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Paradigms

Is Prayer CAM?

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Abstract

Background: Alternative medicine researchers and policy makers have classified prayer as a mind–body intervention, and thus, a modality of complementary and alternative medicine (CAM). As such, numerous epidemiological surveys of CAM utilization—which have included prayer—depict increasing CAM use, particularly in specific racial and ethnic groups.
Objectives: This paper discusses the implications of conflating prayer and CAM, especially regarding the definitions of both concepts and the resulting statistics of CAM utilization.

Introduction

In a 2007 issue of the *Journal of Alternative and Complementary Medicine*, Brown et al. published a study outlining patterns of complementary and alternative medicine (CAM) use with data from the 2002 National Health Interview Survey (NHIS).[1] In this study, prayer was the most common CAM therapy, used by more than 60% of survey respondents. Several studies of CAM utilization reveal that reported use increases dramatically and may even double when prayer is included in the definition of CAM.[1–4] In several studies that define or assess utilization of CAM, prayer has been grouped with spiritual healing, yoga, *t'ai chi*, hypnosis, and various other relaxation techniques.[5] These are forms of mind–body medicine involving the interaction of mind, brain, other body systems, behavior, and, ultimately, health and disease. Scientific investigation of these practices seeks to better understand whether they work, how they work, and for what diseases/conditions and populations they may be used.[6] However, including prayer as a CAM modality fails to distinguish what both prayer and CAM really are. We, the authors, contend that the incorporation of prayer into the definition of CAM has broad implications and should be considered in reference to four key points: (1) there needs to be a clear standard for classifying what is and is not considered CAM, (2) use of the broad term "prayer" fails to distinguish between the diverse forms of spiritual healing utilized by practitioners and the conventional understanding of the word, (3) defining prayer as CAM potentially inflates the statistics of CAM use, and (4) these inflated statistics disguise racial/ethnic disparities in CAM use and access to CAM services. We explore these issues here in the hopes of stimulating discussion within the CAM community about the nature, mechanisms, and role of prayer as a CAM modality.

CAM Is Everything Else?

CAM has been defined largely in relation to conventional biomedicine, as a large residual category of diverse health care practices generally excluded from the dominant medical profession.[7,8] As a result, there is some ambiguity in conceptualizations of what constitutes "complementary" or "alternative."[8,9] The National Center for Complementary and Alternative Medicine defines CAM as a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine.[5] By this definition, any practice that purports to have health benefits but is not considered to be part of conventional medicine is CAM by default. The list of what is considered to be CAM changes continually, as those therapies that are proven to be safe and effective become adopted into conventional health care and as new approaches to health care emerge.[5] As it stands, the distinction implies that CAM encompasses all modalities that are not scientifically proven or accepted as valid by conventional, or allopathic, practitioners. Thus, CAM is a moving target—a point on a continuum of broad acceptance that will eventually be overtaken by increased utilization or study by conventional health care practitioners. As CAM professions grow in the areas of research, academia, policy, and public acceptance,

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the ambiguity of this definition becomes more cumbersome. We assert that a primary example of how an exclusionary definition may lead to confusion is the incorporation of the broad concept of prayer within the field of CAM.

It is suggested by Kaptchuk and Eisenberg[10] that unconventional healing practices, or those not practiced as "mainstream," can be divided into two types. The first is based on nonsectarian or even scientific laws and can be defined as mainstream CAM. The second is based on the beliefs of a particular religion, ethnic group, or region and can be defined as parochial unconventional medicine (PUM). In this taxonomy, cross-cultural or "New Age" healing (e.g., *Reiki, qigong*, or meditation) is included within energy medicine or mind–body therapies and is categorized as mainstream CAM, whereas spiritual healing practices (e.g., mental healing, Pentecostal services or Christian Science, and also religious ethnomedicine practices (e.g., shamanism or *vodun*) are all categorized as PUM. We present this taxonomy not as a way to place spiritual healing in a perceived hierarchy of unconventional medicine but as a starting point for rethinking the inclusion of the umbrella term "prayer" in the field of CAM, by virtue of its being summarily included in "spiritual healing."

"Let Us Pray": Distinguishing Prayer and Spiritual Healing Practices

From the earliest societies to the present, religion and health have been intimately connected. Within the context of religion or spirituality, prayer is not solely defined by appeals for better health, yet this is the measure chosen for much of modern prayer research.[6] In the 2007 Pew Forum on Religion & Public Life survey,[11] it is reported that 75% of Americans pray at least once per week. This is specifically outside of religious services or the presence of a spiritual healer. According to these findings, prayer is an action that most people perform routinely. However, use of the broad term "prayer" in attempts to measure CAM use fails to distinguish between the diverse forms of spiritual healing utilized by practitioners and the common understanding of the word. We suggest that spiritual healing, although it undeniably includes the action of praying, is distinct from the sort of private, devotional communication (which may include daily petitions for health, blessings, forgiveness, and grace), which the word *prayer* conjures up to most people.

To equate all prayer with the actions performed within the context of a spiritual healing ceremony or even that of a prayer group is misleading, even if the daily petition includes a passing reference to the health of ourselves or others. As CAM practitioners, we heartily agree that the spirituality of patients cannot and should not be removed from the healing process.[12] We also acknowledge that the positive intention of prayer may have health benefits. However, to include the generic terms "prayer" and "intercessory prayer" (any prayer for the benefit of others) in CAM, or even PUM, confuses the role of medicine with that of religion.

The ability of practitioners to recognize and respect the role of spirituality in the general health and well-being of a patient is an essential component of truly integral medicine. It is clear that culturally competent and patient-centered care requires sensitivity to and respect for spirituality as a component of the cultural context. However, respecting and even encouraging a patient's spiritual practice does not imply that all who pray at any point in time are CAM users and should be counted as such. We do not need to own prayer in order to respect it. Research has shown that patients' views of what constitutes CAM may differ radically from those of CAM practitioners and researchers.[13] As such, practitioners and researchers in this field need to ask ourselves exactly what we are interested in knowing about prayer and why, and choose terminology carefully to provide meaningful answers. Also, as discussed in the next two sections, we need to understand the statistical and policy implications of how CAM is defined and question whether the inclusion of prayer accurately reflects what we are trying to measure.

"But, Everybody's Doing It!"—Inflated Statistics of CAM Utilization

Research has shown that CAM is used among diverse populations.[14,15] When prayer is included in CAM, utilization estimates increase dramatically. In a 2004 report of CAM use among 31,044 U.S. adults, 62% reported use of some form of CAM therapy during the prior 12-month period. When prayer for health reasons was excluded from the definition, only 36% of adults used CAM therapies in the prior 12-month period.[2] This same report presented a list of the 10 CAM therapies most commonly used within the 12 months measured. Three (3) of the top 10 therapies included prayer (prayer for one's own health, prayer by others for one's own health, participation in a prayer group).

This study is one of many that include prayer in the definition of CAM. However, many studies do not present CAM use estimates with and without prayer, as this one does, making it difficult to distinguish patterns of utilization of CAM as explicit, mind–body healing practices versus CAM more loosely defined as any practice with health-promoting intent that has not yet been adopted by conventional medicine. Reports that do not separate prayer from other CAM modalities present findings that give the illusion that CAM is used by the majority of people, and often do not accurately represent CAM as therapies practiced under the purview and guidance of CAM practitioners. The broad inclusion of prayer in surveys allows CAM to claim as users anyone who attended church in the past year, or prayed for a friend or relative with arthritis pain. This inclusion in essence "pads the numbers" and does not distinguish the act of prayer from experience of spiritual healing.

Perpetuating a Disparity

The paper previously referenced by Brown et al. outlines the prevalence of CAM use in African Americans, analyzing data from the 2002 National Health Interview Survey (NHIS).1 The study concludes that a substantial number of African Americans use CAM; almost 70% of respondents report CAM use within the prior 12 months. Prayer for health reasons was the most common CAM modality, used by more than 60% of respondents, followed by herbals (14.2%) and relaxation (13.6%). Only 1.4% of CAM users surveyed had used an alternative medical system (acupuncture, Ayurveda, homeopathy, or naturopathy) in the past 12 months, and 3.6% reported having ever used one of these systems. The use of prayer was at least twice as high as any other CAM modality in this population.

With the inclusion of prayer in the definition of CAM, several papers have reported equal or higher levels of CAM use among African American populations compared to whites. At least four other studies report high CAM utilization rates in African American populations based on 2002 (National Health Interview Survey) NHIS data.[2,4,16,17] Notably, Barnes et al. observed that 71% of African Americans reported the use of CAM. In this study, African American use of mind–body therapies dropped from 68.3% to 14.7% when prayer was excluded.[2] Several other studies that have not used NHIS data have also reported that prayer is the most common alternative therapy used by African Americans.[3,18–20]

Research conducted in the United States suggests that some sociodemographic characteristics predict use of CAM. A frequently cited study by Eisenberg et al. that surveyed the use of 16 CAM therapies reports that CAM use is most common among women and college-educated people with incomes greater than $50,000 but is less common among African Americans.[15] Interestingly, this study did not include prayer in its analysis. Suggesting a change in this disparity, more recent studies have included prayer in the definition of CAM, making it appear as though African American CAM use is increasing, when in actuality, prayer and spiritual healing have long been a part of African American culture.[21]

The plethora of data that report high CAM use in African American populations may provide the illusion that access to and knowledge of CAM services are equivalent across racial and ethnic groups in this country. Yet while we can find abundant information on "ethnic minority use of CAM" describing the use of prayer and home remedies, it appears that ethnic minority utilization of CAM practitioner-provided services is in fact quite low.[1] It remains a challenge to find reports addressing apparent differential access to and knowledge of these services. Given the distinction between the use of CAM therapies—either including or excluding prayer—and the utilization of CAM services, further research is needed to improve our understanding of how CAM services are being utilized by communities of color. We suggest that this should be a focus of future study.

Conclusions

The broad inclusion of the term "prayer" as a CAM modality, particularly in public surveys of CAM use, has implications that should be considered and discussed. Including prayer in CAM use may encourage health care practitioners to recognize and respect the role that religion and spirituality play in health and healing. That, however, is a separate conversation relevant to all health care providers, and does not require prayer to be considered part of CAM. The ambiguous definition of CAM allows for wide variations of CAM use data, depending on which definition is used. Including prayer in the definition of CAM dramatically increases the percentage of CAM users, particularly among ethnic/racial groups. This leaves us to present two related questions: How should CAM be defined, and does prayer, as distinguished from spiritual healing practices, fit this definition? The goal is to promote discussion. We have raised a number of issues and we hope the CAM community will rise to address them.

Disclosure Statement

The authors declare that they have no competing interests.

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