INTEGRATING SPIRITUALITY INTO TREATMENT

RESOURCES FOR PRACTITIONERS

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PRAYER

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On one side, prayer is our capacity to enter into that vast community of life in which self and other, human and nonhuman, visible and invisible, are intricately intertwined. While my senses discriminate and my mind dissects, my prayer acknowledges and recreates [sic] the unity of life. In prayer, I no longer set myself apart from others and the world, manipulating them to suit my needs. Instead, I reach for relationship, allow myself to feel the tuggings of mutuality and accountability, take my place in community by knowing the transcendent center that connects it all. On the other side, prayer means opening myself to the fact that as I reach for that connecting center, the center is reaching for me. (Palmer, 1983, p. 11)

Nationally representative surveys have demonstrated that in the United States, most people pray, and many pray frequently. A 1993 Gallup survey (Gallup Organization, 1993) showed that 90% of Americans pray at least occasionally. Of the people who do pray, most people prefer to pray silently rather than aloud and alone rather than with others. A large majority of the population (97%) believe that prayers are heard, believe that their prayers have been answered on occasion, and believe that prayer makes them better people (86%). Furthermore, most people (77%) are satisfied with their prayer life.

Many people use prayer to help them cope with life’s problems (Bearon & Koenig, 1990; Ellison & Taylor, 1996; Gurin, Veroff, & Feld, 1960; Nesser, Husaini, Linn, & Whitten-Stovall, 1989) and medical problems such as HIV (Kaplan, Marks, & Mertens, 1997), cancer (Potts, 1996; Soderstrom & Martinson, 1987), sickle cell disease (Ohaeri, Shokinbi, Akinalde, & Dare, 1995), cystic fibrosis (Stern, Canda, & Doershuk, 1992), arthritis (Cronan, Kaplan, Posner, Blumberg, & Kozin, 1989), renal transplant surgery (Sutton & Murphy, 1989), and cardiac surgery (Saudia, Kinney, Brown, & Young-Ward, 1991). People frequently use prayer to cope

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with natural (Harvey, Stein, Olsen, & Roberts, 1995) and unnatural (Zeidner, 1993) disasters.

Older adults in particular seem to use prayer regularly as a technique for dealing with many of the concerns that become salient as one ages, such as relocation to nursing facilities (Armbr, 1994), fears about death and dying (Fry, 1990), widowhood (Gass, 1987), and health problems (Bearon & Koenig, 1990; Conway, 1985–1986). Indeed, some national surveys suggest that older adults use prayer for coping with life’s problems more than do younger adults (Gurin et al., 1960; cf. Ellison & Taylor, 1996).

Prayer is also an important coping resource for caregivers such as nurses (Sodestrom & Martinson, 1987), hospice workers (Schneider & Kastenbaum, 1993), spouses of patients with Alzheimer’s disease (Kaye & Robinson, 1994), parents of children with disabilities (Leyser, 1994), and family members of patients with dementia (Segall & Wykle, 1988–1989).

**PRAYER IS BOTH RELIGIOUS AND SPIRITUAL**

In nearly every religion, prayer is perhaps the most ubiquitous, essential, and personal of religious experiences. Friedrich Heiler, one of the most astute scholars on the psychology of prayer, wrote that it is

> not in dogmas and institutions, not in rites and ethical ideals, but in prayer do we grasp the peculiar quality of the religious life. In the words of a prayer we can penetrate into the deepest and most intimate movements of the religious soul. (Heiler, 1918/1932, p. xv)

Even though prayer is central to religion and religious experience, it is also profoundly spiritual. Even when stripped away from traditional religious frameworks, prayer represents one of the core elements of spirituality—prayer is thoughts, attitudes, and actions designed to express or experience connection to the sacred. Even though Heiler (1918/1932) recognized prayer as a religious phenomenon, he also realized the essentially spiritual functions of prayer, writing that “prayer is the expression of a primitive impulsion to a higher, richer, intenser life” (p. 355).

In this chapter we hope to offer clinicians an expanded understanding of this deeply religious, deeply spiritual phenomenon. The chapter is designed to (a) summarize basic social–psychological findings regarding the use of prayer in the general population; (b) review the quantitative empirical research on the relationship between various aspects of prayer (including frequency of prayer, use of prayer for coping with stress, and types of prayer) and various measures of mental health and well-being; and (c) recommend how practitioners might assess, discuss, and possibly encourage prayer in their work with clients. Although the subject of the chapter—prayer—is the means to the ultimate goal of connecting people to some-
thing that is transcendent and superempirical, our chapter is, in large part, grounded in the assumption that we can learn much about prayer by examining the quantitative empirical research on how it operates in people's lives.1

WHO PRAYS? WHEN DO THEY PRAY?

Although most people pray at least occasionally, not everyone prays with the same frequency. As one might expect, the demographic predictors of prayer behavior are also predictors of general religious involvement. It is well established across many cultures that women are more involved in their religions than are men (Argyle & Beit-Hallami, 1975; P. L. Benson, Donahue, & Erickson, 1989). Similarly, women tend to pray more frequently than do men (Husaini, Moore, & Cain, 1994; Poloma & Gallup, 1991; Taylor & Chatters, 1991; cf. Serey, 1987). Women also report a greater likelihood of praying in a reflective, meditative fashion and experiencing deeper religious experiences during prayer than do men (Gallup Organization, 1993; Poloma & Gallup, 1991).

Racial–ethnic groups also differ on measures of general religiousness and prayer. White people appear to be the least religious demographic group in America (Taylor, Chatters, Jayakody, & Levin, 1996). As one might expect, the percentage of White people who pray is slightly smaller (87%–90%) than the percentage of non-White people who pray (90%–95%; Gallup Organization, 1993; Poloma & Gallup, 1991). In a reanalysis of four nationally representative data sets, Taylor et al. (1996) demonstrated that across several single-item measures of religious involvement (including frequency of church attendance, devotional reading, watching religious TV programming, personal importance of one's religious beliefs, and self-rated closeness to God), Black Americans were much more religious than White Americans. The Black–White differences in the frequency of private prayer followed the same pattern: After adjustments for covariates, the frequency with which Black Americans prayed was slightly higher than the frequency with which White Americans prayed. Non-White Americans also experienced more satisfaction with their prayer lives, more frequently used prayer books when praying, more frequently asked for material things when praying (Gallup Organization, 1993), and

1There is some apparent irony here. The quotation from Palmer's (1983) book with which we began this article suggests that prayer is essentially about recognition of the unity of life. Scientific research (as usually conducted in the quantitative mode) is about observing regularities in the world with the assumption that the subject and observer are distinct, separate, unrelated. However, science is ultimately about discovering the true nature of things. Science and spirituality both share that goal, even though their methods differ sharply. We do not intend to defend an epistemology here, but to report on what we can learn about prayer from existing empirical research.
reported using prayer as a problem-solving strategy more than did White Americans (Neser et al., 1989).

Older adults also appear to be more generically religious than young adults (Levin, Chatters, & Taylor, 1995). As one might expect, older adults also appear to pray more frequently than do younger people (Chatters & Taylor, 1989; Gallup Organization, 1993; Poloma & Gallup, 1991).

**Personality Correlates**

In the past few years, researchers have begun to investigate the relationship between prayer and psychological traits, such as locus of control (D. G. Richards, 1990, 1991) and obsessionality (Lewis & Maltby, 1995). Some of the most interesting research on the relationship between personality traits and prayer has related to the extraversion–introversion, neuroticism, and psychoticism factors hypothesized by Eysenck and Eysenck (1976) to be the basic traits intrinsic to the human personality (Francis & Astley, 1996; Francis & Wilcox, 1994, 1996; Lewis & Maltby, 1996; Maltby, 1995; Smith, 1996).

In general, extraversion–introversion and neuroticism appear to be unrelated to the frequency of church attendance or private prayer. However, the results of many studies (Francis & Wilcox, 1994, 1996; Lewis & Maltby, 1996; Maltby, 1995; Smith, 1996) indicate that people lower in psychoticism pray more frequently than do people higher in psychoticism. Psychoticism is a variable that Eysenck associated with impulsivity, egocentricity, and sensation seeking on one hand and lack of empathy and conscience on the other (Eysenck & Gudjonsson, 1989). People who are high in psychoticism are likely to have antisocial characteristics (e.g., cruelty toward others and criminal behavior). Conversely, people who are low in psychoticism (who are generally more religious and more frequently pray) are characterized as thoughtful, empathic, and tender-minded.

**Prayer as a Function of Problem Severity**

People use prayer as a coping resource more frequently when their problems are more severe, intractable, or unresponsive to conventional interventions (Brown, 1966; Ellison & Taylor, 1996; H. M. Hill, Hawkins, Raposo, & Carr, 1995; Lindenthal, Myers, Pepper, & Stern, 1970). For example, H. M. Hill et al. (1995) found that mothers who lived in areas of high community violence coped differently with community violence than did those mothers who lived in areas with lower levels of community violence. In particular, mothers in low-violence areas used activism to cope more frequently than did mothers in high-violence areas. Conversely, mothers in high-violence areas were more inclined to use prayer to cope than were mothers in low-violence areas.
The relationship between problem severity and prayer seems to extend to health-related stressors as well. In a national sample of African American adults, Neighbors, Jackson, Bowman, and Gurin (1983) surveyed respondents regarding (a) their most stressful life circumstance ever and (b) the strategies that they used to cope with them. Neighbors et al. found that as the severity of the most severe lifetime stressor increased, respondents’ self-reported use of prayer for coping with the stressor also increased. Other researchers have found that mothers pray more frequently to cope with more difficult pregnancies than with easier ones (Levin, Lyons, & Larson, 1993) and that people pray more for symptoms that require medication or discussion with physicians than those who do not (Bearon & Koenig, 1990). Thus, the fact that people are most likely to pray when their needs are greatest appears to be a robust human phenomenon that extends across a wide variety of stressful human circumstances.

**FREQUENCY OF PRAYER: ASSOCIATIONS WITH WELL-BEING**

Some researchers have observed that measures of the frequency with which people pray have had some interesting, but frequently complicated, relationships with measures of health and well-being (McCullough, 1995). For example, frequency of prayer was found to be positively correlated with purpose in life and amount of alcohol consumed among recovering alcoholic individuals (Carroll, 1993; Walker, Tonigan, Miller, Comer, & Kahlil, 1997) but not with purpose in life in a sample of community-dwelling adults (D. G. Richards, 1990). In longitudinal research, the frequency of prayer has been found to be positively correlated with life satisfaction at some time points but not at others (Markides, 1983; Markides, Levin, & Ray, 1987). Frequency of prayer has been positively related to marital adjustment (Gruber, 1985), general life satisfaction, existential well-being, religious satisfaction (Poloma & Pendleton, 1989, 1991), lower delinquency, and more positive attitudes toward school among children and adolescents (Francis, 1992; Long & Boik, 1993; Montgomery & Francis, 1996) as well as reduced fear of death among older adults (Koenig, 1988).

However, frequency of prayer has also been found to be unrelated to negative affect and happiness (Poloma & Pendleton, 1989, 1991), loneliness (D. P. Johnson & Mullins, 1989), rate of anxiety disorders (Koenig, George, Blazer, Pritchett, & Meador, 1993), self-esteem in schoolchildren (Francis & Gibbs, 1996), and depression (Koenig, Hays, George, & Blazer, 1997). Finally, other studies have shown that frequency of prayer was positively related to depression (Ellison, 1995) and poor physical health (Koenig et al., 1997).

The mixed bag of findings regarding the relationship of frequency of prayer to health outcomes is puzzling, but it might be attributable to any
of several methodological and substantive explanations. The first set of explanations refers to psychometric artifacts. First, the inconsistency in this group of studies could be (in part) an artifact of sampling error, which depends on the size of the samples in individual studies (Hunter & Schmidt, 1994).

A second artifact that could explain the variation in these findings is that single-item measures, such as those that are almost always used to measure frequency of prayer, are notoriously unreliable. Unreliability of measurement attenuates relationships between two variables (Shadish & Haddock, 1994), and the effects of unreliability of measurement become more complex in multivariate studies. Were the studies on frequency of prayer and health corrected for unreliability of the single-item prayer measures, we might see changes in the pattern of findings, with positive (but nonsignificant) findings becoming more positive and negative (but nonsignificant) findings becoming more negative (Schmidt & Hunter, 1996).

A third artifact that could explain the variation in the findings is the differing degrees of statistical control in these studies. Many of the studies cited above did not control the relationship between health and frequency of prayer for demographic, psychosocial, or other religious variables (e.g., Gruner, 1985; D. G. Richards, 1990). Other studies exerted a high degree of statistical control over the relationship between frequency of prayer and health variables, some even controlling for other measures of religiousness (e.g., Koenig, 1988; Koenig et al., 1997). Differences in the degree of statistical control exerted on the prayer–health relationship might influence the results considerably, as has been found in research on religious involvement and mortality (McCullough, Larson, Hoyt, Koenig, & Thoreson, 1999).

Two other possible explanations for these inconsistencies among the studies of frequency of prayer and health are more substantive in nature. The first and most obvious of these is that frequency of prayer may simply be positively related to certain measures of health and well-being but negatively related or unrelated to others. The research lacks sufficient replications to allow us to know for certain. Second, the studies on frequency of prayer and health have used a variety of populations (e.g., schoolchildren, community-dwelling adults, recovering alcoholic individuals, and older adults). It is also possible that the relationship between frequency of prayer and health changes across the life span and across populations (see McCullough & Larson, 1998).

**PRAYER AS A STRESS BUFFER: ASSOCIATIONS WITH WELL-BEING**

Along with basic research on the associations of frequency of prayer with various indexes of well-being, several researchers have examined the
efficacy of prayer as a coping resource for people who are undergoing stressful life events. Pargament’s (1997) excellent review of this literature suggests that frequent prayer (measured with single-item measures of frequency of prayer) appears in some studies to be a stress deterrent (i.e., it averts high levels of stress). In other studies, frequent prayer appears to act as a stress buffer (i.e., it averts the negative effects of stress on measures of physical or mental health). In either case, it appears that people who pray frequently are less likely than people who pray infrequently to encounter psychological or physical illness and impairment in the aftermath of serious life stressors.

However, evidence from Pargament (Brant & Pargament, 1995; Pargament et al., 1990, 1994; Pargament, Smith, & Brant, 1995) suggests that the value of frequent prayer in deterring stress or buffering people against the effects of stress is outstripped by people’s more general styles of using their religion to cope with stress (Pargament, 1997). After controlling for people’s general styles of religious coping, the effect of frequent prayer on measures of health and well-being for people encountering potentially stressful life events typically disappears.

What seems most important, then, is whether people engage in styles of religious coping (e.g., seeking spiritual support, seeking congregational support, and collaborative religious coping) that have beneficial effects on health and well-being more generally, or potentially harmful styles of religious coping (e.g., discontent with God or one’s congregation, viewing one’s problems as punishment from God) that have negative effects on health and well-being, rather than the frequency with which they pray. If Pargament is correct, then one must know what type of prayer people use, not simply how frequently they pray, to understand how prayer is linked with indexes of well-being.

TYPES OF PRAYER: ASSOCIATIONS WITH WELL-BEING

Prayer exists in many varieties. D. G. Richards (1991) found that in a group of 345 “spiritual seekers,” the most frequent subjects of private prayer were “guidance for self,” followed by “healing for others,” “thanksgiving,” and “protection for others.” “Healing for self,” “praise of God,” and “prayer to be of service” were also frequent themes for both church attenders and nonattenders. To categorize the many different varieties of prayer people use, scholars have developed typologies for the various forms of prayer. For example, Foster (1992) identified 21 types of prayer (including simple prayer, prayer of examen, prayer of relinquishment, covenant prayer, and contemplative prayer) from the Christian tradition. On the other extreme, Heller (1918/1932) proposed a typology consisting of nine types of prayer, including naïve prayer, ritual prayer, the hymn, and prayer
in public worship). In Heider's typology, these nine types could be divided into two classes of prayer. Primary prayer is nonrational and emotional. Primary prayer expresses original, profound spiritual experiences. Secondary prayer is derivative of spiritual experience but is not authentically spiritual in Heider's view. It is rational, abstract, and highly intellectualized.

In a sort of compromise position between Foster's (1992) 21 types of prayer and Heiler's (1918/1932) two broad classes of prayer, Poloma and Pendleton (1989, 1991) developed a complex but manageable typology of prayer. They developed measures of four basic types of prayer: (a) meditative prayer (e.g., worshipping and adoring God, reflecting on the Bible); (b) ritualistic prayer (e.g., reading from a book of prayers); (c) petitionary prayer (e.g., asking God for things for oneself or others); and (d) colloquial prayer (e.g., thanking God, asking God for guidance, etc.).

Poloma and Pendleton (1989, 1991) administered the multi-item measures of these four types of prayer to a random sample of 560 residents of Akron, Ohio, in the 1985 Akron Area Survey (AAS). Along with the measures of prayer, Poloma and Pendleton collected sociodemographic data, data on other aspects of participants' religious involvement, and measures of subjective well-being. In the following pages, we review the research on types of prayer and measures of well-being using the typology of prayer developed by Poloma and Pendleton (1989, 1991). However, we make one modification: In Poloma and Pendleton's typology, intercessory prayer (or praying for others) is an aspect of petitionary prayer. However, we review research on intercessory prayer on its own terms.

CONTEMPLATIVE-MEDITATIVE PRAYER

What Is It?

As with all of the five types of prayer that we discuss, there is no broadly accepted definition of contemplative-meditative prayer. However, contemplative-meditative prayer generally involves an intimate and personal relationship with the divine and includes components such as "being in the presence of God" (Poloma & Pendleton, 1989). It also typically involves a nonanalytical focus of attention, transcending words and images because of the inadequacy of such cognitions to capture the divine (Finney, 1984). Meditative-contemplative prayer appears to reflect the styles of religious coping (e.g., seeking spiritual support, spiritual support) that Pargament, Koenig, and Perez (1998) found to be positively related to growth in the aftermath of a stressful life event.
Links With Health and Well-Being

In the 1985 AAS, Poloma and Pendleton’s (1989, 1991) five-item measure of meditative prayer was positively associated with life satisfaction ($r = .15$), existential well-being ($r = .32$), happiness ($r = .16$), and religious satisfaction ($r = .58$). Meditative prayer was also slightly correlated with negative affect ($r = .07$); however, this correlation was not reliably different from zero. After controlling for a series of demographics and other prayer measures, meditative prayer predicted unique variance in existential well-being ($\beta = .16$) and religious satisfaction ($\beta = .33$). Thus, among measures of prayer, the use of meditative-contemplative practices might be directly related to existential and religious well-being.

When used as an intervention, contemplative-meditative prayer might facilitate positive changes in psychological symptoms. In an uncontrolled study, Finney and Malony (1985a) found that the combination of standard psychotherapy and contemplative prayer outside the sessions produced substantial reductions in target symptoms among seven psychotherapy patients. Griffith, Mahy, and Young (1986) found that an elaborate, 5-day ritual called mourning in the Barbadian Spiritual Baptist Church (involving seclusion, limited food intake, and extended periods of prayer and mystical experiences) led to pre–post reductions on every subscale of the SCL-90 except the Somatization subscale. In particular, respondents were more than a 1 SD ($d = 1.16$) lower in depressive symptoms and ($d = .76$) lower in anxiety symptoms after the mourning experience. Carlson, Bacasca, and Simanton (1988) also found that Christian college students who participated in six sessions of devotional meditative prayer (involving quiet reflective reading of Christian scriptures and responsive prayer) experienced significantly greater reductions in muscle tension, anger, and anxiety than did students who participated in six sessions of progressive relaxation or a control condition.

RITUAL PRAYER

What Is It?

Ritual prayer involves the repetition of prayers from written material or from memory (Poloma & Pendleton, 1989). It is not clear whether ritual prayer reflects a positive or negative style of religious coping using the categories of Pargament et al. (1998). However, preliminary evidence suggests that ritual prayer might be associated with slightly lower well-being.
Links With Health and Well-Being

In the AAS, ritual prayer was measured with a two-item scale. This measure had near-zero correlations with life satisfaction ($r = .05$) and happiness ($r = .02$). It was positively and significantly correlated with existential well-being ($r = .14$), negative affect ($r = .15$), and religious satisfaction ($r = .22$). After controlling for demographics and other measures of prayer, people's use of ritual prayer had near-zero correlations with all five measures of well-being except negative affectivity. The net relationship of ritual prayer and negative affectivity was positive ($\beta = .14$), suggesting that people who engaged in frequent ritual prayer had higher levels of negative affectivity.

PETITIONARY PRAYER

What Is It?

Petitionary prayer involves asking God to meet the specific needs of oneself or one's significant others (Poloma & Pendleton, 1989). Asking God to provide for one's needs is typically identified as one of the most elementary and earliest developed forms of prayer (Paloutzian, 1996). As one element in one's overall prayer life, petitionary prayer is probably indicative of positive religious and spiritual functioning; however, if one relies exclusively on petitionary prayer for coping, it is likely to reflect "pleading for direct intercession," which Pargament et al. (1998) identified as a marker for psychosocial distress in the aftermath of a negative life event.

Links With Well-Being

This appraisal of the links between petitionary prayer and well-being is also supported by the research of Poloma and Pendleton (1989, 1991). In the AAS, petitionary prayer was measured with a two-item scale. The frequency with which people used petitionary prayer was positively related to their life satisfaction ($r = .09$), existential well-being ($r = .12$), negative affect ($r = .09$), and religious satisfaction ($r = .22$). It was positively correlated with happiness ($r = .07$), although this relationship was not significantly different from zero. After controlling for the effects of sociodemographics and all other measures of prayer, the use of petitionary prayer was not uniquely related to any of the five measures of well-being.

Another perspective on the links of petitionary prayer to well-being comes from a series of studies indicating that chronic pain sufferers who pray for relief of their pain actually reported greater pain and poorer adjustment to their pain (see McCullough, 1995, for an earlier review). These
findings come from a group of studies that have used the Coping Strategies Questionnaire (CSQ) to evaluate chronic pain patients' self-reported methods for coping with their pain. One of the subscales on the CSQ, Praying and Hoping, is a six-item subscale that includes three religious items, of which two are specifically related to prayer (e.g., "I pray to God [that the pain] won't last long") and three items related to hoping or having faith that doctors or other health care providers will eventually find a remedy for the pain (Rosenstiel & Keefe, 1983). On the basis of factor-analytic investigations of the CSQ, other researchers have combined this subscale with items from other scales to create a 12-item Diverting Attention/Praying and Hoping subscale (e.g., Rosenstiel & Keefe, 1983).

In general, these studies show that scores on the Praying and Hoping subscale or the Diverting Attention/Praying and Hoping subscale are related to increased reports of pain (Ashby & Lenhart, 1994; Estlander, 1989; Keefe, Crisson, Urban, & Williams, 1990; Keefe & Dolan, 1986; Rosenstiel & Keefe, 1983; Turner & Clancy, 1986; Tuttle, Shutty, & DeGood, 1991; however, cf. A. Hill, Niven, & Knussen, 1995) and greater disability from the pain (Ashby & Lenhart, 1994; Rosenstiel & Keefe, 1983).

Although it might indeed be the case that prayer is a maladaptive way to cope with chronic pain, there are several reasons to be wary of such generalizations. First, and most importantly, the data on which these generalizations are based come exclusively from cross-sectional studies. It is just as likely that people with the greatest impairment (and for whom other pain management strategies are not proving effective) turn to petitionary prayer in search of relief. This alternative seems especially plausible given the range of studies reviewed above suggesting that people turn to prayer in times of greatest impairment or when their problems are most severe. In fact, the only longitudinal data that we know of in the prayer–pain area (Turner & Clancy, 1986) suggest that when chronic pain patients actually increase their use of praying and hoping over time, their self-reports of pain intensity in fact decrease.

Second, because a common assumption in the pain management literature is that depression, anxiety, and other forms of psychiatric problems can be major precursors to chronic pain (see Kotarba, 1983, for a review), one would expect that "praying and hoping" would be related to greater levels of psychiatric difficulties if praying actually exacerbated chronic pain. However, the self-reported use of praying seems to be unrelated to anxiety, depression, and general psychological distress (Keefe et al., 1990; Rosenstiel & Keefe, 1983; Turner & Clancy, 1986; Tuttle et al., 1991). Thus, if praying and hoping have a deleterious effect on people's ability to cope with pain, it must be doing so through some route other than increasing psychiatric distress. To date, we know of no one who has proposed an alternative mechanism that does not involve the aggravating effects of prayer on psychiatric symptoms.
Third, researchers have not yet dealt with a basic issue of construct validity. The Praying and Hoping scale consists of two items directly related to prayer, one item related to faith in God and three items that are totally unrelated to prayer (and not explicitly religious). When combined with the items on the six-item Diverting Attention subscale, the resulting 12-item Diverting Attention/Hoping and Praying factor score is composed of only two items (17%) that relate to the use of prayer. The term construct validity basically refers to the validity of score meanings (Messick, 1995). It seems questionable that scores on a 12-item scale containing only two prayer-related items could be validly interpreted as “prayer,” although Ashby and Lenhart (1994) used this interpretation with little apparent reflection on the limited validity of such a score meaning. Researchers have not yet addressed this construct validity problem empirically through the refinement of better measures of prayer or the isolation of the relationship between the two explicitly prayer-related items and reliable pain assessments.

Finally, the scope of the two prayer items on the CSQ does not take into account the rich variety of ways that people might pray about chronic pain. Both prayer items reflect a petitionary stance (e.g., “I pray that the pain won’t last long”), and none have reflected the prayers of relinquishment (e.g., “I pray that God will make me a better person through suffering” or “I pray, ‘Thy will be done’”) that Kotarba (1983) hypothesized to be a uniquely adaptive function of religion in coping with chronic pain. They also do not reflect the collaborative style of religious coping (e.g., “I talk to God about my pain and together we decide what it means”) that Pargament (1997) also has found to be an adaptive form of religious coping in other contexts. Thus, it seems inadequate to make any global generalizations about the prayer–pain relationship based on the two limited items that are included in the CSQ. Future researchers on prayer and adaptation to chronic pain should take these basic methodological concerns into account before attempting to shed any more light on how prayer (especially petitionary prayer) might hinder or facilitate coping with chronic pain.

**COLLOQUIAL PRAYER**

**What Is It?**

Colloquial prayer involves conversation with God, and its petitionary elements are less concrete and specific than those of petitionary prayer. In colloquial prayer, people might ask for strength, guidance, or blessings for other people. Colloquial prayer also includes communication of adoration and love for God. It appears that as people progress through adolescence toward adulthood, prayers become progressively less focused on requests for changes in life circumstances and more colloquial in nature, focusing on (a) changing and coping with their own feelings about life circumstances.
and (b) increasing intimacy with God (Scarlett & Periello, 1991; Taminen, 1991; see also Finney & Malony, 1985b, for a review of earlier studies). Colloquial prayer seems to reflect the positive forms of religious coping, that is, they seem to reflect the styles of religious coping (such as collaborating with God to solve problems) that Pargament (1997; Pargament et al., 1998) found to be positively related to health and well-being.

Links With Health and Well-Being

In the AAS, Poloma and Pendleton (1989) measured colloquial prayer with a six-item scale. The use of colloquial prayer was positively and significantly associated with life satisfaction (r = .16), existential well-being (r = .29), happiness (r = .17), and religious satisfaction (r = .48). After controlling for demographics and other prayer measures, people who engaged in frequent colloquial prayer had higher levels of happiness (β = .14) than people who engaged in colloquial prayer less frequently.

INTERCESSIONARY PRAYER

What Is It?

The literature on prayer and health that we have reviewed thus far has examined the role of people's own prayer lives (e.g., the frequency with which they pray, the types of prayer they use, their religious experiences during prayer) on measures of health and well-being. However, many religious traditions, including Christianity, Judaism, and Islam (but probably others as well) have postulated that under certain conditions, people's prayers for other people can be efficacious (McCullough, 1995; Spivak, 1917). Not surprisingly, researchers have examined the efficacy of intercessory prayer statistically. Although the first statistical inquiry into the efficacy of intercessory prayer—conducted more than a century ago (Galton, 1872)—was somewhat short on validity, in time it fostered a variety of modern studies on the efficacy of intercessory prayer in facilitating healing in human beings (see Duckro & Magaletta, 1994, and McCullough, 1995, for detailed reviews). Dossey (1993) has also made the case for the efficacy of intercessory prayer from a spiritual, but nonreligious, point of view. Praying for others

\footnote{Indeed, Dossey (1993) argued that scores of studies have investigated the efficacy of intercessory prayer. He reviewed many experiments—mostly from parapsychology and physics—that have examined the effects of conscious thought and mental effort designed to influence the operation of physical systems (e.g., random number generators) and biological systems (e.g., the growth and function of cells, seeds, plants, and even human thought, physiological activity, or disease processes). Most of these studies used non-theistic or non-religious imagery and visualization or therapeutic touch, or some other healing modality, rather than including "God in the loop" (Dossey, 1993, p. 188). While the paradigms employed in such studies might lack construct validity from a strictly Judeo-Christian view of intercessory prayer, they do seem consistent with a broader, spiritual understanding of prayer as articulated, for example, in our introductory quotation from Palmer (1983).}
should also be viewed as a form of coping with one's own stressful life circumstances (Pargament et al., 1998).

Links With Health and Well-Being

Although many researchers have investigated whether intercessory prayer facilitates health and well-being (e.g., Byrd, 1988; Collipp, 1969; Joyce & Welldon, 1965; O'Laoire, 1997; Walker et al., 1997), results are more equivocal than researchers would like. Byrd found that 192 cardiac patients who were prayed for by anonymous intercessors had significantly fewer problems on 6 of 14 recovery-related variables and that they generally had better courses of recovery overall than a matched sample of cardiac patients who received standard medical treatment but no intercessory prayer treatment.

More recently, Walker et al. (1997) investigated the effects of intercessory prayer on the alcohol intake of patients admitted to a treatment program for alcohol abuse and dependence. The patients who were randomly assigned to an experimental condition in which they received intercessory prayer from an anonymous group of intercessors did not consume significantly less alcohol in the 6 months after treatment than did the comparison group of patients who were assigned to a condition in which they received treatment as usual without being prayed for by a group of anonymous intercessors.

We review one final study of intercessory prayer that yielded provocative results about the efficacy of intercessory prayer. O'Laoire (1997) randomly assigned 90 adults (referred to as "agents") to pray for the needs of another 406 people (referred to as "subjects"). Agents were assigned to one of two conditions: a directed prayer group or a nondirected prayer group. Subjects were randomly assigned to either (a) being prayed for with directed prayer; (b) being prayed for with nondirected prayer; or (c) a no-prayer control group. Agents prayed for their subjects for 15 min a day for 12 weeks. Each subject was prayed for by three agents.

Before the beginning of the prayer tasks, the participants in the study completed measures of depression, anxiety, and self-esteem. As is typical in pre-post designs, scores on these well-being variables improved both for the agents and subjects of prayer over the course of the 12-week period. This finding is not surprising. What was surprising, though, was the comparison of agents and subjects on the well-being variables. At the conclusion of the study, it appeared that the agents of prayer actually had improvements in well-being (in particular, self-rated spiritual health and relationships) that were superior to the subjects.

Given the energy that is being devoted to tracking the health benefits of intercessory prayer, the fairly spotty track record of efficacy in such studies, and the metaphysical and theological conundrums raised by putting
intercessory prayer "to the test," this creative study turns the literature on intercessory prayer on its head. Its results suggest that, regardless of whether intercessory prayer helps to produce therapeutic change in the person for whom prayer has been offered, intercessory prayer just might also change the agent of prayer for the better.

RESOURCES FOR PRACTITIONERS

Patients and health care providers seem to be increasingly interested in the use of prayer in mental and physical health care. For example, in a survey of 203 family practice adult inpatients, King and Bushwick (1994) found that 48% wanted their physicians to pray with them. Some groups of practitioners are responding to this perceived need of patients by sometimes praying with them (Galanter, Larson, & Rubenstein, 1991; Koenig, Beare, & Dayringer, 1989; Olive, 1995). Clinicians have also commended prayer as a therapeutic technique for use with recovering substance abusers (Carroll, 1993; Johnsen, 1993; Ranganathan, 1994; Ratner, 1988), HIV-positive clients (Fredrickson, 1993), sufferers of posttraumatic stress syndrome (Jimenez, 1993), and chronically mentally ill patients (Carson & Huss, 1979) as well as in a variety of other explicitly religious approaches to mental health treatment (Abramowitz, 1993; Azhar, Varma, & Dharap, 1994; Holling, 1990; W. B. Johnson & Ridley, 1992; Saucer, 1991; Tan, 1991).

To us, it seems that the literature on prayer suggests five ways that prayer can be used productively in the course of mental health treatment. First, practitioners can assess the types of prayer clients use to understand their overall style of religious coping. Second, practitioners can encourage clients who pray or who express a desire to pray to use various types of prayer outside the therapeutic hour as an adjunct to mental health treatment. Third, practitioners can use prayer to facilitate cognitive--behavioral change with highly religious clients. Fourth, practitioners might, in some circumstances, find it productive to pray with clients in session. Fifth, practitioners can pray about or for their clients.

Assessing Prayer as a Window Into Clients' Religious Coping and Psychosocial Functioning

Clients' preferences for certain types of prayer might reveal much about whether their style of religious coping is positive or negative, active or passive. This information can have implications for how practitioners discuss or intervene in clients' religious lives in general and thus might be relevant for assessing the effects of client's spirituality on their health and well-being (Pargament et al., 1998).
The use of certain forms of prayer might also reveal unique information about clients’ psychosocial functioning. Recall that pain patients who use petitionary prayer to the greatest extent and those who pray about their symptoms or life circumstances most frequently are typically the people with the worst adjustment to their pain and the people with the most stressful life circumstances. Petitionary prayer is a call for divine help. People tend to call on God or a higher power for help when they do not know how to ease their pain or solve their problems on their own. Knowledgeable practitioners might find such information useful in assessing clients’ distress about their problems in living and clients’ confidence that they possess the resources to solve their own problems.

**Encouraging Salutary Types of Prayer**

Researchers know from the empirical research that there would be little therapeutic value in directing clients simply to “pray more.” Prayer is too diverse and too complex for such directives to have much therapeutic effect. However, clients who are open to using prayer as an adjunct to counseling and psychotherapy might find some benefit from using several forms of prayer, including contemplative-meditative prayer, colloquial prayer, and intercessory prayer. Studies by Finney and Malony (1985a) and Carlson et al. (1988) point to the potential therapeutic benefit to be gained from regular periods of meditative-contemplative prayer. O’Laoire’s (1997) study also suggests that the positive mental states associated with intercessory prayer could be as salutary for the agents as for the subjects of intercessory prayer.

Even in the absence of evidence of “therapeutic efficacy” (an increasingly ambiguous term in the field of psychotherapy research; see Wampold, 1997), prayer might have what we refer to (for lack of a better term) as an “emboldening effect.” It might boost clients’ (a) morale; (b) hope for recovery from and resolution of their problems; (c) comfort with the process of counseling or psychotherapy; and (d) openness to the work of counseling and psychotherapy. Encouraging clients to pray for guidance, wisdom, and strength might help them to obtain such short-range outcomes, helping them become more effective participants in counseling and psychotherapy.

**Prayer as a Vehicle for Creating Cognitive Change**

Encouraging clients to use prayer for coping or encouraging them, if appropriate, to pray in session might help to incorporate therapy into their worldview. Prayers also might productively be viewed as an important source of material about clients’ schemas and beliefs about themselves, others, and the world. Moreover, redirecting clients into more hopeful styles of prayer might be an important vehicle for facilitating changes in
clients' self-talk and beliefs. Some scholars (e.g., Propst, 1996) have proposed that prayer might be a particularly effective modality, for example, in which cognitive–behavioral interventions can be delivered to religious clients. Indeed, several researchers who have investigated the differential efficacy of religious approaches to cognitive and cognitive–behavioral therapies with religious clients (e.g., Azhar et al., 1994; W. B. Johnson & Ridley, 1992; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992) have used prayer as one element of religious psychotherapy. A recent meta-analysis of outcome studies that compared religious approaches and standard approaches to psychotherapy suggests that such approaches might indeed be as effective as standard psychotherapies for reducing depressive symptoms (McCullough, 1999).

Interesting anecdotal evidence for the efficacy of using prayer to deliver interventions comes from Kiesling and Harris's (1989) detailed description of H. Benson's (1973, 1984, 1996) program of research on the relaxation response. Apparently, when H. Benson began to teach clients to achieve the relaxation response through meditation, he found that religious clients were more apt to stay with the method if they were encouraged to use short prayers from their faith traditions as the focus of meditation rather than meaningless phrases such as "one." By praying and meditating on symbols from their own traditions, rather than strange or meaningless phrases, religiously committed patients were able to achieve the same relaxation effects as others. As an added benefit, they did not become as easily bored and drop out of treatment.

Praying With Clients in Session

Clients and therapists should probably pray together only when three circumstances converge: (a) The client requests in-session prayer; (b) a thorough spiritual and religious assessment and psychological assessment have convinced the therapist that engaging in such explicitly spiritual and religious activities would not lead to the confusion of therapeutic role boundaries; and (c) competent psychological care is being delivered. Obviously, in-session prayer is no substitute for competent psychological practice (P. S. Richards & Bergin, 1997).

With these cautions, there may be times when in-session prayer would be appropriate and potentially helpful. Tan (1996), for instance, discussed several forms of collaborative, in-session prayer designed to accomplish specific therapeutic goals. Practitioners should use such methods only when the client and therapist endorse highly similar religious and spiritual worldviews (P. S. Richards & Bergin, 1997). Even then, such interventions still have the potential to be ethically problematic.
Praying for Clients

Although praying with clients is probably wise only in limited cases, it is not unethical, inappropriate, or therapeutically counterproductive for practitioners to pray for their clients in session (briefly) or out of session. This is true even if (and perhaps especially if) practitioners do not let their clients know that they are praying for them. If one believes in this power of intercessory prayer to effect positive outcomes for clients at a distance, this is all to the good (P. S. Richards & Bergin, 1997).

Even if a practitioner feels certain that intercessory prayer does not directly alter reality, it still could be worthwhile to pray for clients. Short periods of intense prayer may open practitioners' minds and yield insights about clients' lives that they might not have gained while they are in the business-as-usual, professional mode of relating to clients in session or in the left-brained, highly analytical mode required to conceptualize clients and design treatment plans. These intuitions and insights might prove valuable for guiding clients through critical moments in psychotherapy (P. S. Richards & Bergin, 1997). Furthermore, it is difficult to feel resentment or dislike for someone for whom one prays. Practitioners might do well to pray in particular for their most unlikable clients or clients for whom they lack empathy or respect. (We have found no research on this topic but think that such client—therapist dyads do occur from time to time.) Such prayers might not be designed so much to change the client; rather, they might be intended to create in the therapist a transcendent view of things—a transformed, empathic perception of the client and the needs that led that client into counseling or psychotherapy in the first place.

CONCLUSION

Prayer is a quantifiable phenomenon that is central to most people's spiritual and religious lives. Most people pray at least occasionally, many use it frequently for coping with life's difficulties, and it is likely that some clients would be favorably disposed to assessment and discussion of their prayer lives in the context of psychological treatment.

Prayer serves as a marker for many other events in clients' spiritual lives, particularly among clients for whom spirituality and religion are important. For that reason alone, prayer merits the understanding and respect of practitioners. Mental health practitioners should continue to maintain a respect for the centrality of prayer in clients' lives. Furthermore, it might be beneficial for practitioners to take advantage of clinical opportunities to use patients' prayer lives as a potential window into their spiritual and psychosocial functioning, to use prayer as a vehicle for creating cognitive—behavioral change, and to encourage clients to pray in ways that will be
salutary and emboldening. Therapists may sometimes pray with clients in
session and may choose to pray for clients privately. Through a combi-
nation of psychological interpersonal pathways (in addition, possibly, to meta-
physical ones), prayer can be a resource for helping clients and therapists
to reach for a relationship—(re)connecting them to themselves, each
other, their worlds, and the transcendent.

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