HOLISTIC NURSING UPDATE™

A Guide to Complementary and Alternative Therapies

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Does Intercessory Prayer Bring Healing?

By Dónal P. O'Mathúna, PhD

HOLISTIC NURSING IS DISTINGUISHED BY CONCERN FOR PATIENTS' spiritual as well as physical, emotional, and relational needs. Prayer consistently tops the list of spiritual practices patients value. Surveys find that more than 90% of Americans pray, and 95% claim their prayers are answered.[1] One third of Americans pray for their health, three quarters believe God answers prayer for healing incurable illnesses, and 14% claim they have experienced such healing.[1] Given that half of all patients want to pray with their physicians, nurses should expect at least as many want to pray with them.[1]

Growing interest in evidence-based practice, and the need to justify the use of all resources based on outcomes research, has revived interest in testing the effectiveness of prayer for healing. What outcomes should patients be told to expect from prayer? Can nurses justify spending time praying with or for patients based on research studies?

Defining Prayer

People differ in what they mean by prayer, based both on different beliefs about how prayer works and on different practices. Prayer can be grouped generally as intercessory or contemplative (reflective). The latter seeks to deepen one's relationship to, union with, or consciousness of a divine or transcendent being or force. Practices are deeply personal, primarily impacting the one praying.[2] Contemplative prayer and its health effects have been researched significantly, but intercessory prayer will be the focus here.

Intercessory prayer is a request to God, a spiritual being, or transcendent energy to bring about a desired end.[3] The words and thoughts are determined by beliefs about how prayer works. Christian, Jewish, and Muslim prayer asks a loving, all-powerful God to personally intervene. Other religions appeal to their divinities. Others believe prayer involves directing nonphysical healing energy toward people. Prayer is "directed" if requests are specified (e.g., "remove this cancer"). Nondirected prayer is more general, typified by, "Lord, let Your will be done." Another nondirected practice is the LeShan method where healers enter an altered state of consciousness

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believed to stimulate the patient's natural capacity for self-healing.[4]

Intercessory prayer is more amenable to scientific study because the person praying can differ from the one prayed for. Controlled studies of intercessory prayer for health and healing in humans will be reviewed here.

Research on Psychological Outcomes

The first controlled prayer study was published in 1957 involving 45 volunteers with various emotional disorders.[5] Subjects were nonrandomly assigned to three groups. Group 1 received weekly standard psychotherapy, Group 2 (all Christians) prayed daily for their own problems to be overcome, and Group 3 had weekly two-hour group therapy sessions. The group therapy participants discussed their problems and prayed for one another, and prayed for themselves between sessions. After nine months, standard psychological tests showed an average 62% improvement in Group 1, no improvement in Group 2, and 72% improvement in Group 3. This study is of historical interest, but its design makes any conclusion tentative.

The next study included patients with either psychological or rheumatic problems.[6] Forty-eight subjects were pair-matched and randomly assigned to prayer or control. Christian prayer groups in English churches arranged for everyone to receive nondirected prayer daily for six months. No significant differences were found between the two groups during standard clinical evaluations for their conditions.

The only intercessory prayer study found in the nursing literature examined patients with chronic undifferentiated schizophrenia.[7] Twenty student nurses were assigned to one-on-one care of 20 Christian patients unresponsive to psychotherapy at a state mental institution. Half the students and patients volunteered for the prayer group while the others engaged in standard therapeutic relationships. The prayer students offered Christian prayer as a group for their patients immediately prior to weekly visits, and began and ended each visit with prayer and Scripture reading. A nursing psychological instrument (of unstated reliability and validity) was administered before the study and after 10 weeks. The control group revealed no changes, while prayer group patients more appropriately and articulately expressed frustration and anger, developed a desire to change, and complained of fewer somatic problems (no statistical analysis given).

LeShan prayer was studied with 40 patients hospitalized for major depression.[4] Patients continued standard therapy and medication, were pair-matched and randomly divided. Nondirected prayer for improved patient well-being was offered daily for six weeks. Validated tools showed no significant differences in depression or well-being scores, length of hospitalization, or number of re-admissions.

The largest psychological study used 406 healthy volunteers randomly assigned to receive no prayer, directed prayer, or nondirected prayer.[3] Prayer was offered to God, with two thirds of those praying being Catholic. Each subject received prayer from three people for 15 minutes daily for 12 weeks. No significant differences were found between any of the groups on 11 measures of self-esteem, anxiety, depression, and mood.

The latest psychological study examined 40 people admitted to an alcohol abuse center.[1] Subjects were randomized after match pairing. Volunteers used nondirected prayer for three patients each for six months. Numerous religious beliefs were initially represented, but only Protestant, Catholic, and Jewish volunteers completed the study. The groups had no significant differences in alcohol consumption.

Research on Miscellaneous Physiological Outcomes

A study finding prayer had no significant difference on rheumatic conditions was already examined.[6] Another study randomly assigned 18 children with leukemia to prayer or control.[8] Each child was prayed for daily by a Protestant family while standard chemotherapy continued. After 15 months, seven of 10 receiving prayer were alive, compared to two of eight in the control (P = 0.1).

Science of Mind healers believe their thoughts

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Questions & Comments

Please call **Paula Cousins,** Associate Managing Editor at (816) 960-3730 between 8:30 a.m. and 4:30 p.m. ET, Monday-Friday.

influence universal energies to bring healing.[9] A double-blind study randomly assigned 96 hypertension patients, who continued standard medication, to either prayer or control. Eight healers used nondirected prayer, but only results of the four most effective healers were used. No differences were found in a general health status index, diastolic blood pressure, heart rate, or weight change, but systolic blood pressure dropped significantly ($P = 0.0144$).

Wirth has published two double-blind studies, the first using LeShan prayer and Reiki for pain following extraction of impacted molars.[10] Twenty-one volunteers were randomly assigned to one group for extraction of the first tooth, and then the other group for their second extraction two weeks later. In addition to standard analgesia, Reiki and LeShan commenced three hours postoperatively, alternating hourly for six hours. Pain intensity was significantly lower and pain relief significantly higher in the treatment group at each hour ($P < 0.05$ or $P < 0.01$).

Wirth's second study was an "exploratory pilot study" with 16 type 1 diabetes patients.[11] A double-blind, within-subject crossover design again was used. Alternating daily for two weeks, the treatment group received either Christian prayer or an adaptation of therapeutic touch practiced through a one-way mirror (for blinding). Insulin use did not differ significantly between treatment and control intervention.

An unpublished study randomly divided 53 post-hernia male patients between three groups.[12] One group used audiotapes suggesting accelerated recovery; the second group received distant or psychic healing during surgery (no details reported); and the third was a control group. Those receiving distant healing had significantly better outcomes in nine of 24 variables measured ($P < 0.05$), including wound appearance, fever during hospitalization, and amount of pain.

Forty pair-matched AIDS patients were randomized in a double-blind study.[13] Healers used Christian, Jewish, Buddhist, American Indian, shamanic, bioenergetic, or meditative distant healing practices. Patients received one hour of nondirected prayer daily from a different healer every week. After six months, the treatment group had significantly better medical outcomes in six of the 11 variables measured, including fewer new AIDS-defining illnesses, fewer doctor visits, and improved mood ($P < 0.04$). Outcomes showing no significant differences included recovery from AIDS-defining illnesses, CD^{4+} count, and quality of life.

Research on Coronary Care Outcomes

In probably the best-known prayer study, Byrd randomized 393 coronary care unit patients to either control or daily prayer from "born-again" Christians.[14] Between three and seven people prayed for each patient for a rapid recovery and prevention of both complications and death. No significant differences between the two groups were found on those outcomes. Twenty-six other medical outcomes were measured, with the prayer group showing significantly better results in six. A tool for ranking patients' overall outcome was developed (but not validated), and showed the prayed-for patients did significantly better ($P < 0.01$).

Harris replicated Byrd's study with 990 coronary care unit patients.[15] This randomized, double-blind study used Christian prayer for 28 days. Thirty-five medical outcomes were examined, with no significant differences on any individual measure. Using Byrd's tool no significant differences in overall outcome were found, but a tool developed (but not validated) by Harris found significant improvements ($P = 0.04$). The prayer group scored 11% better than the control, but the researchers questioned the clinical significance of this.

The MANTRA project's pilot study randomized 150 patients scheduled for cardiac catheterization to receive either prayer, touch, imagery, stress relaxation, or standard therapy.[16] Everyone in the prayer group received Christian, Jewish, Buddhist, and Unity Church prayer. The principal investigator concluded that a feasibility study cannot give "statistically definitive results," but the prayer group did better than all others on every measure of adverse events. The project is now enrolling 1,500 patients at several sites.

Conclusion

Early prayer studies had methodological weaknesses. Overall, the results reveal a pattern of inconsistencies. The Harris study exemplifies the current difficulty in reaching conclusions. The prayer group showed no significant improvement in any individual outcome, but did in a combined measurement. This approach is statistically questionable since individual outcomes are often interrelated (e.g., sepsis and antibiotic use). Additionally, the Harris data showed significant and nonsignificant improvements depending on which assessment tool was used. For those who believe intercessory prayer works, and those who don't, the evidence from clinical studies will not convince them otherwise.

Studies show prayer sometimes brings improvements in some variables and not in others. This raises questions about prayer's nature, a topic avoided in recent research. If prayer involves impersonal energy or an innate human ability, improved research should bring consistent results. But if prayer involves a personal God who

chooses how to answer, controlled studies will never be conclusive. Randomized, double-blind studies can control for the placebo effect, but not for divine choice.

Decisions about prayer are based on people's beliefs, and will remain that way. Clinical evidence does not support or refute those beliefs, rooted in the other evidence people use to form their worldviews. Those beliefs should be respected by knowing enough about one's patients to know who would appreciate prayer. ❖

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Faith and Health: Parish Nursing

By Melodie Olson, RN, PhD

ONE THIRD OF JESUS' MIRACLES WAS CONCERNED WITH health or the relief of illness. The Buddha's first major teachings after the enlightenment were the Four Noble Truths, statements dealing with the existence of suffering and a blueprint for its relief.[1] Islamic groups began hospitals during the crusades. A Jewish Rabbi and a Baptist minister sat side-by-side on a panel during a public health conference. When asked what the word "health" meant to them, both responded that health was anything that helped their members worship their God better. All faith traditions have a mission to support the health of their congregations.

Recognizing that health is a particular ministry of faith communities has given rise to a faith and health movement in the United States.[2,3] The uniting view is that health is a "whole person" concept, integrating the body, mind, and spirit. The movement acknowledges the philosophy/theology of the faith group and the history and traditions of the individual assembly. The role of the faith community in promoting whole person health varies according to each tradition, but one major effort that has achieved prominence and respect across traditions is parish nursing.

Parish nursing builds on the mandate of the congregation to address health issues. It is a health promotion/disease prevention role, focused on the faith community. This role does not embrace the medical model or carry out invasive procedures, medical treatments, or the maintenance of intravenous products.[4] It is not home health. The parish nurse functions as integrator of faith and health, health educator, personal health counselor, referral agent, trainer of volunteers, developer of support groups, and health advocate. The parish nurse is an integral part of the congregation and works with the clergy and health ministry committee as appropriate.

History

Parish nursing began in the 1980s with support from the Kellogg Foundation, when Reverend Granger Westberg convinced several churches in Chicago to hire a registered nurse. During the previous decade, Kellogg

funded a series of Wholistic Centers in churches (clinics staffed with physicians), and found they provided more "whole person" health care than did other settings. Unfortunately, the cost was too great to be continued independently by the congregations. In response, the model shifted to one of collaboration between a health system (e.g., hospital system, collaboration of hospital systems, faith-related foundation, community agency) and a congregation. The congregation would hire a parish nurse and would provide office space, required equipment, authority, a mission of health, volunteers, meeting space, and an organization. The health system, or community agency, would provide some funds for salary and an infrastructure for the parish nurse, including quality control measures, support groups, and continuing education. The health system also might be responsible for legal concerns, professional licensures, OSHA training, and other technical aspects usually provided by a human resources department. Several variations on this model have emerged to provide parish nursing care. Currently, parish nursing is an accepted method of health promotion in Canada, Australia, and Korea, as well as the United States.[5,6]

Education

The parish nurse's education is based on both theology and professional nursing, especially community health nursing, and standards have been accepted by the American Nurses Association (ANA) Credentialing Center.[7] The most widely accepted preparation for parish nursing is a nationally endorsed continuing education course, developed by a group of curriculum experts and based on a job analysis conducted by the International Parish Nurse Resource Center. The five- to eight-day curriculum is offered at several universities and recently has been revised to reflect current practice. Competencies are being developed and a movement toward ANA certification is being studied. There are also several academic courses and graduate programs in parish nursing, some of which are joint programs between Colleges of Nursing and Schools of Divinity.

Research

Rydholm documented the outcomes of 1,800 parish nurse program cases.[8] Documentation was standardized using the nursing taxonomy of the North American Nursing Diagnosis Association and the Iowa Nursing Interventions Classification. Theoretical cost savings were realized primarily by sustaining chronically ill and aged people at home (empowering caregivers), thus preventing premature nursing home admissions, and by helping people recognize symptoms requiring immediate attention, thus avoiding more costly treatment later. Cost savings were estimated to be $400,000 for the first 600 visits. Referral, advocacy, assistance, active listening, and supportive education efforts were major nursing activities. More than half of the concerns addressed by the parish nurses were related to spiritual-psychosocial concerns such as unresolved feelings, transitions, interpersonal tensions, caregiver stress, and isolation.

In a review of the Carondelet Parish Nurse Program in Tucson, AZ, a sample of 15 hypertensive, diabetic, and overweight clients had lower blood pressure readings with a per client average reduction of 10-20 mm/Hg systolic and at least 10 mm/Hg diastolic.[9] In addition, blood sugar readings decreased by 50 dL on fasting samples and there was an average weight loss of 10 pounds per client.

Not all parish nurses work in the same way to achieve their health and healing goals. Chase-Ziolek and Striepe evaluated parish nurse programs in rural and urban areas.[10] The nurses in both programs volunteered their services and appreciated the opportunity to integrate their faith and nursing practices. However, nurses in rural areas most often provided services through home visits and telephone calls, whereas parish nurses in urban settings often provided services in the church building. Rural nurses were more involved with activities like case management and practical assistance, while urban nurses held more educational programs.

In another study of parish nursing practice, 11 nurses ranked the interventions they used most frequently in a single year: listening (6,050), teaching (3,770), touch (2,983), and spiritual care (2,799).[11]

Conclusion

Congregations are meant to be places of caring and healing by tradition and theology. Where congregations accept that mission, parish nursing has been shown to be an effective tool. When parish nursing programs partner with health care systems and public health agencies, they offer a systematic focus on the whole person, contributing a sense of health and wholeness to communities, and a sense of mission and meaning to parish nurses who feel called to this special ministry. ❖

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CE Objectives

After reading this issue of *Holistic Nursing Update*, the continuing education participant should be able to:

1. Converse in a scholarly manner about issues germane to holistic nursing.
2. Apply the principles of holistic philosophy and practice to clinical settings.
3. Discuss why some alternative and complementary therapies are used and why others are rejected.
4. Validate the effectiveness of holistic care and modalities through generation of research ideas.

Controversies in Holistic Nursing

By Karilee Halo Shames, PhD, RN, HNC

Should Religious Expression Be a Part of Holistic Nursing?

NURSING HAS A TRADITION RICHLY INTERTWINED WITH religious thought and expression. From the earliest recorded reflections of the art of nursing, there has been a necessary connection with religion. Nurses care for the sick and dying, people in dire conditions who seek support from their religion and spiritual understanding. How could we not address the religious/spiritual nature of life, and still claim to provide whole person health care?

The question of whether religion should be included in the domain of nursing lingers. The clergy are responsible for caring for the religious aspects of the person in need, while nurses care for the body. More and more, however, nurses are considering their work to encompass caring for both body and soul. Most nurses will agree that caring for the person's spirit is part of nursing, but many will not agree that nurses should be involved in the religious aspects.

Some nurses feel strongly that religious expression must be a part of nursing care, handled carefully; others believe that religious expression is acceptable for nurses in their private lives, but should never be discussed with patients unless specifically asked.

"Nurses need to be knowledgeable about religions and other practices that impact decision-making," advises Susan Dyess, RN, MSN, Coordinator, Parish Nurse Program, Intracoastal Health Systems, Inc., West Palm Beach, FL, and Adjunct Faculty, Florida Atlantic University College of Nursing.

Practicing as a parish nurse, Dyess feels strongly that an important part of the service she provides is related to the practice of religion. She also believes that nurses in other settings may be called upon to help a patient clarify beliefs and find strength through religious ritual and prayer.

Ann Solari-Twadell, RN, MSN, MPA, Director, International Parish Nurse Resource Center, Park Ridge, IL, understands the challenges nurses face with regard to religion. "Nurses need to have knowledge of different religious beliefs, so they can relate to the patients they

serve," she explains. "Evangelizing, however, is another matter, and is a difficult issue to discuss."

When considering whether nurses should pray over a dying patient, Solari-Twadell says there is no one clear answer; it depends on the circumstances. She believes it is best to ask the family what they feel is most appropriate. In those instances where a nurse is alone with a patient, and not knowing, a nurse must operate from her own centered state. If the patient is non-responsive, Solari-Twadell believes the nurse should explore what is most meaningful to herself, in being present with this patient.

However, Eleanor Schuster, RN, DNSc, Professor, Florida Atlantic University College of Nursing, believes nurses in many settings should not incorporate religious expression into their practice. Schuster understands that practitioners may use their religious grounding for their own strength, but they should never offer this to patients unless it is specifically requested from the patient.

Schuster refers to *Holistic Nursing: A Handbook for Practice*,[1] in which contributing authors Burkhardt and Nagai-Jacobson discuss the relationship between spirituality and religion. They suggest that spirituality is a manifestation of each person's wholeness, whereas religion, the organized system of beliefs shared by a group of people, is chosen. These authors suggest that religion reflects a particular understanding of spirituality, but is only one of many ways to access spirituality. Burkhardt and Jacobson suggest that "although some people may not be religious, everyone is spiritual."[1]

Conclusion

I believe nurses should always relate to patients' spiritual aspects, but must exercise extreme caution and care when integrating religious principles in the health care setting. Nurses should do whatever helps them maintain a centered state, and strive to know their patients well enough to know their desires during times of extreme stress, illness, or death.

We must come to know the patient as a caring, whole person, which is our sacred trust as nurses. Only when we know ourselves fully and honor these aspects deeply within ourselves, will we have developed the sensitivity and knowledge base to be able to know what is the most meaningful action to take on behalf of our patients.

Perhaps for this reason, nurses may need to refrain from treading on controversial topics with patients, lest we provoke and distress the patient. Florence Nightingale, who deeply believed in God, was secular in her approach to work. She allowed her close connection to God to empower her work, but was extremely cautious not to stimulate patients who needed rest and quietude. Nurses in most settings might consider strengthening their connection with the patient, and with their own higher power, and leave the rest to clergy. ❖

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Focus on Organizations

International Parish Nurse Resource Center (IPNRC)

In 1986, The International Parish Nurse Resource Center (IPNRC) was developed at Lutheran General Health System. The mission of the IPNRC is to promote the development of quality parish nurse programs through research, education, and consultation.

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Clinical Reviews

With Comments from Lynn Keegan, RN, PhD, HNC, FAAN

Hostility and Coronary Artery Calcification

Source: Iribarren C, et al. Association of hostility with coronary artery calcification in young adults. *JAMA* 2000;283:2546-2551.

Context: Psychosocial factors may play a role in the development and expression of coronary artery disease. Several mechanisms have been proposed to explain why hostility may increase cardiovascular risk, including unhealthy lifestyle behaviors and cynical distrust.

Objective: To evaluate whether hostility is associated with coronary artery calcification, a marker of subclinical atherosclerosis.

Design: Prospective cohort study.

Setting and Participants: Volunteer subsample from Chicago, IL, and Oakland, CA, consisting of 374 white and black men and women, aged 18-30 years at baseline, who participated in the Coronary Artery Risk Development in Young Adults (CARDIA) study. Cook-Medley hostility assessment data were collected at baseline (1985-1986) and at

year 5 examinations (1990-1992). After the 10-year examinations (1995-1996), electron-beam computed tomographic scans were performed.

Main Outcome Measures: Presence of any detectable coronary artery calcification (coronary calcium score > 0), and coronary artery calcium scores of 20 or higher.

Results: In logistic regression analysis adjusting for age, sex, race, and field center, comparing those with hostility scores above and below the median of the distribution of the present sample, the odds ratio (OR) of having any coronary calcification was 2.57 (95% confidence interval [CI], 1.31-5.22), and the OR of having a calcium score of 20 or higher was 9.56 (95% CI, 2.29-65.9). The associations with any coronary artery calcification persisted after adjusting for demographic, lifestyle, and physiological variables. Results using a cynical distrust subscale were somewhat weaker than for those using the global hostility score. Power was inadequate to perform sex- or race-specific analyses.

Conclusion: This population-based study in young adults demonstrates a positive graded association between hostility scores at baseline and coronary artery calcification. These results suggest that a high hostility level may predispose young adults to coronary artery calcification.

Comment: The results of this study are consistent with the hypothesis that hostility may contribute to the development of coronary atherosclerosis not only through poor health habits, but also via other physiological mechanisms. Even though the statistical power was not great enough to generalize to sex or race, these results have important clinical implications for nurses and their patients. ❖

Caring for Depressed Clients

Source: Mullaney JA. The lived experience of using Watson's Actual Caring Occasion to treat depressed women. *J Holist Nurs* 2000;18:129-142.

Context: Each year, 19 million patients are treated for depressive episodes that last six to 12 months, and major depression is diagnosed twice as often in women as in men. The annual economic cost of depression is $16-43 billion.

Objective: To describe the essential structure of the lived experience of depressed women who enter therapy and experience Watson's actual caring occasion (ACO) within the transpersonal caring relationship (TCR). (Many nurses practice from Jean Watson's theoretical framework using the actual caring occasion. The ACO occurs when the nurse enters the patient's phenomenal field, detects the patient's condition of "being," and feels it within her own self-system. This event allows the nurse to respond vicariously and/or intervene so that the patient's pent-up feelings and thoughts are shared and released. Key to this process is the replacement of negative feelings with healthy, positive ones. Thus, in ACO, the nurse and patient, together with their unique life histories and phenomenal field, interact in a human care transaction.)

Design: A phenomenological study following Spiegelberg's research method of inquiry which seeks to uncover, analyze, and interpret the meaning of the lived experience.

Setting and Participants: A purposive sample of 11 depressed women, including one African-American and 10 Caucasians aged 30-48 years. All women were identified as experiencing a single episode of major depression according to DSM IV criteria.

Main Outcome Measures: Spiegelberg's method was used for data analysis of 110 pages of therapist notes transcribed verbatim.

Results: Five essential themes emerged from data analysis of the diagnostic interview.

1. Despite the emotional pain and difficulty of sharing their feelings with a stranger in the initial interview, subjects felt understood, a process that enhanced their trust.
2. Subjects felt not only empowered for the first time since the depression set in, but also that there was a way out of the "dark abyss" of powerlessness, hopelessness, and depression.
3. As subjects became more reflective, they increased their sense of inner power, control, and empathetic perspective.
4. Although subjects expressed negative feelings like rage and self-loathing, their ability to do so enabled self-acceptance and revelation.
5. Subjects felt better and described engaging in behaviors that illustrate effective problem solving and healthy lifeways.

All 11 women stated Watson's ACO caused them to persist in treatment and adopt health-seeking behaviors.

Conclusion: This finding supports the expense of appropriate clinician time for holistic healing in the transpersonal caring relationship.

Comment: This small study serves to remind nurses of the importance of having a caring attitude and approach to all patients and, in particular, depressed patients. Perhaps this investigation will stimulate interest in finding and incorporating other aspects of caring in all patient encounters. ❖

In Future Issues:

Cranberry Juice and Urinary Health

Breaking Negative Addictions