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Prevalence and characteristics of Australian women who use prayer or spiritual healing: A nationally representative cross-sectional study

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ABSTRACT

Objectives: To determine the prevalence and characteristics of users of prayer or spiritual healing among Australian women aged 31–36 years.
Design and setting: This cross-sectional study was conducted as a part of the Australian Longitudinal Study on Women's Health (ALSWH). The sample used in the current sub-study were participants from the 'young' cohort (1973–78) (n = 8180) aged between 31 and 36 years.
Main outcome measure: Use of prayer or spiritual healing
Results: Prayer or spiritual healing was used on a regular basis by 20% of women aged between 31 and 36 years in 2009. Women who had symptoms of chronic illnesses ($p = 0.001$), women who had never smoked ($p = 0.001$) and women who used other forms of CAM ($p < 0.001$) were significantly more likely to use prayer or spiritual healing.
Conclusion: A significant proportion of women use prayer or spiritual healing on a regular basis. Further research is required to better understand their rationale for using prayer or spiritual healing and its perceived impact on health related outcomes and general well-being.

1. Introduction

Younger women are looking for alternative means to maintain their health, and/or manage their symptoms thereby decreasing reliance on conventional care.[1–4] One way that younger women are seeking to address managing their symptoms is through prayer and/or spiritual healing.[5,6] Prayer or spiritual healing therapies are classified as complementary and alternative medicine (CAM), specifically, as mind body therapies, with some spiritual healing therapies such as Reiki also being categorised as energy healing therapies.[4]

Prayer is defined as the conscious willing intent of one or more persons for the well-being of self (personal prayer) or others (intercessory prayer) which may be initiated as a conscious activity or stimulated from the unconscious mind.[7] Spiritual healing is defined as the "systematic, purposeful intervention by one or more persons aimed to help another person by focused intention to improve their condition".[88(p4)] Spiritual healing can occur by use of non- contact healing at the bedside where hands are held a few inches above the body. Both intercessory prayer and spiritual healing may also occur over distance (termed remote intercessory prayer and distance healing) which may occur without prior physical contact or social interaction between the healer and the recipient.[9]

Prayer has been used since antiquity and comprises a significant component of the belief systems of many cultures, including traditional or tribal based religious ideologies and the five major world religions (Christianity, Judaism, Buddhism, Islam and Hinduism).[10] Spiritual healing remains an integral part of traditional health care in many non-Western countries.[9,11]

Complementary and alternative medicine can be broadly defined as a group of medical and health related practices, disciplines or products that are not considered to be within the scope of conventional medicine.[4] CAM also includes therapies that are considered a part of the traditional practices of Non-Western countries, such as Traditional Chinese Medicine or Ayurveda.[12] Previous literature has indicated that CAM practices generally are found to be used more among women compared to men, particularly in regards to use of mind-body therapies such as prayer or spiritual healing.[12] Use of prayer or spiritual healing has been correlated with improved health outcomes for adults living in the community. For example, in a sample of healthy adults (mean age 34

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years; SD 8) personal religious prayer has been associated with reduced respiratory rate, improved regularity similar to controlled breathing exercises, increased heart rate variability and improved synchronisation.[13] Spirituality and faith is also perceived to be beneficial as a means of guidance, support, strength, confidence and protection among pregnant women.[6]

A Cochrane review concluded that whilst the evidence for intercessory prayer is inconclusive, given the lack of adverse effects, advised that current practices in relation to the use of intercessory prayer should be maintained.[14,15] Similarly, three systematic reviews determining the effectiveness of spiritual healing were inconclusive and stated that the area warranted further research including methodologically strong studies that assess expectation and belief.[16–18] There is evidence to suggest that use of prayer or spiritual healing is increasing, with 42% of American cancer survivors utilising faith or spiritual healing, and 61% utilising prayer or spiritual practice.[5] Therapeutic Touch, an energy healing modality that incorporates laying of hands, was also used by 3% of this sample.[5] Energy healing modalities are used in over 50 teaching hospitals in the United States, not including its use in private practice.[19]

2. Aim

This study aimed to determine the prevalence of use; demographic, health status and health service utilisation factors associated with the use of prayer or spiritual healing among Australian women aged between 31 and 36 years (in 2009) using a nationally representative sample (n = 18,145), and in doing so provide important information of relevance to women who use prayer or spiritual healing, health care practitioners and policy makers.[20] Characteristics of use of prayer or spiritual healing among women aged 59–64 years has been explored in a separate paper.[21]

3. Methods

3.1. Sample

The Australian Longitudinal Study on Women's Health (ALSWH) is a population-based study that aims to examine the physical and emotional health, socio-demographic factors, health service utilisation, health behaviours and risk factors, and the significant life events of the women over a period of twenty years.[22] Women involved in the study were recruited using random selection into one "young" cohort (1973–78), which was a nationally representative sample of the population.[23] Initial surveys in 1996 included 14,779 respondents in the young cohort, however only the most recent survey 2009 was used in the analysis.[20]

Eligibility criteria included women that were registered on the Australian Medicare database, which has registered details of the names and addresses of permanent residents and citizens including refugee and migrant women.[22,24] Of selected participants, the response rate was 62% from the 1973–78 cohort in 2009, with the main reason for non-response due to inability to contact women after all possible means were used.[25]

Response rates cannot be precisely specified due to uncertainties regarding accuracy of the Medicare database.[25] Informed consent was obtained by means of a returned signed consent form attached to the initial invitation to participate and questionnaire.[22] Women with a tertiary education were overrepresented whilst some migrant groups of women were underrepresented introducing response bias.[22] Ethics approval for use of the dataset was gained from the Human Research Ethics Committees at the University of Queensland, the University of Newcastle and the University of Technology Sydney.[23]

3.2. Measures of demographic characteristics

To determine the area of residence as urban, rural or remote, current geographical postcode was used. Information regarding marital status, age (in years), ability to manage on available income, level of education, smoking status, alcohol use, and health insurance for hospital cover or ancillary services was obtained.

3.3. Measures of health status

Measures of health status included frequency of experiencing health symptoms in the past 12 months such as difficulty breathing, stiff or painful joints, back pain constipation, difficulty sleeping, intense anxiety such as panic attacks, other mental health problems or palpitations. Women were asked about any diagnosed conditions within the past three years including hypertension, asthma, bronchitis, skin cancer or other cancer. The SF-36 Quality of Life Questionnaire was used to assess physical and mental health related quality of life.[26] It contained eight domains (physical functioning, role physical, bodily pain, general health, vitality, social functioning, role-emotional and mental health), with higher scores reflecting greater health.[26]

3.4. Outcome measure

Women from the 1973–78 cohort (aged 31–36 years in 2009) were asked whether they had used prayer or spiritual healing in the last 12 months, and were given the response options of '*never*', '*rarely*', '*sometimes*' or '*often*'.

3.5. Statistical analysis

Chi-squared tests were used to determine the associations between categorical demographic and health status factors and the use of prayer or spiritual healing. Differences in mean scores between continuous demographic and health status factors and the use of prayer or spiritual healing were tested using one way analysis of variance (ANOVA). For each cohort, statistically significant ($p < 0.25$) demographic and health status factors were entered into a logistic regression model and then a stepwise backward elimination process using a likelihood ratio test was used to determine the model of best fit.[27] Given the large sample size, statistical significance was set at a p-value of $p < 0.005$. Statistical analyses were all completed using the STATA statistical program.

4. Results

A total of 8180 (99.8%) women from this sub-study (1973–78) cohort answered the question regarding the use of prayer or spiritual healing. Prayer or spiritual healing was used *often* by 9% (n = 766), used *sometimes* by 11% (n = 883), used *rarely* by 11% (n = 887) and *never* used by 69% (n = 5644).

Demographic characteristics of women aged 31–36 years (in 2009) who use prayer or spiritual healing are described in Table 1. Women who used prayer or spiritual healing were significantly more likely to have never married ($p < 0.001$), obtained a university degree ($p < 0.001$), never smoked ($p < 0.0001$), and less likely to have hospital cover ($p < 0.001$).

4.1. Symptoms of chronic illness and use of prayer or spiritual healing

In comparison to women who never or rarely experienced any of these symptoms, women that used prayer or spiritual healing were significantly more likely to have sometimes or often experienced difficulty breathing ($p < 0.001$); back pain ($p < 0.001$);