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Article

Making God real and making God good: Some mechanisms through which prayer may contribute to healing

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Abstract
Many social scientists attribute the health-giving properties of religious practice to social support. This paper argues that another mechanism may be a positive relationship with the supernatural, a proposal that builds upon anthropological accounts of symbolic healing. Such a mechanism depends upon the learned cultivation of the imagination and the capacity to make what is imagined more real and more good. This paper offers a theory of the way that prayer enables this process and provides some evidence, drawn from experimental and ethnographic work, for the claim that a relationship with a loving God, cultivated through the imagination in prayer, may contribute to good health and may contribute to healing in trauma and psychosis.

Keywords
healing, prayer, psychosis, trauma

Scholars have known for some time that weekly church attendance keeps people healthy. One study reports that on average, in the United States, it adds 2 or 3 years to one's life (Hall, 2006). Another found a 7-year difference in life expectancy at age 20 between those who never attended church and those who attended more than once a week (Hummer, Rogers, Nam, & Ellison, 1999). Religious observance boosts the immune system and decreases blood pressure (Koenig & Cohen, 2002; Woods, Antoni, Ironson, & Kling, 1999). What it is about religion that leads to such outcomes is far less clear. Because the variable most consistently associated with better health is church attendance (Powell, Shahabi, & Thoresen, 2003), scholars have argued that the effects may be due to social support, operationalized as an

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increase in social networks and more supportive social relationships (Ellison & George, 1994) or to the healthy behaviors of people more hesitant to drink, take drugs, or have casual sex (Clarke, Beeghley, & Cochran, 1990). Many other mechanisms show some scientific support: cognitive outcomes that enable emotional coping efforts (Koenig, Smiley, & Gonzalez, 1988; Sharp, 2010) and, in general a sense of meaning and coherence (Berger, 1967; Ellison, 1991). There is increasing evidence that the way God is understood also affects health outcomes. One study found that people who reported that they experienced God as close and loving also reported significantly fewer psychiatric symptoms compared to those who reported that they experienced God as approving and forgiving, or creating and judging (Flannelly, Galek, Ellison, & Koenig, 2010).

This paper builds upon the anthropological model of "symbolic healing" to argue that the experience of a positive interaction with the supernatural is good for people and may even be at the heart of what gives religion health-boosting properties. More specifically, I argue that the capacity to build this relationship and to experience its effects rests on a learned cultivation of the imagination: to make what is (or must be) imagined more real and to make it more "good". Following Mary Watkins (1986) we might call these "imaginal" relationships: they require the imagination, but are not necessarily imaginary. This paper offers a theory of the way that prayer may enable this imaginal process and provides some evidence, drawn from experimental and ethnographic work, for the claim that an interactive relationship with a loving God, cultivated through the imagination in prayer, may contribute to good health.

This argument has implications for understanding the religiosity of those who struggle with severe trauma. North American mental health professionals are notoriously secular (Baetz, Griffin, Bowen, & Marcoux, 2004; Curlin et al., 2007). They can be tempted to treat the religiosity of their clients as further evidence of their trouble: as symptoms of psychosis or denial, as evidence of their refusal to grasp reality. Drawing upon long-term fieldwork with homeless psychotic women in Chicago, I suggest that clinicians consider the possibility that their relationship with God may be a response to their trauma, and that it is sometimes quite effective.

Making the imagined more real

"Symbolic healing" was coined by Daniel Moerman in 1979 (building on previous analyses like those of Jerome Frank [1961] and Victor Turner [1969]) and explicitly modeled by James Dow in an article in the *American Anthropologist* in 1986. Dow (1986, p. 56) argued that this form of healing had four features:

1. The experiences of the healer and healed are generalized with culture-specific symbols in cultural myth.
2. A suffering patient comes to a healer who persuades the patient that the problem can be defined in terms of the myth.

3. The healer attaches the patient's emotions to transactional symbols particularized from the general myth.
4. The healer manipulates the transactional symbols to help the patient transact his or her own emotions.

The primary intervention is to make an externally given symbol feel emotionally real to the patient—and then to manipulate the symbol, to alter the patient's emotions.

Dow's article ranged over much anthropological and psychological ground, but the essay that captured the process for many anthropologists was Claude Levi-Strauss' "The Effectiveness of Symbols." The essay (Levi-Strauss, 1963) described a Cuna woman struggling in childbirth. The shaman sang a song over her in which he described the woman's distress, and then the midwife's decision to call for him; that she ran along the forest paths to find him; that he came and burnt coca and assembled the little wooden figurines he thought would help. Having described the realistic setting of the intervention, the shaman's song then went on to describe an immaterial world in which good spirits (*ngellum*) marched up the woman's birth canal and battled with the bad spirits of the goddess who stole the woman's soul. The spirits win the battle, and restore good relations with the goddess: and the child is born. Levi-Strauss emphasized the way the shaman shaped the woman's attention:

> Everything occurs as though the shaman were trying to induce the sick woman . . . to relive the initial situation through pain, in a very precise and intense way, and to become psychologically aware of its smallest details. (1963, p. 188)

He emphasized the sensory specificity of the shaman's song:

> The cure begins with a historical account of the events that preceded it, and some elements which might appear secondary . . . are treated with luxuriant detail as if they were, so to speak, filmed in slow motion. (1963, p. 188)

He argued that the cure depended upon making what was unutterable expressible: "in making explicit a situation originally existing on the emotional level and in rendering acceptable to the mind pains which the body refuses to tolerate" (1963, p. 192).

Levi-Strauss (1963) argued that the shaman's intervention was fundamentally similar to Freud's early model for the efficacy of psychoanalysis, in which the repressed unconscious was rendered into full awareness. That argument captures something important. But it also leaves unexplained the problem of how the sufferer actually becomes persuaded that the symbol represents his or her pain; the problem of how the mythic symbol (the little good spirits) become "real." In fact one could describe the shaman's actions more immediately as a means to direct attention to the imagination and to make what was imagined more vivid, so that

what the woman must imagine in order to effect a cure feels more persuasively present. Certainly such an account would be a more direct rendering of the shaman's actions. The shaman helps the woman to experience the spirits as real by drawing her attention to them and telling her that they are real; incorporating them into the narrative without any break from the previous realistic description; giving them vividness; and creating interaction.

If we focus our attention not on the emotional transformation which Levi-Strauss and Dow (and later Thomas Csordas [1994]) rightly took to be important, and instead ask what the Cuna shaman did to make the immaterial spirits more present for the woman, we see four steps:

1. *Expectancy*: The shaman tells the suffering woman that the spirits will appear—now.
2. *Epistemic ambiguity*: The shaman moves the narrative from describing something real to the eye to describing something that can be seen only with the mind's eye. He does not seem to distinguish between the reality of the immaterial and the material, but weaves them together, the technique which in modern literature is called magical realism.
3. *Sensory enhancement*: The shaman describes the visual details and sounds of the good spirits so that the woman can see them for herself—their pointed hats, their loud cries, their bristling, sharp-pointed spears.
4. *Engagement*: The shaman invites the woman to interact with the spirits. She does not talk to them, but they are, after all, walking up her vagina and fighting at her cervix.

These are techniques which help to make what must be imagined more real. They are important because the emotional transformation of symbolic healing can only take place if the symbol is experienced as having external agency; if it seems authentically real to the person experiencing the pain. The problem is not one of belief, but of experience. The woman no doubt believes in the spirits, whatever complicated nuances we might use to interpret the term "belief" (Needham, 1972). But she needs to be able to experience them as real in her life in this particular time and place, just as a Christian might believe in God in general but needs help in experiencing God as responding specifically and in real time to his cry of pain. The shaman must make the spirits present to her.

I suggest that this making-real is one of the most important roles of Christian prayer.

Prayer

If you put to one side the theological purpose and supernatural efficacy of prayer, prayer first and foremost changes the way the person praying uses his or her mind and helps to make what is imagined more real. The central (non-theological) act of prayer is paying attention to internal experience—thoughts, images, and the

awareness of your body—and treating these sensations as important in themselves rather than as distractions from the business of your life[1]. In some sense, of course, we do this all the time. When we work through things in our mind, when we reenact a conversation, when we daydream, we are paying attention to our inner experience. But prayer asks the person praying to treat those thoughts not as private, internal musings, but as in some sense public and external speech: they are conversations with God. The person praying has to learn to use the imagination to experience God as present, and then to treat what has been imagined as more than "mere" imagination. That twofold shift in attention—towards the internal, as the external—is the heart of the skill in prayer.

This capacity to shift attention away from the everyday is basic to dissociation, hypnosis, and trance. All of these share three features: narrowed attention, with a continuum which responds to learning; altered attention; and, at the extremes, a shift in basic organizational structure of the self. The broader name for the mental capacity common to trance, hypnosis, dissociation, and probably to much spiritual experience, but also to most imaginative experience in which the individual becomes caught up in ideas or images or fascinations, is absorption (see also Butler, 2006; Roche & McConkey, 1990; Seligman & Kirmayer, 2008). Absorption is the capacity to become focused in a non-instrumental way on the mind's object—what humans imagine or see around them—and to allow that focus to increase while diminishing one's attention to the myriad of everyday distractions that accompany the management of normal life. It is a cognitive, attentional process. Absorption is measured by the Tellegen Absorption Scale (Tellegen & Atkinson, 1974). It has 34 items which one marks as "true" or "false." A subject gets a point for every "true." The scale does not measure religiosity per se; it has only one item which could be construed as religious. Only one other item asks about a state, and the state is not identified as religious. It asks questions about sensory engagement, about unusual states, and about the capacity to be caught up in one's imagination—to imagine a cracking fire, or to be taken by the shapes clouds seem to make in the sky.

In previous work (Luhrman, Nusbaum, & Thisted, 2010) I demonstrated that in interviews in a charismatic evangelical church in Chicago, a congregant's absorption score was not related to the length of time he or she prayed on a daily basis. That is, the scale did not measure prayer practice *per se*. But the way a person answered the absorption questions was significantly related to the way they experienced prayer. Most remarkably, the way someone answered the absorption scale predicted whether he or she was able to experience God as a person in the vivid, imaginative way that the pastors invited them to do. Those who had high absorption scores were much more likely to report experiencing God as if God is person-like—someone they could talk to easily, who talked back, who laughed with them, and at whom they could get angry. And if one held the absorption score constant, the time spent in prayer was in fact significantly correlated to the vividness of the God experience. Absorption thus seems to be the proclivity to experience what is (or must be) imagined as more real.

Yet prayer also trains people to experience what they must imagine as more real, independently of their proclivity for absorption. Prayer almost directly enacts the four-point structure of symbolic healing. In a Christian context, where the healer is God:

1. The experiences of the healer and healed are already generalized with culture-specific symbols in cultural myth.
2. The subject does indeed come to God, the healer, persuaded that the problem can be defined in terms of the Christian myth.
3. The believing subject does get emotionally invested in the interaction with God.
4. The believing subject imagines an interaction in which God speaks directly to the subject, and asserts his unconditional and healing love.

But none of these can work unless the subjects are able to experience their interactions with God as real.

This is quite a different issue than believing in God; deeply committed Christians can still struggle to experience their specific, moment-to-moment, necessarily imagined interactions with God, as more than "mere" imagination. A committed Christian praying to God to relieve back pain can nevertheless struggle to believe that a mighty God would pay attention. Many committed Christians go through periods when they doubt that anyone really listens to their prayers. Even evangelical Christians, who are often quite public in their assertion of faith and who often confidently assert on a survey that they never doubt their faith (Smith, 1998), can find it difficult to believe that God really hears and responds to all their own prayers (Luhrmann, 2012).

How does prayer practice train people to experience what they must imagine as more real? In the Christian tradition, the shift in attention to one's own thought during prayer is explicitly taught in two named styles of intensive prayer practice: "apophatic" and "kataphatic" prayer. "Apophatic" prayer practice takes its name from the Greek *apophasis*, denial. It is a cluster of techniques through which the thinker detaches from thought. Kataphatic prayer, which takes its name from the Greek *kataphasis*, to affirm positively, by contrast treats thought as more important than an ordinary mental event. Kataphatic prayer asks people to dwell lovingly on what is imagined, and its techniques help to intensify the imagination in the act. They engage the senses, they evoke vivid memories, and they generate powerful emotions. Without a doubt, the heart of most Christian prayer, and certainly the heart of American evangelical prayer, is kataphatic.

What do people do when they pray like this? Modern American Christians who seek to build a personal relationship with Jesus (these are typically evangelical Christians) often pray by daydreaming a back-and-forth conversation with Jesus or God (Luhrmann, 2012). They talk to God the way those in therapy talk to their therapist when not in the therapist's office: formulating questions, imagining answers, chatting in a daydream. They go for walks with God, or have coffee with God. Many, many contemporary texts encourage interactive prayer practices

that demand the use of the imagination. Among the best-selling are Rick Warren's *The Purpose Driven Life* (2002); Richard Foster's *Celebration of Discipline* (1978); and Bill Hybels' *Too Busy Not to Pray* (1998).

The classic examples of kataphatic prayer are the *Spiritual Exercises* of Ignatius Loyola (Ganss, 1992; Tetlow, 1992), which have been handed down to us from the notebooks Loyola compiled as he perfected his technique. Here are Loyola's instructions for praying around the Nativity: the subject is to begin with a standard, scripted prayer (the "readiness prayer") and then immerse himself in a scriptural scene, imagining it from his perspective. For example:

> The salvation story, which this time is how Our Lady, pregnant now for nine months and (as may piously be believed) seated on a donkey, set out from Nazareth. With her went Joseph and a serving maid who was leading an ox. They travel towards Bethlehem to pay the tribute imposed by Caesar on all those lands (see Luke 2:1-14). [Then I] compose myself in the place. Here it will be seeing with the eye of the imagination the road from Nazareth to Bethlehem, considering how long it is and how wide, and whether it is level or goes through valleys and over hills. In the same way, it will be seeing the place or the cave of the nativity, considering whether it is large or small, deep or high, and how it is arranged. [Then . . .] I turn myself into a poor and unworthy little servant, watching them, contemplating them, and serving their needs as if I were actually there.[2] (Tetlow, 1992, pp. 101–102)

At this point in the exercise, Loyola asked the participant to talk to Mary and Joseph. "I turn myself into a poor and unworthy servant, watching them . . . serving their needs as though I were actually there." He did not seem to care whether the participants imagined the cave or the road as long or short, wide or narrow. He cared that the participants imagined intensely, and that the experience mattered to them emotionally. He asked the participant to finish with a colloquy, an unscripted interaction with God, and then with a wholly scripted Our Father.

The formal structure of these prayer practices has four explicit features: expectancy, epistemic ambiguity (or interweaving), engagement, and sensory enhancement.

First, God is invoked directly. The person praying asserts that he is ready to be present with God.

Second, the Ignatian exercises repeatedly interlace scripted prayers (like the Our Father) with private, personal reflection. The practitioner recites the Our Father, and then examines his feelings of the moment. He thinks about the scripture, and then about himself in relation to the scripture, and then about the scripture in relation to himself. This is what modern evangelicals do in daydreams about God, and particularly when praying through the Bible. They think about the old, old passage where Samuel hears God call his name, or where the Samaritan bends down over the beaten man bleeding in the roadway, and they ask themselves what that passage tells them about what they felt that afternoon. This interweaving blurs the boundary between what is external and what is within; between what is real in the world, and what is imagined through the scriptures.

Third, the practice is not passive. The practitioner interacts with what she or he imagines. During each exercise, the participant is supposed to talk to the main characters of the scene directly (the "colloquy"). Usually, this main character is Christ.

Fourth, the Ignatian exercises use sensory detail to intensify that process and make the abstract personal and near. Loyola clearly and repeatedly insisted that participants used all their senses to engage the story. He calls this the "application of the senses." From his text:

> After the preparatory prayer and the three preludes, it is profitable to use the imagination and to apply the five senses . . . in the following manner.
>
> The First Point: By the sight of my imagination I will see the persons, by meditating and contemplating in details all the circumstances around them . . .
>
> The Second Point: By my hearing I will listen to what they are saying or might be saying . . .
>
> The Third Point: I will smell the fragrance and taste the infinite sweetness and charm of the Divinity . . .
>
> The Fourth Point: Using the sense of touch, I will, so to speak, embrace and kiss the places where the persons walk or sit . . . (Ganss, 1992, p. 60, Sections 121–125)

Loyola always wanted people to see, hear, feel, touch, and taste the scripture with their mind's senses. Again, one finds this emphasis on using the inner senses in many contemporary Christian texts, as in Ken Wilson's *Mystically Wired*: "words are useless without the imagination . . . So imagine that you are part of the scene the words invite you to imagine" (2009, p. 106).

Making the imagined more good

The imagination is not only a tool for healing. Anthropologists have suspected since Cannon published his famous article on "voodoo death" in 1942 that what we fear can kill us (Cannon, 1942). For what we imagine to heal us, we must be able to experience it as healing. Here, too, there is a learning dimension. Congregants must not only learn to experience the God they must imagine as real, but as good and as able to heal before symbolic healing can have the healing effects which Dow (1986) and others lay out so clearly.

How might they do that? In 1953 D. W. Winnicott defined the "transitional object" as the "intermediate" area of experience: not quite part of child's body but not part of external reality. This was the teddy bear, or the special blanket—the toy that was more than mere plush. The transitional object was neither separate from the self nor identical to the self. Winnicott (1971, p. 2) called it "an area of

experiencing to which inner reality and eternal life both contribute." He argued that its epistemologically intermediate status enabled the child to use the transitional object to represent the mother's love in the absence of her presence, to feel that the love emanates from the bear despite the child's awareness that the bear is not "really" alive. He argued that this was the psychic domain from which creativity, art, and religion were born.

Self-psychologists have a name for the mental construct this trust creates in the mind: a "self-object." This is a term coined by the Chicago analyst Heinz Kohut (1971), who argued that what made intensive long-term psychotherapy effective was that patients learned to experience the empathic therapist as an internal "object" that was loving, caring, and concerned with what was best for them. A patient who was helped by therapy was able to act and think and feel as if always aware of that therapist's loving concern, as if the patient became the person created within that responsive, attentive relationship. From this perspective, the ideal self-object is a sort of cross between a coach and a teddy bear, always available, never intrusive, whose emotional presence keeps hope alive and self-doubt at bay.

In a study of a Mexican convent, Rebecca Lester (2005) described a trajectory through which religious practice might create God as a self-object. She set out a seven-stage process through which postulants—women (really, girls) who have not professed their vows—travel across the course of a year if they come to experience their vocation as rightly chosen. The seven-stage process is not simply a movement towards the acceptance of a vocation, but also an experience of coming to have an experience of relationship with God.

1. *Brokenness*: the postulant acknowledges a sense of discomfort as a call from God to become a nun.
2. *Belonging*: the postulant comes to feel socially integrated within the convent.
3. *Containment*: the postulant comes to experience her body as complete within and contained within the convent walls.
4. *Regimentation*: the postulant learns to enact certain practices which she experiences as remaking her rebellious, desiring human body into one more suitable for God.
5. *Internal critique*: the postulant chooses to subject herself to intense self-scrutiny, and identifies her faults as the source of her broken relationship with God.
6. *Surrender*: the postulant chooses to turn her self, faults and all, over to God; she comes to acknowledge that she is for God, rather than that she does for God.
7. *Recollection*: the postulant comes to experience herself as truly present with God.

The sequence depends first and foremost on "brokenness." The postulant identifies feeling badly and practices replacing that feeling with a sense of being in relationship with a loving God. The model is above all a description of the way that feeling badly is transformed into feeling good, through a process in which God is internalized as a self-object.

Another way to give an account of the process is that the trusted self-object is created by practicing the experience of God as a trusted self-object even while explicitly acknowledging one's own pain. This is the central action of relational theory, the psychoanalytic approach associated with Kohut and, in an earlier form, the object relations theorists for whom Winnicott was an exemplar (Greenberg & Mitchell, 1983; Mitchell, 2000). In relational therapy, the therapist in effect reorients the client's self-objects by repeatedly evoking the patient's pain and anxiety and responding with care, kindness, and the therapeutic equivalent of love. That repeated process of asserting love in the presence of pain and inadequacy is the central action in the pray ministry one sees in evangelical churches. In these churches, congregants are prayed over repeatedly by others. The person receiving prayer is in distress, often visibly so; the person praying for them asserts that they are loved by God. These churches quite clearly do not presume that congregants automatically experience God as loving. Indeed, they presume that congregants have a hard time believing in the love, and must learn to trust that it is there. In effect, these actual interactions through prayer ministry become ways to practice an imaginal dialogue which is not self-critical but supportive.

Evidence for health implications

What do we know about the health consequences of the capacity to turn the abstract knowledge of God into an imaginal relationship that is experienced both vividly and as good? In the early 2000s I set out to understand how Christian prayer changed people, first through in-depth ethnographic fieldwork in a charismatic church called the Vineyard Christian Fellowship, and then in a study I called the Spiritual Disciplines Project. For the latter, we recruited 128 subjects, largely from similar evangelical churches on the San Francisco peninsula. We told people who called that they would be randomly assigned into one of three spiritual disciplines: imagination-rich prayer, meditation, and Bible study. We gave them various standard psychological scales and a series of computer exercises, and then interviewed them in depth about God, prayer, and spiritual experience.[3] Then we randomized them into kataphatic prayer or Bible study. (We told them that there was a third condition, apophatic prayer or meditation, to deflect suspicion that the study condition was the control condition, but in fact we randomized very few subjects into it.) For the kataphatic condition, we provided four tracks of 30 minutes each, in which a biblical passage was read to background music, and then reread while inviting the subject to use all his/her senses to participate in the scene. For the study condition, we gave people 30-minute lectures from the Teaching Company by Luke Timothy Johnson on Jesus and the Gospels. (We had 30 copies of these lectures.) People were asked to play the iPod 6 out of 7 days a week, for half an hour for 4 weeks. When subjects returned, they repeated most of the questionnaires and computer exercises (and some new ones) and were interviewed again.

Previously published work on the Spiritual Disciplines Project demonstrated that kataphatic practice enabled practitioners to experience their inner worlds as more vivid. On return, those who had done the kataphatic practices had scores on the subjective measures of mental imagery vividness that were significantly higher, compared to their initial scores, than those who had listened to the lectures. They said that their images had more detail. (Meanwhile, proclivity for absorption made a difference. The more items someone endorsed on the absorption scale, the higher their initial score on the two subjective mental imagery items.) They were more likely to report that they heard from God in their minds; that God gave them vivid images; that they experienced God's presence; and that they experienced God more as a person by the end of the month (Luhrmann & Morgain, 2012; Luhrmann, Nusbaum, & Thisted, 2013).

This paper presents additional data suggesting that this increased capacity to imagine may have positive health implications—if the God experienced in the imagination is loving. In their initial interviews, before we sent our subjects in the spiritual disciplines exercises out to practice their disciplines, we gave them some questionnaires. One of them was a series of statements about experiencing God. We asked them to tell us how much those statements described them, on a scale from 1 = *never* to 6 = *many times a day*. Here are some representative items from that scale:

> I feel God's presence.
> During worship, or at other times when connecting with God, I feel joy which lifts me out of my daily concerns.
> I feel God's love for me, directly.
> I feel God's love for me, through others.
> I am spiritually touched by the beauty of creation.

The full scale is called the Daily Spiritual Experiences Scale, developed by Lynn Underwood and Jeanne Teresi to capture people's spiritual experience, rather than their religious beliefs or practices (Underwood, 2006; Underwood & Teresi, 2001).[4] In their work, the more highly people score on this scale, the less anxiety, depression, and stress they report (Underwood, 2011). In the Spiritual Disciplines Project, that pattern also held. In their initial interview, our subjects also completed the UCLA Loneliness Scale (Russell, Peplau, & Ferguson, 1978); the Perceived Stress Scale (Cohen, Kamark, & Mermelstein, 1983); and the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985). The more of these spiritual statements people affirmed, the less lonely they were ($r[111] = -.216$, $p = .023$). The more spiritual statements they affirmed, the less stressed they were ($r[111] = -.268$, $p = .004$). The more spiritual statements someone affirmed, the more they experienced well-being, and the more they were satisfied with the life they lived ($r[111] = .350$, $p = .000$). If you looked at their responses to just one statement—"I feel God's love for me, directly"—all these relationships became stronger and more significant (UCLA loneliness $r[111] = -.313$, $p = .001$); stress $r[111] = -.293$, $p = .002$; Diener

$r = .422$, $p = .000$). That is striking because that statement seems to capture an imagined presence of God which is soothing and loving.[5]

In the return session, all subjects were also given a short widely used scale developed to identify psychiatric vulnerability (the Kessler 10). In this session, the scores for the Daily Spiritual Experiences Scale and the Kessler 10 were again significantly negatively correlated ($r[120] = -.210$, $p = .021$) and again, the correlation was stronger and more significant when looking at the response to "I feel God's love for me, directly" ($r[120] = -.274$, $p = .002$).

There is in these data also the implication that the capacity to imagine will enhance the ability to experience God. At least, a proclivity for absorption appears to be related to spiritual experience. In the Spiritual Disciplines Project, we found that those who scored more highly in absorption also scored more highly on the Daily Spiritual Experiences Scale ($r[112] = .345$, $p = .000$) and in their agreement with the statement "I feel God's love for me, directly" ($r[112] = .253$, $p = .007$). In addition, for all subjects, regardless of discipline, an increased response to the Daily Spiritual Experiences Scale over the course of the month was related to an increase in the number of absorption items endorsed (each scale was given at the beginning and end of the month; $r[110] = .253$, $p = .008$).

Finally, the data also suggest that practice itself, independent of absorption, makes a difference, at least to reported stress. The comparison of the means of the kataphatic and the study group suggests that the kataphatic group experienced less stress over the month, and the study group became more stressed, but the variance is too great for these results to be statistically significant. The stress scale asks 10 questions about difficulties in coping and being upset; the mean change for study subjects was .97 and for kataphatic subjects −.74 ($F[1.98] = 2.248$, $p = .137$), meaning that the study subjects on average reported a rise of about 1 point and the kataphatic a drop of almost 1 point. If you look at those who prayed for 15 minutes or less each day prior to participation (about two thirds of the subjects) the difference does become significant. Kataphatic subjects saw a reduction in stress over the course of the month ($M = -1.31$), and the study subjects saw their stress level rise ($M = 1.95$) ($F[1,68] = 4.657$, $p = .034$). These empirical data support the basic theoretical claim made by the paper: that the practice of cultivating the imagination in order to experience a positive relationship with God may contribute to the health benefits of religion. We now explore these observations in a specific vulnerable population.

Prayer and God among traumatized and psychotic women on the street

Between 2003 and 2006 I conducted long-term intensive fieldwork with women in a Chicago neighborhood with the highest rate of psychosis in the state of Illinois, outside of the Cook County jail (Luhrmann, 2007, 2008). It was a grim world. Most of the women drifted between homelessness, supported housing, inpatient hospitalization, and jail. I worked with a team of students, who did formal

interviews of near 90 women at the nonclinical drop-in center which became the base of the work.[6] In that sample, most of the women were currently homeless and only four had never stayed at a shelter. Nearly half said that they had been arrested. More than half admitted to having been psychiatrically hospitalized. Over 70% told us that they carried a diagnosis of psychotic disorder, received social security payment for disability due to a psychotic disorder, or they were flagrantly psychotic.

Trauma ran like a base note through the lives of these women. Most came from troubled homes. Most left their homes because of violence, and most were raped and beaten on their journey to the street. April, for example, grew up in a chaotic household. Her mother may have been psychotic. April said that her mother locked her in the basement and at one point went after her with an ice pick. April began sleeping with adult men at 13, and escaped her mother's house a few years later. Much of her twenties and thirties remains a hazy blur of drugs and other men. She left the man she married when he beat her. When I met her, she was stably settled in supported housing, but then she met a new man, lost him, and tried to strangle his new woman in front of the Salvation Army. She lost her place, and at the end of my time in the neighborhood, I no longer saw her.

There were many women like April. An observer at the drop-in center would see tables full of talking, laughing women. But they did not trust each other and they did not regard each other as friends. Forty percent of our formal sample told us that they felt connected to no one there. Seventy percent said that they had no friends in the neighborhood. When asked whether they had anyone, anywhere, to whom they could turn for help, a third said no one.

This was also an intensely Christian world. More than two thirds of the women said that they prayed everyday. More than four out of five (82%) said that God was their best friend. At the (secular) drop-in center, there were often Bibles spread open on the tables. People praised God and talked about God's goodness and prayed aloud in public. Often the intense religiosity was woven into the delusional system of psychosis. Regina, for example, was a flagrantly psychotic woman whose words often made little sense. She sat in the drop-in center everyday, copying Bible verses into a three-ring binder. In among the copied verses were her accounts of life stories of women in ancient times who (she wrote) had been raped and tortured but would be freed after hundreds of years of privation, as Regina hoped she would be too some day. (These accounts were not in fact found in the Bible.) Another woman, Tina, had discovered that when she spoke aloud, the harsh voices that she heard continuously were muted. She paced the corridors of her apartment complex reading psalms as loudly as she could, so that the voices could not get through. In neither of these two cases were these women reporting positive imaginal relationships with God, although Tina's technique of quelling auditory hallucinations by talking out loud has been identified as helpful for some people who hear distressing voices (J. Watkins, 2008).

Many of these women did however describe a relationship with a responsive, loving God. Many spoke of a transformative encounter that occurred in a moment

of crisis. Yolanda, for example, was a small Black woman who said that her head was so full of painful memories that she could feel them press upon her skull. She fled from her brutal husband when God spoke to her.

> I didn't have no TV on. It was so quiet. Everything was just quiet and then I was just sitting there. Then, I heard a voice come to me . . . real soft voice. I will never forget that day. I heard a soft voice came to me and told me that everything would be okay. I will never forget that day. I will never forget that day when He came. He came. He came. He had a soft voice. His voice was real tiny, real tiny. I say, "Come back again and speak to me." I say, "Come back again."

Months later, still in the shelter, she did not trust the other women; but she felt that she could talk to God.

Many women said that homelessness made them feel closer to God. Sarah and Hetty were mother and daughter. Shortly before they lost their housing, Sarah saw Jesus in the kitchen—saw him, with her eyes. "He said his name in Hebrew and I just went to my knees. The whole kitchen lit up. It was so beautiful." She called her mother, who also saw him—they were very clear about this, how grand Jesus looked in his robes—and they decided that Jesus had given them a mission to work among the homeless, by their side. And he stayed with them. "He speaks to me. To my heart." Both Sarah and her mother felt that they had become more religious on the street. "If you ain't got no faith, you can't make it on the street."

Shirley's story was the most explicit illustration of a psychotic woman who created and cultivated a positive imaginal relationship with God. Shirley was a success story in this world. She was housed, and she had kept the housing for over three years when I met her. She had long been on the street, sleeping periodically in shelters and in the park, using crack and vodka, selling tricks to get the cash. She had been hearing voices for 20 years. They would whisper at her through the radiators and hiss her when she walked down the street. She had elaborate theories about men who experimented on her at a distance. She could tell when people were sending messages to each other about her by the way they stroked their chins. Once, in an attempt to get the fiends, she deliberately burned down her apartment building.

At some point, Shirley got a job in construction. Her boss was a man she really liked, and who made her feel recognized—"the first guy who actually saw the good in me." It was not a romantic relationship and it did not last long. She got fired soon, and not long afterwards, he died of lung cancer. But then he merged with God in her mind. She had been a lackadaisical Catholic, but incorporating this man into God made God someone she could talk with—not in words she heard in the world, like the men who threatened her and listened through the radiator, but in her mind. She'd talk to God about ordinary, everyday things—what to paint, where to go that afternoon—and she would imagine that he would talk back. And when he told her to stop using crack, she stopped. By the time I met her, she had not smoked it for years. In short, she used her memory of a real relationship to

develop a relationship with God through conversations which she used her imagination to enact. Over time, through repeated imaginal conversations, she came to trust that relationship and allow it to give her good advice.

While the formal interviews we did with the women did not ask directly about health or well being and, indeed, asked little about God, we do have some interesting findings. We used a standard social network survey adapted for this population (Sue Estroff & Donald Patrick, n.d.; see Estroff, Zimmer, Lachiotte, & Benoit, 1994). Twenty-three women spontaneously mentioned God at least once on this survey (for example, in response to, "Whom can you talk to about the things that are important to you?" or "Who is the person you are most likely to trust or turn to when you need advice or reassurance?"). Doing so was significantly correlated with lower reports of loneliness as measured by the UCLA Loneliness Scale: $r(67) = -.251$, $p = .041$. Later in the interview, we asked the women whether God was an important figure in their life. Seven spontaneously added "very." Scoring $0 = no$, $1 = yes$, $2 = very$, their responses were also significantly correlated with lower loneliness scores: $r(67) = -.308$, $p = .011$. And the more the women prayed, meditated, or read inspiring works (self-scored from $0 = never$ to $5 = every\ day$) the lower their loneliness scores: $r(67) = -.244$, $p = .049$. Loneliness has been linked to poorer health in many ways (Cacioppo, Crawford, Burleson, & Kowaleski, 2002). These data suggest that developing a positive imaginal relationship with God may have health benefits for this population.

Conclusion

Spiritual healing, or nonbiogenic healing, uses the mind to heal the body. It allows the mind to change something about the world. This paper argues that in order to make this process effective, the subjects of healing must allow what they imagine—what they experience in their minds—to feel as if it is real, external, not "just" in their minds, and that they must also be able to experience that which they imagine as good. It suggests that there is a learning process prior to the action of symbolic healing, in which subjects learn to experience what must be imagined as more vivid and more present, and in which they learn also to experience what they imagine as good (or helpful). This paper has suggested two mechanisms through which that might happen through prayer: first, imagination-rich (or kataphatic) prayer in effect helps to increase the vividness of the imagination, and helps to make God feel more present; second, the repeated experience of imaginal conversational interaction with a God understood as loving may allow God to be experienced as a soothing self-object. Both the ability to imagine vividly (as measured by a proclivity for absorption) and prayer practice make God experienced as more person-like; and reporting that one feels God's love directly is associated with lower stress, lower psychiatric vulnerability, and less loneliness.

It is important to emphasize that not all those who are religious experience God vividly, and not all of them experience God as good. In Christianity, the representation of God has shifted considerably over its history (Wright, 2009). Indeed, the

representation of God not only shifts from congregation to congregation, but from congregant to congregant. The psychoanalyst Ana Maria Rizzutto (1979) argues that an individual's God-concept can operate for them psychically as complexly and powerfully as any inner object, and that any person's God-concept changes over time in relation to their emotional experience and to the quality of their object relations in general. Rizzutto's work demonstrated that as someone became psychically healthier, their God-concept became kinder and more humane. Christian therapists often understand their main therapeutic endeavor as working with their patient's God-concept so that the patient will come to experience God as loving: and from this, the therapists believe, their mental health will improve (Luhrmann, 2012).

What guidance might the research provided here present to clinicians treating patients who are dealing with distress? How might a clinician determine whether religious experience is the dysfunctional product of psychosis or a positive means of coping that should be nurtured? Mary Watkins (1986) has argued that the difference between imaginal dialogues and psychotic symptoms needs to be made not on the basis of psychiatric diagnosis but psychological quality. When the imagined other is richly characterized; when the relationship is experienced as reciprocal; and when the person is aware of the imagined other as a relationship, Watkins argues, then these experiences are not only therapeutic but a wellspring of human creativity. Christians would probably quote Matthew: "By their fruits, ye shall know them" (Matthew 7:20). Theology aside, the sentiment has wisdom. If the prayer practices appear to be helpful, they probably are. This paper suggests that someone who has learned to experience a loving God—someone who has learned to experience God vividly, and who has internalized that God as reliably good—may have a powerful therapeutic tool to hand.

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Notes

1. There are of course many types of prayer. Poloma and Pendleton 1981, 1991, for example, identify meditative, ritualistic, petitionary and colloquial. Most instances of these prayer types in the Christian tradition involve subjective, internal experience which is treated as interaction with a being external to the self. They treat some words spoken in the mind as important in themselves rather than distractions from action.
2. These are sections 111–117 of Loyola's notes, Joseph Tetlow translation.
3. These were: the Tellegen Absorption scale; the Daily Spiritual Experiences scale; the Spiritual Well Being scale; the Posey and Losch Hearing Voices scale; the Empathy scale; the UCLA Loneliness scale; the Satisfaction with Life scale; the Perceived stress scale; the Berkeley emotional expressivity scale and on their return: the Dissociative Experiences Scale, the O-Life; the Kessler 10 item scale.

4. Copyright Lynn G. Underwood. Perission to use and reproduce the scale at www.dsescale.org
5. The spiritual questionnaire is the Daily Spiritual Experiences Questionnaire (Underwood and Teresi 2002);. For the first 14 DSE questions, including all 128 subjects in the first session: UCLA loneliness corr. −.216 p=.023; Stress corr −.268 p=.004; Diener corr .350 p=.000; for "I feel God's love, directly" UCLA loneliness corr −.313 p=.001; Stress corr –.293 p=.002; Diener corr .422 p=.000.
6. The two students spent one afternoon each week at the drop in center for months. The daily census of the center fluctuated, but it average around 80. Women were asked if they wanted to be interviewed, and offered three buspasses as a token of appreciation if they did. The interviews were conducted to reinforce confidence in the patterns reported in the ethnographic work.

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