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Prayer and spiritual healing in medical settings

David Aldridge, PhD

If you can't handle your feelings, how can you avoid harming your spirit? If you can't control your emotions, but nevertheless try to stop yourself following them, you will harm yourself twice over. Those who do this double injury to themselves are not counted amongst those with long life

Chang Tzu in Palmer (Palmer 1996).

Thus far you have harmonized with your body, having the usual nine apertures, and you have not been struck midway through life with blindness or deafness, lameness nor any deformity, so in comparison to many you are fortunate. So why do you wander around grumbling about Heaven? Be gone, Sir!

Chang Tzu in Palmer (Palmer 1996).

Abstract

Prayer and spiritual healing have been researched over the last forty years. Spiritual awareness, a neglected aspect of much of this research, is finding its way into clinical practice in treatment of a variety of problems. It is a challenge to use spiritual healing in a wholistic and ethical manner.

Prayer in medicine

Prayer is increasingly used in approaches to healing. The use of prayer is related to specific health outcomes (Duckro and Magaletta 1994; McCullough 1995) and is acceptable within medical practice (Magaletta and Duckro 1996). VandeCreek et al. (1999) found that there is both an interest in, and a practice of, prayer as a complementary therapy for breast cancer outpatients.

Although initial clinical research into the benefits of prayer was inconclusive (Collipp 1969; Joyce and Welldon 1965; Rosner 1975) more recent studies, from a broader medical perspective and with larger study populations, have shown that intercessory prayer is beneficial. Several authors argue that religious affiliation and practice are also relevant, even if not beneficial, and that physicians should choose to attend to them (Dossey 1993; King and Dein 1998; King, Speck, and Thomas 1999; King 1997; Magaletta and Duckro 1996).

Saudia, et al (1991) investigated the helpfulness of prayer as a direct coping mechanism used by patients prior to having cardiac surgery. Ninety-six subjects indicated that prayer was used as a coping mechanism in dealing with the stress of cardiac surgery, and 70 of these subjects gave it the highest possible rating on the Helpfulness of Prayer Scale. Prayer was perceived as a helpful, direct-action coping mechanism and was independent of whether individuals believed that their lives were controlled by themselves or a powerful other. The importance of this study is that it emphasises prayer as direct action that the individual uses as a coping strategy.

For renal patients, prayer and looking at the problem objectively were used most in coping with stress (Sutton and Murphy 1989). It is interesting to see that at the pragmatic level of the patient, prayer and looking at the problem objectively are not exclusive but complementary activities in a system of beliefs. This is stress relief using prayer as a coping strategy.

In the treatment of alcoholism there has been an historical influence of spiritual considerations included in treatment plans (Bergmark 1998; Carroll 1993; Eisenbach-Stagl 1998; McCarthy 1984) apart from the temperance movement. Such treatments for alcohol abuse were often composite packages using physical methods of relaxation, psychological methods of suggestion and auto-suggestion, social methods of group support and service to the community, and spiritual techniques of prayer. These procedures are still in use today and have been extended into the realm of chemical dependency and substance abuse (Buxton, Smith, and Seymour 1987; Green, Fullilove, and Fullilove 1998; Mathew, Georgi, Wilson et al. 1996; Miller 1998; Navarro, Wilson, Berger et al. 1997; Peteet 1993). Individuals suffering from substance problems are found to have a low level of religious involvement, and spiritual engagement appears to be correlated with recovery (Miller 1998) while religiosity may be an advantageous coping factor (Kendler, Gardner, and Prescott 1997).

Prayer is described by several authors as valuable in care for the elderly across several cultures (Chatters and Taylor 1989; Foley, Wagner, and Waskel 1998; Garrett 1991; Gorham 1989; Koenig, Bearon, and Dayringer 1989; Koenig, Hays, George et al. 1997; Markides 1983; Reed 1987; Taylor and Chatters 1991).

Medical help seeking and prayer are not mutually exclusive (Bearon and Koenig 1990), as prayer is considered to be an active coping response in the face of stressful medical problems. A study of 160 physicians found that physicians believe that religion has a positive effect on physical health, that religious issues should be addressed and that the older patient may ask the physician to pray with them (Koenig et al. 1989). An influential factor in this questioning is the belief system of the practitioner, which may influence in turn the willingness of the patient to talk about such matters.

Randolph Byrd's study

Randolph Byrd's study (1988) at the San Francisco General Hospital has achieved landmark status in the topography of healing research. He asked whether intercessory prayer to a Judeo-Christian God has an effect on the patient's recovery and medical condition while in hospital, and if there is an effect, what are its characteristics. The hypothesis is that intercessory prayer mediates the process of healing.

Intercessory prayer was taken as the treatment method for the 192 randomly allocated patients, another 201 patients formed a control group. All 393 patient had standard medical care as expected. The intercessors were "born-again" Christians with an active Christian life of daily devotional prayer who partook of fellowship in their local churches. Each patient was randomised to between three to seven intercessors who were given the patient's first name, diagnosis and general condition. The prayer was done from outside the hospital from a distance. Each intercessor was asked to pray daily for a rapid recovery and for the prevention of complications and death. Physicians were informed of the trial but did not know to which group the patients belonged.

Standard medical treatment was given throughout to all patients. Thus prayer was an adjunct to standard medical care not an alternative.

At first glance the statistical results of Byrd's study are impressive, with an overall improvement being attributed to prayer. It does indeed show a touching faith on the behalf of medical scientists in statistical results, partly because the results make medical sense. There is less congestive heart failure, cardio-pulmonary arrest, pneumonia, fewer antibiotics are needed, less diuretic medication and less ventilator support.

My concern with these studies is that while they do demonstrate causal effects of prayer, they miss an important aspect of prayer which is not instrumental, and is spiritual. As this spiritual change unfolds and becomes explicit, the time frame for that explication may extend beyond the time scale of the trial itself. Indeed, many of the changes that can be related to the healing may at first be hidden.

Spiritual healing research in medical settings

Prayer is only one form of healing that is regarded as spiritual. There are a variety of other forms

of spiritual healing and these are comprehensively described by Dossey (Dossey 1993) Benor (200a; b),Braud and Schlitz (1989), and Solfvin (1984). The National Federation of Spiritual Healers in England (NFSH 1999) define spiritual healing as restoring the balance of body, mind and spirit in the recipient with the intention of promoting self-healing, to bring a sense of well-being and peace to the recipient (p2). A further description concerns itself with finding an inner peaceful core, connecting with a universal source of peace and love that is channelled for the benefit of another. This connection with a universal force is also at the centre of “therapeutic touch” and belies its connections with ancient systems of healing (Fischer and Johnson 1999).

While the state of mind necessary for healing has been elusive to research there has been quite extensive research into the physical sequelae of spiritual healing phenomena which has included investigations using controlled trials (Benor 2000a; b). Enzymes and body chemicals in vitro have been studied, as have the effects of healing on cells and lower organisms (including bacteria, fungus and yeasts), human tissue cells in vitro, the motility of simple organisms and plants, on animals and on human problems. While spiritual healing is often dismissed as purely a placebo response, the evidence from studies of lower organisms and cells would indicate that there is direct influence. Even if we introduce the idea of expectancy effects as an influence on experimental data we are still left with a body of knowledge which begs understanding (Braud and Schlitz 1989; Solfin 1984).

General practice

At the level of daily practice some general practitioners have been willing to entertain the idea of spiritual healing and incorporate it into their practice, to use spiritual explanations for some of their patient contact, or as part of their referral network (Aldridge 2000; Brown 1995; Brown and Sheldon 1989; Cohen 1989; Dossey 1993; Pietroni 1986). Cohen (1989) emphasises the value of touch, time and compassion which the healer can offer, and the benefits of referral. Such practice points out the value of working together as a referral network of practitioners.

King et al. (1992) focused on patients who use faith healers and physicians to care for their medical problems to learn about how often physicians see patients who are involved in faith healing, and to learn more about physicians' attitudes about, and experiences with, faith healing. Approximately one half (52%) of the 594 participating physicians were aware of at least one patient in their practice who had had a faith-healing experience. Most physicians came in contact with such patients no more frequently than once a year. Fifty-five percent agreed and 20% disagreed that reliance on faith healers often leads to serious medical problems. However, 44% thought that physicians and faith healers can work together to cure some patients, and 23% believed that faith healers divinely heal some people whom physicians cannot help. Family physicians were divided in their views about faith healing, with a majority expressing scepticism about faith healing and a sizeable minority favourable toward it.

Chronic complaints and recalcitrance

In Brown’s study (1995) of chronic problems in an English general practice of six doctors, adult patients with chronic complaints were referred by their general practitioner to a healing clinic. In choosing the patients, the general practitioner included those who had had a problem of six months duration and had not responded well to usual interventions, other secondary referrals or counselling. Treatment sessions lasted 20 minutes once a week for an eight week period. The spiritual healing used a “laying on of hands approach” to “channel healing energies” and was assessed using a validated quality of life questionnaire that has established population norms for comparison (SF-36). There were significant changes after eight weeks in what was a group of patients with poor health status in role limitations, social function, pain, general health and vitality. These improvements were not extended to an assessment after 26 weeks from the beginning of the study. As the author says, we cannot make any specific conclusions regarding the healing approach as there were no treatment controls. However, for a group of chronic patients, recalcitrant to previous intervention, there was improvement.

Chronic symptoms in general practice are also the focus of Dixon’s study (1998). Like the above study with several general practitioners working together, patients with a condition that had lasted for six months, which was unresponsive to treatment, were referred to a healer. The patients were told that they were going to see a healer rather than a faith or spiritual healer, who would the pass her hands close to the patient visualising the passage of light through the patient accompanied by

relaxing music. We are not told of the control condition, and the use of relaxing music confounds the treatment given that the use of music as music therapy is a known anxiolytic (Aldridge 1996). However, compared to the control scores, there was an improvement in anxiety and depression scores after three months that was maintained at six months for the treatment group. Functional improvements on the Nottingham Health Profile at three months were not maintained at a significant level after six months. These patients were previously unresponsive to treatment and the improvement in general mood state scores indicates a general setting for recovery that is of worth for clinical practice.

A broader ecology of care

The demand for whole person treatment has been strenuously adopted by some nursing groups who remind us that in caring for the patient there is a need to include spiritual needs and to allow the expression of those needs (Boutell and Bozett 1990; Burkhardt 1989; Clark and Dawson 1996; Dossey 1999; Ferrell, Grant, Funk et al. 1998; Grasser and Craft 1984; Harrington, Lackey, and Gates 1996; Labun 1988; Magaletta and Duckro 1996; Potts 1996; Rukholm, Bailey, Coutu-Wakulczyk et al. 1991; Rustoen and Hanestad 1998; Soeken and Carson 1987). Within these approaches there is a core of opinion which accepts that suffering and pain are part of a larger life experience, and that they can have meaning for the patient, and for the caregivers (Aldridge 2000; Nagai Jacobson and Burkhardt 1989). The emphasis is placed upon the person's concept of God, sources of strength and hope, the significance of religious practices and rituals for the patient and their belief system (Soeken and Carson 1987).

When the goal of treatment is palliative, in terminally ill cancer patients with a prognosis of 6 months or less, the most important outcome is improving patient quality of life (Greisinger, Lorimor, Aday et al. 1997). Interviews with 120 terminally ill cancer patients show that their most important concerns encompass existential, spiritual, familial, physical, and emotional issues and that throughout their illness these concerns were rarely a focus of their care. What is of further concern is that doctors underestimate symptom severity 15% of the time (Stephens, Hopwood, Girling et al. 1997), and this has important implications for palliative interventions and the way in which patient understandings are taken seriously.

Doctors, nurses and clergy have worked together to care for the dying (Conrad 1985; Greisinger et al. 1997; McMillan and Weitzner 1998; Reed 1987; Roche 1989), and a community team approach which includes the family of the patient and his or her friends appears to be beneficial (Aldridge 1987a, b, c, d). These principle benefits are concerned with a lessening of state-trait anxiety, general feelings of well being and an increasing spiritual awareness for the dying person regardless of gender, marital status, age, or diagnosis (Kaczorowski 1989). This does not imply that each practitioners has to address all of these components, rather that those involved identify that which is necessary for the patient and can call upon the appropriate resources. The nurse specialising in pain management works with the priest understanding suffering and together with the patient that is in pain. But the patient plays an active contributory role. Technical support is vital but optimal care involves emotional support and these may include techniques of relaxation, visualisation and meditation (Peteet, Stomper, Ross et al. 1992).

Caregivers need care

Increasing numbers of patients with cancer are being cared for by home caregivers (Hileman, Lackey, and Hassanein 1992). The primary purpose of the study of Hilemanet al. was to identify, categorize, and assess the importance of needs expressed by 492 home caregivers and to determine how well these needs were satisfied. Caregivers, unpaid people who helped with physical care or coping with the disease process, were selected from the records of two non-profit community cancer agencies and two hospital outpatient oncology clinics. Six need categories were identified: psychological, informational, patient care, personal, spiritual, and household. Those needs changed over time and required frequent reassessment but it was the caregivers as well as the patients who were seen as in need. If we continually refine our outcome measures to assess the individual patient then we are committing a big mistake by ignoring his ecological milieu.

In a three month study of the perceived needs and anxiety levels of 166 adult family members of intensive care unit (ICU) patients (Rukholm et al. 1991) family needs and situational anxiety were significantly related. Worries, trait anxiety, age and family needs explained 38% of the variation of

situational anxiety. In addition, spiritual needs and situational anxiety explained 33% of the variation of family needs. In threatening situations families need strategies to cope. As Zigmond (1987) writes “On our own, or in our most intimate groups, we devise more personal and idiosyncratic beliefs, rituals and protocols to ward off the potential storms or deserts of uncertainty” (p69). The spiritual dimension, while perhaps not warding off uncertainty, offers a satisfactory strategy by which uncertainty may be understood and coped with.

Spiritual factors are also important for the caregivers. The study of Chang, Noonan, and Tennstedt (1998) examines how religious/spiritual coping is related to specific conditions of caregiving and psychological distress among informal caregivers to community-residing disabled elders. Spiritual coping strategies influence caregiver distress indirectly through the quality of the relationship between caregiver and care recipient. Caregivers who used religious or spiritual beliefs to cope with caregiving had a better relationship with those who were being cared for, which is associated with lower levels of depression and an increased dedication to the role of caring.

Spirituality in the treatment of persons living with AIDS

Comprehensive treatment programs for people living with AIDS recommend that the spiritual welfare of the patient, and its influence on their well-being, should be included (Belcher, Dettmore, and Holzemer 1989; Flaskerud and Rush 1989; Gutterman 1990; Hall 1998; Holt, Houg, and Romano 1999; Kaplan, Marks, and Mertens 1997; Ribble 1989; Sowell and Misener 1997; Warner-Robbins and Christiana 1989). Individuals who were spiritually well and able to find meaning and purpose in their lives were also found to be hardier (Carson and Green 1992)., Cooke (1992) reminds us that the care of HIV-infected patients is demanding as well as the emotional demands of caring for HIV-infected people. Other authors, while supporting an emphasis on the spiritual, also direct our attention to the confounding problem of religions that condemn various aspects of sexuality and the ramifications this has for the person living with HIV or AIDS (Jenkins 1995).

While the term spiritual healing is used here within the context of orthodox medical practices as a complementary or adjuvant approach, the term spirit has other applications. In the absence of a medical cure for AIDS, HIV-infected individuals may seek alternative therapies and folk healing practices. In inner-city New Jersey, HIV-infected Hispanics receiving care at an HIV/AIDS clinic believed in good and evil spirits and that such spirits had a causal role in their infection, either alone or in conjunction with the AIDS virus (Suarez, Raffaelli, and O'Leary 1996). They sought spiritual folk healing for physical relief, spiritual relief, and protection from evil. A minority hoped for cure. We must be aware of the prevalence of folk beliefs and alternative healing practices and cannot assume that when we talk of spiritual healing that it will fit into the conventional views of Western approaches.

Ambiguity in outcomes

Richards and Folkman (1997) found spiritual phenomena were spontaneously reported in interviews of 68 of 125 recently bereaved HIV-positive and HIV-negative partners of men who died from AIDS. Spiritual understandings helped assimilate the deaths and were seen as sources of solace. Those reporting spiritual phenomena also showed higher levels of depression and anxiety and lower levels of positive states of mind, used more adaptive coping strategies, and reported more physical health symptoms than those who did not report spiritual phenomena. While these findings are with partners of patients, it reflects the work of King (King et al. 1999) who found that stronger spiritual belief is an independent predictor of poor outcome at nine months for patients admitted to the acute services of a London hospital. Chronic pain patients who endorse a greater use of prayer to cope with their pain also reported a greater degree of disability (Ashby and Lenhart 1994)..

A distinct danger of promoting understandings, and calling them spiritual, is that they may deflect from pragmatic understandings that are necessary for daily life. An essential element of spiritual understanding is discernment of reasonable and proper applicability not the repetition of ritual exercises and wishful thinking. The guiding impulse behind the development of modern analgesics may be as divine as the exercise of meditative techniques. Knowing when and how to use them is the important factor (Aldridge 2000).

Discernment

There are other dangers in spiritual healing. Some patients are promised fantastic healings by spiritual healers. Others are told that they are not recovering either because they do not want to, or that they do not love others enough, or that they are secretly resisting the healer. Some healers have been known to advise patients to refrain from conventional medical treatments. Such approaches are simply wrong.. Discernment is the key. For those seeking miracles or some sort of magical intervention through healing powers, this cautious reasoned approach may be disappointing. Discernment involves no dressing up in special clothes, nor any fancy hand-passes or magical incantations. Dressing up in clothes inappropriate to the period or the local culture is a warning of spiritual bankruptcy not enhanced powers (Marsham 1990) as is the use of languages strange to the culture. For those seeking the subtle and the hidden, this approach remains less dramatic but no less effective. The attitude of enhancing discernment is one that can be adapted for all healing modalities, including conventional medicine. Discernment can return the spiritual to the subtle level at which it exists. For spirit to be manifested in material effects requires the discernment of practitioners and of those whom they serve.

An integrative perspective

If we are to submit prayer to a test, then we should at least be certain that the observations we will make incorporate the relevant criteria for assessing recovery. Prayer not only brings relief but the expectation is of a new understanding, literally a change in consciousness.

If spirituality is defined as the search for the divine and the achievement of unity, then prayer is the vehicle for this achievement (Aldridge 2000). You can still pray with a broken leg. You cannot run with a broken leg. Knowing the difference between the two is an elementary awareness. The intention of prayer is to be with the divine; then all other cares will fall away. For the sick, illness takes on a different meaning. It too may disappear. To look for a direct cause and effect with prayer is to defy the spiritual teachings throughout the centuries, failing to see the purposes of both sickness and prayer itself.

That the mind influences healing is becoming apparent. This is a knowledge of the world of laws of cause and effect, called science. There is also a knowledge that some call spirituality. Both are important. Neither is to be neglected. Healing comes from learning the relationship between both forms of knowledge. In both perspectives of knowledge, science and spirituality, learning is achieved through teaching and guidance. If the world is given to us by the divine in all its richness, then surely the blessings of medical knowledge, the dedication of various practitioners, and the lessons of illness and healing are provided by the same source.

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David Aldridge, PhD is on the Editorial Panel of *IJHC*.
Biographical note on Editorial Panel page, on line.
Contact
Chair of Qualitative Research in Medicine
Faculty of Medicine
Uni Witten/Herdecke
Alfred Herrhausen Str. 50
58448 Witten, Germany
Tel: ++ (0)2302 926780 Fax: ++ (0)2302 926783
www.musictherapyworld.net davida@uni-wh.de