Can being told you’re ill make you ill?

A discussion of psychiatry, religion, and out of the ordinary experiences

*Introduction*

It’s sometimes claimed that to pathologise is pathogenic: that by calling something an illness, we can cause it to become so.[[1]](#endnote-1) This paper supports that claim, using as a case study ‘out of the ordinary experiences’ (or OOEs): experiences such as sensing the presence of the dead or hearing voices in the absence of anything physical being there. Historically and in other cultures these have often been made sense of religiously (e.g. in terms of mediumship, ancestor veneration, or the cult of saints) but in modern societies today they are interpreted primarily in pathological terms by being closely associated with schizophrenia. Arguing that interpreting OOEs in pathologising terms negatively affects the experience itself, I’ll also explore the implications of this for modern attitudes to medicine and illness more generally.

Here’s how I am going to do it. I’ll begin by outlining some examples of OOEs, and pointing to evidence that OOEs are (incorrectly) automatically regarded as pathological in modern societies. I’ll then argue that describing OOEs in terms of pathology is pathogenic in two ways. First, by describing the experience as an illness and a problem, it can cause it to become so. Second, it can exclude positive interpretations of the experiences (including but not limited to some religious ones) which could otherwise shape the experience positively and therapeutically. Finally, I’ll explore the significance of this for our understanding of illnesses and for our perceptions of medicine more generally.

*OOEs and their pathologisation*

‘OOEs’ refers to a broad range of experiences, including hearing voices, seeing things, or having the sense of being touched, when no one is physically there. Calling these experiences OOEs is an attempt to give a name to experiences described in psychiatry as ‘hallucinations’, and in some religious traditions in terms of mystical or spiritual experience, without presupposing either pathology (on the one hand) or spiritual value (on the other).

OOEs are surprisingly common. For example, studies in the UK suggest that around 13.7% of the general population, and around 50% of people undergoing bereavement, have experiences in which they sense the presence of the dead.[[2]](#endnote-2) Studies that focus on the phenomena of hearing voices or seeing people suggest that around 15.3% of the UK population hear voices, and that around 13.8% see things that other cannot.[[3]](#endnote-3)

The following is a fairly typical example of someone who has a sensing the presence of the dead experience combining hearing voices and seeing the person:

May is in her seventies. She had a long and contented marriage to Owen, but he died from a heart attack six months ago. May has been feeling very low, but she is slowly taking more interest in her church activities, in her grandchildren, some of whom live near by, and in her gardening. About two weeks after Owen died, she saw him standing in the hallway, as she was making her way upstairs to bed. ‘Goodnight love,’ he said. May was startled, and when she looked again, he had gone. Since then she has seen and heard him several times, always fleeting, and always affectionate. The experiences seem to be getting less frequent. She did mention this to her minister, who said it was certainly nothing to worry about, and was something that often happened. She feels that wherever Owen is he is still her husband and loves her. She finds the experiences comforting, though she would not mention them to her friends and family.[[4]](#endnote-4)

May’s response of not telling her family and friends is not uncommon, since many people report keeping the experience secret for fear of ridicule or pathologisation. In fact, according to DSM-5 (the psychiatric manual on the basis of which diagnoses are made), OOEs (described there as ‘hallucinations’) are neither necessary nor sufficient for the diagnosis of one of the disorders with which we usually associate them (Schizophrenic Spectrum and other Psychotic Disorders), though they are one of the possible symptoms.

While this may indicate that in theory modern societies do not automatically pathologise OOEs (regard them as evidence of pathology at first sight), in practice this is not always the case, both in medical practice and in our society more generally. Thus, for example, someone reporting having an OOE is likely to be advised by a non-psychiatrist member of the public to visit a psychiatrist.[[5]](#endnote-5). Though to a lesser degree, there is also evidence to suggest that psychiatrists and other mental health professionals can also automatically pathologise people on the basis of OOEs. This is most famously shown by Rosenhan’s 1973 experiment in which he and eight colleagues in the US visited psychiatrists claiming (untruthfully) to hear voices. All received schizophrenic diagnoses on this basis and were admitted to psychiatric hospitals, and, despite acting normally within the hospital and reporting no longer hearing voices, were forced to remain for some time in the hospital and to take medication. Among other things, Rosenhan’s report emphasises the way in which psychological histories can be interpreted by psychiatrists as pathological, in the light of the person’s claim to hear voices, even if there is nothing pathological about the histories themselves.[[6]](#endnote-6) In 2004, psychologist Lauren Slater undertook a similar experiment. While emphasising the kindness and empathy with which she was treated, Slater reports that she too was automatically pathologised on the basis of reporting hearing voices (like Rosenhan, she denied any other symptoms), being diagnosed, over the course of the experiment, with a number of different disorders (most often ‘depression with psychotic features’) and given antidepressant or antipsychotic medications.[[7]](#endnote-7)

In fact, there is nothing inherently pathological about OOEs such as hearing voices, and so to automatically pathologise them is mistaken. Perhaps they lend themselves to being regarded as pathological, in part because they are not ‘normal’ human experiences (though they are more normal than we think), and in part because they are frequently triggered by stressful or traumatic experiences. However, neither of these things is a good reason to think they are inherently pathological: left-handedness is not normal, and psychological and moral growth is often triggered by stressful or traumatic situations, but neither left-handedness nor psychological/moral growth are usually regarded as pathological. Although there are not clearly defined necessary and sufficient conditions for what constitutes ‘pathology’, distress and loss of function are the most common characteristics of pathology. For this reason, it seems reasonable to suppose that OOEs are pathological only when they are distressing or are characterised by loss of function. While some OOEs are undoubtedly experienced as distressing and give rise to a loss of function, others (perhaps as in the example of May) may be ‘adaptive’ in helping a person to cope with a stressful situation. In such a case, the OOE may in fact render the person less distressed and more able to function, and so less pathological, than they would otherwise be.

*Pathologisation and problematisation*

The problem with pathologising non-pathological experiences is not just that it is not quite the right way to look at them, a kind of benign error. It can also be unhelpful or pathogenic, in making an experience pathological that might not otherwise be so. One way in which it can do this is to present the experience as a problem, and as something that should be fixed. Fundamental to the idea that this can cause pathology is the fact that, as just noted, distress and loss of function are at the heart of our understanding of what pathology is. Because our experiences are shaped in part by interpretation, being told by someone in a position of authority that your experience is a problem, an illness, is likely to lead you to the belief that this is true, and to make you experience it as such - giving rise to characteristics such as distress and loss of function, and so to genuinely pathological characteristics.

That this is indeed at least sometimes the case is indicated by psychological studies that examine the responsive and contextual factors that lead some people who have OOEs to end up experiencing these negatively and to be diagnosed with schizophrenia or another disorder, and other people to experience them positively, without distress or loss of function, and not to end up being psychiatrically diagnosed. For example, Lana Jackson, Mark Hayward and Anne Cooke undertook a study of twelve people who hear voices and experience these positively, in order to discern how these differ from people who experience them negatively. They note that:

Most participants felt that their voice-hearing experiences were meaningful and therefore sought alternative understandings (often spiritual) to an illness-based medical view. Those who had received a diagnosis of mental illness tended to view their voices as more than just “a bunch of symptoms that need fixing” (Rachel). This often conflicted with the medical approach they were offered.[[8]](#endnote-8)

Alternative understandings were regarded as transformative of their experience since, as one person put it, they enabled ‘…understanding what was happening for me, giving it meaning and breaking down the fear that I had around not knowing and thinking that I was a complete freak, really different and ill’. So, interpreting an OOE in positive, rather than pathologising terms, seems to have a positive effect on the experience itself, and this is something that the experients felt was not available through medical channels – and sometimes even conflicted with the medical interpretations they had been given.

In contrast to the people who experienced OOEs positively, in another psychological study, one voice hearer who received a clinical diagnosis interprets it in purely medical terms, as a form of illness:

I’m told that they [the voices] might never go away…. So going forward is quite difficult because I’m still living with the effects of the mental illness that I’ve had. And basically the most salient fact is that it might never go away. In fact, it probably won’t. That’s the problem.’[[9]](#endnote-9) (Leroy, cited in Heriot-Maitland, Knight and Peters, 2012, p. 49)

This second study compares voice hearers who end up receiving a psychiatric diagnosis (the ‘clinical’ group) with those who do not (the ‘non-clinical’ group). One of the interesting findings of the study is that the triggers and initial subjective experience of OOEs tend to be the same for both clinical and non-clinical groups, so it doesn’t seem likely that they are fundamentally different experiences to start with. Where they differ – and therefore what seems to influence whether or not an experience ends up being pathological – is in the responsive and contextual factors by which the people make sense of their experiences. This includes, in no small part, whether the experience is regarded as an illness, or as something more positively meaningful.

This is backed up by an earlier study in which psychiatrists Mike Jackson and Bill Fulford discuss some non-pathological, positive examples of OOEs, and conclude that the responsive and contextual factors influencing the way in which the experience is interpreted can affect whether or not it becomes pathological. In particular, they suggest, interpreting the experience in terms of illness or pathology can have a prescriptive as well as a descriptive quality, since, in the positive cases discussed, ‘if the experiences had been evaluated less favorably (including, for example, as symptoms of mental illness), the subjects concerned might have been left in their state of crisis, and a further cycle of (perhaps more bizarre) experiences could have ensued’.[[10]](#endnote-10)

*Exclusion of positive interpretations*

These studies point to a second way in which pathologising an OOE can be pathogenic: it can exclude positive meaningful interpretations. That OOEs can be positively interpreted and experienced, and that this has a therapeutic effect on the experience, is indicated by some discussions of the way in which some people interpret and experience their OOEs positively in particular religious or spiritual contexts. So, for example, in their study of Spiritualist mediums in the UK, Elizabeth Roxburgh and Chris Roe note that mediums who reported having out of the ordinary experiences that would be regarded as symptomatic of a mental illness in a psychiatric context scored much better than their clinical counterparts, who interpreted their experiences in medical terms, in terms of greater wellbeing and less psychological distress.[[11]](#endnote-11) When they interviewed mediums, they discovered that most had a family background which affirmed the idea of mediumistic experiences. One exception, Sarah, didn’t have this kind of family background, and ‘consequently, she was disturbed and confused by the experiences and it was not until she familiarised herself with a spiritual model that she interpreted her experiences as mediumship’, leading to their normalisation and validation. As this example highlights, interpreting the experience in a positive way can shape the experience itself in a way that renders it non-pathological: in other words, in a way that doesn’t engender distress or loss of function, and may even lead to greater happiness and increased function.

In a Brazilian context, Rebecca Seligman notes how people who are distressed by their OOEs find gaining a mediumship role in Candomblé (an Afro-Brazilian religion) transformative in terms of redefining their identities and status.[[12]](#endnote-12) Stanley Krippner writes about Brazilian mediums he interviewed who initially had psychiatric diagnoses, but chose not to take medication on the grounds that this would be to misdirect their mediumistic gift.[[13]](#endnote-13) These examples highlight how experiences initially identical to those pathologised can be interpreted in different ways – and, in the process, become different (positive rather than negative) experiences. These findings resonate with conversations I have also had with mediums from Umbanda communities (an Afro-Brazilian religion incorporating aspects of Catholic Christianity). During these conversations, I learned how, prior to their initiation, hearing voices was experienced as distressing and accompanied by insomnia and other signs of disturbance; following their initiation into the community, discernment and training as clairvoyant mediums, voice hearing was regarded as arising from a contract with good spirits they had known in past lives, and seen both as a vocation and as a gift.

While I’ve focused on examples that involve beliefs in spirit mediumship, not all positive religious meanings given to OOEs involve what believers would describe in these terms. Jackson and Fulford cite the example of Sara, who, hearing the voice of Jesus, gave up her management career and became a counsellor and spiritual director to priests in the Anglican Church. She describes both the voice hearing and her relationship with Jesus in overwhelmingly positive terms:

It has always enhanced my life; it's brought a great deal to other people and it is benign; it is co-operative; it is loving; it helps me see the beauty of nature; hear the beauty of music; understand myself and others; reach out to others; begin to grasp something about ultimate reality and the way the universe is. It never torments me or taunts me; it teases me lovingly sometimes. . . . If I'm mad, so be it, but this is the most real thing I've ever known.[[14]](#endnote-14)

In the context of studying mourning processes, Joe Yamamoto *et al.* interviewed 20 Japanese widows, finding that people who adhered to cultural beliefs about ancestor veneration which sanction sense of presence of the dead experiences coped better with their loss, experiencing less depression and anxiety as a result of it.[[15]](#endnote-15) This gave rise to the questioning of Freud’s assessment that the goal of bereavement is to sever ties with the deceased, and that the experience of sensing the presence of the dead comprises ‘clinging to the object through the medium of a hallucinatory wishful psychosis’[[16]](#endnote-16) (Freud, 1917, p. 255). This in turn has given rise to the emergence of continuing bonds theory, according to which continuing to have (or perceive to have) a relationship with the deceased can be a healthier way to deal with loss than to sever ties (Klass, Silverman and Nickman, 1996).

Western culture on the whole has fewer ways of enabling the continuations of such relationships than are possible in other cultures or in the past: not only the decline of religious belief, but also the prior Reformation decline of the cult of saints reduced perceptions of the porousness of the boundaries between earth and heaven such that where an afterlife is believed in, it is not within mainstream religions that people are encouraged to communicate with loved ones they have lost (see Davies, 2002). New religious movements are emerging to provide frameworks for such relationships, but problematically these tend to be available primarily to those who have the initiative and resources to discover them, and therefore to be comprised primarily of people from educated, professional backgrounds. Positive meaning-making frameworks may therefore be less available to less educated people, who form a high proportion of people who are diagnosed with schizophrenia and other mental disorders.

*What is the significance of this apart from its implications for OOEs?*

So far, I’ve argued a rather basic point: that if we have a particular experience, it may turn into an illness and a problem if it is described as an illness and a problem, and it may become something positive, comforting and meaningful if it’s interpreted as something positive and meaningful. Despite being basic, I think this point is worth making, since it seems to me that, at least in the context of out of the ordinary experiences, the former tends to happen in modern societies quite a bit.

These two claims are asymmetrical. The first claim, that pathologising interpretations are pathogenic, refers only to experiences that are not inherently pathological, but where pathology emerges as the result of responsive and contextual factors such as interpretation. Pathologising is also a feature that is essential to medical diagnosis, since the job of medical diagnosis is precisely to discern what things are illnesses in the hope of treating them. The solution therefore seems to be for medicine (and for society more generally) to ensure that it does not diagnose or interpret as pathological something that is not. There is nothing wrong with it diagnosing a broken leg as pathological, but OOEs are not inherently pathological; like homosexuality and left-handedness, they are ‘mere-difference’ rather than ‘bad-difference’ phenomena that are prone to being regarded as pathological on account of being the experiences of a minority. If we (whether doctors or members of the public) describe OOEs and other experiences as pathological when they aren’t, by problematizing the experience and causing distress, we may lead them to become pathological.

The second claim, that describing experiences as pathological is pathogenic because it excludes positive meanings, applies not only to experiences that are not inherently pathological, but also to those that are, such as broken legs, and depression, though (precisely because OOEs are not inherently pathological) it’s presented in a particularly acute form in the case of OOEs.[[17]](#footnote-1) The second claim also differs from the first in being contingent on current medical and wider secular attitudes in our society rather than necessary to medical diagnosis *per se.* This is because it relies on us having certain questionable and unnecessary distinctions such that we think things are one thing or another: they are either good OR bad; they are medical OR spiritual; have a natural OR supernatural origin and, correspondingly (we think), goal; they are a problem to be solved OR something that is positively meaningful.

It seems to me that these are avoidable and unhelpful separations: something might be both medical and spiritual; a problem to be solved and something that is positively meaningful. So, for example, the belief that hearing voices is caused by benign spirits one knew in one’s previous, non-bodily existence does not exclude the naturalistic explanations, such that one has a genetic predisposition to ‘psychotic’ experiences, or that experiences of trauma can be a catalyst for voice-hearing. While this example shows the complementarity of natural and supernatural aetiologies (explanations of origins), others combine naturalistic aetiologies with the idea that the experience may have a spiritual or moral meaning, purpose or value. Andrew Solomon, who has written an book drawing on his own experience of depression and those of other people, is supportive of medical treatments such as antidepressant pills and electro-convulsive therapy and of naturalistic explanations that underlie them, and yet he writes of the experience of depression as valuable, as having discovered his soul, of loving more and being loved more, and of having lost his fear of crisis and being able to plunge into the sorrow of others because of it. He also writes of people who have had depression having a ‘heightened awareness of the joyfulness of everyday existence’ and an ‘intense appreciation of all that is good in their life’.[[18]](#endnote-17) The Catholic priest and psychologist Henri Nouwen sought and benefited from psychological therapy, and yet also described his experience of depression as ‘fertile ground for greater trust, stronger hope, and deeper love’.[[19]](#endnote-18)

The solution for the second problem is therefore different than for the first: what is needed is a shift in medicine and society more generally to seeing medical diagnosis as one, important, perspective on an experience, rather than the objective, authoritative one. Relatedly, as a society, we could do with being more open to ways (religious or other) in which an experience (pathological or simply unusual) might be seen perhaps (though not necessarily) as a problem to be solved, but also as something that can, inherently or potentially, have positive spiritual or other meaning.

*Conclusion*

In conclusion, in this paper I've argued that pathologisation can be pathogenic in two ways: in relation to non-intrinsically-pathological experiences such as OOEs it can engender distress and loss of function, and so transform them into something pathological. In relation to intrinsically pathological experiences as well as OOEs, it can exclude or negate positive, therapeutic interpretations. The solution to the first is to ensure that experiences that are not inherently pathological are not interpreted by medicine or the general public as such. The solution to the second problem involves a shift in the way in which medical diagnosis is conducted and perceived, redressing the tendency to see medical diagnosis as the be all and end all of the interpretation of particular experiences.

All this should not be taken as suggesting a pro-religion and anti-medicine stance: there are forms of religion that also pathologise various experiences in terms of ‘spiritual illness’, for instance by describing them in terms of moral culpability, or else demonic possession, and there are plenty of reasons for which to be thankful for medicine in general, and mental health care in particular. This paper does, however, highlight the importance of interpretation in shaping experience and, in so doing, challenges us to ask what costs are associated with designating an experience an ‘illness’ (as we currently conceive it), who has the right to define and interpret our experiences, and why.

1. McGruder, J. Life Experience is Not a Disease or Why Medicalizing Madness is Counterproductive to Recovery. In Brown, C. (ed.). *Recovery and Wellness: Models of Hope and Empowerment for People with Mental Illness* (Binghampton, NY: The Haworth Press, 2001), pp. 59 - 80 [↑](#endnote-ref-1)
2. Hay, D., and Heald, G. Religion is good for you. *New Society* (1987), pp.21- 22 [↑](#endnote-ref-2)
3. Pechey, R., & Halligan, P. Prevalence and correlates of anomalous experiences in a large non-clinical sample. P*sychology and Psychotherapy: Theory, Research and Practice,* 85 (2012), pp.150–162 [↑](#endnote-ref-3)
4. Loewenthal, K. *Religion, culture and mental health* (Cambridge: Cambridge University Press, 2007), p. 16 [↑](#endnote-ref-4)
5. Teeple, R., Caplan, J., and Stern, T. Visual Hallucinations: Differential Diagnosis and Treatment *The Primary Care Companion to the Journal of Clinical Psychiatry* 11.1 (2009), pp. 26–32. [↑](#endnote-ref-5)
6. Rosenhan, D. On being sane in insane places. *Science* 179.4070 (1973), pp. 250 – 258 [↑](#endnote-ref-6)
7. Slater, L. *Opening Skinner’s Box: Great Psychological Experiments of the Twentieth Century* (London: Bloomsbury, 2004) [↑](#endnote-ref-7)
8. Jackson, L., Hayward, M., and Cooke, A. Developing positive relationships with voices: a preliminary grounded theory. *International Journal of Social Psychiatry* 57. 5 (2010), p. 149 [↑](#endnote-ref-8)
9. Heriot-Maitland, C., Knight, M., and Peters, E. A qualitative comparison of psychotic-like phenomena in clinical and non-clinical populations. *British Journal of Clinical Psychology* 51 (2012), p. 49 [↑](#endnote-ref-9)
10. Jackson, M., and Fulford, K.W.M. Spiritual Experience and Psychopathology. *Philosophy, Psychiatry and Psychology* 4.1 (1997), p. 57 [↑](#endnote-ref-10)
11. Roxburgh, E. and Roe, C. Reframing voices and visions using a spiritual model. An interpretative phenomenological analysis of anomalous experiences in mediumship. *Mental Health, Religion and Culture* 17.6 (2014), pp. 641 – 653 [↑](#endnote-ref-11)
12. Seligman, R. From affliction to affirmation: narrative transformation and the therapeutics of Candomblé mediumship. *Transcultural Psychiatry* 42.2 (2005), pp. 272 – 294 [↑](#endnote-ref-12)
13. Krippner, S. Learning from the Spirits: Candomblé, Umbanda, and Kardescismo in Recife, Brazil. *Anthropology of Consciousness* 9. 1 (2008), p. 8 [↑](#endnote-ref-13)
14. Jackson, M., and Fulford, K.W.M. Spiritual Experience and Psychopathology. *Philosophy, Psychiatry and Psychology* 4.1 (1997), p. 47 [↑](#endnote-ref-14)
15. Yamamoto, J., Okonogi, K., Iwasaki, T., & Yoshimura, S. Mourning in Japan. *American Journal of Psychiatry* 125 (1969), pp.1660 – 1665 [↑](#endnote-ref-15)
16. Freud, S. *Mourning and Melancholia.* In J. Strachey (ed. and trans.) *The Stanford edition of the complete psychological works of Sigmund Freud Vol. XIV.* (London: Hogarth Press, 1917), p. 255 [↑](#endnote-ref-16)
17. Depression, it seems to me, is inherently pathological, since it is inherently distressing, and is accompanied by loss of agency and function – which (as already noted) are common characteristics of pathology. [↑](#footnote-ref-1)
18. Solomon, A. *The Noonday Demon: An Anatomy of Depression.* (London: Vintage Books, 2002), pp. 443, 436, 436, 434 [↑](#endnote-ref-17)
19. Nouwen, H. *The Inner Voice of Love: A Journey through Anguish to Freedom.* (London: Darton, Longman and Todd, 2009), pp. 97 - 98. [↑](#endnote-ref-18)