Mental Well-Being, Neuroscience, and Religion

with Gillian K. Straine and Mark Harris, "Mental Well-Being, Neuroscience, and Religion: Contributions from the Science and Religion Forum"; Fraser Watts, "Theology and Science of Mental Health and Well-Being"; Lindsay Bruce and Sarah Lane Ritchie, "The Physicalized Mind and the Gut-Brain Axis: Taking Mental Health Out of Our Heads"; Jaime Wright, "In the Beginning: The Role of Myth in Relating Religion, Brain Science, and Mental Well-Being"; William L. Atkins, "Empirical Mindfulness: Traditional Chinese Medicine and Mental Health in the Science and Religion Dialogue"; and Ben Ryan, "The Church and Mental Health: Theological and Practical Responses."

THEOLOGY AND SCIENCE OF MENTAL HEALTH AND WELL-BEING

by Fraser Watts

Abstract. The approach to mental health and well-being taken here illustrates the complementary perspectives approach and assumes that there are useful and intersecting contributions from science (including medicine) and from religion and spirituality. What counts as poor mental well-being depends on the interaction of relatively objective criteria with culturally contingent value judgments. I then discuss theological perspectives on depression, including a consideration of sources of hope and tolerance of dysphoria, and argue that depression can be part of a spiritual journey. I then look at the relationship between psychosis and religion, including the work of Isabel Clarke, arguing that a spiritual approach to psychosis can complement a medical approach. Finally, I present a pastoral case study illustrating the interface between neurological and spiritual aspects of the sense of presence. A religious perspective can challenge and complement current assumptions about mental health in a potentially fruitful way.

Keywords: depression; mental health; psychiatry; psychosis; sense of presence; spirituality; well-being

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In this article, I will look at mental health, illness, and well-being from the perspective of the dialogue between science and theology. The literature on science and theology is extensive but somewhat repetitive. Some topics

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are extensively covered; others largely ignored. The dialogue between psychology and religion has developed well over the last fifteen years or so but remains patchy, and mental health has not received as much attention as it deserves.

For example, Christopher Cook has edited a helpful collection of essays on *Spirituality, Theology and Mental Health* (Cook 2013) but the essays are mostly very specialized; apart from a brief introduction and conclusion, the book doesn't offer an overview of the topic. He comments (and I would agree) that there is a lack of "critical contemporary theological attention to current constructions of mental health and mental disorders," at least in Western Christianity (xi). Cook has also done some specialist work himself, and his work on alcoholism (Cook 2006) provides a model of an exemplary engagement with a particular behavioral problem from the perspectives of science and religion. Although I have written extensively on the interface between theology and psychology, my *Theology and Psychology* (Watts 2002) says nothing about mental health, though I have written briefly elsewhere about emotional problems (e.g., Watts et al. 2002). There is also an extensive empirical literature on the relationship between religion and mental health in which Harold Koenig has played a leading role (Koenig et al. 2012); however, that doesn't include an exploration of religious interpretations of mental health issues. Other treatments, such as that of Swinton and Willows (2009), are more practical than conceptual.

Somewhat different issues arise about different kinds of psychological disorder. Mental health is a broad category, and you can't force all mental health problems into the same mound. Different issues arise, for example, in relation to emotional and psychotic disorders, and you can recognize that without making assumptions that they are illnesses. One reason for this broad categorization as a starting point is that it makes it possible to engage with the growing literature on spiritual approaches to psychosis, and how that relates to scientific and medical approaches.

This article is in five main sections. In the next two sections, I will look at the relationship between medical and religious approaches to mental well-being and take a complementary perspectives position; and will then look at what counts as mental well-being (or lack of it) and consider the religious contribution to that. The following three sections will be more specific, dealing with emotional problems (especially depression), then with psychosis, and then with problems of mental well-being with a neurological basis (presenting a case study of a specific neurological disorder that called for both neurological and spiritual perspectives).

Complementary Perspectives

The conceptual issue about mental health that has been explored most systematically is the moralistic approach to mental health. That has often

been framed in terms of whether people are "mad" or "bad" (Bavidge 1989). It has often been framed in terms of Christian concepts of sin (Benner 1988; Beer and Pocock 2006), though it does not have to be. There are discussions of particular psychological problems from this point of view, such as despair (Bringle 1990). Christopher Cook considers the moralistic approach to alcoholism (Cook 2006), and rejects it. The most recent, and probably the most thorough, discussion of mental health issues from this point of view is that of Marcia Webb (Webb 2017), who considers the role of lack of faith, selfishness, sin, and demonic influence in mental health issues.

My background assumption here is that the relevant sciences (psychology, psychiatry, neurology) are compatible with a religious perspective, and that together they provide complementary perspectives that enrich our overall understanding. That is the approach I have consistently taken to work on the interface of theology and psychology (e.g., Watts 2002, 2010), and applied to various specific topics such as forgiveness (Watts and Gulliford 2004) and healing (Watts 2011). I want to look here at how there can be a fruitful intersection between the different approaches to mental health issues of religion and science.

It is commonplace to talk about issues of mental well-being in terms of mental *illness.* However, that terminology is already controversial, because it implicitly brings psychological problems and issues within the concept of medicine, and that is much disputed. Let me state my own stance on that issue briefly, at the outset: I take a moderate view. I don't think it is adequate or sufficient to conceptualize psychological problems as illnesses; too many important perspectives are omitted in doing so. However, neither do I don't think that the medical perspective is completely unreasonable and objectionable, to be avoided at all costs. I don't accept that medical and nonmedical approaches are incompatible. In general, I am sympathetic to the kind of perspectivalism that keeps multiple perspectives in play, on the grounds that no one perspective is completely adequate (Watts 1998). That applies to mental well-being too. I assume that the medical approach makes a useful contribution, but that it is far from adequate.

It may seem bland and uncontroversial to suggest that theology and science are compatible and complementary. However, on the specific topic of mental health it seems surprisingly controversial, and may be a minority position. Those advocating a spiritual approach to psychosis seem to be saying (or at least implying) that the two perspectives sit so uneasily with one another that one has to choose between them. I will argue against that position and in favor of a complementary perspectives position that allows medical and spiritual approaches to sit alongside each other in fruitful dialogue.

Theology has distinctive questions to ask about psychology, and I will indicate here some of the key questions about mental health that I think

it is most fruitful for theology to ask. Mental health and illness is often very revealing about a person; it brings many things to light. It is an arena in which the secrets of people's hearts are laid bare, as Saint Paul might have said (paraphrasing 1 Corinthians 14:25). It brings "judgment" in the sense in which it is mainly used in Saint John's gospel (i.e., "revealing clarification" rather than "condemnation"). I suggest that mental health often brings helpful *clarification* about who someone really is and how they are leading their lives. A related theological question about mental health is what *significance* do we see in mental health and illness from the perspective of the providence and purposes of God. It is a theological question that can be asked about many aspects of human life, similar to the question that Rowan Williams suggests that we ask about sexual acts, that is, what is someone prepared for a sexual act to signify (Williams 2014). It is often fruitful for people to reflect on the significance of the mental health problems they are experiencing. It can also be very fruitful theologically to set out a prophetic interpretation of the significance of the problems that humanity is experiencing more generally in a particular time and place, such as the one that Stephen Verney attempts in *Into the New Age* (Verney 1976). Mental health problems are a marked feature of the contemporary human predicament, and one that calls for theological reflection.

God characteristically speaks a language of promise with humanity, so the religious person will also ask how can problems of mental well-being become a source of blessing to them. This is different from the prevailing secular approach to mental health problems, which often just wants to get rid of them. The religious perspective is more likely to ask how there can be a path through mental health problems to something better than what prevailed before. This is not to deny the distress that mental health problems cause, or to try to justify them; rather it is to adopt a frame of reference broad enough to be able to recognize *both* the distress *and* the opportunities that mental health problems bring. Some strands of Jungian psychology also reflect on how attempting to move on too quickly from mental health problems miss the opportunities for "soul making" that they present (Hillman 1975). People can use problems of mental health to grow in psychospiritual depth and to realign how they lead their lives. Theology characteristically emphasizes the *opportunities* that mental health problems present.

Conceptualizing Mental Health: Who Decides?

Conceptualizations of mental health and well-being are always controversial. It is simply not possible to hide behind neutral language, as there is no neutral language, no "view from nowhere." Value judgments always come into formulations of mental well-being (and the lack of it). Because

religion is often intertwined with value judgments, religion is relevant to formulations of mental health and well-being.

A middle way needs to be found, between an unconvincing straining after objectivity and a complete relativism. I don't think either extreme is convincing; judgments about mental health involve *both* objectively defensible *and* more contextually contingent perspectives. Value judgments are inescapable in thinking about which psychological states, behaviors, and experiences represent a threat to well-being.

It is generally not sufficient to take a single person's point of view as definitive, and as settling whether something is a problem or not. There is usually a search for a reasonable consensus. That raises further issues about who the reasonable consensus is among. Different communities can reach different consensus positions, which is why consensus cannot be confused with objectivity. Incidentally, this also raises problems for many versions of natural law theory that are inclined to take moral consensus as support for some kind of transpersonal moral law.

This is an issue with which cross-cultural psychiatry has to grapple (Tseng 2001). Most people are able to make a distinction between eccentric and pathological ideas in their own community. There is usually a reasonable consensus about where to draw the line, but it is surprisingly difficult to make that distinction in communities of which one is not a member. Professionals from one community often need help in making such judgment from someone in the community of the person with whom they are concerned.

This sounds very relativistic. However, there is often objective data that points strongly in one direction or another, though it would involve a kind of naturalistic fallacy to try to derive judgments of pathology entirely from objective data. There is always an element of judgment involved. In some cases, it is fairly obvious that a particular psychological stance arises from biological dysfunction, as when the onset of strange and worrying ideas is associated with a traffic accident. Similar issues arise, though in a way that is slightly less obvious, when psychological changes are associated with hormonal or biochemical changes.

There can also be cases where the consequences of a particular psychological stance are such as to point pretty strongly to it being pathological. At the most extreme, it is usually reasonable to regard beliefs or practices that are likely to result in death, either of the person concerned or of someone else, as pathological. However, that is not necessarily always the case, and someone with a background in the Christian tradition may shrink from labeling Jesus as pathological for deciding to go to Jerusalem where, according to the gospels, he correctly anticipated that he would be put to death. There can be overriding objectives that lead people to put their lives at risk, as is demonstrated regularly by those in the military or the emergency services.

With that example, I have raised the question of the distinctive approach of the religious traditions to the complex matter of what is and is not to be regarded as pathological, and I will briefly explore that. We live in a rather hedonistic, self-serving culture, and I don't want to fall for the idea that such a stance is necessarily healthier than one of sacrificial service. However, it is worth noting that, despite people often being rather self-serving, we live in a culture that admires and celebrates altruistic self-sacrifice, even among those who have no religious affiliation.

For religiously committed people, well-being is never the overarching objective. Saint Ignatius of Loyola makes this point well when he says that, for the Christian, events are evaluated, not in terms of whether people like them or not, but in terms of whether or not they bring them close to God. He calls those that do so "consolations," and those that take us further away from God "desolations" (see Meissner 1992). There is not really much connection between whether or not we like events and whether they bring us closer to God. So, for the Christian, well-being is not the immediate objective, though in the long run a consistent policy of seeking closeness to God may be good for our well-being.

In general, there is more agreement about what counts as a *problem* of mental welling than as what counts as *positive* mental health. One of the most widely known formulations of positive mental health is that of Marie Jahoda (Jahoda 1958) who suggested it had several main features: a positive attitude toward the self, self-actualization, autonomy, resistance to stress, environmental mastery, and an accurate perception of reality. More recently, the "positive psychology" movement associated with Martin Seligman and others has formulated things in terms of character strengths and virtues (Seligman 2011).

Some of the assumptions made about positive mental health look particularly questionable from a Christian point of view. For example, there is often a strong emphasis on self-actualization and self-efficacy. The idea that mental well-being involves believing that we can fix things around us for our own benefit is obviously culturally contingent; people don't necessarily have to assume that in order to flourish.

It is a view that is widely held in both philosophy and psychology. But you don't have to be religious to find it questionable. Iris Murdoch (1970) took strong exception to it in the form expressed by Stuart Hampshire (Hampshire 1959). She objected to the idea that people can make choices and sets goals in isolation from what is around them, believing that they can reach their goals. Murdoch calls this view of human nature "alien and implausible." She says, she has empirical objections ("I do not think that people are necessarily or essentially like that"); she also has philosophical objections ("I do not find the arguments convincing"), and moral objections ("I do not think that people ought to see themselves in that way") (Murdoch 1970, 9).

There are also important issues about making sense of things, finding meaning, and generating a narrative that gives coherent support to one's actions and beliefs. Religion gives strong support to the process of making meaning, and making sense of things helps people to cope; it is one of the key ways in which religion can be good for well-being (Watts 2017). That is evident, for example, from the work that Kenneth Pargament and others have done on religious coping styles (Pargament 1997). One of the most useful findings is that a collaborative coping style (collaboration between self and God) works better than doing it all oneself or leaving it all to God.

But religious meaning making can go too far. It can lead to an overconfident narrative that can justify things that are bad for well-being, one's own and other people's. That is one of the characteristics of religiously motivated evil. It is important that a religious meaning framework is held in a humble, open-minded way, and is open to interrogation and revision. Religious meaning making is good for well-being in moderation but taken to extremes it can work against it.

Emotional Problems: Depression

I turn now to specific mental health issues, and will look first at emotional disorders. I will take depression as my main example, with some briefer comments on worry and addiction.

Depression is a very common mental health problem, and one where many different factors intersect. Biological, social, developmental, and spiritual factors seem to come together in depression, more than with any other mental health issue. Many aspects of depression also raise interesting issues from a Christian point of view, and I will look here especially at how scientific and religious viewpoints interact. The literature on this is more sparse than one might expect; though there is helpful material, for example, in Swinton and Willows (2009), Watts et al. (2002), and Jessica Rose (2013), the fullest treatment so far is that of Stephanie Sorrell (2009). The prevailing secular view of depression is straightforward; it sees depression as a form of severe distress and suffering, and sees its alleviation as an indisputably good thing. Religion sometimes has a different perspective, as do some branches of psychology, including psychoanalysis.

Causes of Depression

One set of questions arises around why someone has become depressed. The prevailing popular view sees depression simply as misfortune, and not the fault of the depressed person. However, both religion and psychology are willing to consider that it might be more complicated than that, and that people might, to some degree, be responsible for their own depression.

The recent psychological literature has widely embraced a "diathesis–stress" model, which sees depression as arising from an interaction between

preexisting vulnerability factors and their current circumstances (Alloy and Abramson 1988). There seems to be some scope for those who are vulnerable to depression to take action to reduce that vulnerability. Indeed, it seems to be one of the advantages of tackling depression with psychological methods rather than medication that it is more likely to make someone less vulnerable to depression.

Religion is also sometimes inclined to regard depression as arising from sinfulness or lack of faith (Bringle 1990; Webb 2017), though the relevant religious literature partly predates the use of the modern category of "depression" and uses other terminology. It can be unhelpful, in pastoral terms, to say to someone who is depressed that they are to blame for how they feel. However, it would be possible to reframe the widely accepted diathesis–stress model in a way that incorporates a spiritual perspective. It seems entirely plausible to suggest that vulnerability to depression includes personality characteristics that can be framed in religious or spiritual terms.

This raises interesting issues about guilt. Being excessively guilty is psychologically harmful, as twentieth-century psychology has made us very aware. "Neurotic" or irrational guilt, in which people become excessively guilty about a wide range of things, can be very debilitating. But Christians would not want to conclude that guilt is always bad. There is a proper and helpful place for the recognition that a person has done wrong and needs to improve, a place for what Christians call "repentance." Realistic guilt can help people to become better adjusted, and to behave in ways that are in everyone's best interests (Ivimey 1949; Watts 2001). It is quite difficult to find a middle way between being excessively guilt-ridden or excessively complacent about ourselves. Guilt itself is multifaceted and has both cognitive and emotional aspects. It is the cognitive aspect, a recognition that one has done wrong, that is perhaps most valuable, and the emotional aspect of guilt that is most likely to run to excess.

The Constructive Role of Depression

However, the point where the religious perspective differs most sharply from the prevailing view that depression is a severe misfortune is over the promise and possibility that depression brings. This is encapsulated in the book title *Depression as a Spiritual Journey* (Sorrell 2009). The idea that depression indicates that the person concerned has important needs that are not being met would be quite widely accepted by psychologists. However, a religious perspective probably places unusual emphasis on the opportunities for personal and spiritual growth that depression creates.

Depression is characterized by negative thinking, about the world, the self, and the future (Beck et al. 1980). That is not at all the outlook to which faith leads, but neither does faith necessarily lead to the antithesis

of negative thinking. Faith doesn't lead to the kind of excessively negative thinking that saps motivation, but neither does it lead to the kind of rosy optimism that doesn't recognize the reality of problems and difficulties. I suggest that faith leads to a commitment to balance and objectivity, rather than to an unremittingly positive outlook.

There is an intriguing phenomenon known as "depressive realism" (Alloy and Abramson 1988). The judgments of depressed people (for example, about how they are regarded by others) can be more accurate than those of people who are not depressed. The formal evidence for this is somewhat inconclusive, but it is supported by the claim of some people with a depressive outlook that they are seeing things more accurately than others, without a distorting rosy glow. That can lead them to see their depressive outlook as a kind of virtue.

There can be a path between the negative thinking that is characteristic of depression and the overpositive thinking that is often an alternative to it, what psychoanalysts might call a "manic defense" (Klein 1940). Something similar emerges from research about coping styles. Negativity doesn't help people to cope, but neither does it help to pretend there are no problems and challenges (Meichenbaum 1974). The most helpful stance is to recognize that there really are problems, but still to think you will be able to handle them.

Similarly, faith does not lead either to optimism or pessimism; it eschews both. However, faith *does* lead to hope; but hope is very different from optimism, as Terry Eagleton has argued in his recent book on *Hope Without Optimism* (Eagleton 2015). Hope is much more flexible and versatile than optimism. It does not depend on circumstances being favorable; indeed, it can come into its own when circumstances are very unfavorable. That is evident in how Victor Frankl found ways to maintain hope in a Nazi concentration camp (Frankl 2004). Hope seems to be more a general attitude or disposition than a prediction about what is going to happen. It also carries a commitment to work for a better future. Optimism is rather passive; it just takes stock, and predicts what is going to happen. Hope, in contrast, transforms the future.

Depressed people are negative about many things, and Beck et al.'s (1980) triad of being negative about the world, oneself, and the future is well known. But there may be another kind of negativity that is especially pernicious, when you get depressed about being depressed (Segal et al. 2012). There are indications that it is when people get into that kind of second-order negativity that depression gets a grip, and becomes difficult to escape from. It seems to make depression self-perpetuating and less sensitive to changing circumstances.

How easily people become depressed may depend on their attitude to depression. I suspect that there have been cultural changes in the West over the last century, and that people now expect at least to be content, if not

happy. So, it becomes a real problem for someone if they are not content; they start to feel that it is unacceptable and get upset about the fact that they are unhappy. I suspect that there is a vicious circle going on here. The more you expect to be content, the more easily you can get locked into depression. Expecting to be happy may actually make you more vulnerable to depression.

If that analysis is anything like correct, the solution lies in a measure of detachment. If you accept the Ignatian approach, that what matters is how close to God you are, not how happy you are, then you may actually be less vulnerable to depression. Mindfulness explicitly fosters this kind of detachment, which is probably why it enhances the effectiveness of psychological treatment of depression (Segal et al. 2012). It trains people to avoid the kind of second-order judgmental thinking, of which being depressed about being depressed is a particularly pernicious example.

Other Problems

I suggest that it is not only depression that can be the starting point for a spiritual journey. In fact that is probably true of all mental health problems. I will illustrate that with two brief examples. The first is worry or, in more technical language, "generalized anxiety disorder." In an interesting chapter on worry, Christopher Cook (Cook in press) has pointed out that the situations that trigger worry are similar to those that trigger prayer. They are both responses to challenging circumstances and to uncertainty. That leads to the interesting idea that they might function as alternatives; if people prayed more they might worry less. Both are ways of thinking through difficult circumstances, but prayer is more constructive than worry and can contribute to adjustment (Watts 2017).

Addiction also raises interesting issues, and again Cook (2006) has done helpful work. He rejects the moralistic approach to alcoholism and instead develops an alternative theological account around the divided self. Those who are addicted to alcohol are often divided about it, partly wanting to be free of their addiction but partly still in thrall to it. There is a compulsiveness about addiction, as there is too much sin (McFadyen 2000) that coexists alongside good intentions, something on which Saint Paul reflects in Romans 7. A constructive resolution of this kind of divided personality often seems to be a spiritual process, either implicitly or explicitly; there is a close analogy between the "twelve steps" process of Alcoholics Anonymous and the religious life. In this sense, addiction is also often the starting point for a spiritual journey and involves embracing virtues such as discernment, honesty, dignity, community, responsibility, simplicity, and "loving our longing" (May 1988).

Psychosis and Spirituality

I now turn from emotional and behavioral problems to psychosis. I will often have schizophrenia in mind, but prefer the broader term "psychosis," as it makes fewer assumptions. Psychosis is a more complicated and controversial topic than depression.

Many people have been impressed by the similarity between psychosis and spirituality. Strange psychotic beliefs are quite often explicitly religious, but there is also a more general similarity in the quality of thinking found in psychotic and religious experiences. They seem to have things in common that differentiate them both from ordinary rational consciousness.

In the course of history, there have been many people who have been both religious and psychotic, and the two have been inextricably intertwined. Of the late mediaeval mystics, Margery Kempe was widely regarded as mad in her own time, for her chaotic life, copious weeping, the quality of her visions of Christ, and her constant hallucinations (Dixon 2015). In the early twentieth century, Mabel Barltrop, shortly after she was released from compulsory detention in Saint Andrew's Hospital in Northampton, became convinced that she was the Daughter of God, and founded a thriving religious community in Bedford of people who accepted that claim. Every day she received revelations from the Holy Spirit, in the form of automatic writing, which she read out to her followers (Shaw 2011).

Recognizing the continuity between religion and psychosis leads to a new approach to psychosis that sees psychosis as some kind of spiritual journey or crisis. Those who have been at the forefront of advocating a spiritual approach to psychosis, such as Isabel Clarke (Clarke 2008, 2010) have mostly seen it as an alternative to the medical approach to psychosis. It is clear to me that there is much of value in taking seriously the religious and spiritual aspects of psychosis and being willing to enter into conversation about them. The disputed question is whether doing so should be seen as broadening or replacing the concept of psychotic illness. That in turn gets caught up in the "psychosis wars," the broader ongoing debate between the medical and psychosocial approaches to psychosis.

The Broader Debate

I do not think a spiritual approach to psychosis needs to be an alternative to the medical approach. Emphasizing the importance of spiritual aspects of psychosis can equally well be seen as a broadening of the medical approach, just as emphasizing social aspects represents a similar broadening. I suspect that Clarke is motivated by a fear of reductionism, that if you accept the illness model of psychosis it will imply that the spiritual experiences entailed are "nothing but" symptoms of illness. However, I believe that we can accept the illness model of psychosis without drawing those reductionist

conclusions, so I am less worried about the implications of adopting the illness model.

The most persuasive exposition of the antimedical, psychosocial approach comes from Richard Bentall (2003). It is beyond the scope of this article to attempt a detailed examination of the complex arguments involved, but I do need to indicate in broad terms where I stand on some key issues. I think Bentall makes a persuasive case, but one that is not wholly convincing.

I agree with him that the attempt to carve up the psychotic territory into a number of discrete illnesses has not really worked. The strongest distinction is that between schizophrenia and manic-depressive psychosis, but even that often gets blurred. People with "schizophrenia" also often differ markedly from one another, but there is no agreed subclassification. We perhaps need to conceptualize psychosis in multidimensional terms rather than in discrete illness categories. However, I don't think that discredits the idea that something has gone seriously wrong with people who become psychotic in multiple ways.

I would also agree that many psychotic features can be found quite extensively in people who would never be diagnosed as having a psychotic illness. That is more true of some features than others. For example, hearing voices is found in many people who would not be considered to be psychotic. We now know much more about hearing voices, partly as a result of an extensive research program at the University of Durham (Fernyhough 2016). Hearing the voice of God is a common feature of the religious life (Dein and Cook 2015).

I think that the "symptoms" of schizophrenia tend to cluster together in a syndrome. Some can be found in other contexts such as hearing voices, but others (the so-called "front-rank" symptoms) are rarely found elsewhere. I am also impressed by the biological aspects of schizophrenia; it has biological markers, and responds to major tranquilizers, though that is not to say that it is exclusively caused by biological factors. Medication can play an important role in helping such people to function in a relatively normal way.

However, despite the fact that particular psychotic features are quite widely distributed in the general population, I still think it is true that there is a narrower group of people in whom multiple psychotic features can be found over a long period, and that such people often have serious problems in coping with life. They develop prominent negative symptoms and incapacities that are at least as disabling as their psychotic characteristics. I don't want to dismiss the idea that something has gone seriously wrong for such people, which is what the idea that they have an "illness" is trying to reflect.

The fact that phenomena like hearing voices can be found in many people who would not be classified as psychotic has led some to propose

a continuous dimension, such as the "schizotypy" proposed by Gordon Claridge (2010). This seems to be a helpful move. However, for Claridge, one of the implications of someone having a high schizotypy score is that they are more likely to develop a psychotic illness. Claridge sees a causal link between the two, rather than seeing the concept of schizotypy as replacing that of psychotic illness.

Transliminal Experience

Clarke uses the word "transliminal," a term first proposed by Michael Thalbourne (1991), for an alternative mode of consciousness, of which psychosis and spirituality can both be manifestations. It has connotations of crossing the border. Sometimes people suggest that spiritual and psychotic people are exploring different worlds or different realities. However, I prefer to talk about two different "modes" of consciousness (one psychotic/spiritual, the other ordinary and rational). I don't want to lapse into a new kind of dualism that postulates two different worlds, and to say that in one mode of consciousness we access one world, and in the other mode we access a different world.

I assume there is one world, but that we experience different aspects of it in different modes of consciousness, and there is a good deal that is accessible in the transliminal mode that is filtered out in the rational mode. We can potentially explore different aspects of it in different modes of consciousness. I see no reason to say that the world we know in our rational mode is real, but that the world we know in our transliminal mode is not. However, the transliminal mode is accident-prone. It is venturing into domains where it is hard to be sure-footed, and easy to get things wrong. In the rational mode, we are playing safer, exploring more limited territory, but being less error-prone.

The idea of filters is helpful in understanding this different mode of consciousness. We never consciously experience everything that goes on in our information processing. It is widely accepted that there are two different modes of processing, one fast and with high capacity, but nonconscious; and another that is slower, conscious, and with much more limited capacity. Obviously, there is filtering that determines what gets into the conscious system; human functioning depends on cognitive "filtering," or cognitive "inhibition" as it is sometimes called. There is widespread agreement that this filtering process is one of the things that goes wrong in psychosis. As Christopher Frith put it, psychotic people have difficulty limiting the contents of consciousness (Frith 1979). It seems reasonable to suggest that there is similarly reduced filtering in people with spiritual or visionary experiences.

There are both individual and cultural variations in how much people use the transliminal mode. Some people are more open to transliminal

experience than others, and there may be a genetic basis for that (Watts 2017). There are also variations between cultures. For example, Africa seems more transliminal than the West. There are things people can do such as trans dancing that make them more transliminal. I suspect that when people are in transliminal mode they are more open to certain kinds of experience, and that spiritual healing works better when people are in that mode.

Though I have suggested that there is similarly reduced filtering in psychotic and religious experiences, they may arise for quite different reasons. There are very significant differences between psychosis and visionary religious states, despite the similarities. I am impressed by the incapacities associated with schizophrenia, the so-called "negative" symptoms, which do not seem to be found in other forms of transliminality. Those incapacities require explanation, and it is not enough to present psychosis as merely a form of transliminality.

The impact of unusual experiences is also very different in psychosis and in religious forms of transliminality. Religious experiences are generally felt to be positive, to be a blessing. But psychotic experiences generally cause distress, and can be incapacitating. There is a similar issue with regard to the similarity to religious experiences of the experiences of people with temporal lobe epilepsy. There are indeed similarities, but the strange experiences of people with temporal lobe epilepsy are distressing in a way that religious experiences are not. That seems a very important difference.

With benign spiritual experiences, people are choosing to follow a path that leads to a weakening of the normal processes of cognitive inhibition and opens them up to a range of experiences that would not otherwise reach consciousness. In psychotic states, something similar happens, but it seems to arise from a pathological process that people have not chosen, and over which they have little control.

Iain McGilchrist (2009) has suggested that in schizophrenia there is a disordered relationship between the two hemispheres, with intrusions from one hemisphere into the other. Clarke (2008) similarly highlights the different logic of the transliminal from our ordinary rational consciousness; the latter operates an "either-or" logic, whereas the transliminal operates a "both-and" logic. One mode splits; the other joins up. It is not straightforward to bring these two modes of consciousness into conversation.

It seems to me plausible that careful conversation about psychotic ideas could help to integrate different modes of consciousness and normalize a disordered mind. It is often thought that psychotic delusions cannot be challenged, but a series of research reports (the first being that of Watts et al. 1973) have shown that this is not the case. It is, however, important in such work to approach things gently, avoiding psychological reactance, and opening up alternative interpretations rather than challenging ideas head on.

It might be thought that people who have taken a psychotic route into the transliminal would emerge from it more at home with transliminal experiences, but it may go the other way round. Once people have extricated themselves from the mires of psychosis, they may be wary of all forms of transliminality. People who have been deeply psychotic may stay clear of religion because it brings them too close to the times when they have lost their footing. Religious people can be seen as having very managed, very controlled transliminal experiences. That may make them less liable to slip into psychosis or, if they do, they may have resources that will help them to navigate the strange world in which they find themselves. That is all a matter for empirical research.

Nevertheless, it seems likely to be helpful to engage with the spiritual experiences of psychotic people, and to take their experiences seriously. It might be feared that taking psychotic ideas seriously and entering into conversation about them would represent an unhelpful collusion with mad ideas. However, it seems potentially to be helpful in rebuilding connections between the transliminal or psychotic experiences and the ordinary rational modes of consciousness, so that people can navigate between the two, and have more control over which they are in.

The Intersection of Neurological and Spiritual Factors

Some distressing experiences that are a threat to the sense of well-being clearly arise from neurological problems. Again, I want to take a complementary perspectives approach, arguing for the integration of neurological and spiritual approaches. It is beyond the scope of this article to attempt a general survey of work on the interface of neurology and religion. Rather, I will focus on one specific neurological symptom of obvious religious relevance, the sense of presence, and I will present a pastoral case study illustrating the integration of apparently opposing scientific and spiritual perspectives. The case study is of a single man of thirty-six who I will call Rob, who I saw in an informal capacity as a family friend.

For the last ten years Rob has had what might be called "feelings of presence." He almost always feels there is someone with him, often over his left shoulder. He particularly feels this presence through soft things, such as furnishings. At night, the presence pokes him in the ribs, interfering with his sleep. He feels the presence is canny and strategic in how it makes its impact on him, knowing his weak points, and so on, and he attributes an intention to cause distress to this presence. He is firmly wedded to the view that there really is someone/something there, and that this presence is evil in its intentions. He sees this in rather new-age spiritual terms, and thinks that there are dark forces at work.

I recognized that the feeling of presence that he was describing is, up to a point, a standard neurological symptom. The most interesting recent work

on it comes from a research group in Zurich (Blanke et al. 2014). They found that feelings of presence are "an illusory own-body perception with well-defined characteristics" associated with damage to three particular regions of the brain, the temporoparietal, insular, and, especially, the frontoparietal cortex. Based on these findings, they developed ways of inducing feelings of presence in normal participants. Their basic contention is that feelings of presence are caused by misperceiving the source and identity of sensorimotor (tactile, proprioceptive, and motor) signals of one's own body.

Two Factors: Neurological and Spiritual

On the basis of these scientific findings, it was tempting to say to Rob that he was simply wrong in his assumptions that he was being troubled by an evil spiritual presence, and that what he was experiencing was *just* a neurological symptom. However, there seemed good reasons for not saying that, both intellectual and practical. I am not comfortable philosophically with the kind of reductionism that says that spiritual descriptions of experience should be discarded once we have a neurological explanation.

There was also the problem that Rob was strongly opposed to the idea that there might be a medical explanation for what he was experiencing. He would probably not have accepted it if I had said that the explanation was neurological not spiritual, and I don't think I would have been able to get him to see a doctor about it. He thought that he would risk being labeled as crazy, and he did not want to take that risk. It is also not clear how it would have helped him to see a neurologist, or what treatment it might have led to. So, I looked for some kind of integration of the neurological and spiritual perspectives, and one that Rob might be able to accept.

The one chink in Rob's objections to a medical explanation concerned a traffic accident that he sustained on his motorbike. It turned out that the feeling of presence roughly dated from that accident. Moreover, the accident resulted in injuries that were particularly on his left side, and he admitted that the presence was usually on his left. As we discussed that together, he came to accept that the injury may have left some "vulnerability" to the presence on that side. However, that didn't persuade him that the presence was nothing but a neurological symptom, and I agreed with him that it didn't prove that.

It seemed that the idea of neurological vulnerability was more likely to be acceptable to Rob if it was part of a broad approach that included spiritual aspects as well. I remained agnostic about his belief in an evil spiritual presence, though I saw no conclusive reason to reject it, and thought I could help him more if I worked within his framework. I felt it was reasonable to accept his view that there was a dark spiritual force at work, and to try again to help him on that basis.

Whether or not Rob was right about an evil presence it seemed that he might benefit from cultivating his spiritual life. After discussion he began to read a few verses of one of the gospels each day, and to use prayers for protection, including a version of Saint Patrick's Breastplate. When I saw him we said it together, and it evidently gave him a powerful sense of protection. On one occasion, his parents joined us and we moved round the house saying these prayers in each room. We also went together to a healing service that was held in his local church. The healing service seems to have been a turning point. He said that while he was in the church he was completely free of the troubling presence, for the first time in ages. Rob had a strong sense of having placed himself under God's protection, and had a strong belief in the power of that protection. As he put it, "The thing knows it can't get at me now, because it knows that He [i.e., God] is protecting me."

After this, he was left with a sense in the background of some kind of presence (which I assume to be a neurological symptom dating from his accident). However, the sense of being a victim of a malign power went almost entirely after the evening of the healing service, leaving him feeling much better. So, the spiritual aspect of the problem seems to have been dealt with quite quickly and effectively.

The integration of neurological and spiritual factors that we arrived at was essentially a two-factor theory. The first hypothesis was that his traffic accident had led to neurological damage that left him vulnerable to a sense of presence. The second was that this vulnerability had been exploited by a malign spiritual force, which had caused him considerable distress. This account took proper account of relevant medical research, though without drawing reductionist conclusions from it, and took proper account of case history evidence about the onset of the problem, where it was particularly experienced in relation to the body (i.e., over the left shoulder). It also took account of spiritual activities and circumstances that affected the problem, and used that perspective to alleviate his distress. It was an account that made sense to Rob, and which he was able to accept; and it led to a marked improvement in his sense of well-being.

Conclusion

In this article, I have approached issues of mental health and well-being from a complementary perspectives position, looking at issues of well-being from both a scientific perspective (psychology, psychiatry, or neurology), and also from a religious, spiritual, or theological perspective. I see no reason to think that there is any incompatibility between them. One does not invalidate the other. For example, in my case study, I did not think that a neurological perspective ruled out the possibility of some malign spiritual influence. Or, conversely, I do not think that taking seriously the

experiences of people with schizophrenia rules out taking schizophrenia as a valid medical category. The main implication of holding these two very different perspectives together is that they both need to be held with humility. Acknowledging that there is another legitimate perspective means that no one perspective can be presented as settling all questions. There are always other angles that call for a different approach.

For those who are in distress of one kind or another, there are different kinds of benefits of the two kinds of perspective. A scientific approach brings a certain kind of objectivity that can be reassuring and helpful, and it may also bring interventions or treatments of known efficacy. A spiritual perspective is usually more experiential, and has more effect on how people experience their problems and issues. Indeed one of the benefits of spirituality is to provide a rich source of experiential approaches. Of course, things are not so simple. Some psychologies try to be both scientific and experiential; also, theology makes claims to a kind of objectivity as well as connecting with personal spirituality. However, the complementarity of scientific objectivity and experiential approaches is closely connected with that of science and religion. My claim is that both are helpful, and that holding both together keeps each one in its place.

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