where these faith traditions predominate, rather than in Western countries where they represent minorities in a largely Christian society (2013, p. 172).*

Hisham Abu-Raiya and Kenneth Pargament make a similar point when they say that one of the main limitations of the current literature on religion and wellbeing is that "the studies that have been conducted and the measures that have been developed have focused almost exclusively on Christian samples, and have been geared largely to members of Judeo-Christian traditions" and that "Further empirical studies are needed to reveal a clearer picture of the relationship between religion and health among different religious groups, especially non-Western religious traditions" (Abu-Raiya and

Pargament, 2012, p. 337; see also Loewenthal, 2007, p. 60; Dein, 2006; Pargament *et al.*, 2011, p. 68, 72).

This bias results in a negative portrayal of SPBEs in relation to mental health, and perhaps especially in relation to psychosis. For example, in a chapter on schizophrenia Kate Loewenthal argues that religious beliefs in general are not pathogenic, even though some religious experience shares some of the characteristics of psychosis, and people with psychotic symptoms may be attracted to religion (Loewenthal, 2007, p. 11-24). In her discussion of belief in spirits and spirit possession specifically, however, Loewenthal argues that, while belief in spirits and spirit possession do not necessarily cause schizophrenia, they are nevertheless terrifying for those who believe them, and are certainly likely to exacerbate existing psychiatric illness (Loewenthal, 2007, p. 32). No mention is made of beliefs in benevolent spirits or positive experiences of spirit possession. This is in spite of the fact that these too can involve (what are psychiatrically defined as) hallucinations, and would therefore seem to be relevant to a discussion of schizophrenia.

Loewenthal's point in relation to the potential for SPBEs to be harmful should not be underrated – for example, Wonder, a woman with bipolar disorder, relates going to a Charismatic Christian counsellor who told her that "she was filled with demons". She reports that she was "never able to get over that experience" and that when she had some psychotic symptoms the counsellor's words came back to her, causing her to feel guilt and dirtiness and to see "demons all around" (Wonder, 2006). The horrendous effects of this kind of approach need to be not overlooked – but we also need to balance this with a recognition that (as I will now argue) other SPBEs include beliefs in non-evil spirits and positive experiences of spirit possession, and these can have a rather different relationship with mental health.

Not all SPBEs are like the SPBEs discussed by the religion and mental health literature. For instance, some SPBEs in Brazil are heavily influenced by Kardecist Spiritism, which often involves the idea that no spirits are evil, though some may have bad intentions (Cavalcanti, 1983, p. 39; Dawson, 2013). To give one example, Umbanda communities typically believe in two kinds of spirit who possess. First, spirit-guides, who include indigenous people, the spirits of African slaves, and the spirits of children, who are at a more advanced stage of spiritual development than humans (and thus do not need to become incarnate), and who advance further spiritually by practising acts of charity, including possessing mediums in order to dispense advice. Second, 'suffering spirits'. These include dead people who do not realise they have died, and accidentally possess humans in order to obtain the energy they get from food and drink, as well as spirits who know they have died, and possess deliberately because they are still attached to the earthly plane. Suffering spirits may also include malign spirits who are vengeful on account of a (real or perceived) grievance caused by the human in a previous life. While in Brazil at the time of writing this paper, Umbanda members mentioned these spirits when I asked whether any spirits were ever evil, and one member replied "maybe not evil, but just because people are dead, it doesn't stop them from being complicated".

Another Brazilian Spiritist tradition, Santo Daime, has been influenced not only by African traditions but also the New Age movement, and so in some communities spirit-guides include Native American warriors, Celtic (including Arthurian and Druidic) figures, and animal spirits (Dawson, 2013, chapter 4, section 3). While Santo Daime and Umbanda are very different in many respects, both emphasise the idea of negative spirit possession being caused by suffering or disorientated spirits, rather than ones who are evil as such. As one medium explains:

> *Some people have spirits on them and don't know it. What shows is sickness, bad feelings and bad things. I had one recently which was the spirit of a young man who died in an accident… and in his confusion attached himself to me. It was not until I was in the work [i.e. ritual] that someone else identified what was going on and we could send him on his way (*in *Dawson, 2013, chapter 4, section 4).*

In Santo Daime, suffering spirits are thought to attach themselves "to the energy fields of the spiritually unwary, ill-prepared or careless human beings" (Dawson, 2013, chapter 4, section 3). Among other things, liberation from suffering spirits may involve voluntary possession into a trained medium's body or surrounding aura, in order to send the spirit on her or his way to the astral plane. This is described in both pedagogical and pastoral terms as 'instruction', 'indoctrination', 'calming', and 'reassuring' the spirit (Dawson, 2013, chapter 4, section 4). The practice of mediumship is seen as a charitable practice (both towards the suffering spirit and the possessed human being), and earns the medium cosmic merit (or good karma). These provide a clear counter-example to the idea that belief in spirits always refers to belief in evil spirits, and that spirit possession is always involuntary, undesirable and distressing – assumptions that are often an aspect of negative views of SPBEs. In these Spiritist traditions, spirits are usually not evil, and even when they are malign, they tend to be understood as analogous to vengeful humans in need of discipline and, at times, charity, rather than demonic.

Furthermore, 'spirit possession' can refer not only to possession by unhappy and vengeful spirits, but also to benevolent spirit-guides possessing mediums: this is perceived as a gift, part of an ongoing positive relationship with the spirit, and desirable within a ritual context. This, too, is linked to illness and health in what seems at least to be a potentially therapeutic way. In some Afro-Brazilian religions such as Camdomblé and Umbanda, people often decide to train as possession mediums in response to experiences of mental distress that would have been diagnosed as depression, anxiety

or psychosis in other contexts (Seligman, 2014). As Rebecca Seligman explains, "Affliction or illness frequently acts as the "door" or entry point to Candomblé mediumship" (Seligman, 2014, p. 69). As Seligman's study shows, following initiation, possession mediums tend to say that their health, and especially their mental health, improved.

Thus, it seems there is some reason to think that spirit-related practices such as possession mediumship may have the potential to be therapeutic. While this is the case, the ways in which these traditions may and may not be therapeutic is more complex than this. Recovery in the straightforward clinical sense of a return to the state before illness is not usually the primary goal of religious traditions, and to interpret them in this way would be reductive and would impose the dominant western medical paradigm on them. Thus, these religious traditions need to be understood in terms of their therapeutic potential, which may go beyond clinical outcomes to include a new and transformed state of being. As William James puts it in the context of melancholy, people who 'find their way out,' often by religious means, may experience not a 'reversion to natural health,' but 'a deeper kind of consciousness than [...they] could enjoy before' (James, 2002, p. 156). This is significant for possession mediums, for example, whose experiences include not only the alleviation or transformation of particular experiences, but also a new and meaningful ministry in which they use their mediumship to help others.

While James seems to have an interior spiritual state in mind, we should not exclude the possibility that the transformation will also have an interpersonal, social or even economic character. This can be the case particularly where religious experiences and consequent roles serve to empower a person who has previously not been considered important within their society, often because of social injustices on account of their sex/gender and/or socio-economic class. *Camdomblé* possession mediums, who are often from very low socio-economic status backgrounds, frequently experience a positive reinterpretation of the self, access to power and respect, and access to economic means that (due to class and gender issues) are not available through mainstream economic networks (Seligman, 2005, p. 86). Likewise, Frederick Smith relates the case of an Indian woman who experienced ongoing bad fortune which she attributed to a spirit that had attached itself to her. Following spiritual treatment, things not only got better for her: the experience also gave rise to transformation in the form of psychic power and spiritual authority (Smith, 2011, p. 3-17). Therefore, the 'negative' possession experience was evaluated positively when perceived diachronically, because it gave rise to personal and social kinds of growth that would not be possible without it.

As this indicates, some SPBEs have therapeutic potential. In order to appreciate this fully we need not only apply a clinical understanding of what is 'therapeutic' to particular situations, though I do not think we should jettison this altogether. In addition to this, we need to take into account the tradition's understanding of therapeutic concepts (for example, healing, salvation, redemption), and also look at the broader social consequences of the SPBEs. To this latter idea, it might be argued that such social and economic concerns are irrelevant to therapeutic (clinical and spiritual) ones. However, to dismiss such social transformation as of secondary importance to spiritual and personal transformation, or to regard it as irrelevant to clinical and therapeutic concerns, overlooks the fact that people are socially and interpersonally constituted, and ignores the social and political dimensions of experiences of mental distress that psychiatry seeks to alleviate.

Why are negative perceptions of SPBEs practically problematic?

I will now turn to the idea that negative perceptions of SPBEs are also problematic for practical reasons. This, I argue, is because, while the bias in religion and mental health studies towards Christianity and Judaism in the USA and western European means that we have limited evidence about the relationship between other forms of SPBEs and mental health, some emerging psychology research suggests that the characteristics we find in some SPBEs are therapeutic, contributing to anomalous experiences becoming less pathological or not pathological at all. It may seem odd to talk about anomalous experiences such as auditory hallucinations being 'non-pathological,' so I will begin by explaining what is meant by 'pathology,' and why it is possible for auditory hallucinations to be (in and of themselves) non-pathological. Drawing on the psychological studies, I will then discuss five responsive and contextual factors which seem to influence the development of anomalous experiences positively, and which are suggestive of the therapeutic value of some SPBEs: (i) engaging with rather than suppressing or ignoring voices; (ii) believing that the voice or presence or spirit is benevolent, and/or having a healthy relationship with it; (iii) setting boundaries around when voices or spirits are communicated with; (iv) making sense of the experience in a positively meaningful rather than pathologising or problematising way; and (v) having the support of a community, some or all of whom share the experience, who validate it, and who (where relevant) provide practical support. As I will argue these studies indicate, some SPBEs provide helpful and therapeutic ways of interpreting certain experiences such as those frequently defined as pathological and psychotic by the western society. Following this, I will defend the idea that we should see these factors as having a *causal* relationship with psychological wellbeing (and the underlying commitment to contextualism) by showing why this explanation is preferable to two inherentist alternatives.

What is pathology, and how could hallucinations be non-pathological?

While it is popularly thought that hearing voices, sensing the presence of the dead, and other anomalous experiences occur most commonly in the context of a psychiatric disorder such as schizophrenia (Teeple *et al.*, 2009), they are also a common experience among people who have no psychiatric diagnosis or other indications of pathology (Jackson *et al.*, 2010; Beaven *et al.*, 2011; Van Os *et al.*, 2009; Loewenthal, 2007; Steffen and Coyle, 2012). Of these, only a minority are diagnosable with schizophrenia or another mental disorder (Romme and Escher, 2000; Steffen and Coyle, 2012). This is because it is distress and/or loss of occupational or social functioning, rather than hallucinations, that are at the heart of schizophrenic spectrum and other disorders according to psychiatric definitions of them. For instance, in relation to schizophrenia, DSM-5 states:

> *The characteristic symptoms of schizophrenia [delusion, hallucination, disorganised speech, negative symptoms or catatonia] involve a range of cognitive, behavioral, and emotional dysfunctions, but no single symptom is pathognomonic [sufficient for a diagnosis of pathology] of the disorder. The diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning' (APA, 2013, p. 100).*
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> *For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (APA, 2013, p. 99).*

Both distress and dysfunction are either necessary criteria or else common characteristics of many mental disorders. For example (focusing on those most relevant to anomalous experiences), dysfunction is necessary for, and distress a common characteristic of, schizophrenia, while distress is necessary for, and dysfunction associated with, schizophrenic affective disorder (APA, 2013, p. 107). Either one of distress or dysfunction is necessary for mental disorders such as Substance/Medication Induced Psychotic Disorder (APA, 2013, p. 110), Psychotic Disorder Due To Another Medical Condition (APA, 2013, p. 115), Unspecified and Other Psychotic Disorder (APA, 2013, p. 122), Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (APA, 2013, p. 122), Major Depressive Disorder, which can include psychotic symptoms, and so on (APA, 2013, p. 161). Both the general public and psychiatrists can be guilty of pathologising by attributing or diagnosing a mental disorder purely on the basis of hearing voices (Teeple *et al.*, 2009; Rosenhan, 1973; Krippner, 2007). In the absence of distress or dysfunction such attributions and diagnoses are mistaken; experiences are usually not deemed pathological unless they are marked by distress or dysfunction (see Van Os *et al.*, 2009). Indeed, this may in fact be reflective of our underlying conception of what illness is: as Bill Fulford has argued, agency is a core value of medicine, and loss of agency an underlying defining characteristic of both mental and physical illness (Fulford, 1989).

Consequently, by current psychiatric definition, an auditory hallucination is only likely to be considered pathological if it is characterised by distress and/or by dysfunction. We might at this point question whether the psychiatric literature is wise to define pathology in terms of dysfunction and distress, and thus to define optimal human existence as their absence. In terms of distress, many religious traditions have at their hearts other conceptions of optimal human existence according which, even if suffering is an inevitable part of human experience, human existence can nevertheless be valuable. For some of these traditions, human existence can be valuable despite distress and dysfunction; for others they are valuable partly because of it (see Scrutton, 2015, 2016). As I have argued elsewhere, the former allows both for the recognition that distress and suffering are (all other things being equal) experiences we should seek to eradicate and/or alleviate where possible, while balancing this with the idea that life can be lived well even when the elimination of suffering is not possible (Scrutton, 2013, 2015, 2016). Thus, distress does seem like a sensible way for psychiatric literature to characterise pathology – though there is perhaps also the need to re-balance this with a place for positive meaning when the elimination of suffering altogether is not possible (see Carel, 2013).

Dysfunction is a more complex matter. As the example of the Native American woman indicates, there is a risk of attributing dysfunction and pathology to behaviour that is merely unfamiliar or abnormal by American and European standards. Furthermore, because we live in a society that values a certain kind of function (one characterised by productivity) particularly highly, there is a risk that 'curing' people to make them more functional will make people conform to the dominant paradigm – one that not only distrusts difference but that also perpetuates capitalism and the injustices that arise from it. At the same time, the ability to function seems to be a good thing in so far as choice and self-determination are good things, and dysfunction can cause suffering not only for social reasons but (arguably) also because of the more inherent ways in which some instances of dysfunction can limit people's lives (see Barnes, 2016, chapter 5 for a fuller discussion of these issues).

With these things in mind, I will focus on how particular features of ways of responding to anomalous experiences (whether in the context of SPBEs or in the context of therapy interventions) affect pathology qua distress and suffering, without also ruling out the possibility that they may also have an impact on pathology qua lack of agency and dysfunction. Discernment of whether lack of agency and dysfunction are

appropriate criteria for pathology needs to be undertaken with cultural sensitivity and with some of these wider political and social issues in mind. However, a fuller discussion of this is a task beyond the scope of this paper, and so, while pointing to some limitations of the current psychiatric understanding of pathology, I do not think it is altogether wrong, and broadly presuppose it in what follows.

Van Os *et al.'s* large scale review indicates that environmental factors strongly influence whether an anomalous experience becomes pathological or not (2009). Recent psychological studies have focused on environmental (more specifically, responsive and contextual) factors that seem to have a therapeutic effect on anomalous experiences; that is, to diminish or pre-empt pathological features of them, such as distress. Some of these studies focus on SPBEs (Roxburgh and Roe, 2014) but most focus on secular examples or else include religious and spiritual examples including SPBEs only incidentally. All are, however, relevant to this paper in being suggestive of the potentially therapeutic nature of some SPBEs.

(i) Engaging with rather than repressing voices

Psychiatric treatments traditionally encourage experients to ignore or suppress rather than engage with the voices, and experients are frequently prescribed antipsychotic medication. Such medication is far from entirely effective since many people continue to hear distressing voices (Leff *et al.*, 2013), and it is often accompanied by undesirable side-effects. The international Hearing Voice Network pioneered by Marius Romme and Sandra Escher offers an alternative approach by encouraging voice hearers to engage with rather than repress the voices they hear. An important emphasis of the Hearing Voices Network is that experients' own interpretations are respected and not overridden by pathologising medical or other accounts. Experients' interpretations range from the voice being interpreted as spiritual or paranormal communication, to it being a psychological but not necessarily pathological response to a traumatic event, to it being one of the natural variations between different people. Romme and Escher themselves tend towards the second of these views. Hearing voices, they suggest, is a (non-pathological) response to traumatic events and life difficulties, and engaging with the voices is helpful because the voices are links with the person's past. The voices therefore provide a means of exploring past events and dealing with these. Ignoring the voices and treating them with pharmaceutical drugs constitutes suppressing vital means of healing and growth (Romme and Escher, 2000).

Evaluating the effectiveness of the Hearing Voices approach depends to some extent on how one measures outcomes, or how one defines healing and recovery. Some voice hearers find they cease to hear voices. Others find the voice is no longer distressing or problematic, or even that it can become friendly and comforting (Roxburgh and Roe, 2014; Vaughan and Fowler, 2004). This is in contrast to suppressing or ignoring the voice, since "...the tendency of individuals to react with suspicion and lack of communication with the voice... [is] uniquely associated with distress" (Vaughan and Fowler, 2004, p. 150). By diminishing or eliminating distress caused by voice hearing, this approach of engaging with the voices diminishes the pathologisation of the experience in two senses: it lessens the likelihood that an experience is diagnosed or named as a mental disorder, and (because mental disorder is strongly associated with distress) it also diminishes the chances that it will be experienced in a pathological way.

Aspects of the Hearing Voices movement are now beginning to be incorporated into mainstream therapies. In 2013, a research team at University College London developed a computer programme to enable voice hearers who are unresponsive to medication to create an avatar of their voices, in order to help hearers engage with the voices (Leff *et al.*, 2013). While the long-term clinical outcomes of this approach are not yet known, the pilot study found that voices that begin as persecutory became more friendly and less intrusive, and in some cases disappeared altogether. This development was well-documented in UK media, but the portrayal was problematic, in respects strikingly similar to mainstream perceptions of beliefs in spirits: the phenomenon of voice hearing was presented as overwhelmingly negative (with voices being dominant and bullying), and the goal of therapy to 'oppose' and so gain 'control' over them (BBC, 2013; *The Guardian*, 2013; *Daily Mail*, 2013). As some of the examples we will discuss below highlight, this is by no means always the case in relation to hearing voices (see Heriot-Maitland, 2013).

The Hearing Voices Network, avatar therapy and some SPBEs share a common response to phenomena such as hearing voices – namely, that voices should be engaged with rather than repressed. If this is therapeutic in the context of secular treatments such as the Hearing Voices movement and avatar therapy, then there is some reason to think that it might be in SPBE ones too.

(ii) Whether the voice is regarded as benevolent or malevolent, and how it is related to

Paul Chadwick and Max J. Birchwood interviewed twenty-six people with schizophrenic diagnoses concerning their beliefs about the voices they heard. Of these, twelve people believed the voices to be malevolent, six benevolent, and five (who heard multiple voices) both benevolent and malevolent. Ten of the eleven benevolent voices provoked positive emotions such as amusement, reassurance, calm and happiness, while all seventeen malevolent voices provoked negative emotions such as anger, fear, depression and anxiety. The exception was a person who responded with anxiety to a benevolent voice, probably because the voice issued warnings about possible dangers (Chadwick and Birchwood, 1994, p. 192). Chadwick and Birchwood conclude that "The beliefs

that voices are benevolent or malevolent adequately explained important differences in distress" (Chadwick and Birchwood, 1994, p. 195). This is relevant to our discussion of SPBEs since, as we have already noted, the assumption is often made that spirits are malign, but this is by no means always the case. Benevolent spirits can include spirit-guides, saints, ancestors, and departed loved ones. These, Chadwick and Birchwood's study seems to indicate, are far less likely to be associated with distress, and more likely to be associated with positive emotions – which are likely to be therapeutic of the experience.

Other research suggests that, while Chadwick and Birchwood are along the right lines, the picture is more complicated than this. In particular, the relationship with the voice needs to be perceived diachronically rather than at a particular point of time (Vaughan and Fowler, 2004, p. 144). For example, Jackson *et al.* focus on positive rather than negative experiences of voice hearing, interviewing five people who use mental health services and seven people who do not (2010). They note that the relationship between voice and hearer changed over time, and that a core process for these experients was a decline in feelings of fear for the voice, and the development of positive feelings such as love and compassion. Thus, for example, compassion-focused therapy encourages people to foster an empathetic attitude to the voice rather than (for example) one in which the hearer engages with the voice antagonistically, for example, by trying to switch the dominant partner from voice to hearer. In so doing, it enables hearers to move to cooperate processes and to feel safe with the voice, rather than activating the threat-response system, which stimulates the amygdala and triggers defences (Heriot-Maitland, email communication, October 12, 2014). A religious or spiritual tradition that enables the development of positive feelings towards the voice may therefore be therapeutic. This is further suggested by the fact that, although it was not a deliberate focus of the study, all except one of the participants of Jackson, Hayward and Cooke's study (all of whom experienced voice hearing positively) belonged to religious or spiritual groups, and most of these heard voices they ascribed to some kind of spirit (whether of dead relatives, pets, ancestors, the voice of nature, or spirit-guides).

Vaughan and Fowler argue that people's relationships with their voices are analogous to inter-human relationships (2004, p. 145). Contrary to their expectations, they found a link between submissiveness to the voice, in the context of a benevolent voice, and *less* distress. They concluded that "[…] it is not the perceived powerfulness of the voice *per se* that is problematic, but perhaps the way in which the voice is perceived to *use* its power" (Vaughan and Fowler, 2004, p. 150). This seems to resonate with the possession experiences of some mediums, who will voluntarily 'submit' to the presence of a spirit with whom they have developed a relationship. The phenomenology of spirit possession varies widely in different traditions in relation to consciousness and agency, but in the case of at least some Umbanda mediumship, this entails the medium giving up consciousness completely and so submitting in a very full sense; that this is desired is indicated by the fact that it is experienced as a form of 'craving' which must not be given in to if the time or context are not right.

(iii) Communicating with spirits within chosen boundaries

Studies suggest that being able to choose when and where to communicate with voices is important, in terms of having a sense of control an enabling the hearer to integrate and balance the voice with other aspects of their life (Jackson *et al.*, 2010, p. 489; Roxburgh and Roe, 2014). As Mary, a Scientologist voice hearer, puts it in the context of Jackson, Hayward and Cooke's study:

> *I just say "go away, I'm not going to listen", and if they are persistent, especially if it is a [deceased] relative, I will just call my guide in, my inspirer and ask "please can you ask them [deceased relative] to come back [later], because it is not appropriate. And they have to take notice of you (Jackson* et al.*, 2010, p. 490-491).*

Other experients who act as mediums in the British Spiritualist tradition describe how they set boundaries in the context of ritual space; as Sarah puts it:

> *For me I am working or I am not, you know, so it would be absolutely no point spirit talking to me unless I'm working... so I am not aware of spirit unless I want to be... and that depends on the person, if you are an open book all of the time then you are going to feel spirit because our families are around us, so you are going to feel them but for me that feels unhealthy (Roxburgh and Roe, 2014, p. 648).*

Many Umbanda groups have a strong emphasis on discipline, including setting boundaries around when spirit-guides can possess. At some rituals trainee mediums sit behind the 'full' mediums and practised *resisting* possession. During the ritual spirits are sung in (at which point the medium allows the spirit to possess) and sung out again (at which point the spirit leaves and the medium's consciousness returns).

Voice hearing is often particularly distressing when it is intrusive and when the person feels they have no control over it. Some SPBEs can enable people to develop mental control over when and where interaction with spirits takes place, and to set aside certain times and places for this; in so doing, they may help to establish boundaries, eliminate feelings of impotence, and enable the person to function in relation to everyday activities.

In addition to decreasing or eliminating distress and dysfunction, enabling people to control voices is depathologising in a second sense. Part of DSM-5's definition of hallucinations is that they are 'not under voluntary control (APA, 2013,

p. 87). While volition is a vague concept and it is difficult in particular cases to know whether 'voluntary' begins and 'involuntary' ends, learning to control voices and set boundaries may also be therapeutic by increasing the hearer's volition in relation to the experiences since, in so doing, they can also render the term 'hallucination' inappropriate, and so locate the experience outside the realm of psychiatry and pathology.

(iv) Attributing positive meaning

Jackson *et al.* note that in their study of people who experience voices positively:

> *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 (Jackson* et al.*, 2010, p. 149).*

This was transformative of their experience since, as one person 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" (*in* Jackson *et al.*, 2010, p. 492). Some SPBEs are a way of providing positive meaning for such experiences; for instance, in their study of UK Spiritualist mediums, Elizabeth Roxburgh and Chris Roe mention that the family context is important in their study's participants' identification with and development of a mediumistic vocation, and that "These elements combined to provide a normalising and validating function, giving meaning to their experiences and fostering further development" (Roxburgh and Roe, 2014, p. 649).

The quality of an experience can change radically if the experience is regarded as having meaning. Of course, this is true of negative as well as positive meanings: 'hallucinatory' experiences that are interpreted as demonic possession as a result of sin (as in Wonder's case) have meaning, but the meaning is linked to guilt and a sense of distance from God, and the ensuing quality of experience is marked by terror and by feelings of shame. In contrast, superficially similar experiences in which a positive meaning is perceived can be marked by a sense of peace, wonder and joy as a result. For example, Frederick Frese, a retired director of psychology at a public psychiatric hospital who has himself been diagnosed with schizophrenia relates his experience in the following way:

> *When, in Milwaukee, I was breaking the code of the universe, I discovered the power of the Trinity as I have come to know it. My experience taught me that directly to approach the Deity in such a presumptuous manner can be fraught with terror and disaster. Such a thing is far too powerful an experience for a mere mortal to handle. I still have a code, of course. You may have noticed that I have used a generous sprinkling of sevens, twelves, and forties, as well as threes, as I constructed this narration. These religiously oriented mystical numbers give me little bits of joy as I go about any of my work. I know that this does not make rational sense, but I am most confident that neither I, nor anyone else, is a totally rational being. And my 'secret code' unlocks innumerable joys for me throughout each day (Frese, 1994, p. 25).*

In addition to finding joy in his work as a result of the meaning he gives it, Frese explains that his own experiences have a beneficial effect on his work as a psychologist, making him a sign of hope to others diagnosed with schizophrenia (for example, by demonstrating that it is possible to have a successful career and family life), and by giving him insight into their words and behaviour. As this example highlights, a positive meaning (which often includes, though is not limited to, a positive religious or spiritual meaning) can give rise to a richer, more therapeutic experience than a biomedical account of a phenomenon such as hearing voices is able to do on its own (Stanghellini, 2004; Scrutton, 2015). This is true whether the experience or condition is something that might be temporary or could be 'cured,' but also if it is not, when a broader notion of 'healing' is required (Scrutton, 2016).

(v) Community support

Attribution of positive meaning is closely related to community support, particularly in relation to validating responses to the experience. In their 2012 study, Heriot-Maitland *et al.* distinguish factors involved in having an anomalous experience from factors involved in such an experience 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 can be illustrated by the following two accounts, the first of which is from a clinical and the second 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, was, 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 scrutinised 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 (Holly* in *Heriot-Maitland* et al.*, 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 (Clive* in *Heriot-Maitland* et al.*, 2012, p. 47).*

As Heriot-Maitland *et al.* note:

> *For the individual who is, perhaps, already slightly hesitant about how best to incorporate their experience into their social worlds, the difference between these two interactions could be immense. This seems to be the first major difference between C [clinical] and NC [non-clinical] groups, who until this stage of the report have generally reported quite similar experiences (in both triggers and subjective nature) (Heriot-Maitland* et al.*, 2012, p. 46).*

These and the other findings in the study lead Heriot-Maitland *et al.* to the conclusion that there is nothing pathological in the experience itself. Rather, the 'pathology' seems to emerge from the experience "when the meaning of the out of ordinary 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; see also Fulford and Jackson, 1997). Integration may fail to take place as a result of a number of factors, such as fewer multiple appraisal options arising from a lack of conceptual and intellectual resources by which to make sense of their experiences, and negative responses by people to whom they choose to recount them.

Some SPBEs, I suggest, pathologise in terms of 'spiritual' illness (as in the case of Wonder), whereas others provide a positive interpretation of the experience. That such responses can be therapeutic of the experience is indicated by the fact that as Seligman notes, people who experienced distress prior to their initiation as *Candomblé* mediums ceased to do so, on account of their mediumship role redefining their identity and status and providing social support (Seligman, 2005). In addition to support at the moral, interpretative level, Krippner argues that communities can provide practical support such as mediumship training, and that in cultures such as the USA in which mediumship is regarded as abnormal and training not provided, mediums are more likely to exhibit pathological symptoms (Krippner, 2008). This indicates that community support, such as that found in some SPBEs, can be therapeutic in relation to anomalous experiences, in the sense of providing a positive interpretive and practical framework, and so helping to prevent the experience from becoming pathological.

Is the contextualist view justified? Avoiding a circular argument

The studies of responsive and contextual factors support the contextualist view, which regards anomalous experiences and other mental states as pathologically indeterminate, with pathology emerging as a result of responsive and contextual factors. However, my discussion of these studies, and, to the extent that they propose a causal relationship, these studies themselves, have also presupposed a contextualist view by not explicitly considering other, non-contextual, ways of interpreting the findings. In order to avoid a circular argument, I therefore need to consider these and argue that we have reasons to prefer a contextualist view over them. In so doing, I hope to contribute to future studies and discussions that support contextualism by showing why contextualism should be preferred to inherentist ways of interpreting the evidence.

One alternative explanation to the contextualist view is that the studies that discuss which responsive and contextual factors determine whether the person receives a clinical diagnosis do not in fact indicate anything about whether the experience has become pathological. They simply indicate that such responsive and contextual factors mean that a pathological experience remains undiagnosed because the contextual factors mean that the experient does not visit a psychiatrist (e.g. because they visit a spiritual healer or join the Hearing Voices Network instead). On this view, anomalous experience AE1 would be diagnosed if person P1 saw a psychiatrist; the fact that P1 does not see a psychiatrist does not mean that it is not pathological, but simply that it is not diagnosed as such. It is possible that AE1 could be pathological but undiagnosed, provided that one accept that an anomalous experience's being pathological does not depend on it being named (via diagnosis) as such. However, whether one does accept this or not, this does not seem to be the case with most of the positively experienced anomalous experiences described in the studies. The reason for this relates to the fact that, as we saw above, distress (and also dysfunction) are common features of, and frequently necessary conditions for, diagnosis of a mental disorder such as schizophrenia. Because the positive experiences described in the studies are not characterised by distress (or dysfunction), a diagnosis of pathology would not only be less likely in practice because they would be less likely to visit a psychiatrist. It would also be inappropriate in theory, because of what the idea of pathology involves. Therefore, a causal and contextualist explanation is to be preferred to this alternative.

A second alternative explanation is that the responsive and contextual factors examined in the studies are a correlate rather than a cause of the pathological status of the anomalous experience. According to this argument, AE1 is inherently non-pathological, and P1's experience and interpretation of it as non-pathological and, say, spiritually transformative, reflects rather than causes its non-pathological status, and is reflected in the responses of people around her. In contrast, AE2 is inherently pathological, giving rise to P2's pathological experience of it, as recognised by the people around him.

This alternative differs from the first inherentist alternative, in part because the former tends towards the idea that all anomalous experiences are inherently pathological, whereas the latter tends towards the idea that some anomalous experiences are inherently pathological (in origin and

potential) while others are not, perhaps being inherently spiritual or mystical instead. While there is no necessary relationship between this view and the idea that religious and spiritual categories are natural kinds (or between contextualism and social kinds [see Fulford and Jackson, 1997]), this view is likely to make an appeal to two fundamentally different natural kinds of anomalous experience – the pathological, and the religious. I think this kind of distinction should be rejected, not only in relation to natural kinds, because (as already noted) there is no basis for it, but also because (whether construed in terms of natural or social kinds) it seems to raise more questions than it answers (what is meant by 'religious' and where do religious anomalous experiences come from and why? Why are they so similar to pathological ones in terms of trigger and initial subjective experience?). This kind of account would also need to account for various features of the studies' findings, without appealing to naturalistic causes: for example, that experiences can cease to be pathological when the person begins to make sense of them in a positive way (e.g. Roxburgh and Roe, 2014, p. 647; Rachel *in* Jackson *et al*., 2010, 2004; Seligman, 2005, above), the effectiveness of cognitive behaviour therapies that focus on challenging people's beliefs (Wykes *et al*., 2008; Gaudiano, 2006; Cormac *et al,* 2004), and the fact that knowledge of multiple appraisal options is positively associated with non-pathological status (see Heriot-Maitland *et al*., 2012). Appealing to divine intervention – a deity who blesses the practitioners of a number of different religions (along with members of the Hearing Voices Network) with positively meaningful anomalous experiences superficially similar to naturally-arising pathologies, who changes experiences to the non-pathological variety in the event of religious conversion or a change in non-religious beliefs, and who bestows a knowledge of multiple appraisals or ways of interpreting the experience on his preferred people – would be possible. However, here we are left with a rather odd-looking deity, and it seems to me that this explanation is less intuitive and more complicated than the idea that interpretations causally affect inherently indeterminate experiences.

In addition to these reasons, I suggest, there is also a practical reason for preferring a contextualist view to an inherentist one. A contextualist view leaves open the possibility that experiences diagnosed as pathological have the potential to be or become (in addition, or instead) a positive religiously- or spiritually-construed experience, while inherentist ones exclude this possibility. Conversely, a contextualist view allows for the possibility of experients making sense of their experiences in both religious and medical terms, and benefiting from both forms of therapy (see Scrutton, 2015). Giving this kind of hope, and allowing both forms of therapy, are only likely to be effective if contextualism is true (if anomalous experiences really are pathologically indeterminate); if contextualism is not true, then giving such hope is futile. However, if contextualism is true but it is assumed that inherentism is true, experients are deprived of hope and potentially therapeutic forms of treatment: people whose experiences are deemed 'pathological' would be deprived of the idea that their experience could also have spiritual value, and of religious and spiritual forms of therapy, and people whose experiences are deemed 'religious or spiritual' deprived of medical or psychological therapies. Working on the basis of contextualism would therefore seem to be therapeutic if true, and neutral (neither therapeutic nor pathogenic) if false; working on the basis of inherentism would be neutral if true, but damaging if false. This means we have a practical as well as an intellectual reason to prefer contextualism.

Conclusion

In conclusion, I have argued that negative assumptions about SPBEs in the West are problematic, both because they erroneously extrapolate aspects of some SPBEs to all SPBEs, and because they discourage people from SPBEs and so shut down a potentially therapeutic avenue. This does not entail a stance that is pro-religion or pro-SPBE *per se*: other SPBEs such as those experienced by Wonder, in common with some other religious beliefs, can be extremely harmful. At the same time, this paper suggests, western society might have something to learn from certain SPBEs with respect to anomalous experiences and other forms of human experience. In addition to this, I have provided a philosophical basis for the idea that pathology emerges in anomalous experiences as a result of responsive and contextual factors, defending this claim against the alternative idea that pathology is inherent in all, or some, anomalous experiences, regardless of the context or culture in which they are interpreted.

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