

Divine therapy?

LIKE many psychologists I do not believe in God. But I am intrigued by religious and mystical experience. I am also happy to credit the healing effects of the revelatory experience of feeling oneself at one with nature, or with God. The Archbishop of Canterbury says revelation challenges ‘the pretension of consciousness to constitute itself’. It invites us into a world not of our own choosing. Revelation ‘is essentially to do with what is generative in our experience’ (Williams, 1986/1999 p.134). What, however, does psychology tell us about the hard-wiring of such experience in the brain?

Why therapists should ‘dream’ for their clients

One of the founders of modern psychology, William James, wrote over a hundred years ago about the generative, enlivening and transforming effects of revelation. He recounted examples of people being healed from fragmenting self-division through sudden or gradually occurring oneness with God. Such transformations, he argued, are mediated by the unconscious, ‘transmarginal’ or ‘subliminal’ region of the mind. He added:

If the word ‘subliminal’ is offensive to any of you, as smelling too much of psychological research or other aberrations, call it by any other name you please, to distinguish it from the level of full sunlit consciousness. Call this latter the A-region of the personality, if you care to, and call the other the B-region... It is the source of our dreams... In it arise whatever mystical experiences we may have... In persons deep in the religious life...the door into this region seems unusually wide open (James, 1902/1960, pp.462–463).

But what happens when this door is closed? What happens when the B-region does not mediate God, but disturbing sexual drives? Freud believed that remaining unconscious of these drives contributes to the problems for which patients seek psychoanalytic help. Hostile to religion, he nevertheless borrowed from religious or mystical practice to unlock what James called the door to the B-region of the personality. Freud described this



JANET SAYERS on the potential of a meeting of psychoanalysis, neuropsychology and religion.

door as the effect of dream-work repression. James argued that mystics unlock it through passively surrendering their will – medieval mystics called this the *via negativa*. Freud called it ‘free association’. He encouraged patients to say whatever came into their minds – dreams included – without any let or hindrance, censorship or selection.

But what happens when one cannot dream? The following is a case in point. With four- or five-minute gaps between each sentence, the patient told his psychoanalyst:

I have a problem I am trying to work out... As a child I never had phantasies... I knew they weren't facts so I stopped them... I don't dream nowadays (quoted in Bion, 1955, p.227)

In such instances, said Wilfred Bion – who in 1947 was chair of the Medical Section of the British Psychological Society – it might be necessary for the psychoanalyst to do the dreaming for the patient. To do this he recommended that psychoanalysts should follow the mystic’s *via negativa*. He encouraged them to empty their minds of all memory, desire and quest for understanding so as to maximise their ‘at-one-ment’ with the sensory nothingness – ‘O’ – occurring psychologically between themselves and their patients. He urged them to attend to whatever intuitions, images, dreams that thereby emerge.

Bion also emphasised the importance of psychoanalysts’ keeping their resulting hypotheses, interpretations, or ‘pre-conceptions’ open to whatever the subsequent testing of these interpretations against reality might reveal. In this, he argued, psychoanalysts should follow Darwin, who, according to his granddaughter Nora Barlow, said that in science ‘it is a fatal fault to reason whilst observing, though so necessary beforehand and so useful afterwards’ (Barlow, 1958, p.159). He also talked of the shift from what cannot be known – which he variously called ‘O’, ‘Godhead’, or ‘the formless infinite’ – to knowable ‘ α -element’ dream images.

Bion described this process of transformation as ‘dream-work- α ’. He said it operates on ‘stimuli arising within



Vermeer’s *Little Street in Delft* – art as ‘ α -element’ dreamscape

and without the psyche' so that they become 'ideogrammaticized' (Bion, 1992; further details in Sayers, 2003). Bion likened this to Vermeer's transforming his impressions of an urban scene into a painting:

[The artist] helps the non-artist to digest, say, the Little Street in Delft by doing α -work on his sense impressions and 'publishing' the result so that others who could not 'dream' the Little Street itself can now digest the published α -work of someone who could digest it. (Bion, 1992, p.144)

Bion compared transformation in art, science or psychoanalysis to mothering. Through her 'at-one-ment' with her baby, he suggested, the mother takes in her baby's 'harvest of self-sensation', her baby's raw ' β -element' sense data. Through her 'capacity for reverie', for doing dream-work- α , she dreams this data into the ' α -element' form needed for it to be psychologically registered and stored (Bion, 1962). Drawing on Bion's work, others have described mothers imagining themselves into their babies' inner world. Through putting into sounds and words their resulting imaginings, mothers, it is said (see e.g. Kristeva, 2000), transform their babies' otherwise basic biological drives into semiotic and symbolic meaning.

The importance of the hippocampus

Non-analytic psychologists have similarly written of parents transforming, through 'motherese', their babies' babbling into talking and thinking. Prior to this, neuropsychologists suggest, although sense data may be stored bodily by the baby, they are not stored psychologically. During the first two years of life, it seems, the hippocampus (an area of the temporal lobe at the side of the brain involved in registering and storing sense data) is not fully functional. Nor is it fully functional subsequently when, during trauma, steroid hormones energise other areas of the brain at its expense. Trauma may therefore not be psychologically registered by the hippocampus in a form available for conscious recall.

Dreaming also involves the hippocampus. Some neuropsychologists (e.g. Hobson *et al.*, 2000) dispute this. They argue that dreaming involves the hippocampus and other higher cortical processes only peripherally. Fundamentally, they claim, dreaming (in the sense

described by Freud) is the mindless effect of lower brain areas – the pons in the brainstem – controlling rapid eye movement (REM) sleep. Other neuropsychologists (e.g. Solms & Turnbull, 2002), by contrast, argue that dreaming is not mindless – that it centrally involves higher regions of the brain. They argue this on the basis of evidence that dreaming

'the same areas of the brain involved in dreaming seem also to be involved in... religious experience'

occurs in non-REM sleep, and in patients with damage to the pons. Dreaming, however, does not occur in people with damage to higher regions of the brain. It does not occur in people with damage to the junction of the occipital, temporal and parietal regions of the brain (which receive, analyse, and store visual, auditory and somatic sense data). Nor does dreaming occur in people with damage to the nerve fibres linking the limbic system (including the hippocampus and other areas serving memory and emotion) with the ventromesial quadrant of the frontal lobes (concerned with rational, chronological and reality-based thinking).

Solms and Turnbull accordingly hypothesise that dreaming results from arousal of the higher regions of the brain by REM sleep, by thoughts from the previous day, by feelings, or by the body's inner biological drives. The hallucinations of dreaming, they suggest, are due to this arousal activating the occipital, temporal and parietal lobes uncensored and unchecked by the prefrontal central executive system, which is inactive during dream sleep (see also Braun *et al.*, 1998).

From the unknown to the known

Putting this together with Bion's ideas about godhead, art and psychoanalysis, it seems to me that dreaming can be a form of self-therapy. It can work to transform what is otherwise psychologically unregistered and unknown, the 'primal repressed' (Laplanche & Pontalis, 1973), the inchoate stuff of earliest infancy and of trauma, into knowable ' α -element' form which can then be tested against reality when we wake up. In this sense, I would argue, dreaming is indeed therapeutic. I do not, however, agree with those who claim that dreaming is divinely inspired.

Nevertheless, I find it fascinating that the same areas of the brain involved in dreaming seem also to be involved in mystical and religious experience (see e.g. Cook & Persinger, 1997, and critical overview by Andresen, 2001).

Are these areas of the brain the physical substrate of what William James described as the B-region of the personality in his account of the healing effects of God-like or divine experience? Unlike James, who despite finding it difficult to believe in God was friendly to religion, many of us, like Freud, reject it, not least because it often involves stultifying – cruel even – anti-scientific dogma. But the above theories and evidence from psychoanalysis and neuropsychology convince me that accessing what James called the divine, and Bion called unknowable and unknown, might well be therapeutic, restorative, enlivening. Or as the Archbishop of Canterbury, with whom I began this article, says of revelation, such access initiates 'new possibilities of life' (Williams, 1986/1999, p.134).

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