

**IN-SANITY**  
**EXPLANATORY MODELS FOR**  
**RELIGIOUS EXPERIENCE**

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1. Beliefs about Being Human
2. In-Sanity: Responses to Religious Experience

*These two papers were written five years apart, using quite different presentation styles. The first, on the polarities of consciousness, was produced in 2000, in response to an invitation by Peggy Morgan, to give a talk to a meeting of the Oxford/Cotswold Group of the Alister Hardy Society to which students of the MA in Religious Experience at the University of Wales, Lampeter had been invited. The aim was to explore explanatory models for religious experience using case studies from different cultures throughout the world. This paper became misplaced during the move from Oxford to Lampeter, and it is thanks to the excellent memory of Anne Watkins that she found it on the shelves in her room, some five years later.*

*The second paper is a report, written in 2005, after I gratefully received an award from the Alister Hardy Research Centre. This was to conduct research into those religious experiences, held in the archive centre at University of Wales Lampeter, that were said to warrant psychiatric attention. I had long wanted to explore data about professional and social responses to religious experiences, and this provided an excellent opportunity.*

**Paper One:**  
**BELIEFS ABOUT BEING HUMAN**

**INTRODUCTION**

This paper is based on a talk, given to the Alister Hardy Society in Oxford, in January 2000. It presents various beliefs about the nature of human existence and cultural explanations for 'unusual experiences'. The aim is to explore different explanatory models for religious experiences that are perceived as negative, or in need of psychiatric assistance. My proposition is that our beliefs about the nature of physical existence and consciousness beyond death, influence our judgement, and affect our understanding of religious experience.

Over the years as our beliefs change, it is my opinion that our responses to religious experiences are modified. One hypothesis is that religious experience taps into a dimension, which some people access deliberately, some by chance, and some access it but are anxious or traumatised and may confuse it with 'common-consensus reality'. The explanatory model we choose depends on our belief system about the nature of reality, influenced by the common consensus view of our cultural background. In the text I discuss whether models of 'non-corporeal consciousness' or 'non-physical dimensions' might provide a different framework for understanding certain types of religious experiences.

Using anthropological case studies from societies throughout the world, the first part of this paper weaves different cultural stories about human existence from conception through birth, life and death. The second section examines the concept of 'inter-dimensional reality' and 'non-corporeal consciousness' and those who claim to work with it deliberately (e.g. shamans, psychics, mediums, seers, and therapists) or, those who have spontaneous expression of it (such as religious or mystical experiences, Near Death Experience, Out of Body Experiences, or altered states of consciousness). The last part examines unusual human experiences and discusses whether or not they might be veridical. It addresses issues around mental health and religious experiences.

In order to explore the relationship between religious experience and mental illness, several factors are examined from Western and non-Western cultural viewpoints. These include beliefs about: the nature of human physical existence from birth to death, and 'non-ordinary' states of consciousness. Three propositions are explored:

- religious experience and certain symptoms of mental illness are the polarities of consciousness: they exist within a continuum.
- a non-physical dimension exists alongside our physical world, which transcends space and time, where non-local vision is possible, and where other-than-human-beings with identity are present and veridical.
- our own beliefs about both the nature of physical existence and consciousness beyond death, has influenced our response to religious experience over the years, regarding the diagnosis and treatment of mental health cases.

Many of the peoples presented from different cultures in the case studies in this paper, believed in some kind of non-physical world. This fundamentally affected the nature of their understanding of life and death, and human consciousness. The question put, is whether these case studies are simply anecdotes of interest, or whether people in those societies might be tapping into some deeper underlying reality, which will help us comprehend certain types of religious experiences.

What is religious experience'? The parapsychologist Rhea White chose to use the term 'exceptional human experiences' in her attempt to explore phenomena, which she claimed occurred beyond a religious framework (White 1997; 86). In contrast Donovan explained various types of religious experience from a rationalist perspective (1997). Many people considered their experiences to be 'spiritual', though we are still unsure as to whether spirituality is a belief or an experience, a practice, a process or a religious dogma. In issue 28 of *De Numine* in 2000, one author suggested her experiences occurred outside a religious framework (Thornton 2000; 2). The author of a second article said he had had an 'anomalous experience' (Richardson 2000; 7) and John Franklin, author of a third said his experience did not appear to relate to the religion he had been taught (2000; 14).

At first it was thought that so called negative 'exceptional human experiences' lay within the field of psychology (Hardy 1979; 63), but Jakobsen suggested that both good and bad experiences illustrate the human condition and the existence of a spiritual realm (Jakobsen 1999; 3). She conducted a survey of around 170 'encounters with evil' held within the archives of the Alister Hardy Society. She noted that in Western society people tended not to share their negative experiences for fear of being labelled mentally unstable. In her final comments she notes that the experiences 'often have a similar pattern to mental illness' (ibid.; 52). Those people who have transcendent experiences communicate with others about it. Those who have other 'non-ordinary' or negative experiences often maintain silence (Tobert 2000). These issues are covered in more detail in the following Occasional Paper, which directly investigates the archive for professional and social responses to those having religious experiences. Evidence from the archives suggests there was a popular perception for several decades amongst a few people, who believed religious experiences *per se*, were a sign or symptom of mental illness.

### **An Anthropological Perspective**

This paper explores religious experience within a cross-cultural framework using the discipline of anthropology. This becomes more difficult due to our efforts in the West to classify what we observe. Our education system appears to fragment 'life' into certain categories of knowledge. For example, religion, health and consciousness studies are discrete scholarly disciplines in which specialists undertake research, whereas in other cultures the concepts are inter-related. Within the field of 'mental health', research into treatment is still biological or humanistic, although more holistic and transpersonal approaches are now being explored. In the West, some practitioners assess 'mental health' experience within a social, environmental or spiritual framework. Some do not. Sometimes there appears to be a gap between intellectual awareness and front line services.

In many non-Western societies, the indigenous boundaries concerning concepts about life are interwoven: anthropology libraries like those at Lampeter abound with monographs about autochthonous interpretations of consciousness within the context of 'life' as well as 'religion' and 'health'. For example, the anthropologist Reichel-Dolmatoff explains that Tukano peoples of the NorthWest Amazon Basin in South America believe that humans on earth are inextricably linked to the cosmos, and they have a framework for understanding different states of consciousness (1997). They believe all their activities are inter-connected: the relationship between human existence, the physical world of nature and the spiritual dimension is explicit. The Tukano believe in two inter-locking worlds whereby the physical world of material things and the spirit world are discrete but co-exist. Human beings interact with nature and the spirits: they are considered incapable of existing independently. Not only do the Tukano experience inter-connectedness between humans and nature, they also experience inter-connectedness between nature and the spirit world. I am sure they would not consider very many visual or auditory 'religious experiences' mentioned in the RERC archive, as pathological.

The concept of interlocking dimensions is common to many societies throughout the world and is found time and again. During his fieldwork Reichel-Dolmatoff often heard people talk about 'the other house' or 'the double house'. He said it took him nearly two years to understand they were speaking about the other dimension, the abode of spirits, or the non-physical dimension. When he asked his informants why they had never explained this, they replied, "You never asked us". When he first began his fieldwork, like so many anthropologists (including myself), he conducted research within the boundaries of his own

knowledge. However, he meticulously recorded native people's interpretation of the material he collected and his work is exceptionally sensitive to the society he worked in (Reichel-Dolmatoff 1997). Many non-Western societies often have a multiplicity of explanatory models for ill health, which include both physical and non-physical causes. The non-physical aspects of reality are important for our re-evaluation of certain religious experiences, in particular those where the person experiencing or those near to them have either questioned the validity of the experience, or considered it a symptom of a psychiatric condition. The Western bio-medical system has tended to assume that illness occurs as a result of organic disorder within the patient's body, though this perception is fast changing among health care practitioners.

## **BIRTH AND DEATH**

It is my opinion that a wider understanding of explanatory models for birth and death may throw light on certain manifestations of religious experiences. The ideas of indigenous peoples concerning the nature of existence fill anthropology publications. But how do we 'Westerns' interpret them? Perhaps we have tended to subtly discount the concepts they offer us as false, irrational or culture-bound, especially if the concepts lie beyond our own knowledge base. In the West we talk about certain groups of people having 'culture bound beliefs' but we have not always been self-reflexive enough to ask whether our own Western beliefs are 'culture bound'. Often concepts which fall outside the boundaries of our own belief system are considered to be 'other people's beliefs', which may be irrational and not part of empirical reality: and we assume the biological model of birth and death is the only empirical model. With regard to the term 'belief' Byron Good suggested that its use did 'indeed connote error or falsehood' although this was seldom explicit (1994; 17). Good claims that the word 'belief' has long been used to connote 'mistaken understandings' whereas 'knowledge' is assumed to mean 'correct explanations'. Today anthropologists use the phrase 'culture-bound knowledge' but it may be used to mean the same thing as 'belief'. The case studies below present beliefs about birth and death, and explore whether the biological theory of procreation is universal, or whether there are additional explanatory models.

In the West we used to hold certain beliefs about the human body. We used to say: we know we are born, conceived by an act of intercourse between people of different gender (though with technological developments this is not necessarily the case). We assume people lived a certain amount of time on earth, then died, and often many said that we didn't know what happened after death. But the version of life presented above is simply one 'belief system' of the West, from a materialist perspective. The understanding of human experience within the cosmos is quite different in other parts of the world, and examples of this are given below. This section discusses cross-cultural explanatory models for life transitions such as birth and death. Using anthropological case studies, it explores the nature of human existence from different perspectives, and presents various explanations for birth, death and survival beyond bodily death. I would like to move beyond the Western culture-bound materialist belief system, and explore which explanatory models fit within the consciousness / energy paradigm. This paper presents alternative frameworks for understanding religious experiences and what have been considered in the past as certain symptoms of mental illness. I suggest a new framework which may help those who have religious experiences that occur outside their former framework of reality. It may help them to come to terms with their experiences.

### **Assumptions around Birth**

In the 1920s the anthropologist Malinowski discovered that concepts of death and birth were intertwined (1929; 145). In Papua New Guinea, the islanders believed biological conception and birth occurred only after death: the spirits of their ancestors were the source of incoming babies. This belief of the regeneration of ancestors was also recorded in Northern Alaska in the 1990s (Goulet 1994; 157). Sexual intercourse was considered necessary for procreation, but it was not enough: it was divinity that created the child, a belief also held by the Dinka of Sudan (Lienhardt 1990; 39). Among the Laboya peoples of Indonesia, pregnant women were considered to be containers of ancestral breath and as such they were temporarily in touch with the 'realm of the dead' (Geirnaert-Martin 1992; 230). In Micronesia, new mothers wore the same dress as widows who mourned the death of their husbands. One ushered in a new physical birth, the other oversaw the birth of a new ancestor (Battaglia 1990; 44). The beliefs about regeneration of an ancestral being into a new foetus in the womb, is ubiquitous throughout the world, except in white USA, white Britain and Europe, and white Australia (except of course for those inclined towards spiritualism). This has implications regarding the validity of experiences of those who have been bereaved and claim to see their deceased spouse. We may interpret their experience as veridical or hallucinatory, depending on our own belief system about the nature of human reality.

There is a belief that a new-born baby is made up of several components alongside their biological form. This may be a soul, a breath, vital energy, and/or a life force (Battaglia 1990; 39, Laderman 1983; 144). There is a belief that the life force can leave the body, which is especially risky in a new born (Geirnaert-Martin 1992; 102). In Thailand there are ceremonies to tie the life force to the baby, so that it doesn't become restless (Heinze 1982; 5). Once a child is older, the life force tends to wander around less, though it can wander during sleep (Eves 1998) and in the case of specialists like shamans, they can deliberately wander, even during the day. This has implications on the validity for those who claim to have religious experiences where they seem to be transported 'elsewhere', that is, elsewhere from their bodily form. There is now a growing literature on remote perception and remote viewing (Stewart 2005, Morehouse 2000, Brown 1997). There seems to be some aspect of the self that can move away from the physical form and engage in remote perception. Perhaps this 'non-corporeal consciousness' is a normal human faculty held by people who have religious experiences? It is more normal for informants from non-Western civilizations to talk about it, since it doesn't challenge their world-view, their ontological framework.

### **Assumptions around Death**

The possibility that conception occurs through the regeneration of an ancestral soul, results in various cultures' concern with having a 'good' death, so that ancestors may reincarnate and not remain in limbo like ghosts (Parry 1994, Obeyesekere 1981, Fuller 1992). In India, people who died a 'good' death were cremated, which resulted in rebirth and renewal. Those who died a 'bad' death were blocked from being reborn. Much human misfortune was attributed to ghosts of those who died an untimely death (Parry 1994; 226). The belief in ghosts, those who have unresolved situations in life is ubiquitous in Asia. The ghost requires prayers in order to become an ancestor and be recycled and reborn as a baby. Physical and mental illness, childlessness and other misfortunes may be attributed to the ghosts of the 'untimely' dead (Fuller 1992). People believed malevolent spirits took possession of the living and controlled their minds and bodies. In India, there is however, a widespread distinction between 'bad' spirits that possess their victims, and 'good' spirits that possess

diviners or ascetics. I am interested to see whether there is any correlation with this way of thinking in the archives. Do people who have benevolent visions consider them veridical, and those who have negative experiences consider them pathological? Perhaps it is not as simple as that?

Ancestral relationships are considered to affect the health and well-being of people in different ways. In the West if a discarnate being should appear to the recently bereaved as a hallucination or apparition, this may be considered delusional or a case of 'complicated grief', whereas in other societies it might be a welcome vision. In Sri Lanka visions are not considered pathological, whereas if they occur in the West they may be considered as 'symptoms of deep-rooted pathology' (Obeyesekere 1981; 165). There, a 'bad' case of possession is unsolicited, and a 'good' case is solicited whereby the incoming spirit is transformed into a benevolent healer or clairvoyant. In the archives, those who claim to see an angel, or Jesus Christ, or be looking apparently through the eyes of a deceased grandmother, do they regard their experience as benevolent or pathological?

### **De-Possession in the West**

The concept of 'good and bad death' in Western society is fully explored in Peberdy et al. (2000, 95ff). However, the meaning of the concept is rather different from that found among non-Western societies, whereby those who die a 'bad' death are said to remain in an earth-bound limbo and afflict the living: and spirits (or non-corporeal consciousnesses with personality) are believed either to benefit or to harm human beings. Accounts of spirit possession as described in the gospels (Mathew and Luke in Jakobsen 1999; 4), bear striking resemblance to certain symptoms of schizophrenia. I wonder which is veridical, schizophrenia or spirit possession, or both? It depends on common consensus and our ontological frameworks. There is some recognition of the phenomenon of possession in Western society, for example, the psychiatrist Scott Peck believed cases of possession existed but were rare and required special assistance. He observed cases of purported possession, described the method for 'release' followed up by psychotherapy. There are cases in the archive described as such. Peck suggested there had to be a significant emotional problem for the possession to occur in the first place (1989; 192). He noted that anthropologists study possession as if it was 'over there' and asked whether the phenomenon is cross-cultural. Similarly, Bishop Dominic Walker (Co-Chair of the Christian Deliverance Study Group) has worked with people who go to church, often as a last resort, when they feel they are under demonic attack. Although he says schizophrenia would seem the obvious explanation for those who complain of hearing voices or thought insertion, there are cases where the symptoms disappear 'after the appropriate ministry' (Walker 1997; 3). Deliverance is the word used by the Guild of St Raphael to refer to the release or exorcism of spirits.

As well as the above examples, there are various therapies in the West, which appear to acknowledge the model that life after death (and earth-bound discarnate entities) may afflict the living. For example, in London, the College of Past Life Regression Studies offers a course on 'Spirit Releasing Therapy'. In the prospectus they suggest that the disorders which the clients present appear to be caused by spirits of deceased human beings (1998; 5). Practitioners who work with clients using hypnotherapy, say they enter a dialogue with the possessing entity, and it is the client, him or herself who acts as the medium. The practitioner negotiates with the entity, invites it to leave willingly and without trauma to itself or the client. Some clients claim to know an entity is attached and affecting their decisions and behaviour. The college says that an entity can ride with a person's soul

through several incarnations, and attach itself each time at conception. Are they suggesting that entities ride on ancestral beings and are already attached when they reincarnate as a new-born baby? Now that is a challenge to the 'fresh slate' school!

Spirit Releasement is a practice also used by Sanderson, a former National Health psychiatrist. He uses a technique of hypnotherapy, which has its roots in neo-shamanism and is based on a guided journey or visualisation. He observed that his patients diagnosed with spirits attached, presented with conditions of depression, anxiety or panic and did not necessarily associate their condition with possession. He suggested patients diagnosed as suffering from multiple personality disorder (now known as dissociative identity disorder) were often extreme manifestations of spirit attachment. He believes "that patients diagnosed as schizophrenic, largely on the basis of auditory hallucinations, are primarily cases of spirit attachment" (Sanderson 1997; 3). He notes that when 'spirit possession' is mentioned in psychiatric literature it is often explained away "as a delusional or culturally sanctioned belief." He says that ideas on the causation of mental disorder are still mostly biological, with psychiatric diagnosis being descriptive, not aetiological. He found the taboo, surrounding the subject of non-corporeal existence, made it difficult to report his cases. I wonder whether these attachments might provide an explanation of the evil entities reported in the archive and published by Jackobsen (1999).

### **The Concept of Reincarnation**

The idea that discarnate beings might exist in some kind of non-physical dimension and overshadow human beings, is found in many societies which have a belief in existence after death. This is often accompanied by a belief in the possibility of rebirth or reincarnation. Many religions have some concept of rebirth after death and the continuance of the soul beyond physical life. Belief in reincarnation is widespread, and underlies many eastern faiths, whereby the soul is eternal and reborn repeatedly. The concept of *karma* means enduring in this life the consequences of behaviour in the previous: the present life is the sum total of past deeds. Followers believe the physical human body holds memories of its ancestors, and its soul holds memories of past incarnations since time began, which may also be held at a cellular level. Obeyesekere, notes that many people have taken it for granted that India was the home of rebirth beliefs, with the accompanying concepts of karma and the cycle of reward and punishment and salvation. But, he suggests that India is only one place among many to hold this belief: it wasn't recognised as being central to African and Native American beliefs and cosmologies (1994). It was known by different labels and came under polytheism or pantheism, or was subsumed by other cosmologies.

The biologist Ian Stevenson brought a professional approach to the study of reincarnation and he made attempts to verify the information (1997). He presented an analysis of 225 examples where people had been born with birth-marks or birth defects and claimed these related to past lives or the manner of past deaths. In particular, lives which ended in violent deaths seemed to be more remembered. He has selected birth-marks rather than any other kind of memory since he considers that they provide an objective kind of evidence. In some cases he found children had birth marks, which corresponded to the fatal wounds in a previous life, which could be checked against autopsy records. In one case from Turkey, the medical certificate of the recalled past-life person was traced. Stevenson's work suggests that there is some kind of memory transmitted between lives, some kind of karmic replay, which can affect the physical body. He proposes reincarnation as the most suitable explanation.

How does this influence the way we interpret peoples' experiences in the archive? Is it possible that extra-cerebral memories be transferred from one life to another? Is it possible for one human being to actually see another who has died? Charles Tart says that Stevenson's data make it clear that we know very little about reincarnation (1997; 169), and our theories do not account for all the data. This kind of data perhaps suggests that human bodies and consciousness are not necessarily limited by time and space. He puts forward the theory, that if there are ancestral spirits, they must exist somewhere in non-physical worlds (NPW). However, many people may disagree with his interpretation. For example Edwards suggests that Stevenson's supposition that there is a

non-physical storage depot of extra-cerebral memories ... must surely be dismissed as nothing but a vague picture which is of no scientific value whatsoever (1994; 306).

Mark Fox reiterates the importance of 'testimony' as the driving force for recording tales of religious experience. He says we investigate these things 'through the lens of another's testimony or self-story' (1999; 14). The rest of this paper continues to question the relevance which beliefs about consciousness beyond death have on our understanding of certain religious experiences.

### **Opening to New Explanations**

According to material in the RERC archives, many visionary and auditory experiences occur within religious experiences. In previous decades, it is likely that a particular phenomenon was called 'religious experience' if an individual was of a stable mental disposition, and those around them believed in the validity of the experience. However, if those around them didn't believe in the validity of such experiences, then the individual would be encouraged to see a psychiatrist, especially if they were depressed or unstable. The label of schizophrenia might be assumed. Sadly the response depended on the beliefs of the observers. There seems to be different weighting given to 'The Central Christian Revelation' seen by a number of people and, private revelations seen by individuals: Moses saw the burning bush and many people saw the Resurrection of Christ. Others experienced auditory input: a number of religions were begun when charismatic people heard voices, which inspired them. These include the Quakers and Shakers, the Seventh Day Adventists, Mormon, Paul on the road to Damascus, Joan of Arc, and Muhammed and the Qur'an. Even Florence Nightingale, who claimed to have heard the voice of God in 1837, was inspired to set up nursing and midwifery training schools, the forerunner of our Health Services in the United Kingdom (Keighley 1999, Wright 2000; 14).

For many people, questions remain: as to whether visions were produced by the human psyche, whether they were authentic visions generated by the imagination, whether they were externally manifest, or whether they were implanted by 'god' into the human mind. Mysticism and schizophrenia have often been linked (Wapnick 1981; 321). Psychosis was said to be an incomplete withdrawal from the spirit state, a failure to return to this reality, while in comparison, the mystic was controlled and came back completely to everyday reality. Wapnick proposed that the behaviour of schizophrenics was expressive of the experiences they were undergoing, their 'otherworldliness', rather than the expression of a deranged mind. The mystic joined the inner and outer world whereas for the schizophrenic the two worlds remained separated. The psychiatrist Stanislav Grof claims that

Western psychiatry does not differentiate between mysticism and psychosis and tends to treat mystical experiences of any kind as manifestations of mental disease (1998; 79).

Donovan suggests a materialist perspective, that bio-chemical imbalance in the brain may cause mystic states (1998; 144).



I wonder whether there is a relationship between our beliefs about consciousness after death and our understanding and interpretation of religious experiences? Is it possible that there is a correlation between our Western beliefs about the nature of human existence and our beliefs about what is, and what is not, pathological? What exactly does a human being consist of? Many non-Western peoples believe that once the physical body dies, consciousness and some form of identity continues. There are beliefs that the method of death can affect the nature of a discarnate being; that a human being consists of various non-physical components, some of which precede and survive death.

Although transpersonal psychology ‘takes account of beliefs such as the soul and the survival of bodily death’ (Fontana 1999; 10), this way of thinking has been considered heretical in the West for hundreds of years. The Roman Emperor, Constantine the Great embraced Christianity and called the first ecumenical meeting of the Council of Nicea in June 325 CE. At that meeting the Nicene Creed was adopted, and from that time, the systematic persecution of dissident Christians began. Originally tolerant, Constantine forbade heretics to assemble in any public or private place. The Council of Nicea marked the beginning of the end of concepts of pre-existence and reincarnation. Even before mass printing was developed, from 325 CE the church banned heretical writings. Today the Nicene Creed is still recited in many churches. At the Fifth General Council of Nicea (probably CE 545) it was decreed

... if anyone asserts the fabulous pre-existence of souls, and shall assert the monstrous restoration which follows from it: let him be anathema [excommunicated].

Is it possible that this decree influences our thinking today?

What happens if we start to consider reincarnation and the pre-existence of souls? If there is reincarnation, could there be ancestral dead, or discarnate beings? After all, where would souls go after the body is deceased? Most of us do not see them around. Is human consciousness simply generated at physical conception, and does it return to nothing upon death? Do we believe that ‘specialists’ (like the psychics and shamans mentioned below) who say they have access to spirits of the dead, can see and talk to them? If there are ancestral spirits of the dead, could they afflict the living? Could possession be a reality? Can ancestral spirits manifest in the physical world? Is it possible that some people who have religious experiences may be accessing a non-physical dimension and picking up visual and auditory material? If they confuse it with common consensus reality would they be labelled psychotic? Undoubtedly! It may be easier for both experiencers and therapists to believe in the reality of pathology, since the other possibilities are so challenging to our belief systems about the nature of existence. The possibility of conscious beings existing in a non-physical dimension may cause ontological shock.

### **Porosity**

Then there is the question of the human body’s porosity. In autochthonous societies a ‘being’s identity’ is rooted within the local cosmology even before conception, and the human body is considered ‘permeable’. People believe the body can be made sick by both physical and non-physical elements. Csordas has suggested that in the West we tend to understand the body as a ‘bounded entity’ (1994; 2) with the surface of the skin serving as the boundary between the individual inside and the world outside. Illness occurs within the body, but may be caused by certain things, which permeate the body: through the skin, breathed in, ingested through the mouth (or transmitted via any other opening), or after injury via intrusion of a foreign object (e.g. a thorn or knife). Another way of understanding (not commonly accepted in the West) considers the body as ‘not individuated, but ...

diffused with other persons and things' (ibid.; 7). This kind of body is permeable. I wonder if people who have religious experiences are more porous than those who don't?

Extending the concept of permeability to family members, the French psychologist Canault gives examples of individuals who experience 'trans-generational sickness'. This term suggests that hidden grief or unresolved trauma in one person is suppressed but surfaces in the memory or behaviour of subsequent generations. It is passed on until it is revealed or resolved. Psychologists suggest suppression may result in psychosis in later generations. In such cases, becoming conscious of a secret promotes healing and enhances mental health (Canault 1998). She says that within a lying explanation for a traumatic death or sexual experience, the event itself is buried. For example, child death or suicide stays in the unconscious of those who do not talk about it, and gets transmitted from one generation to the next. It can come from the mother or the father, or from more distant relatives. However, if we recognise the transmission of hidden information from one generation to the next, one wonders what the mechanism is, and whether we also accept the existence of telepathy or pre-cognition? Canault suggests that when we create a baby, we create not only a physical body, but we also give them the unconscious memory of the parents which is transmitted to a newborn at the same time as the biological breath (ibid.; 88). This concept appears to suggest that sometimes people react to memories, which didn't originate with them, but belonged to an older relative. This explanation is interesting since it suggests we are affected by those ancestors who precede us, and it raises the question again as to whether an individual is 'born free', with a 'clean slate'.

This above concept is very challenging and I am not brave enough to address it here. However, the question of human 'porosity' resulting in unusual experiences is even more complex in the following example. In America, Pearsall was a psycho-neuro-immunologist who collected testimonies of heart transplant patients who believed their organs retained memories of the donor (1998). He reported a story about an 8 year old girl, who received the heart of a murdered 10 year old, and then had such disturbing nightmares that her mother took her to a psychiatrist. Based on the girl's descriptions, her mother and the psychiatrist eventually went to the police, who found and convicted the donor's murderer (Pearsall 1998; 7). The question remains, whether it was the cells of the heart which retained memory, or that the recipient received information by telepathy (from the deceased?), or whether the donor's spirit overshadowed the recipient. The explanatory model we choose depends on our belief system about the nature of reality, influenced by the common consensus view of our cultural background. I have written at length about assumptions around birth and death and porosity, because I wanted to emphasise that there are a plurality of frameworks for understanding human existence and human experience. The physical materialist explanation does not answer all the questions raised. However, belief in one model does not exclude the others from existing. It does raise another question: when someone has a religious experience, whose is it? Is it always theirs, or could they be picking up data from someone else?

## **ALTERED STATES OF CONSCIOUSNESS**

The material in the previous section has highlighted the many different beliefs in both Western and non-Western societies, about the human condition and the nature of birth and death. We have looked at topics like conception, soul, life-force, good and bad death, spirit possession, reincarnation, and porosity. The above examples offer interesting case studies, but are they simply ethnographic anecdotes, which illustrate interesting, but irrational,

beliefs of people in different cultures? Perhaps we may ask ourselves whether their beliefs about the nature of reality are culture-bound within superstitions of the past, or whether it is our own beliefs that are culture-bound (within superstitions of the past)? Whose truth is the truth? Do we believe that truth is always a cultural construction?

The following section is written, based on the underlying assumption that a spiritual dimension exists, and that there is a non-physical dimension interwoven with our physical world. I present a brief overview of various kinds of people who claim to 'go between' the worlds. This includes both specialists like shamans and mediums who say that they focus deliberately on inter-dimensional reality, and also those who have involuntary episodes like Out of Body or Near Death Experiences (OBEs or NDEs) or 'religious experience'.

In the West 'religious experience' embraces various conditions including dissociated states, visual and auditory input, which have sometimes been considered pathological. Altered states of consciousness are an integral part of various religious practices, whether large scale and organised or smaller and more ad hoc. One example in contemporary Britain where altered states are deliberately sought are the Mind-Body-Spirit Festivals which offer experiential workshops. These workshops offer a wide range of opportunities to participate in shamanic journeying, training for lucid dreaming, channelling, vision questing, trance dance, yogic practices, singing bowls and chanting mantras. The inspiration for these has been gleaned from Indian, African, Native American and Tibetan techniques to name just a few. One difference between this type of spiritual experience and psychosis is that the experience is solicited in the former case, and it does not overwhelm the individual (or the community). There are those however, who argue that a genuine religious experience is one which occurs spontaneously, and not one which is obtained by different tools and techniques.

### **Inter-dimensional Reality**

In an attempt to further understand the mechanisms, which may result in religious experience, I take a look at the concept of 'inter-dimensional reality'. Throughout the world, most societies have specialists, who claim to work inter-dimensionally, that is, they claim to see, talk to, interact or negotiate with non-physical entities. In our society they are called psychics or mediums, elsewhere they may be known as shamans. Their functions regarding consciousness are different - and various names have been given to those with similar skills (healer, medicine man, witch doctor, sorcerer etc). In the DSM (Diagnostic and Statistical Manual of Mental Disorders) certain diagnostic criteria for schizophrenia are rather similar to the desired conditions of shamans in an altered state of consciousness. Within the bio-medical model, the First Rank symptoms 'have formed the basis for most modern systems of diagnosing schizophrenia' (Thomas 1997; 19). Psychiatry is based on signs and symptoms rather than known causes. Both biological and psychological models of schizophrenia suggest that its origins are located in the brain or mind of the individual (Thomas 1997; 51). However he notes 'there is considerable evidence that society including family, social, economic and political factors, is inextricably linked to the nature of schizophrenia' (ibid.). The National Schizophrenia Fellowship notes that 50% of those experiencing schizophrenia in India and Africa are cured, compared to 6% in Denmark, 25% in Britain (Kirkness 1997; 10). Thomas notes that psychological pathology presupposes that 'hallucinations are inherently abnormal' and are believed to arise out of a disease of the mind (1997; 24). Certainly in the Western world, that was the belief for numerous decades during the 20<sup>th</sup> century. The following paragraphs explore emic explanations for inter-dimensional activity (emic: i.e. peoples' own explanations, rather than the observer's interpreted explanations: etc).

## **Shamans**

A shaman is a man or woman who intentionally communicates with the non-physical world. They may undertake a journey to the non-physical dimensions for various reasons: on behalf of others, for the benefit of the community, to gain information, or to effect healing. During journeys to non-physical realms, time and space are said to collapse. Shamans can master the spirits and can introduce them, at will into their own body. Their body is a receptacle for the spirits, and using guiding spirits they can treat the sicknesses and afflictions of kinsmen. Although spirits do sometimes possess the bodies of shamans, shamans do not need to be possessed to do healing work or undertake remote vision. The shaman's journey is a way of travelling into other states of awareness, or alternative levels of consciousness (Vitebsky 1995). Shamanism is not a religion, more a way of being. A shaman's job is to harmonise between individuals, and between humans and nature (Lewis 1991; 178). The practice is linked with ecological stability and is a powerful force in controlling and managing the relationship between humans and natural resources. Shamans deliberately choose to experience alternative states of reality however; a person who remains in the spirit world and cannot function in everyday reality is not respected.

Different cultures interpret alternative states of consciousness differently and what is considered 'normal' varies from society to society. In the Western Christian situation trance has sometimes been considered on a par with mental disability, and Christian mystics were deterred from speaking out by the threat of heresy (Lewis 1991; 34). Lewis claims that shamanism and spirit possession are part of the same phenomena. The shaman solicits contact with spirits. A sick person does not. The Tungus in Siberia believe sickness is caused by spirit possession and they too differentiate between people who are possessed involuntarily and those possessed voluntarily. Lewis acknowledges that in the West, although possession may seem bizarre, in other countries it is a culturally normative experience. Fernando notes that other cultures' way of thinking about the spirit world is often dismissed in the West as 'superstition'. He suggests that in the US, people of African descent, Hispanics and Native Americans have been 'over-diagnosed' as schizophrenics. He notes that in Western psychiatry, mystical or trance states are associated with 'loss of ego control' and they are seen as pathological because 'self control' is considered important in Western culture (Fernando 1991; 190).

## **Psychics and Mediums**

Individuals who have religious experiences where they appear to be seeing or communicating with deceased relatives, could they be having experiences on par with the spiritualists? Those who attend Spiritualist Churches believe that a medium is a messenger bringing information from the spirit world to a person in the physical world. Charles Tart says that messages interpreted as coming from the dead have been in vogue for spiritualists since the mid-19th century. But he notes that people rarely conduct research into this, and he asks whether the link is between the medium and the deceased, or the medium and the questioner's mind (1997; 167). Spiritualists believe that the soul comes from our higher self, and can leave at will, while the spirit resides in the body and leaves on death. When we die we move to a different state of being, but our spirits do not necessarily become enlightened. Badham claims that cases of contact with the deceased have been recorded since the fourth century CE. He suggests that the stream of consciousness may be perceived to continue after death, and there is a strong case for the existence of extra-sensory perception. If thoughts can pass from one brain to another in the living, it may be possible for there to be communication between the living and the dead. If there was such a thing as life after death, thoughts could be passed telepathically into an embodied human being (Badham 1992). In the past, contact with a deceased person either visually or through words has

frequently been considered to be either a hallucination or that the person is suffering from delusions. Various types of non-physical manifestation have been described by the ethnologist Capdecemme as a result of her field work among 'seers' in Wales. She comments on the silence of those who see 'the returning dead': a silence borne of fear of being labelled susceptible to hallucinations (1997; 18).

A psychic is someone who is an inter-dimensional 'seer' (regarding past, present or future time). A clairvoyant may see spirits: objectively i.e. with the eyes open, or subjectively through their soul i.e. with eyes closed. A clairaudient hears voices, while a clairsentient is filled with knowing and understanding. 'Seeing' is a question of vibration: a seer raises his or her vibration in order to function: they say non-physical beings occupy the same space as us but vibrate at such a high frequency that we can't see them. Badham suggests that there have now been numerous cases, and it would be better to consider many cases as 'veridical', (coinciding with fact, i.e. corresponding to what happened). A channel is someone who deliberately allows their body to be overshadowed by a non-physical entity, which then communicates through them. Like Badham, Tart suggests that psychic manifestations such as telepathy and clairvoyance are 'probably the basic modes of communication' in life after death. He suggests humans are psychic beings who are sometimes not limited by time and space (ibid.; 196). The question is ... if human beings have a facility for 'being psychic', when they are having religious experiences, I assume there is plenty that distinguishes the 'seeing' of the psychotic, from the 'seeing' of the psychic, however, case studies in the archives suggest that this depends on the time, place, and common consensus opinions of those around the seer.

### **Neo-Shamanism**

While these days it is common for psychics and mediums to remain silent about what they do or don't see in the non-physical realms, those who undertake experiential neo-shamanic journeys have a wide following, with journals devoted to the practice, and many books have been published over the last decade. In the West the interest in neo-shamanism has greatly increased over the last couple of decades. This is an experiential practice in the West, which was originally influenced by Native American and African traditions. Shamanic journeys require an individual to deliberately undertake a lucid dream, with the intention of finding out or healing something for themselves or the benefit of others. The experiencer intentionally goes into an altered state of consciousness using drumming, drugs, or certain standing postures. Users claim to transcend space and time, doing a kind of remote viewing in the non-physical worlds, seeing spirits of the dead, and undertaking psychopomp work (which helps those who have died a violent or untimely death resolve the issues). In New Age journals, therapists explain openly how they interact with earth-bound spirits. For example the O'Sullivan's describe how ancestors can attach to their living relatives to such an extent that they develop 'physical symptoms consistent with the ill health the deceased had in life' (O'Sullivan 1999; 13). They present a case of an individual who experienced a sudden death but did not know they had died. These and other experiential practices seem to bridge the dimensions of consciousness between health, life, time and death. Also they seem to shorten the distance between cultural perceptions.

### **Non-corporeal Vision**

In theory, shamanic practices seem to require paraphernalia in order to reach the non-physical worlds via altered states of consciousness, whereas psychics and mediums simply appear to be able to 'switch on'. There are other examples whereby the consciousness of individuals itself appears to be 'non-physical' and apparently exists outside of the body.

Certain conditions have attracted scientific attention. Charles Tart records a case whereby a woman experiencing an NDE (Near Death Experience) saw what was happening around her in the operating theatre. This was considered particularly remarkable, since she had been blind since birth (1997; 177). A similar case was recorded by the anthropologist Richard Katz, who conducted fieldwork among the !Kung San of the Kalahari who live in Southern Africa (1976). These hunter-gatherers, previously known as "Bushmen", experience heightened states of awareness, during which they can effect healing and achieve a transcendental experience. The dance provides healing which is a way of dealing with misfortune and illness. Once they reach a heightened trance, they appear to develop clairvoyant vision, and become a conduit for healing energy. A blind man explained how, during the dance, God gave him back his eyeballs so he could 'see' again. People are able to contact the other world, places where ghosts and dead ancestors live. Sometimes they are able to converse with spirits there. People consider that this state of alternative consciousness is one of their most important abilities for dealing with ordinary daily life. It is seen as a temporary state, since whoever does it still has to perform as a hunter in ordinary reality. Those who remain in a state of trance are considered to have made a mistake.

Among the aforementioned Tukano peoples of the Amazon, crystals are used for remote viewing: shamans use the quartz stones for scrying, as a 'kind of television screen' (Reichel-Dolmatoff 1997; 152). The shaman uses a crystal to look out over the territories of neighbouring peoples. In this way he can view distant forests, hills, and houses. Using the crystal as a medium he can assess people and their actions, the environment, and plant and animal resources. This ability is a powerful force to monitor natural resources. Remote viewing using geographical co-ordinates and rigorous protocols, is a technique which has been employed by the US military, with individuals being trained at the Monroe Institute in Virginia (Brown 1997; 15). Those trained, could 'see' beyond national boundaries and their skills were used for spying (Morehouse 2000). Once again, this skill appears to be a facility of the human species. I wonder whether certain types of religious experience are the result of individuals switching into other geographical locations, unintentionally? If one is not aware of the possibilities, and if one doesn't have a framework of understanding, then this could be extremely confusing for anyone experiencing it.

Case studies by the psychiatrist Peter Fenwick and his wife, describe hospital patients who viewed their body from above. Some travelled outside the room (i.e. they undertook remote viewing and saw situations occurring elsewhere). Very few travelled any great distance. They reported seeing deceased or religious figures, visions of the future, brilliant lights, and felt as though they had extra sensory perception (1995). The cardiologist Sabom reports a case whereby in 1991, a 35 year old woman described the procedures for brain surgery which she perceived during her own operation for an aneurysm. At the time 'her heartbeat and breathing stopped, her brainwaves flattened, and the blood drained from her head. In everyday terms she would be dead' (Sabom 1998; 37). She said "it was not like normal vision. It was brighter and more focused and clearer than normal vision" (ibid.; 41). She could also hear the medical team's conversation as the operation progressed.

With regard to Out of Body Experiences (OBEs), the main characteristic is the feeling that one's centre of perception is located somewhere outside the body (Osis 1997; 166). In an OBE the mind is clearly separate from the body and is capable of the same level of rational conscious thought. The psychologist Osis describes recorded cases whereby external observers 'see' the person as an apparition, at the same time as he or she is experiencing an OBE. He suggests that "[a]n apparition experience is awareness of the presence of a personal being whose physical body is not in the area of the experiencer, provided the experiencer is sane and in a normal waking state" and "... apparitions that are collectively seen do suggest a disembodied agency" (ibid; 165).

It would seem that these cases are talking about a 'centre of perception which appears to function outside of the body'. At first glance, this sounds very similar to the properties of the 'soul' or 'life force' which various native peoples such as the Thais or the Melanesians describe as being able to travel outside the body. I wonder whether certain native people have a greater understanding about the nature of consciousness than we have in the West? For example, during trance dance a blind Kung Bushman claimed to see, in the same way that Tart reports a blind patient who 'saw' during an operation. The Kung reached a state of heightened awareness through dance, while patients in the West might achieve heightened awareness through suffering or trauma. There are monographs in our anthropological libraries, which appear to question native peoples' perception about apparitions, yet there are scientists in the West like the psychologists Osiris and Tart, who suggest they are possible. There are examples in the RERC archive, which describe the seeing of apparitions and remote perception.

### **Liminality**

The concept of liminality is interesting with regard to understanding psychosis. Arnold Van Gennep identified three stages of transition: 'separation' (from an earlier condition); liminal (the condition of being in transition); and post-liminal (incorporation into a new situation) (1960; 21). He noted that shamans go into liminal states to conduct their rituals. Their visions of spirits who have died a 'bad' death are seen in a liminal state of consciousness (I guess it might be something like purgatory). Altered states of consciousness occur in a liminal space, where 'time and place' are meaningless. Shamans deliberately choose to experience alternative states of reality, but I wonder how many case studies there are in the archives, where individuals have been diagnosed as psychotic or schizophrenic, who have simply switched, unsolicited into liminal space? These days, this diagnosis of schizophrenia is happening much less, but in the past, it was prevalent.

## **THE POLARITIES OF CONSCIOUSNESS**

### **Non-physical Dimension and Verity**

This section discusses the ethnographic case studies mentioned earlier, and asks whether they have any relevance to religious experience, and to its occasional interpretation as pathological. I am wondering whether in the past we (Westerners) have ever ignored the non-physical attributes of existence, assuming perhaps that they were figments of a culture-bound imagination? The material presented in the section above, indicates that those who conduct scientific studies like Tart and Sabom are suggesting the existence of a non-physical dimension. This has a relevance to the topic of religious experience and pathology. Either shamans and psychics are delusional, or it could be possible that people, with their skills and faculties to see beyond the five senses, can see manifestations of subtle energy with far more clarity than we in the West are accustomed to. During OBEs and Near Death Experiences, it seems that individuals are somehow accessing a non-physical reality. It may be possible that certain individuals who experience religious experience and are labelled as psychotic, have accidentally tuned into a non-physical dimension, but have no framework on which to hang their understanding, and no on/off switch with which to return to common consensus reality.

In the same way, if a non-physical dimension was a reality with collapsed time, would it be possible for an individual to slip back unsolicited, into a previous or earlier existence and

become rather confused and distressed? If somebody shifts into a different time-frame from those around them, and has no conceptual framework for describing this 'reality', surely confusion would result? Likewise, if they find their centre of perception has shifted not only in time, but also in geographical location, so they are apparently seeing a place far removed from the location of their physical body (and physical eyes), wouldn't this also result in confusion? However specialists like shamans claim to do this at will. They claim to switch on and switch off an experience at will.

It would seem that interpretation of events like the above, depends so much on the belief system of the observer. When someone sees 'something' which those around them don't see, is it a hallucination, a delusion, a vision, or an apparition? At what stage is the phenomenon judged to be veridical, and by whom? According to dictionary definitions, 'to hallucinate' is to see something which is not there, but it could also be: - to see something which other people say is not there. Likewise 'a delusion' is: - a false belief, an error, hallucination, but it could also be: - a belief which other people disagree with. A vision is: - something seen by a mystic, or a sighting, which other people accept has occurred. An apparition is something startling which some people may believe has appeared and some may not. It may be considered to be veridical. Veridical means: - telling the truth, coinciding with fact, i.e. that something is corresponding to what happened. It would be interesting to go through the archives, simply looking for peoples' responses to religious experiences, to see what actually occurred after an event. This is what I have done in the following paper.

There are cases whereby anthropologists working in the field have seen things, which affected their belief system. Edie Turner is an anthropologist with the University of Virginia who conducted fieldwork in Zambia in 1985 and reported on a Ndembu healing ceremony. While she participated in the Ndembu rituals she actually saw a spirit manifestation (1992; 1), and she was not willing to push this experience aside. In the preface to her book she writes "I felt that there was some human birthright which we possessed, which like sex in the Victorian age seemed taboo to anthropologists (ibid.; xiii). She notes that anthropologists have sometimes argued that the people they observed were prone to self-hypnosis, which induced hallucinations, and the effects were imagined owing to a need for mystical reassurance. She asks "[w]hich world of logic is the correct one, theirs or ours?" (ibid.; 4). She notes that the doctor / shaman does not see with the eyes of his or her body, but the eyes of his or her soul. What is seen, is considered to be 'out there' and not projected through the mind. She quotes the anthropologist Paul Stoller who experienced sorcery while working among the Songhay of Niger with a priestess called Dunguri. He says

all of my assumptions about the world were uprooted from their foundation on the plain of Western metaphysics. Nothing that I had learned or could learn within the parameters of anthropological theory could have prepared me for Dunguri.

Edie Turner claims that these visionary experiences 'are not projected through the mind' (ibid.; 171).

The above examples raise various points: one questions whether psychic phenomena exist in their own right, and why some people see them and not others. Why do some people have religious experiences and others don't? The question as to whether the psychic occurs in our brains, in our consciousness, or whether it is actually external to us has concerned numerous researchers. Carl Gustav Jung frames the question

Were the dissociated psychic contents - to use our modern terms - ever part of the psyches of individuals, or were they rather from the beginning psychic entities existing in themselves according to the primitive view as ghosts, ancestral spirits and the like? (Jung 1933; 170).



He noted that native peoples believed ancestral spirits were not hallucinations: it was not their imagination; rather the spirits appeared of their own volition. One might ask whether there are really non-physical entities, which can overshadow (take possession of) our bodies and affect our health either detrimentally or enable us to become clairvoyant. The empirical evidence lies in the testimonies and case studies of those individuals who present to a psychiatrist, and claim they have someone with them, within them, confusing them, talking to them.

If we acknowledged as veridical, those unusual aspects that seers, psychics and shamans claim about non-physical dimensions, perhaps we might re-evaluate our response to certain types of religious experience. For example, Olga Kharitidi was a Russian psychiatrist who worked in a mental hospital in Novosibirsk in Siberia and had personal experiences of 'voices in her head' and 'visions' which shattered her view of reality. During one of her visions she was told that time should be taken to determine the cause of mental ill health:

... if you are mistaken in the cause, then your attempt to heal will actually feed the disease and make it worse (Kharitidi 1997; 177).

It is possible that a grasp of different dimensions of consciousness might offer an alternative model for the treatment of certain mental health patients in the West. The psychiatrist Stanislav Grof has done a considerable amount of research about altered states of consciousness. He suggests that when individuals in Western societies have experiences of spirit dimensions, which are not integrated, they may question their sanity (1998; 11). Examples of this are found in the archive.

If we look beyond the cultural paraphernalia of ritual practices – if we look beyond the cultural assumptions of practicing observers – perhaps we could learn something profound about the subtle human condition from native peoples' understanding of consciousness? Perhaps the ethnographic accounts, which fill our libraries, are not just anecdotal, perhaps they provide us with information about subtle levels of existence? Is it possible that some people see manifestations of subtle energy with far more clarity than most of us are accustomed to? Have those people who have had religious experiences, and then been diagnosed as schizophrenic, tapped into the spiritual dimensions in an uncontrolled manner?

### **A Different Explanatory Model?**

Let us suppose that what we assume to be delusional is veridical; that mystics can spontaneously see visions and hear voices; that specialists can recall past lives, their own and other peoples', communicate with the dead, become deliberately overshadowed by spirits, experience 'extended empathy', and undertake remote viewing (within various geographical locations and time frames). Is it possible that 'normal' human faculties could include: past life memory recall (whereby consciousness stays in the same place, but at 'other times'); remote viewing (whereby the body stays within the same time frame, but non-corporeal consciousness moves to and reports back on 'other places'); perceiving individual consciousness remotely from the body; seeing spirits of the dead (whereby consciousness exists at the same time/place, but tunes into discarnate entities in other dimensions); experiencing spirit possession (whereby a human body is 'porous' and can be overshadowed by incarnate or non-incarnate beings); hearing voices (whereby live and dead beings verbally assault/assist the client); and other discarnate presences are felt. While acknowledging the role of trauma and anxiety (bodily, personal, social, environmental and political), and that the mind can create or generate any of the above, as well as hallucinations and delusional thinking, is it possible to consider an alternative framework? If there was a non-physical dimension, and if the above were veridical, it may well cause

ontological shock, but would we be able to develop a different explanatory model for certain types of religious experience? Would we be able to promote a different attitude towards the mid 20<sup>th</sup> century pathologising of experience?

Some neurologists claim they have found the link between religious feelings and the brain's temporal lobes. The psychiatrist Persaud suggests that what he calls 'supernatural beliefs' might have a biological basis, and that the interconnectedness native peoples experienced with the universe, was a survival mechanism (1999). Instead of using biological data to exclude the non-physical dimension, perhaps we might encourage a model of existence that incorporated both. In Western society, is it perhaps because we do not have an ontological model for life after death, that we have experienced confusion when trying to understand religious experience and psychosis? Although we are beginning to accept the idea of consciousness after death, we may still find it problematic to embrace the concept of non-corporeal discarnate consciousness with personality (spirits). Likewise there has been reticence to perceive that the human body is in some way porous and, like a radio transmitter, can tune into different planes of time/space, or be tuned into by non-corporeal entities. Today, more and more people consider the possibility of consciousness continuing after bodily death, rather than denying it. Our earlier lack of understanding regarding non-physical aspects of human beings, and our former culture-bound explanations for certain symptoms of mental suffering, are being resolved. There are now more holistic approaches to understanding religious experience. If we went through the archives today, I suspect we would find there was a shift in attitude over more recent decades, as both health care practitioners and the public became more supportive of a holistic world view.

*Natalie Tobert, 2000*

This paper was adapted and used for a chapter on 'The Polarities of Consciousness', in the book: *Psychosis and Spirituality: Exploring the New Frontier* (edited by Isabel Clarke, Whurr Publishers, London, 2001).

**Paper Two**  
**IN-SANITY: RESPONSES TO RELIGIOUS EXPERIENCE**

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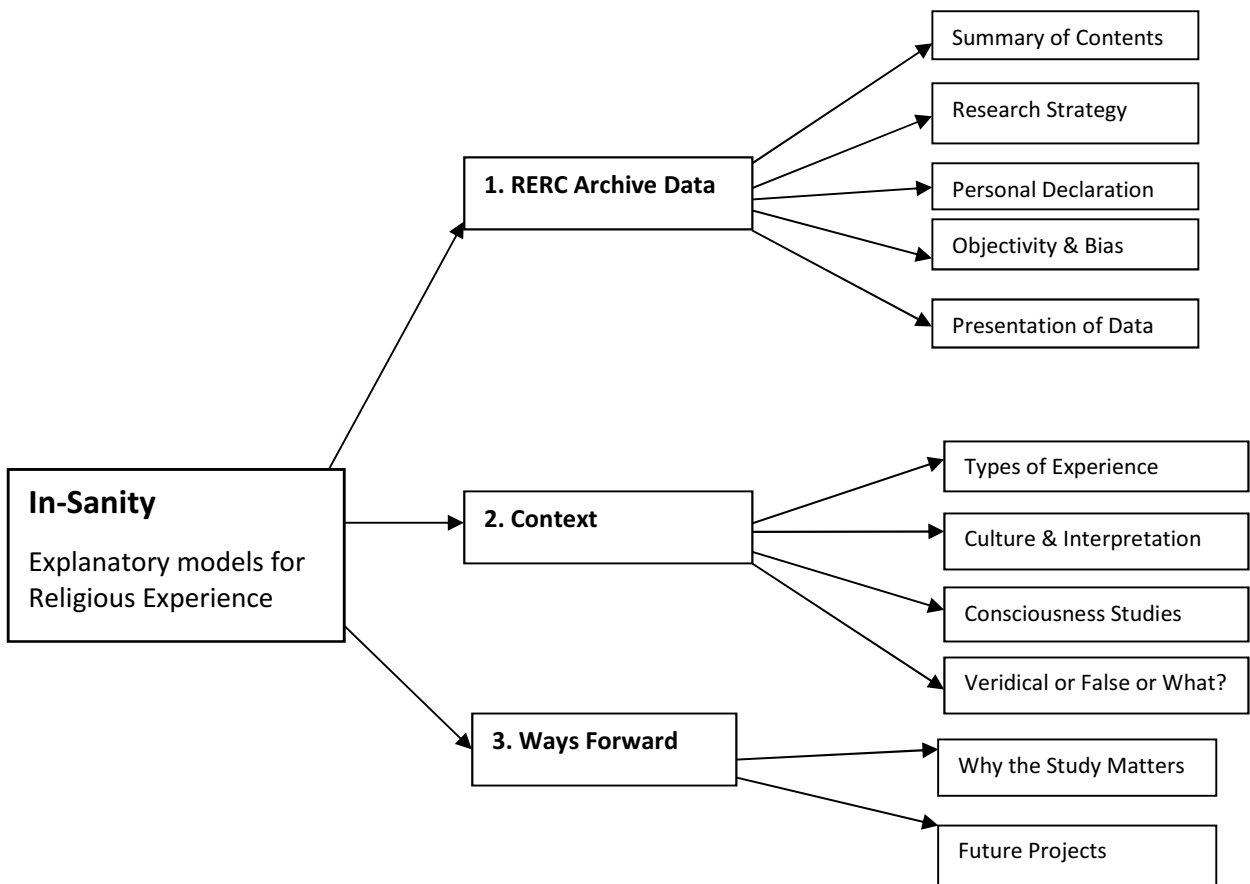
## INTRODUCTION

This report is organised in three parts: the first presents data from the Religious Experience Research Centre archive, the second situates it in literary context, and the third explores ways forward for future research into religious experience and health.

The paper explores peoples' responses to religious experiences, based on records, found in the RERC archive at Lampeter, University of Wales. I was interested in the *response* to the experience rather than the content itself. **In particular, I wanted to explore the explanatory**

**models for religious experience that were perceived by society as negative, or in need of psychiatric assistance.** This study is important because it explores whether there is a gap between: public perception, psychiatry's health care strategy, and practices in different locations.

## SUMMARY OF CONTENTS



## RESEARCH STRATEGY

In this section, I explain how I went about the research, using the archive for the first time. I used one large file in the archive, which John Franklin had suggested, in order to find a series of key words to search on. These words are set out in figure 1. Then I found out the number of times they each occurred as keywords in the subject field. However, I found out on a subsequent visit to the archives, that I could also search on all the words in the text. For example, there was no incidence of the word 'psychiatrist' in the subject field, but it occurred many, many times within the text itself.

**Figure 1**

**Terms selected, based on one case study, then searched in subject keywords**

Mad	Doctor
Insanity	Psychiatrist
Mental illness	Psychologist
Schizophrenia	Clergy Priest Bishop Vicar
Depression	Counsellor
Mental breakdown	Interpret
Unstable	Misinterpret
Consciousness	Explanation
Lunatic	Belief
Cause	

In order to sample the database and its contents, I decided to use three words only, from the incidence of topics found in the subject field, during the first search. My first indicator of mental health problems (real or assumed) was the use of any of the three keywords: madness, insanity, schizophrenia. I wondered how accurate the archive keyword was as an indicator of frequency? In order to explore the kind of data I would like to collect, I took a trial of three samples: selecting the 10<sup>th</sup> example from each of the 3 categories: insanity, madness and schizophrenia. (fig. 2)

**Figure 2**

<b>Trial, first 3 cases:</b>	3683, 1241, 1517

Then I prepared a chart of the contents (fig.3) relevant to my research, which contained a selected number of fields. I wanted to record the person who had the experience, the content of the experience, how it was explained and interpreted, the effect it had on them, whether any intervention or healing took place. I was interested in the meaning that was ascribed to the experience and the things that people said might have caused it to occur. I wanted to know how they (the experient) understood it, and how it was interpreted (by professionals, religious and medical, and by family and friends). I finalised the chart in which to enter the data. In the event, I didn't always fill in all of the fields, but it provided a solid way for me to start collecting data.

**Figure 3. chart for data entry**

Person:	No.
Content	
Effect	
Intervention	
Healing	
	Contextual understanding
1 <sup>st</sup> Person Experience	
Professionals' meaning	
Notes:	

I was not particularly interested in the content of the experience, or whether it was considered to be a positive or negative event, rather I was interested in people’s response to having had an experience and the response of those around them, both personal and professional. I was curious to see how people explained the experience and how it fitted into their framework of understanding about the nature of existence.

During my first visit to Lampeter, I sampled 20 cases in all. There were 140 incidences of the three keywords ‘madness, insanity, and schizophrenia’ in the subject field of the archive’s 6,000 items. Once I had sampled three cases, I had an idea of the kind of material that was available for data collection. I returned to the list of occurrences and sampled every 7<sup>th</sup> case. I wondered how accurate the archive keyword was as an indicator of frequency of an actual mental health issue? I checked over the content of each of the first twenty cases, and noted the results. (fig. 4)

**Figure 4** First sample, every 7<sup>th</sup> case

Terms Selected from Text field:				
Insanity	2034	2411	3071	
	3683	4139	4552	
Mental illness	0781	1282	2565	3134
	3937	3833	4144	4150
Schizophrenia	0593	3266	3455	4440

**Figure 5. Accuracy of keyword**

Evidence of pathology	11111 11111
Pathology, cured by prayer, healing	111
No evidence of pathology	111
No evidence of pathology acc my terms	11
No evidence but pathology in old age	1
Experience was healing, valued	11
Neurotic	1
Cataloguing error	1

**Accuracy of keyword.**

In order to assess the accuracy in the subject field, of keywords ‘insanity, madness, and schizophrenia’, I looked over the 20 cases I had noted during my first visit. Of the 20 cases reviewed, there were 13 women and 7 men. I felt there were 10 clear cases of pathology, and one with neurotic pathology. Within these 10 cases, 3 were eased by experiences of prayer and healing. I felt there were three cases where there was no evidence of pathology in the texts, and another two which I personally would not have called pathological. There was a further one in which there was pathology in old age, but no evidence of it earlier on during correspondence. In two cases the experience was healing and valued. I felt one case must have been a cataloguing error.

## **EVIDENCE FOR PATHOLOGY: Sample Group**

I wondered whether the use of the words 'insanity' or 'madness' in the subject keywords was an indicator of actual pathology of the respondent, or whether those keywords were input in response to some other trigger. The findings from the total sample group suggest that the number of times a keyword is mentioned cannot be used as an adequate indicator of the presence of mental illness.

There were three cases where there was no evidence of pathology, although the term 'mental illness' was used in the keywords. For example, in one case (0778) the respondent worked in a psychiatric setting, as a social worker. It was her place of work, and was not related to her religious experience, when she was overwhelmed by the magnitude of nature, nor as a response to it. Likewise, in America, one man's mother (4849) threatened him with an 'insane asylum' if he didn't stop his stories of Out of Body Experiences and remembered past lives. However, he regarded his experiences as veridical, and there was no evidence in the text that they were pathological. Due to his mother's threats, he stopped speaking about his experiences. Similarly in another case a woman wrote in and described a friend with mental illness, but there was no evidence that her own experience triggered ill health (4803). In the three cases mentioned in this paragraph, the use of the term 'mental illness' as a keyword, was not supported by a more detailed search in the text. That is, its presence was not an indicator of mental illness of the respondent.

However, other respondents clearly had life events or experiences that did trigger mental illness. One woman received a message from her deceased father-in-law and it did trigger a mental illness (2712) then it transformed her life. Similarly another's psychotic attack was triggered by her father's death (3697). She was admitted to an asylum. There is one case of those sampled, when a man was possessed by another being (3284), and he had been mentally ill. However, the assumption of the respondent was that the possession was veridical, and could be cured by prayer: he questioned the universal applicability of the concept of religious experience. Another man's doctor and vicar assumed that his experiences of voices and white light, were symptoms of mental illness (4346) and he did spend some months in an asylum. One woman explained that she was psychotic, due to her daily life problems (0210), and experienced divine presence while she was locked away in a psychiatric ward. Another had a psychotic episode at her mother's death, but then found her experience of healing through prayer (3066). One said her family had had schizophrenia, and she did later in life, but it is not known whether this was the result of her experiences (0216). However another two women's experiences did lead them to symptoms of mental illness and subsequent diagnosis (4174, 3683). One was diagnosed with schizophrenia and had to leave her nursing career. The other was prescribed tranquillisers from the age of 16: her psychiatrist described her symptoms as 'chronic neurosis'.

There were more cases where the terms were used, where respondents were clearly having mental health problems. For example, one woman who over indulged in alcohol in 1950s, was placed in a mental asylum abroad (1517), and was diagnosed as schizophrenic. However, she didn't feel she was insane. Perhaps she would be considered neurotic rather than psychotic. Her experience, which had occurred while she was inside, gave her strength. In contrast another respondent did describe herself as schizophrenic (1050). Although she hadn't written about any professional intervention, it looked as though she valued the experiences. Likewise, one man had manic depression, fed by his 'insights' (1784). His condition was clearly pathological since he was unable to function on his own, or within society.

In one case (2335), a man was locked up in Broadmoor, a prison for the mentally insane. He felt the presence of God when he cried out for help from his cell window. We do not know from his papers, whether his religious experience was the result of his insanity, whether this triggered it, or whether his criminal activities were as a result of his religious experience. However his note said he found the experience 'healing'. The keyword may have been used because of the place where he was incarcerated. Another man who was an ordained vicar lists 33 experiences with their dates (0536) for the archive. The term 'mental illness' was in the subject keywords. There was no evidence that the original respondent or his colleagues considered his religious experiences as pathological, but there is evidence from his wife's note that he experienced pathology in old age.

There was one case (2264) where mental illness was used as a subject keyword, but it was probably a cataloguing error, since there was no mention of pathology in the papers, and the respondent said she found the experiences comforting. There was another case, whereby I had transcribed the number wrongly (4178 instead of 4174). It seemed as if the use of particular words as key terms in the subject field, was subjective. Different people had input the data to the archives, and the presence or absence of the keyword may have been a subjective decision. Closer attention was required to look more precisely at the body of the text.

During my second visit, I was made aware that I had only searched the subject field for key words, so I spent the first part of the day going through the computerised archive once again. In the body of the text of each record, I found many more instances of the three keywords: insanity, madness and schizophrenia. I highlighted those that had questioned the experience or noted its link with mental illness, and then I made a more detailed search on those highlighted. Many were examples where the term had not been used as a key word by the cataloguer, but had been written in the body of the text. Later during the visit, when I became interested in specific questions, I did not fill in the whole data input chart I had designed, but just noted those elements that were relevant to the points I was searching.

### **Key Points re. Sample**

- The presence or absence of the terms 'madness, insanity, schizophrenia' in the subject field keywords alone, is not necessarily an indicator of the frequency of experienced pathology.
- The term 'pathology' is understood differently by different people.
- The term 'insanity' in the subject field might refer to a place of work, or residence, or a threat by another.
- A pathological event may occur much later in life, and be unrelated to a person's religious experience.
- In some cases the experience led to a pathological event.
- In some cases the experience was comforting, healing.
- Even if there was pathology, it may or may not be linked to the religious experience.
- Cataloguing errors and researcher errors occur.

It is my opinion that the interpretation of data (more than the gathering of data) raises concerns over bias. I have declared my personal bias in the text below, followed by a note on objectivity.



## PERSONAL DECLARATION

Before continuing with this paper, I would like to declare my basic assumptions regarding religious experiences, so that readers are clear about my biases. In my twenties I had visionary experiences, whereby I seemed to 'tune in' to a person during the World War II. For years, I spontaneously remembered scenes in a concentration camp 'experimental research hospital'. It was the darkest kind of human existence I could conceive of, and I prayed that these scenes would stop. They lasted about a decade, then they stopped completely. Throughout I always knew which was common consensus reality, and which were memories, either from a past life I'd lived, or from someone else's life. These memories influenced my emotions and my body cells, but not my intellectual mind, or so I thought. I am still reticent to allow any kind of medical intervention. I always felt 'as if' I had experienced trauma, although actually in this incarnation, I had not.

In my thirties, I became interested in shamanism, and began attending workshops and trainings to do 'journeying', like lucid dreaming, or remote viewing. The things that I 'saw', the experiences that I had, I assumed then, and I assume today, were veridical. It was clear to me that there were different ways of knowing. The more workshops I did, the more sensitive and porous I became. In all those years, I only had one experience I considered to be an hallucination. This was like a movie film that I could not stop at will. It occurred during a university conference in the 1990s: I knew what was happening, it fitted within my existing explanatory framework, so I took myself to bed, and hid under the duvet for several hours, until it stopped. From that day onwards, I stopped attending all experiential workshops. Completely. I realised I was receiving 'more data' than I could handle, and I wanted to desensitise myself. I wanted to become less permeable. I prayed that the seeing would stop, and after several years it did. These days I only see common consensus reality. Throughout the years I was fortunate: I could always distance myself and would witness any visionary experience I had.

Throughout those decades, my only encounters with psychiatrists were social or as colleagues, through my membership of the Scientific and Medical Network. For some reason I assumed my experiences were a normal part of the human condition, available to everyone. When I became aware that within psychiatry there had been another body of thought regarding religious experience and mental health, it felt inadequate to me. Talking to psychiatrists I resolved this, for they made me aware that it was only through having a combination of symptoms that a person would be considered mentally ill. However, it still felt as if there was a mismatch between public perception and the most sensitive and aware psychiatrists.

I wanted to explore the nature of this mismatch, to determine its extent with regard to religious experiences. Using the Alister Hardy archive I searched for those records, which had the words insanity, madness or schizophrenia in the keywords. I wanted to find out how people who had the experience, responded to it, and how those near to them reacted. However, even before I considered this, it was clear that there seemed to be one way that respondents to the archive reacted to a religious experience, and this was not to talk about it, to keep it a secret. Some people seemed to attach a stigma to having a religious experience, and so an early section of this paper considers the topic of 'stigma'.

## OBJECTIVITY AND BIAS

Due to my own experiences, mentioned above, it is obvious that I am likely to interpret the cases found in the archive, in a different manner from someone who has not had experiences. The topic of religious experience may so challenge our perception of reality, that I feel unbiased objectivity is not feasible. It is fine for collecting and monitoring the data, but not for interpreting it. This is because I am of the opinion that data will usually be interpreted according to the observer's own knowledge base (Tobert 2005a).

I do not consider that the having of religious experiences *per se* is indicative of pathology. The ability to function in everyday life, and not to be of harm to oneself or others needs to be taken into account. This may be in contrast to some (like Claridge 2001) who might consider the having of experiences themselves to be an indicator of a schizotypal personality (no slur or stigma intended). In the past, distinctions were made between real and false religious experiences (Donovan 1997; 16), that is whether they occurred spontaneously, or through action engaging a specific technique. It is my assumption that the experiences themselves are similar through whatever agent or agency they do or do not occur. It is my opinion that our interpretation is a variable: our intellectual distinctions may be false.

### Section One: PRESENTATION of DATA

## ASSUMED STIGMA

Some respondents indicated that there was a certain amount of stigma attached to mentioning religious experiences to other people. People who had them, didn't speak about them, for fear of being thought foolish, or insane, or of being misunderstood, for example if they held a belief about different paradigms of existence. Sometimes the response of established religion played a role in the unease felt by respondents. However, the work of Alister Hardy was valued, because it encouraged people to speak out about their experience and thus reduce fears. [Sir Alister was probably aware of the importance of collecting people's stories about unusual events, since he had been a President of the Society for Psychical Research.]

In order to explore the concept of stigma, I searched the database text field for the terms 'never speak' and 'never spoken', trying to exclude those, which specifically related to mundane experiences of not speaking (e.g. as in a family quarrel). There were 8 cases of 'never speak' mentioned, and 30 examples of 'never spoke'. This group however did include a couple of examples of presences, which never spoke. For many respondents, Sir Alister Hardy's press and television requests for examples of religious experience, appeared to be the first time many people had spoken or written openly about them. One said: it was

quite impossible for me to speak of my feelings of experiences – and indeed, I have never done so up to this time (1501).

Other respondents wrote:

I never speak of these things I have told you  
I never speak of my experiences.

There was also a fear that if they did mention their experience, then they would not be understood:

I never speak of this because I know I cannot make myself understood.

The following chart (fig. 6) sets out the records where these words were found.

**Figure 6. Never speak**

	0239	0256	0374	2716
	3192	4072	4542	4572

People said of an experience in the past: “I never spoke about it”, and they kept quiet about what they believed about their experiences “I never spoke to anyone of my beliefs”. It wasn’t correct to mention religious experiences “One never spoke of such things”, or “I had never spoken a word”. If they did share the experience with someone close, then that was a one-off occasion “We never spoke about it again”. There were also those who saw presences of God or Christ or other beings, and of them they said “He (the presence, or God) never spoke”.

**Figure 7. Never spoke**

0119	0278	0431	0446	0682	1155
1169	1439	1553	1730	1880	1936
2056	2132	2364	2432	2440	2464
2532	2577	2737	3015	3067	3079
3127	3378	3382	3535	3567	3707
3843	3863	4178	4344	4396	4520
4526	5394				

The chart above (fig. 7) shows the number of times the term ‘never spoke’ was found upon searching the texts in the database. One woman would have liked to talk about her experiences: she wrote that she

wanted everyone else to share this knowledge but, since it challenged established processes of thought, the response was hostile, and implied doubts about my sanity (3696).

She held her silence both due to the shadow such talk would cast on her mental health, and because she felt she had some understanding of different paradigms of thought that others did not have. Others felt it important to speak out about their experience and were glad that Alister Hardy was undertaking this research. They felt it would help those who were confounded by what they experienced. One said she was sad that

the majority of people who have unusual and wonderful experiences are often afraid to talk about them for fear of being thought foolish, or even mad (2565).

Another man, who had been hospitalised said he would not talk about his experience, even though he knew others who’d had similar experience: ‘because you, like the psychiatrists, would consider me mad’. In fact the Alister Hardy Society staff did engage in written communication with him several times (1998).

A trained nurse (3697) was advised by her doctor: 'don't speak unless you have to' when she went psychotic after the death of each parent. Another who experienced extra sensory perception (3683) suggested that it was her own enforced segregation of her experiences that led to her breakdown, and restricted her ability to lead a normal life. Once she had accepted the experiences rather than try to suppress them, she felt more healing and integration.

Sadly, one woman commented that 'it is in the realm of the church that I find myself least listened to' (2565). She was sad that the church 'doesn't welcome this kind of thing', sad that people didn't believe. It was 22 years later that she spoke about it. The maintaining of silence about personal unusual experiences was mentioned in an earlier paper, where I noted that psychics and mediums tended to remain silent, but those with shamanic experiences tended to be more open and spoke about them (Tobert 2001a). This is borne out by Capdecorme who conducted research with psychics in Wales (1997).

### **Key Points: Stigma**

- There is, or was, a stigma attached to having religious experiences.
- Some people who had them, didn't speak about them, for fear of being misunderstood, or being thought foolish, or insane.
- Being misunderstood also related to a belief in different paradigms of existence.
- Established religion played a role in the stigma felt by respondents.
- The work of Alister Hardy was valued, for its encouragement of people to speak out.

### **FEAR of INSANITY**

There seemed to be a link between silence about an experience and a fear of being thought insane, or that having an experience might shift a person over the edge. I wanted to see whether there was an assumption about the relationship between religious experience and mental illness, and between schizophrenia and visionary experiences. It felt important to explore the relationship between popular and professional perceptions of religious experience, and to understand the ways in which respondents interpreted their experiences.

Naturally, according to the previous section, there was a clear link between not speaking out, and the belief that others would find the experient lacking in sanity (0115). In order to throw light on the above topics, I searched in the text section of the database for the use and frequency of the word 'sanity'. I was interested in finding out the extent to which the respondents made a link between religious experiences and their mental health. The following section explores their beliefs about the experience in more detail.

The fear was frequently articulated, that having those kinds of experiences was likely to tip people into insanity. There was quite a high correlation, linked to stigma, and therefore respondents chose not to speak about the experience, because people would assume the experience was an indicator of mental illness. Sometimes it seemed that many psychiatrists had long left that perception aside, but it was still prevalent in popular thought. There was a mismatch between popular and professional perceptions. For example, one respondent talked about her experience, and said:

doctors laughed at my fears of impending insanity but I forced an interview with a psychiatrist. He offered nothing except I was an 'interesting case' (3455).

In the 1970s there was another example of a psychiatrist with the same positive awareness who reassured the woman who approached him (2547).

There was talk of a border, tightrope, or no-man's land between sanity and mental illness, together with the belief that having a religious experience somehow crossed this fine line, upset the balance, or disturbed the equilibrium. It was like a boundary that must not be crossed over. One, seeing an external force in the bedroom said the pressure

threatened to send me over the border of insanity  
and

I recognised my walking on a tightrope at times on the borderline of – or in no man's land between sanity and psychotic states (1918).

However, mundane life stressors might also generate this feeling:

... I have ... more than once felt myself to be on the border of insanity (2819).

There were others who felt as if they were 'tipping the balance': one when he found poignant passages in the Bible; another when she practiced yoga; and a third when she had repeated intuitions, pre-cognitive dreams and visions, said she had

always attributed it to the 'insanity' in our family (200005).

One woman said she felt her religious experiences were 'unhealthy' (0216), and another respondent assumed that insanity was inherited (0307).

One woman was in conflict due to her Roman Catholic faith (which suggested her dreams about deceased people were the work of the devil) and she found the validity of her own experiences was questioned (2943). She wrote:

... as an RC we know this is dealing with the devil, as the human mind is not meant to know these things, it often results in nervous breakdown or even insanity.

Upon having the experience, individuals were certain their sanity would be questioned (0372). They doubted their own sanity, since their assumption was that they had experienced a symptom of mental illness.

A woman who received messages from her deceased husband, was certain however, that she was sane: "my family will vouch for my sanity" (0546). Although she had no doubts, she still made a link with mental illness, as did another woman who was pregnant and saw her body filled with light and felt a state of peace (2589). There were others who said people could vouch for them, or who felt they needed to prove their sanity in some way. In contrast some found it hard to maintain equilibrium. One who had visions and dreams of Christ said:

the experience went on for two years, and I was sorely tasked to keep my sanity (1170).

The assumption that what they were experiencing was a dream (rather than a vision) was a technique people used to convince themselves of their sanity. One who saw an angel with wings in white light explained:

it then vanished and I awoke, assuming as I do for the sake of my sanity, that it was a dream (2697).

One woman became suspended in time and space. She experienced her rebirth, and lost her fear of death. She commented that

... as a clinical psychologist I began seriously to feel that my sanity might be in the balance! (3046).

Another woman who during prayer felt a burning sensation like an electric shock, running down her body, which sounded similar to those who have *kundalini* energy, was convinced about the presence of the experience:

to some it would appear that I had suffered some sort of hallucination, or was in a temporary state of insanity, but this experience will never leave me (3071).

Another wrote that

people tend not to speak freely for fear of being thought odd.

She felt that

mental illness and these experiences can be linked

and

the experience can sometimes be the cause of a breakdown (4150).

One man who seemed to have remote perception of a weapons manufacturing site clearly thought he was going insane (3455). He believed he was led by a divine hand, and suggested that 'a form of schizophrenia seemed to possess me'. However, his experience sounds more plausible when one hears of experiments with remote viewing, undertaken not only by the CIA in America, but also on a more modest level by Professor Peter Stewart in the UK (Tobert 2005b). These involve not only remote perception at different locations, but also during different time frames. Perhaps this man could have spontaneously tuned into a weapons site, but did not have a framework to understand what was happening.

### **Key Points**

- There was a link between fear of insanity and speaking out.
- There was an assumption about the relationship between religious experience and mental health. The underlying assumption (of some respondents) seemed to be that religious experience was a symptom of mental illness. The fear was that having an experience might tip a person over the edge.
- The association between schizophrenia and visionary experiences was articulated.
- There appeared to be a mismatch between popular and professional perceptions. Popular misperceptions seemed to last, in spite of professional reassurance.
- Respondents convinced themselves they were having dreams rather than visions (dreams fitted better into their paradigm of existence: 'strange dreams' were more culturally tolerated).

### **PSYCHIATRIC CONTACT**

The term psychiatrist did not appear as a keyword in the subject field, but when I checked for it in the text, it occurred at least 64 times. In fact it happened many more times than this: sometimes psychiatrists were simply referred to, or mentioned, rather than actually consulted. My interest was in those records where they were consulted, or where they intervened.

**Figure 8. Incidence of the word psychiatrist in the text**

0067	0235	0244	0286	0307	0350	0649	0666
0736	0738	0746	0907	0977	1031	1055	1077
1088	1170	1171	1176	1261	1297	1368	1449
1597	1679	1726	1753	1784	1800	1998	2071
2124	2245	2486	2515	2547	2559	2589	2688
2820	2856	2958	2988	3024	3066	3159	3268
3405	3414	3477	3524	3741	3800	3814	3903
4085	4108	4139	4150	4174	4367	4414	4422
4568							

+++ many more

Some respondents were under a psychiatrist as outpatients, others were hospitalised as a result of having had the religious experience. Some were hospitalised for some other cause, and then they had a religious experience, which transformed them. A number mentioned how grateful they were for the psychiatric treatment they received. A farmer in UK relied on electroconvulsive therapy (ECT) and drug therapies to maintain his ordinary life (1784). He found significances in minute things. Others were pleased with ECT treatment: a woman felt that the ECTs she received in a locked hospital had saved her life (3697). In contrast, another woman (0210) who felt a divine presence while in a psychiatric hospital, felt that the experience cured her nervous breakdown. She felt God's forgiveness and this led to an overnight healing after which she went home.

Another woman gave up her nursing career when she was diagnosed as schizophrenic, and received an injection every two weeks (4174). One man in Canada experienced the voice of God directly

my psychiatrist a wonderful man, relies on shock treatment and pills to control it (the voice) (1368).

He said only his wife and the psychiatrist knew of his condition.

A woman, who believed humans could tune into other dimensions and channel other beings, received a channelled message. After the message she told her psychiatrist she didn't need him, stopped the tranquillisers, on which she had been for nine years, and emerged as a new balanced person (0649). The channelled information was transformational.

For some a psychiatrist was just one of several professionals they tried to talk to in a desperate attempt to make sense of the experience:

I visited various priests, vicars and psychiatrists in my struggle to understand what was happening to me (0235).

One man noted that he was thoroughly examined after his experience, but it looked as though he was not considered psychotic:

I was examined by a psychiatrist with thoroughness for some days, and at the end written off as an obsessional neurotic (0307).

Another man also felt his experiences would be dismissed. He had felt a pulsating blackness, outside himself, but assumed psychiatrists would say it was memories of his intrauterine life (1996).

The responses of the psychiatric profession were clearly mixed. Some people found the psychiatrist was sympathetic and aligned with their beliefs, for example when it concerned the relevance of Biblical texts (0738). Another reassured a woman she was sane (2546). In contrast one respondent who had a breakdown in 1938, was sent to a psychiatrist, who said her 'vicar's influence was evil' (1800). One man had a nervous breakdown in 1953. He went to a psychiatrist, who persuaded him to 'look elsewhere for reassurances'. He later felt extraordinary peace with God (1297). Another saw a beam of light, which hit him from behind so his body glowed all over. He told his experience to an RC priest, who told him to see a psychiatrist, who discussed his outlook on life (2958).

A female psychiatrist had just one experience when in her 50s:

I became conscious of a huge cross with the figure of Christ on it, high up in the room and on my right. A shaft of love poured down from the shadowy figure.

She found the experience 'extremely moving' (1597).

One woman, a teacher at a college of Psychiatry and Psychology when she wrote in, had experiences since she was a teenager (3683). She experienced a 'personal confrontation with a level of reality' of which she had no understanding. She assumed her mind was unbalanced and consulted psychiatrists, who prescribed tranquillisers for chronic neurosis. She noted that psychic perceptions were not recognised by the scientific world during the 1960s, when she was being treated. She wanted these 'areas of human experience' to be seriously investigated.

A man who saw a shaman in feathered robe, on a bronze age hill and tumulus in UK, was told by a 'friendly' psychiatrist that it was due to 'a psychotic attack', but the individual remained unconvinced about that. He said he felt 'psychologically enhanced by the whole thing'. But he was concerned about sharing the experience with others, and therefore felt more alone (4139). Similarly, the husband of one woman was not happy with the professional intervention: he refused to have her committed to the local psychiatric hospital after she had experiences (1261). Another respondent wondered whether Alister Hardy's research might lead to religious treatment for mental illness (3134).

The sad stories of loneliness, rejection, and fear of madness continued. For example there was one woman in the United States, who had many experiences, and saw apparitions.

Feeling desperately lonely because I had no one to share my experience, I sought out a psychiatrist to see if I could communicate with someone, but they had no idea what I was talking about (2071).

She entered hospital in 1967. Again she made the assumption that having been hospitalised, this invalidated her experience for Alister Hardy:

I suppose because I went to hospital you wouldn't be interested in it as much as other people.

Her family rejected her when she mentioned life after death, and other professionals did not take her seriously.

I asked the Chaplain and he ignored me. I asked my psychiatrist and she ignored me. I tried to talk to my family and they laughed ... .. they have called me every name in the book ...

She was grateful when she heard about Sir Alister Hardy's research, and I assume this was because at last she could locate her experiences within a framework that bore similarities to her own perceptions:

I was so tickled when I got your letter at least someone does not scoff.



Then there is the sad case of another woman from the USA. In the 1970s her husband thought she was imagining her symptoms, of seeing a brilliant white light come through the top of her head. She went to several doctors, had her eyes examined, had an electrocardiogram (ECG), x-rays for a brain tumour, and visited a psychiatrist.

None of them could find anything physically or mentally wrong with me (3205).

In my opinion, this last case typifies the assumptions of pathology that were present in the last century, and it makes me wonder how many experiences were treated in this way. It highlights the problems of diagnosing and interpreting other people's experiences according to one's own framework of knowledge. If we were to conduct a survey of medical students and health care practitioners, it would be interesting to determine their response to specific case study examples. This might be used to explore which belief systems carried more weight within academia and our training institutions. If the same survey was conducted in other countries, we could explore the nature and extent of culture bound explanatory models for religious experience. The following section explores experient's opinions about the nature of their experience and whether it was veridical or not.

### **Key Points**

- This section concerns times when psychiatrists were consulted or intervened, not the frequency with which the term occurred in the text field.
- Some respondents were hospitalised as a result of having had the religious experience, others saw a psychiatrist as outpatients. Some were hospitalised for some other cause. Some felt the religious experience itself cured them.
- Some respondents mentioned they were grateful for the psychiatric treatment they received. Other respondents and their families were unwilling to accept the label of psychosis, after having an experience.
- Some tried to speak to several religious and medical professionals in order to understand their experience.
- Others underwent extensive medical tests to determine the pathology that caused the experience.
- People were grateful that Alister Hardy was conducting this research, since it might validate their religious experiences.

### **VERIDICAL or NOT ...?**

To be, or not to be veridical, that is the question. But, is it the right question? This part explores respondents' beliefs regarding religious experience and mental illness, presenting material from the archive that addressed how people responded to their experiences, and whether or not they considered them valid. Examples that date from the mid to late 20<sup>th</sup> century, present the assumptions of professionals towards religious experiences which were prevalent at that period. The implicit question was often 'is this experience veridical, or is it a hallucination?' However Isabel Clarke suggests other explanations: the web site discussing several different ways of knowing is: <[www.psypiritstory.co.uk](http://www.psypiritstory.co.uk)>.

One man in the UK wrote about his response to the experience, rather than any of the content (3833). For 9 days in 1958, he was in an altered state

perceiving sights and voices having no apparent source or cause and which were not apparent to others when such happenings occurred in the presence of other people.

He wanted to make a clear distinction between a valid experience and a mental illness. He assumed his experience was 'a symptom of mental disturbance' and he consulted six doctors including two top psychiatrists and a neurologist. But he decided he was not distressed or disturbed, and could look after himself and handle day-to-day activities. He rejected their opinion that 'the experience was a symptom of mental illness.' The six independently thought he was psychotic and should go to a clinic or hospital. But he was convinced they were not familiar with his type of experience which he was certain was 'valid', and he refused to go into an institution. He wrote

it leaves me wondering however whether the high incidence of mental illness today is not in part at least due to the intolerance of the medical profession towards religious experience.

He felt that if he had accepted medical advice and undertaken therapy, he

would have become convinced that my experience was a sick one rather than, as I now feel, the most meaningful occurrence [sic] of my life.

There were several who felt that because they had been hospitalised, this threw doubt on the veridical nature of their experience. To them it seemed real and true. One who had been hospitalised for two months for 'religious mania' wrote when she sent in her story:

this is perhaps an account of insanity, but I thought it was a religious experience at the time (3107).

She was an example of someone who had mental health problems, and who was hospitalised, but she like others seemed to be able to tell the difference between a veridical experience and a psychotic one. However *many others were convinced that what they saw was veridical*: one who felt Jesus was with her said,

I was struck by the sanity and reality of all I heard (3214).

Another woman who had 'mental breakdowns' and spent some time in hospital, still felt her experiences were valid. She noted that

a lot of normal people would not admit to such experiences,

but because she had been in hospital, people would think her experiences were

a case for her insanity (0781).

One man with depression, who couldn't look after himself, wrote

I am aware that during mental illness people suffer from 'so called' religious experiences

but he felt that this was not the case for him (4144).

In the 1970s during a nervous breakdown after marriage break-up, one woman ended up inside a psychiatric ward. She found the experience of being there most humiliating. But she was confident her experience was veridical.

The humiliating part is the derisive way one is treated in psychiatric hospitals. I know beyond any doubt that these are religious experiences but if one talks about them one is considered to be a 'crank' or a religious maniac (3099).

A woman who was already seeing a psychiatrist to address her childhood issues, experienced a controlling influence, a possession over her person. She seemed to assume that Alister Hardy would see things from her perspective. She said

being men of science ... I am sure you appreciate the validity of my experiences (1726).

Another man who had a nervous breakdown with hallucinations, was concerned about how real the experiences were, and asked what the difference was between a hallucination (false) and a vision (veridical). His counsellor suggested he see a psychiatrist (4552) although there is nothing in his entry to say whether or not he did. He articulated the difference between intellectual and mental health: and explained that he was intellectually healthy. That suggested that his mind worked according to common consensus: his intellect functioned, even though he experienced depression, breakdown, and hallucinations. In America one man felt his experiences were veridical, even when as a child, his mother threatened him with going to an asylum (4849). One woman in Australia experienced the person of Jesus Christ in the room 'as real and living as I am', and then felt a glorious feeling of love (1282). A year after writing into to Alister Hardy, she was diagnosed with schizophrenic psychosis, having strong delusions of a religious nature. Her husband wrote in and asked that no-one should contact her again, unless they went through him to vet the letters.

In the 1940s one man's numinous experiences during army duty in Egypt did lead to a stay in an asylum (1241). He felt the forces of evil were trying to overwhelm him, and he saw great light shining from ancient stones. He was advised to see the Army Doctor and then invalided home, with an assumed nervous breakdown. I wonder whether he would have been incarcerated these days? There appeared to be no other evidence of pathology. He assumed his experiences were real. There was another case of a woman (2034) who had encountered an angel. She asked her bishop whether it was natural or insanity. He referred her to her vicar, and she wrote to her doctor. She wanted her experience to be validated. By not replying to her questions, these professionals caused her frustration. She corresponded at length with the Alister Hardy Society. She knows what she saw was veridical. From her papers, it looks as though there was no evidence of pathology, according to current viewpoints.

### **Key Points**

- There are examples during the 1940s, 1950s and 1970s, which suggest that medical professionals assumed religious experiences were a symptom of mental illness or 'nervous breakdown', even when the client showed no social or mental impairment, nor any distress or disturbance.
- Respondents felt that because they had been hospitalised, this cast doubt on the validity of their experiences. However, in spite of being hospitalised, respondents felt their experiences were veridical.
- Some respondents made a clear distinction between a valid experience and mental illness. Some rejected the opinion that their experience was a symptom of mental illness.
- Frustration was felt with medical and religious professionals who failed to validate the veridical nature of the experiences, and whose assumptions did not align with those of the respondents.
- There was an underlying positive feeling that Alister Hardy's research would look objectively at religious experiences.

## **PSYCHOTIC and SPIRITUAL EXPERIENCE ... a fine line**

A number of respondents remarked on the fine line between psychotic and spiritual experience. This is well documented in the literature (Grof 1998, Jackson 2000, Roney-Dougal 2001) and is the subject of Isabel Clarke's book (2001). A visit to the web site Isabel and her husband set up is further evidence of the prevalence of this assumed connection <psychosisspirituality@yahoogroups.com>. One female respondent to the RERC archive felt that

religious experience, paranormal experience, the experience of insanity and also the inspiration of genius, may all spring from the same source (3046).

There were others who could see a relationship between religious experience, spirituality and psychosis:

The dividing line between insanity, and revelation involving high spiritual perception is very find indeed (2411).

However one woman (diagnosed with schizophrenia) believed that the brain shrunk with mental illness, and expanded with health. She compared the visions of saints with those of mental patients, and then likened the brain to a radio receiver and transmitter (3266). In the USSR, one woman heard crystalline music, as if on glass, and later in life had a dream of beings in a sky craft. She commented that many people with experiences thought they were ill, but in her opinion they were not. She said people who had these faculties were afraid. Parapsychologists thought these people were not ill. She thought Alister Hardy's work would extend understanding of these phenomena (3937).

One person who had a peak experience in nature considered it to be of considerable importance, and felt it was essential to share the experience and receive feedback on it:

I take religious experience seriously and consider it to be of central importance to human life and well being. ... I see a relationship between faith and psychosis: shared experience and social feedback are an essential aid to sanity (5353).

He too noted the relationship of spiritual experience with psychosis.

There were some who were convinced about the veridical nature of their experiences, and they wanted to help others who had experienced similar events (2222, 2565). Mr Edward Robinson, then Director of the RERC, in response to one woman's letter from Turkey (4440) replied saying it was difficult to distinguish between schizophrenia and religious experience.

In the end the only criterion seems to be the general quality of life of the person who has these experiences.

I am certain that many psychiatrists today would echo this view, however there still seems to be a small gap between professional awareness and front-line practice.

### **Key Points**

- Respondents felt there was a fine line between religious or spiritual experience and psychosis.
- Some people who had experiences wanted to help others.
- Staff at the archive felt it was difficult to tell the difference between symptoms of schizophrenia and religious experience.
- In spite of the ideal level of awareness about spirituality and psychosis, in actual practice, there seems to be a gap at the front line for experients.

## TRANSFORMATIONAL IMPACT

Many people felt a transformational impact after having had a religious experience. Respondents who experienced the sublime were overwhelmed by forces outside of themselves. Many felt there was another dimension to life, one which interlocked with this world, or a power beyond. These experiences impacted hugely on respondents' lives, and were in contrast to mundane events. Some found comfort within the established religions, while others felt disillusioned by them.

One woman asked for God's help while in hospital, and was overwhelmed by a great force of love, outside herself (2565). She knew there was another dimension to life. Another believed that

the other realm is obscured from us because it is so overwhelming and glorious, that it would make mundane life unbearable (4150).

One respondent, a former vicar, felt his experiences were an indicator of two interlocking worlds (0536). A theology student posed the following question:

is religious experience something I feel within myself, or can it be felt as an outside force? (3284).

He had been using the healing power of prayer on a man he felt was possessed, and after that, the man reduced his high dose of tranquillisers.

A woman who had several experiences (0210) felt disillusioned by the church, reassessed her ideas on religion and rejected the idea of God as the punisher of all wrong doings. However, another found peace through repeating the Lord's Prayer for three days (3066). She had been taken to a psychiatric hospital with acute schizophrenia, after 'loosing her reason' triggered by her mother's death.

As a teenager, one girl was diagnosed with schizophrenia, after having a flood of experiences, and was hospitalised for 2 months. She met a psychiatrist who said she was a mystic, and discharged her (0593). She realised that her experiences helped her, but she didn't know how to deal with them:

as a human being I find myself aided by these sublime experiences, but in many ways hopelessly inadequate and ill-equipped to deal with them and use them to good effect.

A woman who also described herself as schizophrenic (1050) said she felt there was a 'power beyond' which guided us.

One respondent had been an in-patient in a psychiatric hospital. He felt that the experiences themselves were like tools to find meaning in life

all psychic experiences ... are legitimate objects for a more far reaching pursuit of 'meaning' than the customary psychiatric approach.

He discussed ordinary reality, the paranormal, normality and parapsychology. I found myself sympathetic to his comments, since somehow I felt he may be right, i.e. that religious experiences are so challenging for our ontological reality, that it is easier to accept a pathological diagnosis of oneself. He wrote:

the phenomenon is so traumatic that most patients come to accept the diagnosis of the psychiatrists, rather than face up to the memory of what they actually experienced themselves (2295).

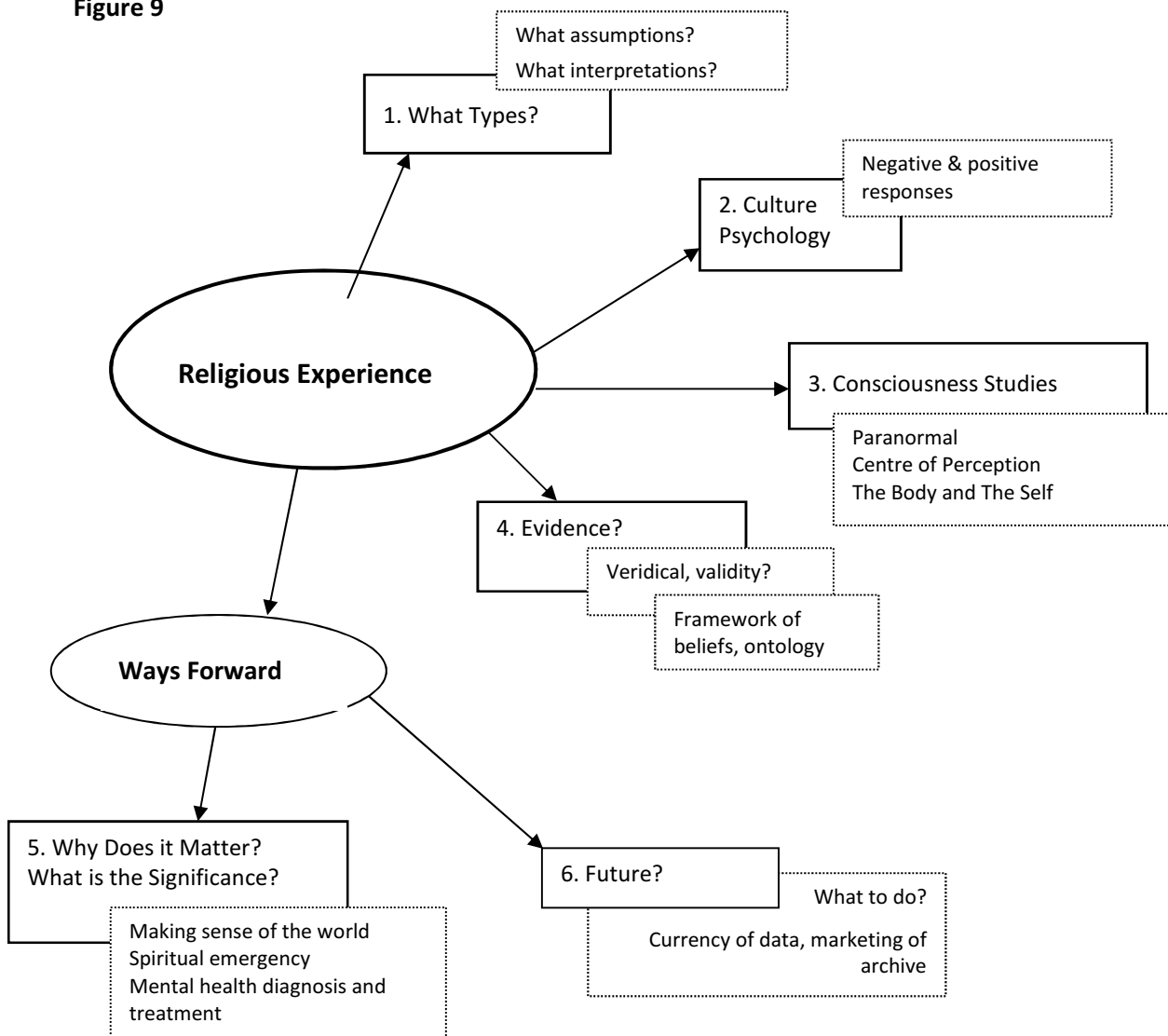
### Key Points

- Religious experiences were often transformational, of great impact.
- Some experiences were of something greater, outside the self, a 'power beyond', another dimension.
- Some respondents found comfort within established religions, while others felt disillusioned by them.
- People didn't always know how to integrate their experiences.
- Experiences helped some to find meaning within their lives.
- Some respondents may prefer a psychiatric diagnosis, rather than entertain the possibility of a veridical experience.

## Section Two: CONTEXT & SUPPORTING LITERATURE

Topics 1-4 are covered in Section Two  
5-6 are covered in Section Three

Figure 9



## **WHAT IS THE ISSUE?**

In theory, mental illness is said to exist when a combination of symptoms occurs, including deteriorating ability to function within social or occupational contexts; plus deteriorating ability to care for themselves; and threats to self harm or to harm others.

In practice, it looked from the archive records presented in Section One, as though the presence of a 'religious experience' episode on its own was sometimes enough for mental health pathology to be considered. There was clearly a difference between the ideal response to a religious experience event, and the actual response. It made me wonder what research had been done to explore health care practitioners' opinions about pathology and religious experience ...

In Section One, I focused on religious experiences that were perceived (rightly or wrongly) to warrant psychiatric attention. The data from the RERC archive, seemed to suggest that there was sometimes a mismatch between popular and professional perceptions about an experience, and it seemed that there was also a difference between professional practices themselves. I also found there was a mismatch between my own opinions on pathology, and those recorded by cases in the archive. As I mentioned earlier, due to the nature of my experiences, I am bound to express a certain point of view. I am also aware that some respondents may have excluded certain material from the accounts they sent into Sir Alister Hardy, that is, respondents may have edited events from their letters.

If there was a mismatch between psychiatric and popular opinion, if as it appeared from a study of the archive, some respondents had been treated differently for similar events, then my question for the future was: 'What could be done to address this'? I wondered whether there was a difference in response to religious experience over time, as the decades progressed? Perhaps the mismatch was related to social or cultural perceptions, or to medical and health care training in different institutions? These seemed ripe themes for further research.

### **Key Points re. Issue:**

- The ideal descriptor for mental illness has not always fitted the experient's symptoms: sometimes an episode of religious experience was itself regarded as a symptom of pathology.
- Some respondents were treated differently for similar events.
- There appeared to be a mismatch between popular and professional opinions.
- Data from this paper may inform future research.

The following section is divided into six parts, which are presented in Figure 9 above. These consist of:

- Types of Experience
- Culture and Interpretation
- Consciousness Studies
- Veridical or False
- Why the Study Matters
- Future Projects

I present various topics in order to contextualise and discuss the material in Section One. These include: a brief summary of publications on the different types of experiences; cultural and social responses to the interpretation of experiences; the field of consciousness studies; evidence for experiences to address whether they are veridical or false; the significance of religious experiences, and a discussion into why studies of them matter; and finally I propose a couple of surveys for future work to add currency to the data held in the archive. The final part of this section presents the kind of research surveys, which I recommend might be carried out in the future, in order to provide information on the currency of attitudes and practice.

### **WHAT IS A RELIGIOUS EXPERIENCE?**

The elements making up religious experience are discussed in detail by other writers, so I will not do that. However, I would like to note that experiences may have religious, mystical, spiritual, numinous, 'paranormal', or clairvoyant aspects.

This first part outlines recent literature, in which summaries of different types of religious experiences can be found. For example, Marianne Rankin presents an overview of the publications that have been done to date including Hay (1990), Argyle (1997), Maxwell and Tschudin (1996). She lists the types of experience and suggests there may be a continuum of experiences, from a feeling that there is something beyond, to full transcendent awareness of the divine (2005). She calls all the experiences she mentions 'religious experience', and in the RERC database the term religious experience seemed to strike a chord with how people interpreted their experiences. Perhaps this reduced the fear of admitting that a religious experience was actually not part of any religion, and may have served to lessen the stigma attached to 'unusual experiences' (p.15). Hardy also noted that a spiritual or mystical experience may not be related to a religious tradition (1997). Rankin explained how these usually transformational religious experiences differ from ordinary experiences (2005, 12) and she questioned whether the experiences were always beneficial. She explained that there was a kind of non-sensory apprehension of the divine (p.5), which may manifest as transcendence, the numinous, or as a higher power. It may be like a wider reality, beyond the ordinary, or there may be contact with angels or deceased relatives. These topics raise questions of consciousness beyond death, and so called paranormal experiences, which I address later.

Badham (2004) also summarised the results of more recent surveys of religious experiences, and noted the number of people affected (e.g. 65% of ordinary passers-by in a London street). People suggested the experiences were rare events but transformational, leading to social and environmental change. Argyle looked at more positive responses to religious experiences: that of well-being, moral values and religiosity (1997), while Fontana (2003) discussed the psychology of many varieties of spiritual, mystical and religious experiences. Hardy experienced 'the beauty and joys of nature' and was convinced of the reality of human experience (1997) but was advised to build his scientific reputation before conducting research into religious experiences. He used scientific methods to make systematic studies of texts about religious experience. He felt the significance of such a study would throw light on the nature of life itself. In fact it now appears that the studies he initiated have indeed thrown light, not only on the nature of life but also on consciousness beyond death and beyond the body. I wonder whether he was anticipating this aspect of his interest in the science of human experience?



## CULTURE and INTERPRETATION

What is or is not normal  
may have much to do with the labels  
that are applied to people in particular settings  
(Rosenhan 1973).

The case studies in the archive suggest that some respondents (plus their relatives and professional consultants) assumed that their religious experiences were a symptom of mental illness. This section explores the nature of pathology, and attempts to define the nature of mental illness. It looks at responses to an event, and the meaning given by psychologists to the terms: schizotypy and schizophrenia.

Early in the 20<sup>th</sup> century there was a tendency to consider any dissociated state as pathological. Jakobsen noted that in Western society people tended not to share their negative experiences for fear of being labelled mentally unstable. She wrote that the experiences 'often have a similar pattern to mental illness' (1999; 52). Her reason for studying negative religious experiences was to make them more available to those who experience them. I have noted in an earlier paper (2001a) that Western society's responses to religious experiences may themselves be culture bound. In this paper I was not interested in the negative content of the experience itself, rather the response to the experience, whatever its content.

As mentioned earlier, mental illness was defined as: behaviour the patient's culture group would consider implausible: deteriorating ability to function within social or occupational contexts; plus deteriorating ability to care for themselves; and threats to self harm or to harm others. It is 'inappropriate behaviour' which attracts a response. This is different in different societies, but most are clear about what constitutes inappropriate behaviour. However, 'implausible experiences' may be open to the interpretation of the onlooker, and interpretation is usually based on one's own framework of knowledge and beliefs (Rosenhan 1973).

The question as to what is and what is not 'religious experience' has concerned psychiatrists for many decades. Littlewood and Lipsedge have mentioned the problem of distinguishing between religion and mental illness (1997; 187); and Dein has explored the relationship between religiosity and psychiatric practice, an area he suggested was 'fraught with difficulty' (2000; 173). Both medical and religious practitioners have identified problems with regard to defining schizophrenia. Thomas (1997) suggested that people used to be diagnosed with schizophrenia, because their experiences were not understandable to those psychiatrists, who were interpreting symptoms according to 19<sup>th</sup> century phenomenology, assuming it was a discrete disease. More recently, Bentall critiqued the bio-medical model of mental illness, using an empirical psychological approach (2003). He tried to make madness more understandable, and suggested that labels were meaningless. Likewise Boyle (2002) explained that illness and disease were lay terms identified by the patient: it was the physician's task to identify the pattern and label it. She discussed the legitimacy of psychiatry, and her explanation as to why schizophrenia doesn't exist is claimed to be among the most coherent ([www.metzself.info](http://www.metzself.info)). There are specialists within the church who have suggested schizophrenia-like symptoms disappear with the appropriate religious prayers (Walker 1997; 3).

Chris Clarke suggested there were different ways of knowing which went beyond our mundane awareness (2005), and this theme was taken up by Isabel Clarke who drew

together psychiatrists, psychologists and others to explore the theme 'linking the highest realms of human consciousness with the depths of madness' (2001; 1). She presented examples of research that explored the relationship between spiritual and religious experience and psychosis, and this theme is followed up in her website <[www.psyspiritstory.co.uk](http://www.psyspiritstory.co.uk)>. The psychologist Claridge used the term schizotypy to indicate the personality of people who tended to have 'unusual cognitive experiences'. Although this term looked as if it might suggest pathology of personality, this was not apparently what Claridge intended, although reviewers of his book say it is "unambiguously associated with schizophrenia" (Siever 2002). Extensive research by Claridge and his collaborators suggests that schizotypy (openness to unusual experiences) exists on a continuum (2001; 104). As well as being associated with vulnerability to psychotic breakdown, 'high or benign schizotypy' has been linked with creativity, and is said to facilitate artistic and literary expression (Fontana 2003; 139).

Jackson undertook research into the relationship between psychotic and spiritual experiences using case studies from the RERC archive. He compared those who'd had benign experiences with those who had been distressed and treated within the mental health system (Jackson 2001; 189). He noticed a borderline between benign spiritual experience and psychotic illness, and identified concerns of diagnosis (2002). Then there were those who suggested that incidences of mental illness may be related to spiritual experiences occurring too fast, within a person who could not integrate all their experiences at once (Courtney 2005, Grof 1998).

#### **Key Points:**

- Pathological symptoms of mental illness are clearly defined.
- Different people interpret the same symptoms in different ways.
- Different professions deal with similar symptoms in different ways.
- There are multiple ways of knowing.
- The term 'schizotypal' has been used to describe people who have 'unusual cognitive experiences'.
- Religious experience and psychosis exist within a continuum.
- Ways of considering religious experience change over time.

#### **CONSCIOUSNESS STUDIES**

As I mentioned earlier, I wondered whether Sir Alister Hardy was aware that the case studies he was collecting, would provide so much evidence for consciousness and so-called paranormal studies. Consciousness studies are concerned with a whole range of topics: from survival beyond death, the presence of apparitions (Rees 2001), and the concept of reincarnation (Stevenson 1997, Bowman 1997); to the centre of perception being outside the body and ability to travel at will to remote locations and through time (Stewart 2005). Consciousness studies also covers NDE and OBE (Near Death Experiences and Out of Body Experiences) which have attracted the attention of the medical profession (Fenwick 1995, Sabom 1998). The material in the RERC archive also adds to the evidence about the nature of the body and the self (permeability, porosity, and fluid boundaries); and psychotic experience where there appears to be an external locus of control (Chadwick 2002). Other people have covered the topics above, so I will only mention them briefly below.

The parapsychologist Rhea White attempted to explore phenomena which she claimed occurred beyond a religious framework (White 1997; 86). She chose to use the term 'exceptional human experiences', which resulted in an expansion of the self or heightened awareness. Some people could send their centre of perception out from the body, either during meditation, by using shamanic journeying techniques, or through remote viewing. Stewart claimed that information about events could come from direct cognition, if the person deliberately willed their attention to other places or time zones (Tobert 2005b). This centre of perception may be shifted through an act of will or intention, by using any of the above techniques, but I imagine it might cause some confusion and distress if it occurred spontaneously to any of the archive respondents. It would be particularly disturbing if such an event did not fit within the knowledge framework of the experient. This would cause ontological distress, and perhaps the respondent would indeed feel that they needed the advice of a religious cleric or psychiatrist. I regard these experiences as a normal human faculty, but if they occurred outside an experient's framework of understanding of the world, I believe this would cause distress and confusion.

Peter Chadwick, noted that the events he experienced lay 'outside of the theories of either current psychology or current physics' (2004, 13). At the borderline between sanity and insanity, this distinction was transcended, and one was pervaded by the experiences. Chadwick described it as the difference between being the container of one's experiences, and being contained by them. It was his opinion that religious insights occurred within this borderline zone. At the borderline zone, he suggested that humans could 'be genuinely open or permeable to light or dark forces' (14). He noted the term 'existential fragility' could be used to refer to the schizophrenic experience, where the boundary between the self and others became blurred, and more permeable: as if there was an external locus of control, that is, life itself was controlled by an outside force (2002).

What exactly was the essential self made up of? Not only of our post natal experiences, and the social forces and psychological responses, but it would also include pre-natal experiences, inherited through our parents and grandparents (Horizon Nov 05, Canault 1998). It may also include events experienced by our other 'selves', whether from our own previous incarnations, or through tuning in to other people's selves, through empathy, projection or clairvoyant alignment. Our explanatory framework for understanding and interpreting events, usually lies within the boundaries of our own knowledge. Unless we experience direct cognition, it may be hard to accept as knowledge, concepts offered through indirect cognition: reading or listening to others' perceptions.

### **Key Points:**

- Alister Hardy collected data which could be used to inform studies of consciousness, survival, the paranormal.
- The self is experienced in various ways.
- The boundaries of the self may be fluid.
- Perception may be experienced beyond the body.
- The self may experience forces beyond the body.
- The self may be made up of pre-natal and extra-corporeal experiences as well as post natal psychological responses.
- A wider framework of understanding may reduce confusion about 'unusual cognitive or religious experiences'.

## VERIDICAL or FALSE?

Sir Alister Hardy collected case studies on religious experience, and they appear to provide a source of data on many types of phenomena related to consciousness studies. In the last few decades, the data on this type of phenomena has been added to: a large body of experiences have been gathered by medical personnel on Near Death Experiences, Out of Body Experiences reported during resuscitation, and experiences suggestive of survival beyond death (Sabom 1995, Fenwick 1998, Piersal 1998, Rees 2001, Parnia 2005). Many experiences appear to occur spontaneously, although there are those specialists who can deliberately will an event to occur. Certain experiences appear to be suggestive of survival of consciousness beyond death, although the events are open to plural types of interpretation. Whether or not we judge the data and information as veridical, may depend not only on the context, but also on our own belief system of knowledge. However, as a record of peoples' stated beliefs, the data is valid (even if we assume they are erroneous).

In this section I have presented cross-cultural comparisons with experiences from the East, to determine whether there are any similarities. I explore what we in the West tend to understand by the term 'paranormal', and what scientific research is done on it. My proposition is that there is a multiplicity of ways in which we interpret the same data. Finally I look at the underlying assumptions that support beliefs about the nature of reality. The question for myself is: are these experiences veridical or not, or do they suggest that there are multiple ways of knowing? The experiences reported are valid, but if they are also veridical, do they suggest evidence for survival beyond death, and do they suggest new avenues for diagnosis of certain types of conditions that have in the past been considered within the realms of psychiatry? I wonder whether the experience of 'beyond' (however one interprets it) is a normal human faculty, which Courtney described as 'our birthright' (2005).

Badham (2004) wrote that

religious experience, East and West is pointing to the same ultimate reality at the heart of religious consciousness.

He commented that the imagery of patients being resuscitated was 'remarkably similar' to that described by Buddhist teaching (p.21). He discussed whether belief about a future life, after death was almost as universal as the belief that death was the end of the physical personal existence. He asked how such beliefs emerged (p.3), and noted that beliefs were always 2<sup>nd</sup> hand, unless a person had 1<sup>st</sup> hand experience. Badham compared the imagery of Jodo Shinshu Buddhism scriptures with that seen by resuscitated patients during their NDEs (p.8) (see reports by Fenwick, 1995). With regard to Near Death Experiences, he noted

as a result of modern medicine's ability to resuscitate people ... We now appear to be getting evidence which is strongly suggestive that earlier beliefs in a life beyond may actually have some real evidential support.

He noted that 'beings' seen during an experience, were perceived from a person's own religious or cultural perspective (2004; 17). He compares Buddhist and Christian ways of documenting religious experience, and notes the commonalities of NDEs in the West with those mentioned in Tibetan Buddhist writing. Sushan offered a comparative study of conceptions of the afterlife experience in Ancient Egypt and Vedic India, evaluating the similarities and differences (2002; 55). He said the evidence suggested "the existence of some sort of universal element" whereas the dissimilarities were due to culture specific elements.

I find these points significant: visionary phenomena reported even occurred in people who had been blind for many years (Tart 1997). Dewi Rees, former Medical Director of a hospice

in Birmingham went further, suggesting that visions of presences (or apparitions) of recently deceased were veridical and usually beneficial (2001; 263), and were recognised as a normal feature of bereavement (apparently Freud dismissed them in three lines as 'psychotic hallucinations', p.264). However, Rees conducted his own research and presented scientific longitudinal studies into the phenomena in the UK and US, and repeated his findings. In Tucson, Arizona, Schwartz conducted a series of triple blind scientific experiments into the afterlife, using mediums to explore whether survival of consciousness was a reality (2003).

There are however, those who have questioned the interpretation of religious experience as evidence of survival. For example, Kurtz (1997) brought into question the whole concept of survival after death. He suggested that Near Death Experiences (NDEs) were an indicator of a neo spiritualist revival (p.230). He questioned evidence on reincarnation as being 'highly questionable' and the result of 'creative imagination' by suggestible researchers (p.231). He suggested that there may be 'alternative naturalistic explanations, psychological and physiological, that can be given without postulating the existence of an afterlife (p.229). Finally he suggested that these concepts were taken up by those desperate to give meaning to their lives (p.238), desperate for a world beyond, and unwilling to accept finite human experience. In fact, he is not alone. Donovan was also very critical of the possibility of religious experiences being indicative of anything. He argued that people who were not familiar with religious systems 'can hardly be said to be capable of religious experiences' (1997; 36). He explored what people meant by religious experience, and posited a difference between valid and invalid experiences (1997; 61). He distinguished between those, which were reliable, and those, which might be the result of 'shared erroneous beliefs'. He asked whether

religious experiences really prove anything, one way or the other, about the truth of religions (p.51).

I feel that is not the right question. My own perceptions on the topic are not concordant with Kurtz's or Donovan's: direct cognition seems to be very persuasive. My basic assumption is that religious experiences prove something about common core human faculties, of our ability to experience 'all that is' both physical and non-physical. My belief is that this faculty, and these ways of knowing, are beyond culturally determined religious practice or dogma. However, the content of the experience is more likely to be culturally determined. It is my opinion that awareness of consciousness beyond the brain has always been open to specialists in all cultures throughout the world. Sages like Sri Ramana Maharshi in India realised that human beings were more than just a physical body and he like Sri Aurobindo remained in awareness throughout his life. Specialists can use their intention to have experiences beyond the brain, and stop them at will.

A good example of specialists are those who engage in shamanic practice (Harvey 2003, Tobert 2005c). The shamanic journey has many similar features to NDEs.

for millennia, most human beings have chosen not to confront and explore the realms of death and after-death experience, preferring to leave such frightening investigations to a small, secret elite of shamans, yogis, and other mystical specialists (Doore 1990; 267).

These specialists have dissolved the illusion of separateness and can assist others to heal their own psychophysical illness. In 1990 Doore wrote that

even if the evidence for survival is inconclusive by scientific standards, we are still acting rationally if we choose to believe in an afterlife for the purposes of 'testing' that belief ... (p.278).

At that time he suggested the evidence and arguments of materialists and survivalists was inconclusive (p.273). However, some 15 years later, relevant research into other specialists (mediums) conducted at University of Arizona by Gary Schwartz appears to provide evidence that consciousness survives death. He suggested that it is likely that the survival hypothesis is true (lecture SMN 2005). In addition details are now available from the Scole Experiment, a 5 year investigation into human interaction with paranormal phenomena, published in the *Journal of Psychical Research* (Solomon 1999).

Ancient sages have long expounded the proposition of consciousness beyond the body (Sri Aurobino 1949, Bailey 1986). This is however supported by clinical case studies by psychiatrists and psychologists (Powell 2001, Sanderson 1998) on ways their clients are interpreting their experiences. Rupert Sheldrake has conducted research into psychic experiences (2001) and full discussions are available on his website. In the more popular press we are beginning to see anecdotal stories of personal experience of existence after death (Heathcote-James 2003, Courtney 2005, Bowman 1997). For example a mother accepted her children's non-ordinary experiences (Bowman 1997; 284), and after collecting other stories she, like the GP Dewi Rees, questioned why the church discredited reincarnation (2001). [In CE 553, when the Council of Nicea met, they singled out reincarnation and condemned it. Set up in CE 325 by the Emperor Constantine, he wanted feuding Christian factions to agree on a single creed.] The evidence from the case studies in the archive suggests to me that human beings have a core faculty that allows them to have experiences beyond the five senses. However, the presence of this faculty has its problems.

#### **Key Points:**

- Similarities are noted between Western experiences and Buddhist teachings.
- Longitudinal studies exist on the occurrence of presences.
- The content of experiences tends to be culturally specific.
- Evidence from the archive suggests human beings have a core faculty for seeing beyond the five senses.
- Anecdotal evidence in the public domain supports this, as do clinical case studies of psychiatrists and psychologists.
- Specialists like shamans and mediums also access this faculty.
- Some suggest survival theories are created by those desperate to give meaning to their lives.
- Personal beliefs about the nature of reality influence our underlying assumptions about the world.
- Plural interpretations of similar phenomena are possible.
- Experiences may be veridical and valid, yet still be believed to be erroneous.

### Section Three: WAYS FORWARD

#### WHY DOES THE STUDY MATTER?

Religious experiences help us make sense of the world, and find meaning in personal existence. They offer an insight into divine or non-physical worlds. They illustrate a continuum of human experience. They throw light on consciousness beyond the brain, beyond death. They offer insight into spiritual emergency and mental health. These are some of the many reasons why the study of religious experiences are important.

In the first sentence of his paper entitled 'Why Religious Experience Matters' (Badham 2004), he notes that the experience is 'the primary basis for religious belief' for both religious practitioners, and also for those with no particular religious affiliation. He presents examples of religions based on revelation, worship and personal direct experience, and discusses the philosophy about the existence of God. He asks what causes people to have religious experiences, and draws a distinction between inculturation, shaped by specific worship, and experiences that appear to come from nowhere.

However, I feel there are additional reasons why the study of religious experience matters, reasons that go beyond the finding of meaning in our human existence. It would seem that human beings have extended faculties, wider than the five senses, that allow them to experience not only divinity, but other aspects of a non-physical world. In this section we explore the significance of the experiences, and why it might matter to human beings. These experiences help us make sense of the trials and tribulations of life, and the grieving of death, loss and bereavement. However, one important reason to study religious experiences further, is due to its perceived relationship with mental health.

A comparative study between the state of 'spiritual emergency,' described by the psychiatrist Grof (1998), and also reported by Courtney (2005) leads me to suggest that in some cases religious experience and spiritual emergency, may be two terms for the same event, received differently. Perhaps the way we respond to and interpret one or the other depends on our own ontological framework, our own beliefs about the nature of human existence? Grof suggests ways of diagnosing, treating and containing those who have spiritual emergency. He notes that not all religious experiences are spiritual emergencies: each case needs to be assessed on its merits. For example, Chadwick explained that he collapsed completely and required anti-psychotic drugs to bring him out of it (2002). In my case, my own experiences were not psychotic, or delusional: I was always cognitively aware of the differences between what I saw and mundane common consensus reality, although my emotions were not always unaffected.

Grof suggested that

endogenous psychoses, particularly schizophrenia, represent one of the greatest enigmas of modern psychiatry and medicine (1985; 294)

and he presented theories of psychosis from the organic to the psychological. The current scientific paradigm for understanding psychosis was determined by Western philosophy, which was Newtonian and Cartesian, and the current medical model was culture bound with its consideration of what was 'normal' and what was 'acceptable' (Grof 1985; 297). Phenomena that occurred beyond the understanding of materialist Western science were

pathologised, however this was not the case in other societies (Tobert 2001a). In different cultures, the psychiatrist and the shaman seemed to have similar societal roles, though they carried them out in different ways (Tobert 2001b). Grof suggested that the current medical model was based on culture-bound value judgements “rather than on objective scientific opinion” (p.299). He presented an architecture for understanding emotional disorders and psychosis (p.310), and noted that the materialist medical model applied to psychiatric problems and emotional disorders had been criticised (p.319).

I have already mentioned Bentall (2003), Boyle (2002), Thomas (1997), and Szasz (1961) each of whom deconstructed aspects of mental illness. Szasz (1961; 319) suggested that much mental illness should be regarded as expressions of an individual’s struggles with daily life. To medicalise these illness presentations “reinforces the passive and dependent role of the client” and he suggested that the solution lay within the authority rather than a person’s inner resources. It was a complex problem for professionals to decide who was mentally ill and mentally healthy, and the decisions may not always have been rational (p.328). Grof cites Rosenhan’s study as an example of the problem: once labelled, one’s every action is considered insane. Rosenhan set up an experiment in the 1970s to send pseudo-patients to 12 psychiatric hospitals across America: when they wrote notes in the ward, it was recorded that ‘they engaged in writing behaviour’ (1973).

The empirical study of experiences is important because of its perceived relationship with mental health. In addition my proposition is that the experiences described in the above sections as religious experience, e.g. spiritual emergency, NDEs, OBEs, and remote viewing, all lie on one end of a continuum of normal human experience. At the other end lie psychotic experiences. I assume that everything subsumed within Hardy’s definitions of religious experiences include so-called paranormal experiences. Maslow (1964) suggested that peak or religious experiences need not be considered pathological, and Grof would like this extended to all perinatal and transpersonal experiences.

The content of religious experiences throws light on consciousness beyond the brain, and the comparative study of content cross-culturally throws light on consciousness beyond death. The mechanism of religious experiences (trying to explain how they occur) throws light on the concept of non-corporeal consciousness, and suggests the centre of perception can go outside the body. Case studies provide empirical evidence for remote viewing. If the above are veridical, and are common core faculties of human existence, then our previous strategies for identifying mental pathology may need to be reconsidered.

### **Key Points:**

- Religious experience matters because it offers insight into the human condition, makes sense of life, and throws light on consciousness beyond the brain.
- Professionals sometimes had problems differentiating mental illness from religious experience.
- There was a tendency to pathologise experiences professionals didn’t understand, or that didn’t fit within the materialist paradigm.
- Religious experiences and spiritual emergency lie on a continuum.
- Multiple interpretations are possible.
- We need to audit our strategy for identifying mental pathology.



## **FUTURE RESEARCH PROJECTS**

What are the implications of the material presented in this Occasional Paper? What might we do with this knowledge in the field of mental health? Current case studies in the archive suggest that the professional response to experiencers was not consistent: there could still be deeper interweaving and communication between the disciplines of Religion, Theology, front-line psychiatry service providers and the popular press. It will be interesting to see the results of Lampeter University's Templeton Project exploring religious experience in China. But also I feel it would be appropriate to follow in Sir Alister Hardy's tradition and make further empirical collections of people's experiences, to determine how the experiences affect their lives, as a result of not only the event but of professional and social responses to the event. It might be useful to extend the concept, beyond the comparative safety of 'religious experience' and collect empirical data directly from the (anonymised) clinical records of psychiatry, or invite those who have experienced spiritual emergency such as the respondents to the psychosis and spirituality website <psychosisandspirituality.com>, Grof 1998, Roney-Dougal 2001, Courtney 2005).

It is my opinion that the insights about consciousness and multiple ways of knowing are valid. I then wondered to what extent they are being discussed and brought into training for front line practitioners of all grades: psychiatrists, community psychiatric nurses and others. It is my proposition that a psychiatrist and a healer working together would address various symptoms of mental health: one to provide the appropriate pharmacology, the other to investigate the problem (or illness) at a non-physical level, and make appropriate recommendations. Scientific and clinical research is needed to investigate this, to refute it or accept it. Base line clinical data could be recorded, with treatments and changes noted. I wondered to what extent this was already happening? One study has already been conducted.

In the abstract to her BA thesis at Oxford Brookes University (2001), Eeles explained that spiritual experience had been identified as being similar to psychotic experience, and noted that this can pose a dilemma for mental health nurses when they evaluate individuals. She set up her study to discover which features nurses considered were important and how these influenced their understanding. She found that nurses also made intuitive interpretations and explored the value of the experience for the individual concerned. Her research raised issues regarding objective assessments, reduction of bias, and autonomy. She noted the wide varieties of phenomena that people consider to be religious experiences, and mentions the difficulties practitioners may have in distinguishing the pathological from non-pathological. She obtained ethical approval from the Local Research Ethics Committees and used scenario examples taken from the Alister Hardy RERC Archive. She identified seven areas that were valued differently by her participants (p.48):

- "Unusual nature of the experience
- religious involvement / congruency with beliefs
- precipitating emotional stress
- individual expectation of experience
- experience shared by others
- importance of context
- unusual behaviour as a result of experience"

There were inconsistencies in the diagnoses of her participants: they

... exhibited different understandings of spiritual experience and mental illness which caused them to come to different conclusions concerning the mental health of particular individuals (p.49).

She noted that the identification of pathology was essentially value laden, and she raised the question as to how one determines the existence or otherwise of mental illness. In a subsequent publication, Eeles et al (2003) explored the criteria that nurses used to evaluate patients' spiritual experiences and noted that the form and content of spiritual experiences and psychotic symptoms had many elements in common. They asked how clinicians judge the pathology of a client in order to provide the most appropriate care plan for treatment. The nurses in their study considered both the nature of experience and the outcome for the client, as well as the personal and cultural context. They noted the importance of team working to reduce bias and 'idiosyncratic decision making' (Eeles 2003; 197).

Based on Eeles' survey, it seems that there is a concern regarding the training of front-line service providers. The empirical study of experiences is important because, in spite of all the material that has been published over the last 3 or 4 decades, it seems that there is still a reticence by front line psychiatric service providers to diagnose and treat experiences in a uniform standardised manner. There appears to be a gap, between academic awareness, and front line practice. Treatment of experiences often depends on such things as:

- the 'luck of the draw',
- 'being at the right time and place',
- 'having friends and relatives who are aware',
- the ontological beliefs of those in proximity,
- the framework of knowledge about the nature of human existence of those consulted.

### **Suggested Further Research**

Based on the above discussion, I suggest three areas for further research, that are feasible, but require funding to carry them out.

- Current practice, service providers: In order to disprove fears about front line service providers, a survey or an audit of responses needs to be undertaken to establish diagnostic and treatment patterns.
- A similar survey to that of Eeles (2003) needs to be designed and conducted at medical and health care practitioner training institutions, in order to gauge current students' attitudes towards religious experiences.
- Current practice, users: An invitation might be extended to participants of certain websites, to send in their experiences to add to the database. For example, respondents to Isabel Clarke's website, offer evidence of differential diagnoses, and the examples given by Hazel Courtney suggest that an experience receives a different response to their event(s) depending on their personal circumstances, and this is backed up by material in the archive.

There appears to be an ad hoc, and haphazard manner in which professionals respond to religious experience, however, if new respondents were invited to submit material to the RERC archive, the above suggestions may be disproved as out-dated.

### Key Points:

- The implications of this study throw light on consciousness beyond the body, and also on our understanding and interpretation of certain symptoms of mental illness.
- Research needs to be undertaken to explore the currency of the findings from the RERC archive.
- A study consisting of an audit of current practice, regarding the diagnosis of symptoms and the treatments.
- A survey to explore attitudes should be undertaken in medical, psychiatric, and health care training establishments.
- More publicity needs to be generated to invite more people to respond to the archive, so we can be sure of an up-to-date input of records. The archive needs to be marketed.

Natalie Tobert, January 2006

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<https://www.facebook.com/SpiritualPsychiatries>

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