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Editorial

Introduction to the Special Issue "Religious and Spiritual Experiences"

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William James's seminal book, *The Varieties of Religious Experience* (1902/2012), describes the phenomenology and 'fruits' (James 2012, p. 20) of different types of religious experiences, such as mystical experiences, extraordinary visions, voices and a sense of presence.

James wanted to explore intensive cases reported from what he calls religious 'geniuses' (James 2012, p. 6). In more recent research such experiences have been termed extraordinary, non-ordinary, paranormal, anomalous, or (within a psychiatric context) religious hallucinations. These experiences are still of interest to today's scholars in the discipline of psychology of religion (Hood et al. 2009; Geels 2003; Hood 2005; Wulff 2000) and are represented in this special issue as out-of-body experiences (de Boer 2020), religious visions and voices (Ouwehand et al. 2020), religious hallucinations (Noort et al. 2020) and extraordinary healing experiences (Austad et al. 2020).

The scope of phenomena called religious or spiritual experiences is broader than that of extraordinary experiences. This was acknowledged by James; however, he viewed intensive, extraordinary religious experiences as 'pattern-setters' (James 2012, p. 6) of more everyday or habitual religiosity, consequently turning everyday religious practice into secondary or derived experiences.

When calling for papers for this special issue, we did not want to restrict religious experiences to extraordinary ones. Instead, we wanted to include articles on religious/spiritual (R/S) experiences that are more mundane and closer to everyday life, such as taking part in religious rituals, singing psalms or reading from the Qur'an. In this issue, Saarelainen et al. (2020) describe the religious experiences of older people in Finland, as exemplified by the following quote:

> When we were little, our mom used to gather us around the table, and together we sang psalms and spiritual songs every Saturday . . . In those days, we sang a lot. It is really a good thing that we sometimes still sing together.

Experiences like the quoted one are not only included as secondary experiences, as James would term them, but are also seen as part of the core of religion/spirituality. This inclusion reflects a focus on everyday religion, which has become prominent in religious studies. Everyday religion, however, which may happen around the kitchen table, is not separated from institutional religious life or otherwise shared religious and/or spiritual traditions. This matter is underscored in the paper by del Castillo et al. (2020), focused on Catholic novices' religious formation in the Philippines. Religious experience is more than what is described by institutional religion, although it is often connected to aspects of practices, interpretations and relationships in religious institutions. They may be in line with institutional practice, but they may also subvert expectations.

It is difficult, however, to draw a line between extraordinary and ordinary experiences, whether or not they are connected to religious institutions. As spiritual and religious experiences are interwoven with their contexts, what is perceived as extraordinary in one

milieu may be viewed as part of daily R/S congregational life in another. As described in the article by Austad et al. (2020), extraordinary experiences are included in religious narratives and thus may be familiar to religious communities, and even expected. Recent research has shown that an R/S milieu may influence the religious or spiritual experiences of its members, not only by welcoming such experiences or providing an interpretive framework, but also by modelling and thus facilitating the learning of how to hear voices and receive visions from God. In other words, an individual's religious culture seems to be strongly related to his or her likelihood of having a life-changing religious or spiritual experience. Although this position is debatable—and some will rather emphasise that extraordinary experiences originate in pre-cultural phenomena, as they are often featured as spontaneous experiences with no associated practice and expectation—we underscore the cultural component. Acknowledging that cultural contexts mediate and shape religious and spiritual experiences without necessarily fabricating them, the articles in this issue present culturally situated and culturally interpreted experiences.

The articles are diverse in terms of the institutional and cultural contexts they present, such as hospitals, nursing homes, religious and spiritual congregations, and private homes. Furthermore, the studies are situated in different countries: the Philippines, the Netherlands, Belgium, Finland and Norway. The religious affiliations of the studies' participants are Protestant, Catholic, Baptist, spiritual affiliated, atheists and not affiliated. Although we had wished for greater diversity in terms of the geography and religious affiliation of the informants in the articles, the different studies that are included give a rich cultural insight—as there are complexities, hybridisation and features of subcultures—to the mentioned cultural categories. Culture is multivoiced, meaning that a religious experience may have multiple cultural components.

James characterises religious experiences as taking place among 'individual men in their solitude' (James 2012, p. 31). Notwithstanding that the unit of analysis in the present special issue is the individual and his/her experiences, the articles incorporate more socio-cultural interpretations and practices than James's definition does. They point to socio-cultural practices as religious experiences, the impact of the socio-cultural milieu for the phenomenology of the experiences and the complex web of meaning making based on cultural discourses—be they religious, spiritual and/or medical/health discourses.

The seven studies included in the issue investigate religious and spiritual experiences such as the following:

- extraordinary R/S experiences in clinical contexts, in which professional care is also involved (Noort et al.; Ouwehand et al.)
- extraordinary R/S experiences outside clinical and professional care contexts (Austad et al.; de Boer—most of the participants)
- ordinary R/S experiences outside clinical contexts (Saarelainen et al.; Del Castillo et al.)
- ordinary R/S experiences in clinical contexts (Desmet et al.)

If we combine James's notions of differentiating ordinary and extraordinary religious experiences with the currently stressed cultural complexity connected to these phenomena, we conclude that researchers nowadays ought to include more multidimensional explanations to the phenomena. In what follows, we introduce the various articles and highlight how the authors combine explanatory models when reflecting on and making sense of religious experiences.

Eva Ouwehand et al. (2020) present a case study that emphasises the interpretation process of a person with a bipolar I disorder struggling to connect these essential experiences to his disorder (outside a medical healthcare context). Research shows that finding meaning in those experiences can be a crucial issue and is often confusing, as it is unclear just what role the illness plays. Taking into account the diverse cultural explanations that are present in this particular case, the authors examine this process from the perspective of the dialogical self-theory of Hubert Hermans. Such an approach might be constructive in healthcare contexts, they argue, to explore the psychological dimension of valuing one's

experiences and to seriously consider the various 'voices' in the interpretation process over time. The case study demonstrates that a 'both religious and pathological' explanatory model for religious experiences consists of a rich and changing variety of I-positions that fluctuate depending on the mood episode. Being able to switch from spiritual and medical perspectives allowed space for a more balanced attitude towards such experiences and less pathological derailments. The dialogical self-theory, with its focus on multivoicedness, might support caregivers in exploring medical and spiritual 'voices' in the complex interpretation of religious experiences.

Annemarie Noort and her colleagues (Noort et al. 2020) focus on religious delusions (RDs) and hallucinations (RHs) in geriatric psychiatry. Although these phenomena are common, there is limited research on the frequency, the exact content and the religious affiliation related to these RDs/RHs. Based on their approach, one could argue that the authors also take into account multivocal explanatory models. First of all, they investigate the connections between RDs and RHs and specific affective or non-affective psychotic disorders based on the medical explanatory model. Furthermore, according to the authors, religion (as an important cultural factor) may influence specific types of psychopathological expressions in a supportive way or by provoking extra existential suffering. Based on semi-structured interviews with 155 inpatients and outpatients at a geriatric psychiatry department in the Netherlands, Noort et al. (2020) conclude that 'religion is likely to act as a symptom-formation factor for psychotic symptoms in strict Protestant older adults.' However, they add that a fuller understanding of how these strict religious beliefs may affect the content of psychotic symptoms and unintentionally add a component of existential suffering is needed. Furthermore, the relationships with mental health professionals are important. Secular mental health professionals seldom know how to recognise or address religious content or beliefs and their significance, at matter that makes the interpretive room smaller.

Echoing the reasoning in Ouwehand's contribution, in her study of out-of-body experiences (OBEs), **Elpine** de Boer (2020) underlines that people need to make sense of their (extraordinary) experiences when the self is perceived as located outside their body. Moreover, the article shows that the respondents use more than one explanatory model (for instance, medical, spiritual and/or psychological) especially when the OBE does not fit into one's own existing belief system. De Boers' main research question, however, concerns the relationship between OBE and anxiety. When psychological, spiritual or medical explanatory models fail to make sense of these intense experiences of self-loss, more anxiety is perceived, as it is more challenging to find a new meaningful life narrative. In the cases in which there is a relational component (i.e., mystical experiences) there is no relationship between anxiety and self loss. In discussing these findings, the author reflects on this particular cultural self-concept, emphasising a stable and coherent self, thus leading to anxiety when the self is destabilised.

The importance of the relational aspects brings us to the contribution of **Anne** Austad et al. (2020). As an alternative to the notion of a duality of body and mind, as well as the suggested holistic solution that is often referred to as the 'bio–psycho–social–spiritual' dimension, the authors take the concept of 'the lived body' as their starting point, articulating that the previously mentioned aspects are 'not only interrelated but also intertwined'. From this perspective, they investigated healing experiences in diverse Christian Norwegian contexts. The results of their analysis of 25 individual interviews emphasise that healing experiences manifest as becoming 'more whole', which seems to fit with the transformational powers involved much better than relating them to the bio-medical model, with its focus on particular aspects of the human being. Interestingly, whereas most participants described their healing experience in terms of an intertwined holistic understanding, quite a few tended to describe their sufferings with partial explanations—i.e., relational, mental or medical. The healing experiences characterised by ('targeted, energetic, emotional and love-providing') touch seem to activate religious and cultural meaning attribution.

Suvi Saarelainen et al. (2020) studied the religious experiences of older people (n = 5) who were receiving end-of-life care in their own homes. 'Ordinary' lived religion was the focus of the study. The most important theme in these daily life religious experiences was their embeddedness in personal relationships. Consolation was not located in larger congregational networks but in nearby relationships with spouses, family members and neighbours. In general, their religious experiences were just as diverse and multi-layered as life itself. Therefore, struggles and comfort were both seen as meaningful and connected to religious life. When facing one's mortality and planning for one's death, religion was more implicitly present. Its calming effect was seen as related to the idea of continuing bonds after death, although many had unclear views regarding the afterlife. These older Finns draw on different resources in constructing their religious experiences, that is, mostly from the Lutheran tradition, but with a twist of modern spirituality.

Fides del Castillo et al. (2020) studied the religious experience and spiritual well-being of 50 Catholic novices from different religious congregations in the Philippines. The central focus was on how spiritual well-being during their religious formation was seen as connected to their sociality. By using the Spiritual Health and Life-Orientation Measure, the authors found a clear dissonance between the novices' ideals and their lived experience. Their 'congruence level of harmony' (spiritual well-being) was measured across four dimensions: (1) personal spiritual well-being, (2) communal spiritual well-being, (3) environmental spiritual well-being and (4) transcendental spiritual well-being. The authors suggest that the directors of religious formation integrate the four dimensions, and especially the communal domain, to improve their spiritual health. This research shows, in line with other articles, that lived religion may differ from traditional religious ideals and that relationship with other people in the community is important for the construction of religious experiences- and for spiritual wellbeing.

This special issue includes one article on spiritual needs. As Desmet et al. (2020) point out, among older adults, the identification of spiritual needs is the first step to providing the best possible spiritual care during hospitalisation. Through an integrative review of the existing literature, the authors underline four subcategories among the needs: (a) the need to be connected with others or God/the transcendent/the divine, (b) religious needs, (c) the need to find meaning in life and (d) the need to maintain one's identity. Moreover, and in line with the aforementioned focus on everyday practices, spiritual needs may turn into relational spiritual practices and, consequently, R/S experiences. In care contexts, many of these needs remain unmet for the following reasons: (1) current needs are often overlooked (2) many caregivers lack the knowledge, competence and training required to address spiritual needs; (3) time restrictions play a role; and (4) these issues are often considered private or too intimate to discuss.

In summary, the findings in this special issue on religious and spiritual experiences reflect a concern: if people need to make sense of their extraordinary R/S experiences, and/or in case healthcare professionals want to support people in these processes, they will usually ask for more than one (explanatory) perspective. The integration of diverse dimensions of religious beliefs and practices, as well as social, and medical perspectives, may contribute to a 'more whole' interpreted experience. This cultural and interpretive complexity should affect not only healthcare but also future research, especially when designing new questionnaires and measurements of R/S experiences.

Conflicts of Interest: The authors declare no conflict of interest.

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