

AN EXPERIMENTAL STUDY OF THE EFFECTS OF REMOTE INTERCESSORY

PRAYER ON DEPRESSION

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JASON GARY WRIGHT

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This dissertation has been
accepted for the faculty of
Liberty University by

Dr. Ron Hawkins
Chair

Dr. Fred Milacci
Reader

Dr. Gary Sibcy
Reader

Abstract

AN EXPERIMENTAL STUDY OF THE EFFECTS OF REMOTE INTERCESSORY PRAYER ON DEPRESSION

by Jason Gary Wright

The present study utilized a double-blind, controlled, pre-test/post-test design to examine the effect of remote intercessory prayer on 20 participants who received counseling for depression in various clinics throughout central Virginia. The researcher randomly drew from a pool of 20 numbers; participants given even numbers were assigned to the experimental group and were prayed for by assigned intercessors for 28 days. Participants given odd numbers were assigned to the control group and were not assigned intercessors. Twenty-eight days (or as soon as possible) after all participants took the first BDI-II (Beck Depression Inventory, second version) they completed the BDI-II for a second time. It was hypothesized that the experimental group's mean BDI-II post-test score would be significantly lower than the control's, indicating more improvement in mood and less depression for the experimental group. Findings showed that mean group BDI-II scores decreased for both groups, and the experimental group ended the study with a lower mean group BDI-II score than the control (M = 17.40 for the experimental group; M=23.00 for the control group); however, after statistically controlling for pre-treatment BDI-II scores, differences were not significant.

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CHAPTER I: THE PROBLEM

Currently within the fields of medicine and counseling a new respect is developing for spirituality and its role in recovery and healing (Turkington, Norvell, & Thornton, 1997). Recent studies have demonstrated the positive therapeutic effects of integrating spiritual and religious factors into treatment including forgiveness (Enright, 1992), love (Dossey, 1993), altruism (Long, 1997), and faith (Turkington et al.). Some mainstream spiritually oriented interventions, such as Alcoholics Anonymous, have demonstrated consistent effectiveness over the long term (Miller, 1999). Other, more novel spiritually based counseling interventions are also proving to be effective (Miller). Despite the increase in attention given to spiritual and religious themes in treatment, the medical profession is identified in the literature as currently being more in step with “society at large” (by including spiritual themes in treatment), than is the mental health field (Kahle & Robbins, 2004, p. 70).

One of humanity’s most significant religious and spiritual practices has been prayer (Brown, 1994; d’Aquili & Newberg, 1999). Historically, prayer has been a practice that humanity has utilized in a variety of styles and forms to restore health, impact society, and connect with the transcendent (Joseph, 2001). Considering the integral role that spirituality, and more specifically prayer, has played in the lives of men and women in every culture throughout history (Brown, 1994), it would seem clinically irresponsible to theorize an approach to people-helping that did not include an acknowledgement and utilization of a

client's spiritual and religious values and practices. Although patients may understandably be resistant to those therapists and doctors who attempt to enforce their own spiritual values into treatment, patients nevertheless appreciate those helpers who at least have a respect for their own spirituality and spiritual practices (Turkington et al., 1997).

The effectiveness of prayer has been demonstrated in numerous medical studies (Astin, Harkness, & Ernst, 2000; Braud, 1994; Byrd, 1988; Harris et al., 1999). Few studies, however, have examined the effects of prayer on mental health (Astin et al.). Although there is some indication in the literature that prayer can have a positive effect on mental health (Connerly, 2003; Tloczynski & Fritsch, 2002), these studies are in the minority, especially when compared to the medical research.

Problem Background

Throughout professional clinical psychology and counseling circles there has historically been strong opposition to the integration of spirituality into the counseling process (Kahle & Robbins, 2004). Many have viewed religion and spirituality as a weakness, a crutch, or even worse a pathology (Kelly, 1995). Despite significant antagonism by some of the most influential thinkers in psychological theory and practice (e.g., Freud, Skinner, Ellis), spirituality is beginning to play more of a role in counseling and mental health treatment (Cutting, 1998; Turkington et al., 1997).

Spirituality is as much a part of human functioning as is biology or psychology, and has played a role in every culture since humanity's genesis (Joseph, 2001). There is ample archaeological and anthropological evidence showing that spirituality has played an integral role in the lifestyle of ancient humanity dating back to what some researchers refer to as "Cro-Magnon Upper Paleolithic" man, and even to the supposed "Neanderthals" (Joseph, p. 16). It is believed by some that "Neanderthals", despite their limited intelligence and brutish mannerisms, engaged in burial rituals for their deceased to prepare them for the "Hereafter" (Joseph, p. 20). Similarly, Cro-Magnon man is believed to have engaged in detailed and elaborate spiritual rituals; some believe they were the first to come to a conception of "god" (Joseph). According to Joseph, "Regardless of time and culture, from the Aztecs, Mayans, American Indians, Romans, Greeks, Africans, Cro-Magnons, and Egyptians" humanity has consistently engaged in ritualistic practices involving common symbols and values, including the ritual of prayer (p. 56).

Although some may take issue with the above terms (e.g., Neanderthals) used to describe ancient humanity (and many of the assumptions of Classical Darwinism have been brought into question in the literature [Hayward, 1995; Johnson, 1991, 1993]), the vital issue to take note of is that even those within traditionally non-spiritual circles are beginning to recognize the common nature of humanity's quest for the transcendent. Many in the medical and counseling communities are in agreement with this trend and are theorizing approaches to

treatment that include spirituality, and more specifically intercessory prayer (Braud, 1994; Cutting, 1998; Dossey, 1993; Sweet, 2004).

Literature Review

The potential for intercessory prayer to effect change in the person prayed for (the intercessee) has been repeatedly demonstrated in the literature (Byrd, 1988; Connerly, 2003; Dossey, 1993; Harris et al., 1999; Leibovici, 2001; Matthew, Marlowe & Macnutt, 2000; Tloczynski & Fritzschi, 2002). The most notable and referenced study of remote prayer was one that involved prayer to the Judeo-Christian God (Byrd). In Byrd's study it was shown that those coronary patients in a cardiac unit of a San Francisco hospital who were prayed for remotely (without knowing whether or not they were in the group being prayed for) showed clinically significant improvements in functioning over those patients assigned to the group that was not prayed for. Similar findings were reported in a study by Harris et al. in which the procedures were essentially replicated from the Byrd study with a few modifications.

The few studies that have examined the effects of remote intercessory prayer on mental health (Connerly, 2003; Tloczynski & Fritzschi, 2002) have demonstrated positive effects in regards to anxiety (Tloczynski & Fritzschi) and depression (Connerly). However, the dearth of studies examining remote intercessory prayer and mental health warrants further controlled clinical trials in this area (Astin, Harkness, & Ernst, 2000).

The potential for remote intercessory prayer to effect change in the person prayed for is due to the fact (as proposed in some manner by many world religions) that humanity has been created in the image of God, or at least possesses various qualities in common with the transcendent, such as personhood, morality, consciousness, or simply energy (McDermott, 2000). Connection with God through prayer is possible because mankind possesses inherent qualities that enable spiritual and religious experience (Richards & Bergin, 2005). Although there are differences in opinion as to what “image of God” means (Hoekema, 1986), the researcher interprets this to mean that humanity is comprised of three distinct but intricately related domains - namely body, mind/soul, and spirit (Cunningham, 1998). Whereas the body/brain is the realm of biology and medicine, the mind and spirit are the domains of psychology and spirituality respectively, and without giving attention to all three domains one cannot be fully healthy or well (Barnett & Chambers, 1996).

Prayer is effective because humanity has been created with the capacity to connect with God (Joseph, 2001) via the inherent characteristics of the image of God in humanity. Tillich (2000) refers to God as the “ground of being” - that “power” (energy) that is the source of all things. Mankind, created in the image of God, has been holistically fashioned in such a way as to associate and intermingle with God, and thus the healing energy of God. Holistic health is only possible when one is connected with the healing energy of God (Barnett & Chambers, 1996). This does not mean, however, that illness is necessarily a

spiritual matter. People who may suffer from illness can nevertheless be just as spiritual and religious, if not more so, than those who are not ill.

The literature suggests that in order for prayer to be effective it must be done out of genuine concern, love, compassion, and awareness for the intercessee's need, on the part of the intercessor (Dossey, 1996). This writer refers to these principles, as well as others to be discussed in Chapter Two, as components that, in their totality, constitute a "law" of prayer, which functions in a manner similar to other natural laws in that it is applicable to all people and thus all faiths. This is consistent with the literature, which suggests that remote intercessory prayer is equally effective among different religious orientations (Braud, 1994; Dossey; Sweet, 2004).

Purpose of the Study

Considering humanity's historical use of prayer to bring about healing and procure physical, emotional, and spiritual well-being (Brown, 1994; d'Aquili & Newberg, 1999; Joseph, 2001), as well as prayer's demonstrated effectiveness in modern research (Byrd, 1988; Dossey, 1993; Sweet, 2004; Tloczynski & Fritzs, 2002), one could conclude that there may be something truly unique and powerful about this practice. If prayer is an effective means to restore health and can be scientifically demonstrated to do so, it could potentially be utilized in any of the health professions as a useful and effective adjunct to standard clinical treatment. Psychotherapy and counseling could be health professions that may potentially benefit from this practice.

To include remote intercessory prayer in treatments such as counseling could provide clients with an additional means to restore health beyond counseling that does not provide this avenue. Thus, the spiritually-sensitive counselor who acknowledges the potential impact of remote intercessory prayer to restore emotional health in their clients would offer a more comprehensive treatment approach compared to counselors who do not offer remote prayer as a facet of their therapeutic intervention.

A truly comprehensive counseling approach would give due attention to the psychological and spiritual concerns as well as the biological needs of clients (e.g., making sure clients receive a thorough physical by their primary care physicians to rule out biological contributors to depression such as blood sugar imbalances, thyroid dysfunction, and nutritional health; and assessing spiritual health, utilizing appropriate referral resources as needed) (McMinn, 1996). Mainstream (non-religiously oriented) psychotherapeutic approaches have traditionally focused solely on the psychological and biological domains at the expense of spiritual concerns, thus excluding an important element that is essential to health (Clinton & Ohlschlager, 2002; McMinn; Miller, 1999).

The purpose of the present study was to contribute to the knowledge of the relationship between remote intercessory prayer and depression. Specifically, this study demonstrated the effects of remote intercessory prayer on depression levels for individuals diagnosed with and receiving counseling for a depressive disorder (e.g., Dysthymic Disorder, Major Depressive Disorder), which may or

may not have been comorbid with other diagnoses found within the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV; American Psychiatric Association, 1994). Given the relative paucity of research in the area of remote intercessory prayer and depression in counseling as compared to other conditions (e.g., physiological and medical problems), researchers see this as a needed area of further study (Astin et al., 2000).

Research Hypothesis

It was hypothesized that remote intercessory prayer would have a beneficial effect on treatment outcome translated in lower scores on the most recent version of the Beck Depression Inventory (BDI-II). The specific hypothesis of the present study is as follows:

Research Hypothesis: If two groups of clinically depressed clients, both receiving counseling for depression, are compared – one group receiving remote intercessory prayer and the other not – the mean group BDI-II scores of the experimental group will be significantly lower at post-test than the mean group BDI-II score of the control group, indicating a lower level of depression for the group prayed for.

Null Hypothesis: Mean group BDI-II scores will not be significantly different between the experimental and control groups at post-test.

Limitations/Delimitations

There were limitations inherent in a study such as this. First, this writer assigned intercessors to perform the intercessory prayer for participants in the experimental group. The impossibility of perfectly measuring the intercessor's prayer and knowing exactly how he or she prayed, or in fact if they had prayed at all, is a limitation in this study. Given that effective prayer must include subjective qualities within the intercessor such as genuine love, concern, and compassion (Dossey, 1996; Nouwen, 1999), it was never possible to objectively measure these characteristics within the intercessors perfectly. Journals aimed at recording prayer activity controlled for some ambiguity; however, in the end the researcher simply had to take each intercessor at his or her word that he or she had in fact prayed in the manner necessary for this study.

A second limitation pertains to the intercessory prayer of others not assigned to be intercessors for this study. It was acknowledged that it would have been impossible to fully control for the intercessory prayer of others (e.g., family members, friends) outside of the study for those participants included in the control group. This is significant because the researcher was never completely certain as to whether or not the participants in the control group in fact received no remote prayer from others not formally involved in this study. If participants in the control group did in fact receive remote intercessory prayer from others outside of the study results could have been compromised.

However, the researcher controlled for this as much as possible through randomization.

A final limitation of this study pertains to the mental health treatment each participant received during the course of this study. Because the sample size included participants who were receiving counseling from different counselors in a variety of clinics, it was not reasonable to expect that each participant received exactly the same treatment experience. All counselors had achieved at least a reasonable level of competence as evidenced by their licensed status, or at least were supervised under a licensed therapist; however, participants undoubtedly received different treatment interventions based on their counselors' theoretical orientations, as well as the specific issues related to each participant's circumstances.

Related to the issue of different therapeutic interventions is the degree to which spiritual interventions (e.g., in-person prayer) were used in each client's therapy. If some participants received in-session prayer during their treatment while others did not, (regardless of whether they had been included in the experimental or control groups) this could have potentially compromised results. However, if spiritual themes were raised by participants during their mental health treatment (e.g., counselors praying for or discussing spiritual concerns with their control-group clients in session), it would have been unethical to not address and allow these interventions if they were something the participant viewed as relevant and important for discussion. To have avoided addressing

these concerns in treatment simply because a participant was involved in the present study would have been unethical and antithetical to sound treatment.

Given the above-stated concerns it was assumed that the random assignment of participants to the experimental and control groups controlled for the disparity that existed between the therapeutic experiences of the participants. Regardless of what type of intervention each of the participants received (either spiritually oriented or otherwise), random assignment nullified this concern as much as possible.

Finally, it is important to note that the therapists who provided the counseling to the participants did not know which participants had been included in the experimental and control groups during the performance of the remote prayer by the intercessors. Likewise, participants themselves were not aware of which group they were members of. The double-blind nature of this study helped avoid the scenario of therapists consciously or unconsciously treating participants differently based on their membership in either the experimental or control groups. Since participants were blinded, they were also unable to impact the therapist and/or therapeutic process based on knowledge of which group they belonged to. Thus, discussion of spiritual themes with some participants and not others, although potentially a limitation, was not considered a significant one in this study.

Sample size was the significant delimitation of this study. There were ten participants assigned to the experimental group and ten assigned to the control

group. The researcher encountered significant difficulty in obtaining participants for the present study. The number of participants chosen for this study was seen as a good compromise between practicality and the need for an adequate sample size. Obviously, with more participants would have come greater certainty that effect sizes were significant.

Definitions

A description of the terms used throughout this study is necessary in order to provide clarity to the reader as to this writer's intended meanings. Some of these terms may have alternate or slightly varied definitions in other contexts. Thus these terms should be understood in the manner intended in this list.

God will be referred to as "God", "the Ultimate", "the Absolute", or "the Divine".

Holistic health is the harmony or balance of energy fields both within the individual (body, mind/soul, spirit), as well as between the individual and their environment (and God) (Albright & Ashbrook, 2001).

Intercessees are those participants who are prayed for.

Intercessors are those praying for the participants in this study.

Religion is defined as the "creedal, institutional, and ritual expression of spirituality that is expressed with world religions and denominations" and will refer to the "codified, institutionalized, and communal connections to the Ultimate" (Kelly, 1995, pp. 4-5).

Remote intercessory prayer in this study is defined as an attempt to

communicate with the Judeo-Christian God in petition for the recovery and well-being of another outside of the awareness of the one being prayed for.

Spirituality is “a personal affirmation of a transcendent connectedness in the

universe”, and will include attention to such values as a sense of purpose to life, an altruistic attitude towards others, and a personal relationship with God (Kelly, 1995, p. 4).

This writer/The researcher refers to the one conducting this study.

Importance of the Study

A demonstration of a positive effect for prayer in this research (through the literature review and/or study) could provide impetus for therapists to create clinical remote prayer groups that would have as their aim an additional positive impact on their clients’ mental health beyond that which is provided during sessions. These clinical remote prayer groups would be seen as just as essential as the therapy itself – simply another dimension of sound clinical practice. Clinical remote prayer groups could involve therapists meeting together at certain times to pray for their (and others’) clients’ recovery (maintaining confidentiality), and would take place without their clients being present.

Alternately, other therapists may choose to pray alone for their clients remotely, without involvement in clinical remote prayer groups. At the very least a demonstration of a positive effect for prayer could lend support to an argument

upholding a genuine respect and validation of a client's spirituality in therapy, considering the current lack of attention given to spiritual and religious themes in mental health education and practice, compared to the medical field (Kahle & Robbins, 2004). The potential for this study to contribute to the existing literature on the role of prayer's effect on (mental) health could lead to additional avenues for sound clinical treatment.

CHAPTER II: REVIEW OF THE LITERATURE

A Re-Integration of Faith into Treatment

Researchers emphasize the need for the further study and subsequent development of health care systems that integrate spiritual and religious interventions into various forms of mental health, physical, and medical treatments (Astin, Harkness, & Ernst, 2000; Perrin, Barnes, Plotnikoff, Fox, & Pendleton, 2000; Townsend, Kladder, Ayele, & Mulligan, 2002). Additionally, a consistent theme in the literature asserts that the integration of spirituality and religion into the healing process is a growing interest to both laypersons and clinicians alike (Dossey, 2000; Kahle & Robbins, 2004; Koenig, 2004; Miller, 1999; Sloan, Bagiella, & Powell, 1999; Turkington et al., 1997). In a study of 150 patients treated in three family practices in Vermont, Astrow and Sulmasy (2004) note that the majority of patients (52%) believe it was appropriate for physicians to inquire about their religious beliefs. Additionally, "85% [of the patients] agreed that they [doctors] should be aware of their patients' religious or spiritual beliefs" (p. 2884). On a nationwide scale, Kahle and Robbins report that 95% of Americans affirm a belief in God, 90% of Americans pray, and 75% of Americans report praying on a daily basis.

Medical schools are beginning to offer courses in the integration of spirituality and medicine on an increasing basis (Koenig, 2004). Fortin and Barnett (2004) note that out of the 126 accredited medical schools in the United States, only 17 offered courses in spirituality in 1994. However, by 1998, 39

schools offered courses in spirituality and by 2004, 84 medical schools offered courses.

Unlike medical schools, mental health educational programs have not shown the same trends towards the integration of spiritual and religious themes (Kahle & Robbins, 2004). Of 40 counseling psychology programs reviewed in the United States, 82% did not offer courses with a predominantly religious or spiritual theme (Kahle & Robbins). Additionally, 61% of the above-stated counseling psychology programs offered either no courses in religion or spirituality (33%) or only one course (28%) (Kahle & Robbins). This limited attention to spiritual and religious themes in mental health training and practice led Kahle and Robbins to suggest that “the religious gap between psychologists and society at large continues to be significant” (p. 70). Although there has been a movement in both the medical and mental health fields towards an integration of spirituality into treatment, this movement has been slower in the mental health arena.

Historically, the integration of medical and spiritual interventions (such as prayer) in healing has been commonly practiced (d’Aquili & Newberg, 1999; Joseph, 2001). Only within the last century has Western civilization divided science and faith, taking a strictly modernistic approach to healing (Gerber, 2000; Johnson, 1993). Modernism, with its “strong emphasis on rationality and certainty” (Erickson, 2001, p. 161) and its reliance on the scientific method and empirical observation, gradually replaced the pre-modern emphasis of faith and

spirituality during the late 19th century. Regarding this paradigm shift towards modernism, Dossey (1996) states that it is unnecessary, and even destructive “to compartmentalize our lives, putting our intellect in one corner and our spirituality in another. The scientific evidence behind prayer can help heal these painful divisions in the modern psyche” (p. 13). Dossey thus proposes a post-modern view of the healing profession – an integration and acknowledgement of the strengths of pre-modernism (e.g., faith) along with the benefits of modernism (e.g., empiricism.)

The recent re-integration of science and religion into medical treatment is largely due to two reasons: the demonstrated effectiveness of spiritual and religious interventions (Barnett & Chambers, 1996; Gerber, 2000), and the fact that many “have become frustrated with the medical profession -- and its lack of interest in spirituality” (Turkington et al., 1997, p. 14). This frustration with modern medicine has resulted in many people turning “to alternative healers and practices – herbalism, yoga, meditation, hypnosis, (and) aromatherapy” (p. 14). Prayer is also considered an intervention in this “alternative therapy” trend (Barnett & Chambers; Dossey, 1996). Thus the post-modern era has moved various therapeutic interventions to the forefront that had previously been viewed in the era of modernism as little more than religious custom and tradition.

Prayer Studies

As the interest in alternative therapies has increased in the post-modern era, so has the interest in studying these interventions for their clinical utility (Dossey, 1993). The landmark study on remote intercessory prayer was a double-blind medical experiment that explored the effectiveness of remote intercessory prayer on coronary patients in a San Francisco hospital (Byrd, 1988). Two groups were compared in Byrd's study: Both received the standard medical treatment while only one group received remote intercessory prayer via the intercession of "born again Christians" (as described in the Gospel of John 3:3) to the Judeo-Christian God. The intercessors in this study were described as "active" Christians with lives "manifested by daily devotional prayer and active Christian fellowship with a local church" (p. 827). Results showed the group that received remote prayer recovered quicker, had fewer occurrences of newly diagnosed ailments and experienced lower mortality rates.

In an attempt to replicate Byrd's (1988) findings, Harris et al. (1999) studied the effects of remote intercessory prayer on 990 coronary patients admitted to the Coronary Care Unit (CCU) at the Mid America Heart Institute (MAHI). Intercessors represented several Christian traditions and were divided into 15 teams of five members each. One intercessor was assigned to be the leader in each team. During the study, participants were blinded to the purpose of the study - they were not informed that they were taking part in a study on remote intercessory prayer. The effect of intercessory prayer was measured by

the MAHI-CCU score – a scoring system utilized by the University of Missouri-Kansas City School of Medicine to assess outcomes for CCU patients. Harris et al. concluded that “remote, intercessory prayer was associated with lower CCU course scores”, thus indicating statistically significant improvement in health for the group prayed for. Based on these findings Harris et al. suggested that “prayer may be an effective adjunct to standard medical care” (p. 2273).

In his study of the effectiveness of remote intercessory prayer on patients hospitalized for bloodstream infections, Leibovici (2001) suggests that remote intercessory prayer “should be considered for use in clinical practice” (p. 1450). In this case the remote intercessory prayer was unique in that it was conducted 4 to 10 years after the treatment had been completed – thus retroactively. Leibovici’s study involved 3,393 participants who were diagnosed with bloodstream infections in a hospital in Israel from 1990 to 1996. A random numbers generator randomized the patients into experimental and control groups in 2000. A coin toss designated the experimental group. One intercessor prayed a “short prayer for the well being and full recovery of the [experimental] group as a whole” (p. 1451). In this study Leibovici concludes that “Remote, retroactive intercessory prayer said for a group is associated with a shorter stay in the hospital and a shorter duration of fever in patients with a bloodstream infection” (p. 1450). Positive results for the use of prayer for medical problems have also been reported for hypertension (Miller, 1982), recovery from surgery

(Green, 1993), AIDS (Sicher, Targ, Moore II, & Smith, 1998), and chronic illness (Wiesendanger, Werthmuller, Reuter & Walach PIB).

Bruce and John Klingbeil, founders of "Spindrift" (a non-profit research organization which studied the effects of prayer, mostly on biological organisms), conducted numerous randomized, controlled studies over a twenty-year period, most of which yielded significant effects for prayer from pre-test to post-test. Their studies demonstrated the positive effects of prayer and/or consciousness (termed "psi") on the growth rates of various biological organisms such as yeast cells, bacteria, and mold (Sweet, 2004). Other studies showed a significant prayer effect on the germination rate of seeds and the growth rates of plants and corn (Nash, 1982; Solfvin, 1982; Sweet, 2004).

To a much lesser degree a few studies have attempted to assess the effect of remote prayer on mental health (Connerly, 2003; Tloczynski & Fritzsich, 2002). In the Tloczynski and Fritzsich study, eight students in a Bloomsburg University class served as the participants. The study utilized a multiple baseline across subjects research design, and was conducted over a seven-week period. The first week was the baseline period, in which no prayer was conducted by the intercessor. After the baseline period the first two participants were prayed for until the study concluded. At the fourth week the third and fourth participants were prayed for until the end of the study. Beginning in the sixth week participants 5 and 6 were prayed for until the study's conclusion. The final two

participants (8 and 9) served as controls during the entire study and were never prayed for.

The Minnesota Multiphasic Personality Inventory-2 (MMPI-II) and the Taylor Manifest Anxiety Scale served as the tests used to measure effect size in the Tloczynski and Fritzsich (2002) study. The intercessory prayer was not related to any particular religion, although strict guidelines for the performance of the prayer were given and followed by the intercessor. Neither before nor during the study were participants informed that they were prayed for. The significant trend noted on both the MMPI-II and the Taylor Manifest Anxiety Scale occurred on anxiety measures. It was discovered that, for the most part, the longer participants received the remote intercessory prayer the greater the decline in anxiety observed. The only participants that did not report a decrease in anxiety were those who served as the controls (those that never received prayer). Thus the Tloczynski and Fritzsich study shows a correlation between the amount of intercessory prayer performed for a select group of undergraduate psychology students and their subsequent level of anxiety – as the amount of remote intercessory prayer increased, the level of anxiety reported by participants decreased. Keeping in mind that participants were blinded to the independent variable, the Halo Effect was thus controlled for.

Another study that explored the effects of remote intercessory prayer on mental health involved two groups of clients receiving outpatient counseling for depression (Connerly, 2003). One group of participants received psychotherapy

with remote prayer, while the other group received psychotherapy without remote prayer. Depression levels were measured by the BDI-II. Results showed that the treatment (prayer) group was significantly improved compared to the control group, which was indicated by lower scores on the BDI-II for the treatment group, and thus lower depression levels. The results of the study led the experimenter to conclude that remote intercessory prayer could be an effective intervention for those receiving outpatient counseling for depression.

After reviewing 130 medical “healing” studies, many involving prayer, Dossey (1996) concluded that the majority significantly gave credence to the effectiveness of prayer. Dossey promotes the assertion that regardless of religious orientation, “Prayerlike [sic] thoughts, offered from a distance” have demonstrated efficacy in healing, including, for example, an “increase in the healing rate of surgical wounds, and ... faster recovery from surgery” (p. 5).

Although many in the research community have suggested positive correlations between prayer and healing, some have not (Cohen, Wheeler, Scott, Edwards, & Lusk, 2000; Hamm, 2000). Posner (2002) indicates that he found “no evidence” for the effectiveness of prayer in his study, while other researchers questioned the results from the Harris et al. (1999) study on coronary patients, suggesting inaccuracies in the study’s statistical procedures (Karis & Karis, 2000), and its method of study (Goldstein, 2000). Others, such as Astin, Harkness, and Ernst (2000), acknowledge in their meta-analysis of “distant healing” that it is

“difficult to draw definitive conclusions about the efficacy of distant healing” but also suggest that “the evidence thus far merits further study” (p. 903).

Matthews, Marlowe and Macnutt (2000) studied 40 patients at a private rheumatology practice to assess the effectiveness of prayer on patients with rheumatoid arthritis. All of the participants received six hours of education and six hours of in-person intercessory prayer, while only 19 of these participants received remote intercessory prayer. At a one year follow-up there was a “significant overall improvement” for those receiving in-person intercessory prayer. However, there were “no additional effects” observed for those who received the supplemental, remote intercessory prayer (p. 1177). Matthews et al. concluded that “In-person intercessory prayer may be a useful adjunct to standard medical care for certain patients with rheumatoid arthritis” (p. 1177), but did not suggest the same for remote intercessory prayer.

Although there are some who question the utility of prayer in research and treatment, many studies, as the ones mentioned above, conclude that prayer can have a beneficial effect on medical outcomes. This research thus provides a foundation for the examination of remote prayer within the non-medical context of counseling, which has not yet received the degree of attention that the medical field has (Astin, Harkness, & Ernst, 2000; Tloczynski & Fritsch, 2002).

Using Prayer in Counseling: A Clinical Framework

Kelley (1995) suggests that although prayer “is generally congruent with good mental health”, and that “considerable, albeit mixed, research evidence and

extensive personal experience support the positive psychosocial and physical benefits of prayer”, utilizing prayer in the psychotherapeutic process should nonetheless be used within a specific framework and under limited conditions (pp. 226-227). According to Kelley, prayer should be used only in situations meeting all three of the following conditions: 1. When the counselor sees it as a legitimate means to promote healing (not just a means to “distract from legitimate therapeutic work”), and the client either requests the prayer or the counselor infers that the client has an interest; 2. The counselor has a positive regard for prayer, and is “adept in prayer consistent with the client’s beliefs”; and 3. There is a “mutually congruent spirituality between the counselor and client”, and the counselor does not work outside the parameters established by the agency or setting in which the counseling is taking place. Additionally, Kelley suggests that at no time should prayer be used in counseling when contraindicated by the client (p. 227).

The clinical framework offered by Kelley (1995) applies to in-person prayer in which the client is aware that he or she is being prayed for. However, Kelley makes no mention of clinical guidelines for remote intercessory prayer. Dossey (1993) suggests that regardless of a client’s interest in prayer, the counselor could remotely pray for a client, even without the client’s awareness, given its demonstrated utility in the literature. Dossey also supports praying remotely for those with religious or spiritual views different from the intercessors’, a practice that Kelley does not support for in-person prayer.

Additionally, it may be indicated in the counselor's faith to pray for people (Colosians 1:9-14), even if his or her faith is different from that of the client's.

McCullough and Larson (1999) suggest five ways prayer may be used "productively" in counseling according to the literature (p. 99). First, counselors can assess how their clients utilize prayer in order to better understand their "style of religious coping" (p. 99). Second, counselors can encourage their clients who are interested in prayer to utilize a variety of styles of prayer outside of therapy sessions as an adjunct to counseling. Third, cognitive-behavioral changes can result from a counselor's respectful use of prayer during counseling. Additionally, some counselors may find it helpful to pray with their clients during sessions, providing a fourth option for therapeutic intervention. Finally, and related to the theme of this study, counselors may choose to "pray about or for their clients" (p. 99).

While addressing spirituality and utilizing in-person prayer in psychotherapy can be effective and beneficial, it can conversely be just as harmful if used by the therapist in a coercive manner or as a distraction from good therapy (McMinn, 1996). McMinn suggests that prayer should be utilized within a disciplined context and never as a substitute for competent therapy, or as a way for counselors to compensate for deficient clinical skills.

The Image of God and Prayer

Encountering God through prayer is possible because each person is created in the image of God (Albright & Ashbrook, 2001; Hoekema, 1986). An

implication of this view, and a theme that is similarly shared by many world religions (Brown, 1994), is that there is some degree of similarity between God ("the Universe", etc.) and humanity – some overlapping qualities of comparison between both which may facilitate connection and relationship. However, what "image of God" means exactly has been a question of debate among theologians and philosophers alike (Hoekema).

According to Macaulay and Barrs (1978) what "image of God" does not mean is "that man [is] completely like God" (p. 13), but "a limited, physical creature, male and female, who [is] totally dependent on the Creator not only for the origin of his existence, but also for its continuation" (p. 13); yet despite these differences, "man [is] like God because man [is] a person" (p. 14). Macaulay and Barrs are promoting the idea that the various qualities of mankind, such as personhood and the ability to relate to others, equate mankind with this image: "we are like God in that we are persons" (p. 14).

Bockmuehl (1997) states that God's image is related to the role he plays: "The form of God pertains to the beauty of his eternal heavenly appearance, which is expressed in the eternally present but historically realized act of taking on 'the form of a slave'" (p. 21). Still others see the image of God as related more to humanity's ability to have dominion and rule over the creatures of the earth – "the idea that man is 'made in God's likeness, having dominion,' has changed the face of the earth" (p. 33).

Although some believe that the image of God in humans is related simply to the fact that they are capable of relationship or even that they have the authority to exercise dominion over the creatures of the earth, others see God's image in humanity as primarily related to an inherent composition (Cunningham, 1998). Throughout history many within the fields of theology, philosophy, and psychology have attempted to understand humanity by identifying and defining the various characteristics that constitute human nature and attempts have been made to analyze the relationship between these characteristics (Moreland & Rae, 2000). Although there have been significant differences in thought on this subject, some hold to the idea that humanity is holistically comprised of the components of body, soul/mind, and spirit (Cunningham; Moreland & Rae).

There has been much debate as to whether the components of body, soul/mind, and spirit exist as separate domains, or as an integrated whole (holistically) (Moreland & Rae, 2000). Recent trends in the literature, however, support a holistic conceptualization of these three characteristics (Barnett & Chambers, 1996; Gerber, 2000). How this holistic conceptualization of humanity, involving body, mind/soul, and spirit, is related to prayer will become evident in the following analysis of these components.

The first of the three dimensions under consideration is the body; and the brain is that element of the body that is most significant to theology and psychology (Albright & Ashbrook, 2001). The main divisions and structures of

the brain are the brainstem, cerebellum, diencephalon, and cerebrum (Carola, Harley, & Noback, 1992, p. 401). The brainstem has been referred to as the “stalk of the brain”, and functions generally to relay messages between the spinal cord and the cerebrum (Carola et al., p. 401). It controls such aspects as sleep cycles, alertness, cardiac functioning, and respiratory control. The cerebellum “regulates balance, timing and precision of body movements, and body positions” (Carola et al., p. 406). The diencephalon is considered to be the “deep part of the brain” and connects the midbrain to the cerebral hemispheres. It has many different functions, but some of the most significant are that it serves as a processing center for all sensory impulses (except smell), regulates water and electrolyte balance, and also controls temperature and metabolic activity (p. 416).

These first three major components of the brain are important because they uniquely (and to different degrees) work in tandem with the final area to be mentioned – the cerebrum. This fourth division of the brain is the most significant to the realms of religion, spirituality, and psychology (d’Aquili & Newberg, 1999; Joseph, 2001). The cerebrum is the “largest and most complex structure of the nervous system”, and performs a significant number of different functions, including creating and organizing thoughts and emotions (Carola et al., 1992, p. 408). The frontal lobes of the cerebrum “bring together emotional responses and ‘gut feelings’, symbolic logic and sensory data” and “help to devise the philosophical, religious, and ethical systems that provide a framework for choices” (Albright & Ashbrook, 2001, p. 138). A subsection of the cerebrum,

the limbic system (along with the hypothalamus), has been referred to as “the heart of the brain” (Palfai & Jankiewicz, 1997, p. 125). Functions of the limbic system include such processes as memory formation and olfactory functioning: It also “plays an important role in all emotions” (Bassett & Hill, 1998, p. 237).

The limbic system has been shown to become highly active during prayer and meditation (Joseph, 2001), leading some to conclude that humanity is biologically equipped to connect with the transcendent through prayer (Albright & Ashbrook, 2001; d’Aquili & Newberg, 1999; Joseph, 2001). Joseph proposes the idea that “every human is born with a brain and mind that serves as a transmitter to god” (p. 9), thus identifying a biological element (the limbic system) as the focal point for spiritual activity and a “transmitter” for prayers.

The second major element of the human composition, as it pertains to the image of God, is the mind (or soul). The mind has been referred to as “the total of all our mental activities - including thinking, learning, problem-solving, willing, perceiving, concentrating, remembering, attending, and experiencing thoughts and emotions” (Collins, 1988, p. 16). Unlike the brain, the mind is not a tangible object, but “a word we use to refer to human thinking, knowing, and feeling” (Collins, p. 16). Prayer often involves one or many of the above-stated functions of the mind including consciousness (perceiving and experiencing) (Russell, 2000), thinking and learning (Foster, 1992), and attending (Merton, 1961).

The final characteristic of the image of God in humanity is the spirit, which has traditionally been thought of as that element of humanity that lives

after the death of the body: in short, the only infinite characteristic of man (Elwell, 2001). Osterhaven (2001) refers to the spirit as “the aspect of life which lies in one’s inmost being” and states that the “spirit of mankind fulfills its true destiny when it lives in conscious relationship to God its Creator “ (p. 1133). Related to the issue of the spirit is spirituality – “a personal affirmation of a transcendent connectedness” (Kelley, 1995, p. 4).

According to Kelley (1995), several of the “identifiable values” of spirituality include:

confidence in the meaning and purpose of life, a sense of mission in life and of the sacredness of life, a balanced appreciation of material values, an altruistic attitude towards others, a vision for the betterment of the world, and a serious awareness of the tragic side of life. (p. 4)

In addition, spirituality, or the active God-centered life of one’s spirit, is also seen as making an honest attempt to live out the above-stated values in order to impact oneself, others, and nature as well as God (p. 4). The functions of the spirit are holistically tied to those of the mind and body (Barnett & Chambers, 1996) during prayer, and therefore are an essential element in the appropriation of prayer.

Revelation, Image of God, and Prayer

The current post-modern paradigm suggests that the composition of the individual (body, mind/soul, spirit) includes both the realms of science and faith, which, as previously stated, have until recently been separated into distinct

domains via the modernist ideology (Yancey, 2003). Theologically speaking, science and faith are characterized as specific forms of divine revelation to humanity, known as general and special revelation (Erickson, 1983, 2001). According to McDermott (2000), revelation is defined as “the unveiling of something that was hidden so that it might then be seen and known for what it is” (p. 46). Additionally, revelation not only refers to the actual process of God disclosing the nature of his being and purpose, “but also to the knowledge of God that results from that disclosure” and it is this knowledge that “reveals the meaning of all the rest of reality” (p. 47).

General revelation refers to God’s revelation through the material world, (Erickson, 1983, 2001): This is the realm of science. For example, the biology student may experience the general revelation of God by studying the rich complexity of the human body. Likewise, the astronomer may also come into contact with God’s general revelation through contemplation of the vastness of the universe, or, for instance, studying the profound mysteries of black holes (Haught, 2000).

Special revelation, according to McDermott (2000), is that revelation by God that pertains more to God’s personal attributes and offices, rather than His creation. For example, in the Christian faith the Bible is seen as the ultimate vehicle of special revelation (Erickson, 1983, 2001; Kennedy, 1980; Willard, 1980). Thus as general revelation is seen as the realm of science (e.g., the physical body/brain), special revelation is seen as the realm of faith (mind and spirit.)

Health, Balance, and Order

The need for balance and harmony between the elements of body, mind, and spirit (thus general and special revelation) is important for health (Albright & Ashbrook, 2001). For example, if one's view of humanity is purely physical then one is more likely to see mankind in a purely naturalistic manner, such as that proposed by the Darwinists of the early 20th Century (Hayward, 1985; Johnson, 1991). However, giving attention to only the spiritual realm of an individual at the expense of the physical (e.g., extreme fasting and self-deprivation for spiritual purposes) could lead to poor physical health and illness; although, some see a potential benefit to this (Glucklich, 2001).

Optimal holistic health is only possible when a harmonious relationship exists between the body, mind, and spirit (Santillo, 1984). Disease has been defined as "a state of imbalance that causes disruption in optimal functioning of the body, mind and emotions" (Barnett & Chambers, p. 8). Thus disease "is the body out of balance" and health "involves moving toward wholeness" (p. 8). Consequently, to be "in balance and harmony with ourselves and our environment" should be a primary personal goal (Barnett & Chambers, 1996, p. 8). Braud (1994) summarizes this point when he states:

Physical, mental, and spiritual balance and wholeness are facilitated when one recognizes and experiences the connections between different parts of the mind, between the mind and the body, between people, and between people and all of Nature. (p. 71)

Merton (1961) also addressed the importance of harmony and balance both within the individual and between the individual and his or her environment:

The “spiritual life” is then the perfectly balanced life in which the body with its passions and instincts, the mind with its reasoning and its obedience to principle and the spirit with its passive illumination by the Light and Love of God form one complete man who is in God and with God and from God and for God. One man in whom God carries out His own will without obstacle. (p. 140)

It is proposed that an encounter with God through intercessory prayer can facilitate this balance, both within the intercessor, as well as the intercessee (O’Laoire, 1997).

Sweet (2004) summarizes the position of the Spindrift research organization in regards to health, illness, and the mechanism by which prayer creates healing. Prayer facilitates connection with the “ordering force” (an inherent characteristic of the universe that brings order to chaos):

When a person becomes sick or injured, the components of the body are no longer arranged or specified in the original (and intended) order. Healing involves restoring that disordered structure toward “the intended order.” ... Any deviation from a person’s intended order is a deviation from intended functioning. (p. 64)

Energy Fields and Prayer

As one approaches balance between the body, mind, and spirit one approaches the optimal condition for health (Barnett & Chambers, 1996). In this study “balance” refers to the energy that comprises human functioning. Researchers support the notion that human beings are comprised of a “dynamic (not static) energy system” in which “energy fields interact not only within the individual but also between individuals and their environment” (Albright & Ashbrook, 2001; Barnett & Chambers, p. 20; Gerber, 2000). This idea rests on the assertions of some ancient forms of spirituality, and is given empirical support in the findings of quantum physics, which suggest that all substance within the universe is composed of “particles of matter created by the temporary intersection of ... energy fields” (Barnett & Chambers, p. 20) – this includes the “matter” that comprises the human being.

In quantum physics these energy fields are characterized as “vibrating energy”, which includes light rays, sound waves, X rays, cosmic rays, and microwaves, as well as others (Gerber, 2000). The difference between these various forms of energy is simply the frequency at which each oscillates (Gerber). Since the atoms that make up the human body (including the brain) consist of energy, Gerber proposes the idea that “people can be considered complex bundles of ... energy” (p. 6). He continues by stating, “Since all energy vibrates and oscillates at different rates, then, at least at the atomic level, the human body is really composed of different kinds of vibrating energy” (p. 6). Thus, expanding

its definition as indicated above, health is viewed as the optimal balance of energy, both within the individual, as well as between the individual and his or her environment.

The Communication Progression Principle

The holistic harmony and energy balance that can result from an encounter with God via prayer implies a relationship dynamic between the elements of body, mind/soul, and spirit – elements that are holistically tied together and have an effect on one another (Moreland & Rae, 2000, Santillo, 1984). Three different views of this relationship dynamic are identified in the literature. The first view is offered by Backus (1996) who states “your spirit communicates with your mind, and your mind communicates with your body” (p. 28). This implies is that there is an order, or a systematic progression in the way the elements affect each other. As the spirit impacts the mind, the mind subsequently impacts the body/brain: Thus the mind is the connection between the spirit and the body -- “the brain is a computer programmed by the mind” (Backus, p. 29). The spirit is viewed as “a receptacle originally designed by the Creator as an abiding place for his Holy Spirit” and “communicates its empty restlessness to your mind, until you find yourself asking those ultimate questions: ‘Where am I going?’ ‘Who am I?’ ‘Where have I come from’ ‘Why am I here?’” (Backus, p. 29). The mind, through its functions of thought, will, and emotion, subsequently communicates to the body/brain. Additionally, as it relates to wellness and health, Backus acknowledges that the spirit and mind not

only influence the actions of the body, but also have “a powerful effect on the health or illness of the body” (p. 29).

A second view highlighting the relationship dynamic between the mind and brain is that proposed by d’Aquili and Newberg (1999): “The mind is the name for the intangible realities that the brain produces” (p. 47). Thus, d’Aquili and Newberg have reversed the relationship between body and mind. Where Backus sees the progression as spirit first, then mind, then body/brain, d’Aquili and Newberg promote the relationship dynamic as: brain, then mind/spirit. It should be noted that Backus represents the view held by many evangelical Christians, whereas d’Aquili and Newberg represent a neurotheology perspective. D’Aquili and Newberg state, “By neurotheology, we mean ... how the mind/brain functions in terms of humankind’s relation to God or ultimate reality” (p. 18).

Despite the differences between the two above-stated perspectives, both agree that the individual consists of various elements that work together via a specific relational dynamic, although the progression of communication may be different from spirit to mind, and mind to brain/body. Joseph (2001), although somewhat within the camp of the neurotheologists, acknowledges a communication progression between body, mind, and spirit. According to Joseph, God communicates to man through the limbic region of the brain. Because the limbic region (via the amygdala, hippocampus, and inferior temporal lobe) has been “shown to subserve and provide the foundation for

mystical, spiritual, and religious experience” and becomes “highly active, and even hyper-activated” during religious experience, Joseph concludes that it is through the limbic region of the brain that man encounters “god” (p. 7). Joseph’s relational dynamic would appear like this: God (in some form), then brain/body, and then mind. Again, the order seems to be unique, compared to the previously stated two approaches, yet the basic elements of God’s image in the individual are present.

The human being, comprised of a “dynamic energy system” (Albright & Ashbrook, 2001), is, as previously described, organized in a progressive manner, integrating the various elements of his or her being (body, mind, spirit) into a unified whole (Jones & Butman, 1991). The relational dynamic that exists between body, mind, and spirit emphasizes the important point that the individual, in his or her very essence, is in fact process-oriented. For example, the functioning of the brain takes place as its neurons “engage in interactive processes” with energy (in its varied forms) coming from the environment, as well as other neurons (Albright & Ashbrook). Thus an intimate intermingling takes place between the energy of the word and the energy of humans. Albright and Ashbrook summarize this point when they state:

[T]he distinction between matter and energy, once a cornerstone of physical science, has rather thoroughly broken down. As Einstein’s ...theory of relativity has shown us, and the physics of quantum mechanics have demonstrated, matter may be transformed into energy,

energy becomes matter, and for some purposes the two may be seen as one and the same. *Matter and energy are inseparably intertwined* (emphasis mine). The world, and we humans ourselves, are ever interactive with everything else. *Everything at its core is interactive*. We humans shape the world – animate and inanimate – and are shaped by it. (p. 139)

Prayer and the Communication Progression Principle

How does all of this relate to prayer, and more specifically remote intercessory prayer? Given that humanity is comprised of energy (Barnett & Chambers, 1996; Gerber, 2000); that humans, created in the image of God, possess the characteristics needed to connect with the energy of God (e.g., a brain wired for transcendent experience) (Joseph, 2001); and that humanity is “intimately intertwined” with both the world and God (Albright & Ashbrook, 2001), a continuation of this logic would suggest that prayer is the utilization of various mental, physical, and spiritual energies in such a manner as to “intermingle” with (the “Energy” of) God. Tillich (1952, 2000) proposed that God is the “power of being”, suggesting that God, in the words of Jones (1991) “is a power or force of being that keeps the threat of not-being at bay and sustains everything in existence” (p. 126). Therefore, God is the very source of both matter and energy – to connect with God through prayer is to connect to that which is “the source that sustains existence in the face of nothingness and provides the courage to live in the face of life’s inevitable uncertainty” (p. 127).

The Law of Prayer

The research on the effectiveness of remote intercessory prayer supports the assertion that it can be effective regardless of religious orientation (Dossey, 1993). Although the landmark study on remote prayer involved intercessors praying to the Judeo-Christian God (Byrd, 1988), and a replicated study consisting of all Christian intercessors also showed a significant effect size (Harris et al., 1999), other studies demonstrating a positive effect for remote prayer have either not utilized Christian intercessory prayer (Tloczynski & Fritzsche, 2002) or have used a variety of prayer methods by various “healers” (Wiesendanger et al., 2001). Given that adherence to a specific religious denomination does not offer an advantage in regards to remote prayer, there are specific elements that have been identified in the literature as necessary for the success of prayer outside of religious orientation (Dossey; McCullough & Larson, 1996; Russell, 2000; Sheets, 1996). Collectively these will be referred to as elements of a “law” of prayer (Dossey), similar to the function of other natural laws (e.g., gravity) in that it is applicable to all people and thus all faiths.

The Carthusian writer Guiglo II provided a starting point for understanding the law of prayer when he outlined his view of the “correct way to read Scripture” (McGrath, 1999). Viewing the reading of Scripture as an encounter with God, Guiglo highlights three characteristics necessary for a proper interpretation of Scripture: meditation, prayer, and contemplation.

Through meditation one allows his or her mind “to focus and concentrate upon

the meaning and imagery of the text” while excluding all external thoughts (p. 85). Once in a meditative state, one can pray allowing for an intended dialog with the Divine. In the contemplation stage one is lead “to a quiet entrance into the presence of God” (p. 85). McGrath quotes Guiglo’s explanation of the intimate relationship between these activities:

Reading without meditation is sterile.

Meditation without reading is prone to error.

Prayer without meditation is lukewarm.

Meditation without prayer is barren.

Prayer with devotion achieves contemplation. (p. 85)

Guiglo’s conceptualization, a highly influential one in the Middle Ages, asserts that effective prayer is dependent upon a quiet openness and submission to God through meditation. Thus through meditation (openness and submission) one begins to create an internal environment conducive to a harmonious transcendent relationship with the Divine, which, as previously mentioned, is vital to health and opposes disease (Merton, 1961; Santillo, 1984).

Prayer is less likely to be effective if it is done in a rote, sterile manner (Dossey, 1996). This idea is supported by McCullough and Larson (1999) who suggest that repetitive, self-serving prayer is generally associated with positive outcomes less than prayer that is characterized by an honest desire and passion for God’s will and an openness to it. McMinn (1996) notes that prayer “should be an extension of the passions of our heart. By praying persistently and

consistently, we remind ourselves to seek God while telling God our deepest desires" (p. 71). Others such as Hawkins, Hindson, and Clinton (2002) also emphasize the necessity of "passion [and] compassion" when attempting to meet the needs of others (pp. 102-103), underscoring the important role that the motivation of the helper/intercessor plays in healing and recovery.

In addition to openness, submission, passion, and compassion, love is also identified in the literature as a necessary element of intercessory prayer. The presence of "love, empathy, and deep caring appear to catalyze or set the stage for prayer's effects" and sincerity has also been shown to be necessary for effective prayer (Dossey, 1996, p. 34). Foster (1992) supports this by stating: "Intercession is a way of loving others" (p. 191). The presence of love in the intercessor seems to set the stage for the necessary characteristics of effective remote prayer thus far identified (compassion, passion, and selflessness). Without love it is difficult to imagine how one could appropriate the compassion, passion, and selflessness necessary for effective intercessory prayer.

Additional literature points to the necessity of faith (Sheets, 1996) for the effectiveness of remote prayer. Kierkegaard (1843, 2003) noted that faith "is the greatest and most difficult of all" spiritual disciplines (p. 80), yet is the "highest passion in a human being" (p. 146). Faith, or the "movement of trust going out to, and laying hold of, the object of its confidence" (Elwell, 2001, p. 431), or "the active trust in God" (Nouwen, 1999, p. 63), implies an internal action, incorporating spirit, mind, and body, in which profound trust and confidence in

the Divine is established and maintained (Nouwen). As a result a passionate unity is reached between the intercessor and the Divine. This unity, similar to the Buddhist doctrine of “no self”, implies a condition in which a “person is purely contingent, totally dependent on the system of being (God)” (McDermott, 2000). As the intercessor submits and opens his or her will to the Divine through faith their will becomes transformed to that of God’s. Thus the openness and submission mentioned previously cannot occur unless faith is present.

The unity that exists between the intercessor, intercessee, and God during prayer is described by Nouwen (1999):

To pray for others means to make them part of ourselves. To pray for others means to allow their pains and sufferings, their anxieties and loneliness, their confusion and fears to resound in our innermost selves. To pray, therefore, is to become those for whom we pray...it is in and through us that the Spirit touches them with God’s healing presence. (p. 145)

A final characteristic identified in the literature as vital to remote intercessory prayer is consciousness (Russell, 2000; Sweet, 2004). Consciousness, or “subjective awareness” (d’Aquili and Newberg, 1999, p. 183), “especially focused consciousness held in prayerful thought, has been shown to trigger healings at great distances” (Gerber, 2000, p. 366). In addition to the idea of consciousness as being “subjective awareness”, Dossey (1993) broadens the concept of consciousness by acknowledging the role that the unconscious mind

can also play in prayer. Dossey asserts that most of one's life is lived not in conscious awareness but in unconscious awareness; thus he states, "the unconscious can be extraordinarily helpful and benevolent in our quest for help. In fact *the unconscious mind can initiate or cooperate with prayer and even mediate the effects*" (Dossey, p. 82). In regards to the unconscious, Jung (1957) asserts "it is the medium from which the religious experience seems to flow" (p. 102). Thus the conscious and unconscious minds are supported in the literature as being intricately involved in the mediation of remote prayer. Henri Nouwen (1999) summarizes the role of the conscious and unconscious mind in prayer, as well as some of the other elements (previously discussed) that comprise humanity's holistic composition, when he states:

Prayer is the bridge between my unconscious and conscious life. Prayer connects my mind with my heart, my will with my passions, my brain with my belly. Prayer is the way to let the life-giving Spirit of God penetrate all the corners of my being. Prayer is the divine instrument of my wholeness, unity, and inner peace. (pp. 35-36)

The idea of consciousness being "local", or simply within the individual, is challenged in the literature (Dossey, 1993; Jung, 1957; Russell, 2000). Dossey proposes the Jungian concept that consciousness is in fact "non-local" - "the mind cannot be limited to specific points in space (brains or bodies) or in time (the present moment), but is infinite in space and time; thus, the mind is omnipresent, eternal, and immortal" (Dossey, p. 115).

Given the proposed characteristics of the “non-local” mind (consciousness), Dossey (1993) has compared this to the scientifically validated phenomenon of “non-local” events discovered in quantum mechanics. In quantum physics, non-local events refer to the actions of subatomic particles when they have initially been paired and then separated (Bell, 1964). Research in non-local events has shown that when a change occurs in one particle, (which was at one time paired with another particle but is then separated) there is a simultaneous change in the particle with which it was once paired, regardless of the current distance between the two particles or how long they have been separated (Bell). Although no one knows exactly how non-local events occur, some suggest that the loving, compassionate consciousness of the intercessor (towards the intercessee) may be the means by which the non-local mind, through prayer, promotes healing in others (Dossey, 1996).

A natural law of prayer, as suggested in the literature, must therefore, involve the intercessors’ loving awareness (consciousness) of the intercessee and his or her need, which may even involve specific consciousness in the form of visualization (Dossey, 1996; Russell, 2000). Additionally, remote prayer must also include an openness and submission to the will of God (Merton, 1961), passion and compassion for those prayed for (McMinn, 1996; Kierkegaard, 1843, 2003), and faith in God’s ability to answer prayer resulting in unity between intercessor, intercessee, and God (Foster, 1992; Nouwen, 1999; Sheets, 1991). The literature

proposes that when these elements are present prayer is most likely to effect positive change in those prayed for.

Given that prayer functions much like a law it would be erroneous to suggest that an experimental study of prayer “tests God” (Cutting, 1998). This logic would be as erroneous as suggesting that studying the effects of gravity, or any other natural event, puts God in a “test tube”.

Although this law of prayer is similar to other natural laws in that it is applicable to all people and thus all faiths, it is nonetheless different from other natural laws in that people can choose to either obey or disobey it. Other natural laws, such as gravity, are different in that there is no choice but to be subject to them: These laws exist within the broader domain of the Law of Nature (Lewis, 1943, 1980). Lewis proposes that in addition to the Law of Nature there is also a “Law of Human Nature” that is similar to the Law of Nature in that it is applicable to all people and thus all faiths. For example, the general rules of morality for different civilizations (regardless of time or location), while they may differ somewhat on specifics (societal and governmental laws), contain an undercurrent of similarity. Murder for its own sake has never been universally accepted by any culture, although different societies may have different laws on how to address it. Although this Law of Human Nature is similar to the Law of Nature in that it is applicable to all people, it is different from the Law of Nature in that one can “choose either to obey ...or to disobey it” (Lewis, p. 18), and depending on one’s choice the respective consequence will be experienced.

Prayer exists under this Law of Human Nature. Although different cultures and religions may have different prayer styles and rituals, there are nonetheless common factors (e.g., consciousness, faith, love, compassion, passion) that must be in place in order for prayer to be effective. Thus, “union with God (through these elements of prayer) is solidarity with all humanity” (Nouwen, 1999, p. 79). However, intercessors may choose to pray in a manner that does not include these elements and will experience the subsequent results.

Although it is proposed in this work that prayer functions as a law, it is acknowledged that God can at any time intervene outside of the law he has created (a Creator is not subject to the laws that have been created); and it is in these cases that one may say that a “miracle” has taken place (Evans, 1982). Evans describes a miracle as a “special act of God” performed “at a particular place and time, an act distinct from his ‘normal’ activity of sustaining the universe, including its natural processes” (p. 107).

Forms of Prayer

Prayer is a practice that is essential to most, if not all, world religions and spiritualities (Brown, 1994; Dossey, 1993; Saint-Laurent, 1999). Additionally, the practice of prayer stretches far beyond one specific approach and can involve numerous nuances and styles (Brown; Nouwen, 1999; Oman, 1997; Richards & Bergin, 2000). Thus, to engage in prayer can mean many different things. Elwell (2001) states, “True prayer, in the prophetic or biblical sense, bursts through all forms and techniques.... It is both wrestling with God in the darkness and

resting in the stillness. There is a time to argue and complain to God, but there is also a time to submit" (p. 947). Another view defines prayer as "thoughts, attitudes, and actions designed to express or experience connection to the sacred" (McCullough & Larson, 1999, p. 86). Others see prayer as a closed system of communication in which God, through those open to His will and leading, speaks to Himself: "If the Holy Spirit speaks in the man, then in prayer God speaks to God" (Lewis, 1963, p. 68; Merton, 1961). Additionally, prayer can also be either individual or corporate; and the goal can be for both personal happiness and (in the Christian perspective) for the advancement and extension of the "kingdom of God" through intercession for others (Elwell, p. 947). To one degree or another prayer in most religions will include at least some elements of the above-stated conceptualizations (Brown).

Foster (1992) identified 21 different forms of prayer that he divided into three chronological categories. In his view as individuals develop and mature in their prayer lives they progress from "moving inward" (becoming internally transformed) styles of prayer, to "moving upward" forms, with the focus being primarily on seeking intimacy with God. The third and final category of prayer, (which Foster refers to as "moving outward") is the utilization of prayer for serving others and holding their needs as primary: Foster includes intercessory prayer in this final ("moving upward") category. Regarding this he states:

In the ongoing work of the kingdom of God, nothing is more important than Intercessory Prayer. Individuals are living lives of quiet desperation,

without purpose or future. And we can make a difference if we learn to pray on their behalf (p. 191).

Many in English-speaking societies assume that prayer means the same thing throughout all of the various religions and cultures of the world (Brown, 1994) (e.g., prayer is talking to a personal, monotheistic God). However, Brown cautions against this assumption by noting that “prayer”, in the English sense of the word, is not universal (e.g., may not involve talking and may not involve a monotheistic God). Yet, although “prayer” as specifically understood in English is not universal, nonetheless “all the necessary building blocks are there” throughout various cultures, “and societies (tend) to put these blocks together in ways not unlike the way they are put together in the meaning of the English word *prayer*” (p. 45).

A Biblical Basis for Prayer

Speaking from a Judeo-Christian worldview, this writer acknowledges his preference for prayer to a personal, transcendent God; although, as previously discussed, the effectiveness of remote prayer has been demonstrated across religious affiliation and prayer style (Dossey, 1996; Wiesendanger, Werthmuller, Reuter, & Walach, 2001). A biblical basis for prayer acknowledges the assumption that to encounter the Judeo-Christian God is to participate in transformation (John 7:37-38 [New International Version]), and the manner this transformation takes depends ultimately on God’s will (Hebrews 13:20-21). To encounter God can mean to struggle with Him, and tearfully consult Him in

times of distress. Seemingly countless people who are mentioned throughout biblical scripture have found God when He was most urgently needed.

Ironically, the biblical God is often discovered right in the middle of one's pain, comforting, advising, guiding, and leading according to His wisdom (Acts 27; Exodus 13-16). At times, encountering God is seeing someone born blind who is only later given sight - all for the sake of divine glorification and ministry to others (John 9:1-5). At other times, as in the case of Lazarus, the encounter comes in the form of blessing wrapped in trauma - all for a greater good (John 11:4-6). On the road to Damascus Paul's transformation came in the form of temporary blindness, yet with new insights (Acts 9:1-19). Jacob's wrestling with God resulted in a limp, yet a renewed blessing (Genesis 32:22). And Job, after all his suffering and loss, was "blessed the latter part of [his] life more than the first" (Job 42:12). According to biblical scripture, encountering God can also be an ecstatic, life-changing experience, providing an ultimate sense of joy, serenity, and passion (Acts 2:1-13; Galatians 5:22; James 4:9).

This life-changing encounter with God can often take place through the vehicle of prayer (1 Timothy 2:1-4). Noting the potential power and extreme importance of prayer, biblical scripture provides direction on how to pray (Matthew 6:9-13, Philippians 4:6-7, I Thessalonians 5:17-18), and promotes the assertion that prayer should be a regular practice in one's life (Matthew 6:11). Christians are told to pray for the forgiveness of sins (Matthew 6:12), seek the Lord's mercy through prayer (Psalms 105:1-4), and call on Him in times of

adversity (Psalms 50:15). When Christians seek God through prayer, and dare to encounter Him, Scripture assures them that He will hear them (Psalms 34:15-18).

The Intercessor's Experience

Intercessory prayer creates a meeting with the transcendent: "Intercessors meet with God; they also meet the powers of darkness" (Sheets, 1991, p. 50). As intercessors meet with God through prayer they may expect to experience, in the words of Saint John of the Cross, their own personal "dark night of the soul" (May, 2004). Foster (1992) agrees that "darkness" can be experienced in prayer (p. 19). In fact darkness is to be expected and even "embraced" (p. 19).

Paradoxically, many who have "traveled far into the interior realms of faith have reported intense feelings of alienation from God" (p. 19). As previously mentioned, increased intimacy with God often requires a surrendering of one's own will, and this experience can be agonizing for some (May; Merton, 1961). In regards to this dark element of prayer, Nouwen (1999) asserts:

Prayer therefore is the act of dying to all that we consider to be our own and of being born to a new experience which is not of this world. Prayer is indeed a death to the world so that we can live for God. (p. 39)

Thus, one's wrestling and struggles during intercessory prayer can be a transforming experience, both for the intercessor as well as the intercessee (O'Laoire, 1997).

Prayer that Seems Impotent

Thus far it has been proposed that prayer can be a clinically useful intervention in counseling and psychotherapy; however, prayer may not necessarily bring a client to an immediate relief of pain (Sheets, 1991). When an intercessor prays for the benefit of another there is almost always the goal of (beneficial) change in mind on the part of the intercessor for the intercessee (e.g., less depression, less anxiety, greater serenity, etc.) (Sweet, 2004). However, the change necessary for an alleviation of emotional suffering can oftentimes itself be a painful process (Prochaska, Norcross, & DiClemente, 1994). Thus, many clients who are confronted with positive change options (as a result of the prayer of others) may nonetheless choose not to change, deciding to remain in old destructive habits that are familiar and comfortable, yet keep them in destructive emotional patterns (Miller & Rollnick, 1989, 2002; Prochaska et al.). Therefore, praying for some clients may not lead to an immediate remission of pain and this may explain why some of the literature questions prayer's effectiveness (Cohen, Wheeler, Scott, Edwards & Lusk, 2000; Hamm, 2000; Posner, 2002). At other times prayer will alleviate pain and bring relief, as demonstrated in the literature (Byrd, 1988; Harris et al., 1999; Leibovici, 2001; Sicher, Targ, Moore II & Smith, 1998; Tloczynski & Fritzs, 2002). In either case prayer *is* a transforming process, supported both by biblical scripture and science, and should be used both directly with clients (within specific parameters) (Kelley, 1995; McCullough and Larson, 1999) and remotely (Dossey, 1993).

Summary

Numerous studies conclude that remote intercessory prayer can have a statistically significant effect, most of which have focused on physiological problems (Byrd, 1988; Green, 1993; Harris et. al, 1999; Leibovici, 2001; Miller, 1982). Only a few studies have explored the effect of remote intercessory prayer on mental health (Connerly, 2003; Tloczynski & Fritsch, 2002). The present study analyzed the effect of remote intercessory prayer on clients receiving mental health treatment for depression, which may or may not have been comorbid with other DSM-IV diagnostic categories. The hypothesis of this study implies that there is an inverse relationship between intercessory prayer and the intensity of depressive symptoms. Those participants who received remote intercessory prayer would report less depression than those participants who did not receive remote intercessory prayer, as indicated by lower scores on the BDI-II. The null hypothesis states that there would be no significant difference between the two groups in regards to depression severity.

CHAPTER III: METHODOLOGY

The present study utilized an experimental design to examine the effects of remote intercessory prayer on depressive symptoms. This chapter will first describe the research design, including a description of the selection of participants as well as the psychometric instrument used. Additionally, assumptions and limitations of the study will be described. Next, the Procedures section will outline the exact steps taken to perform the study. Finally, the Data Processing and Analysis section will clarify the research and null hypothesis, and the statistical test used.

Research Design

The present study utilized a randomized, double-blind, control-group, pre-test/post-test experimental design. The treatment was remote intercessory prayer, and the measure of interest was the degree of depressive symptoms reported by participants as measured by the most recent version of the Beck Depression Inventory (BDI-II), both before and after the treatment.

Participants in the experimental group were the recipients of the remote intercessory prayer, while the control group received no remote intercessory prayer. All participants were actual clients receiving counseling for depression. Measures of depression severity for each of the 20 participants were taken twice during the study - once before the introduction of the treatment, and once after the treatment had been applied for a 28-day period. The pre-test mean BDI-II score of the experimental group was compared to the pre-test mean score of the

control group. Similarly, post-test mean scores on the BDI-II for both groups were also compared.

Selection of Participants

Recruiting participants for the present study proved to be a difficult task for the researcher. Numerous clinics in the Central Virginia region were informed of the present study and given a detailed description of the study's design. The managers, therapists (or both) of these clinics and agencies were also given assurances that their clients' confidentiality would be protected and that therapists would never be asked to alter any aspect of their typical therapeutic interventions. Agencies that identified themselves as providing a "Christian-oriented" approach in their counseling were the only agencies that agreed to participate in the present study. Thus, despite the researcher's desire and attempt to include participants from clinics of diverse theological and philosophical perspectives, all participants in the present study were obtained from treatment settings that advertised a "Christian" orientation.

Counseling clients, age 13 or above, receiving mental health treatment for depression (either solely or comorbid with other DSM-IV diagnostic categories) in central Virginia were considered as potential participants for this study. Counselors in the central Virginia area received a letter of invitation (see Appendix A), which explained the study's purpose (to explore the effectiveness of remote prayer on depression), and the criteria necessary for the participants (clients suffering from depressive symptoms). Willing counselors briefly

explained the study as outlined in Appendix A to their clients who met the criteria for inclusion into the study. Counselors then asked these clients if they would be interested in participating in the study. Consequently, participants were actual clients receiving treatment, although not all from the same counselor. Half of the clients (n=10) were assigned to the experimental group, and the other half (n=10) were assigned to the control group.

Instrumentation

Pre- and post-treatment effects were measured by changes in BDI-II scores. Numerous studies support the reliability and validity of the BDI-II and acknowledge its user-friendly nature (Beck, 1984; Barroso & Sandelowski, 2001). The adult version of the BDI-II is a self-administered instrument that has been praised for its ease of use – it typically takes only 5 to 10 minutes to complete (Farmer, n.d.). Moreover, the BDI-II has a “very strong empirical foundation” to support its effectiveness (Farmer). One internet source (“The Beck Depression Inventory,” n.d.) gives the BDI-II a reliability of 0.86 (coefficient alpha) and a convergent validity of 0.68 and 0.65 when compared to the Hopelessness Scale (HS) for major depressive disorder (recurrent) and dysthymic disorder respectively. Given its ease of use, as well as its longstanding demonstrated success in accurately assessing depressive symptoms, the BDI-II seemed to be the best choice for this study.

The 21 items on the BDI-II each contain four statements arranged in increasing order of severity related to particular symptoms of depression. The

test gives one total score of depressive symptoms, which can range from 0 (indicating no depressive symptoms) to 63 (indicating the greatest possible amount of depressive symptoms). The BDI-II manual (Beck, Steer & Brown, 1996) also includes a description of score ranges (“cut scores”) that indicate depression severity. These cut scores are delineated as follows: Minimal (0-13); Mild (14-19); Moderate (20-28); Severe (29-63).

The item content of the BDI-II includes the following: sadness, pessimism, past failure, loss of pleasure, guilty feelings, feelings of punishment, self-dislike, self-criticalness, suicidal thoughts and/or wishes, crying, agitation, loss of interest, indecisiveness, worthlessness, loss of energy, changes in sleep patterns, irritability, changes in appetite, concentration difficulty, tiredness and fatigue, and loss of interest in sex (Arbisi, n.d.).

The predecessor of the BDI-II, the BDI, has been described as “an effective measure of depressed mood that [has] repeatedly demonstrated utility”, which has been “evidenced by its widespread use in the clinic as well as [its] frequent use ... as a dependent measure in outcome studies of psychotherapy and antidepressant treatment” (Arbisi, n.d.). Considering the success of the BDI, the BDI-II “represents a significant improvement over the original instrument” in that it has adjusted its item content to tie in with a more recent version of the DSM (the DSM-IV) and “should supplant the BDI” (Arbisi, n.d.). The BDI-II was chosen for this study due to its ease of use among a relatively diverse population, considering that the education level of the participants in this study was

assumed to be widely varied. Another attractive aspect of the BDI-II is the brief amount of time it takes to complete. Given that all participants completing the BDI-II were active clients, it was the desire of the researcher to interfere as little as possible with the in-person therapeutic process, and thus find a self-report measure that was the most minimally intrusive.

Limitations

One of the most significant limitations in this study was the impossibility of controlling for the remote intercessory prayer of others not directly involved in the study. Ideally, members in the control group would receive no remote intercessory prayer during the 28-day testing period – only participants in the experimental group would receive the remote prayer. However, given the geographic location of the present study (within the “Bible Belt”) it is likely that participants in the control group had friends, family or others who prayed for their improved mental health. Additionally, asking others not to pray for those in the control group is fraught with numerous ethical and moral difficulties. In short, it was impossible to ensure that the independent variable had not been applied to some participants in the control group.

A second (possible) limitation was in regards to the counseling that each of the participants received. Since many of the participants in the study received treatment from different counselors it was impossible to assume that each participant had received exactly the same mental health treatment. Some participants may have in fact received different interventions, which could have

had a direct impact on their depression level outside of the effects of remote intercessory prayer. It is assumed, however, that the randomized assignment of participants to either the experimental or control groups served as a control for this limitation.

A final limitation pertains to the remote prayer of the intercessors. Intercessors were given specific instructions that outlined the minimum requirements of how to pray for participants in the experimental group. The literature supports the notion that effective prayer generally involves common characteristics as previously mentioned in the Literature Review (e.g., openness to God's will, love, sincere concern). Intercessors were also given a journal to complete that provided a record, based on their word, of how long they prayed for participants each day, and if they prayed at least in the manner indicated in the letter that the researcher sent them. However, ultimately it was not possible to know for certain if intercessors had in fact remained faithful to the instructions provided by the researcher, and whether or not they had prayed in the manner identified in the literature to be most effective, as previously mentioned.

Procedures

Counselors in the central Virginia area were petitioned for participation in a "research project exploring the relationship between remote intercessory prayer and depression" via an invitation letter to therapists (see Appendix A): Counselors were petitioned in a variety of counseling centers. This letter explained the purpose and rationale of the study and outlined the counselors'

responsibilities in the study. An instruction sheet (see Appendix B) was also given to counselors explaining the major steps of the study for both the counselor and the participant. Counselors also received a questionnaire (see Appendix C), which gave the researcher information on each therapist's therapeutic modality and treatment approach, among other clinically relevant issues.

Those counselors who agreed to participate were asked to give their willing clients a packet of information containing an Invitation Letter to Potential Participants (see Appendix D), which introduced their clients to the general nature and purpose of the study. Clients who agreed to participate in the study reviewed, filled out, and signed an Informed Consent form (see Appendix E) and a Client/Participant Questionnaire (see Appendix F), both also included in the packet. The consent form and questionnaire were completed and given back to the receptionist at their respective clinics, and were kept for the researcher to pick up.

After the consent form had been signed, the first BDI-II was administered to each participant by his or her respective counselor, and was completed at the counselor's clinic. As participants completed the first administration of the BDI-II they left it with the receptionist of that clinic. As the researcher received each participant's first BDI-II he randomly selected a number between 1 and 20 and assigned the respective participant that number (as numbers were drawn they were removed from the number pool). Thus, half of the participants were assigned an even number and half were assigned an odd number: The researcher

recorded this number on the participant's consent form so that the consent form contained the participant's signature, age, initials, and case number. When participants dropped out of the study, their numbers were placed back into the pool to be reselected when additional participants could be secured.

Participants receiving an even number were assigned to receive remote intercessory prayer. Odd-numbered participants were subsequently assigned to the control group that received no intervention. Those participants assigned an even number were assigned to an intercessor to begin the remote prayer. A Summary Sheet (see Appendix G) was utilized by the researcher to record participant information. This sheet included columns for each participant's case number, initials, and age. Additionally, pre-prayer and post-prayer columns were also included to display scores for each even and odd-numbered participant, both before and after the remote intercessory prayer had been administered for the even-numbered participants.

The researcher sent intercessors four forms. First, a Modified Summary Sheet (see Appendix H) was sent (an abbreviated version of the Summary Sheet), which included the initials and ages of those participants that were assigned even numbers earlier in the study. This modified status sheet provided intercessors limited information on those they prayed for (their initials and ages), but not enough to compromise their identity. Second, along with the Modified Summary Sheet, a letter (see Appendix I) was also sent to intercessors, written by the researcher, which explained the rationale of the study. The letter also directed

the intercessors to pray for everyone on the list, at least 10 minutes per day for 28 days. Additionally, intercessors were asked to complete a prayer journal (see Appendix J) daily for 28 days (for each participant), as well as a questionnaire (see Appendix K). Both the prayer journals and questionnaires were returned to the researcher in the included self-addressed stamped envelope at the conclusion of the 28-day period.

Intercessors were chosen in a manner similar to the way they were chosen in Byrd's (1988) landmark study – self-described as “born again Christians” as mentioned in John 3:3: Seven were selected by this writer for participation in this study. Five intercessors were required, modeled after the Harris et al. (1999) design. Two additional intercessors volunteered during the course of the study and were allowed to participate. Due to some indication in the research that supports a positive correlation between the amount of prayer given and its effectiveness (Tloczynski & Fritsch, 2002), the researcher hypothesized that the greater the number of intercessors the higher the likelihood of an effect on depression level. The 28 days of required prayer by the intercessors was also modeled after the Harris et al. study. The intercessors were asked to contact this writer in the event that they would not be able to complete the required amount of praying, so that another could be found to take his or her place. None of the intercessors dropped out of the study.

Immediately after the 28 days of prayer were completed the researcher informed counselors to administer the BDI-II for a second time to each of the

participants who completed the first administration, with the same testing conditions as in the previous administration. Just as before, participants left the second BDI-II with the receptionist at the respective clinic.

When all of the tests were received the researcher recorded the post-test scores in the corresponding column of the Summary Sheet. Thus, when the Summary Sheet was completely filled out it included both the pre-test and post-test BDI-II scores of each participant, thus allowing a statistical analysis of the results.

It is important to note that at no time were clinicians required to change any aspect of their typical interventions beyond what has been specifically described in these procedures. Additionally, at no time did the researcher have any direct interaction with the participants of this study. The only exception would be in the event that a participant did not return their second BDI-II in a timely manner and he or she could not be reached by his or her therapist. In these cases the researcher would call the participants and politely ask them to complete and return their BDI-II in the self-addressed stamped envelope provided by the researcher.

Participants who could not be reached either by their therapist or the researcher regarding completion of their second BDI-II were excluded from the study. The numbers that they were assigned were placed back into the numbers' pool to be randomly selected again as subsequent willing participants became available.

Data Processing and Analysis

It was hypothesized that remote intercessory prayer would have a beneficial effect on depression by lowering depression severity as indicated by a significantly lower mean BDI-II post-test score for the experimental group as compared to the mean post-test score of the control group. The null hypothesis suggested that there would be no significant difference in mean post-test BDI-II scores between the experimental and control groups.

A repeated measures ANCOVA was employed to determine if the difference in pre-test and post-test group mean scores between the experimental and control groups was significant. The difference between both groups at the beginning of the study was considered to be the covariate, and the ANCOVA statistically controlled for pre-treatment BDI-II mean group score differences.

CHAPTER IV: FINDINGS

This chapter presents the data and a statistical evaluation derived from the aforementioned prayer study and is organized in the following manner: First, there will be a brief statement of the purpose of the study, followed by a detailed description of the participant sample demographics. Additionally, therapist and intercessor demographic information will be given. Second, descriptive statistics for the experimental and control groups will be highlighted in tabular format. Next, the hypothesis will be examined, with a description of the statistical test used and a table summarizing the results of the test. Finally, a brief summary of all the findings will conclude this chapter.

Purpose

The purpose of the present study was to explore the effectiveness of remote intercessory prayer on the depression of people receiving counseling for depression, which may or may not have been comorbid with other DSM-IV diagnostic categories. The primary goal of this study was to research a potentially useful clinical intervention that could be seen as an adjunct to other established, clinically sound interventions.

Participant, Therapist, and Intercessor Demographics

Participants

Twenty-two participants were involved in the study overall. Two participants (one from the experimental group and one from the control group) did not complete the second BDI-II and were excluded from the study leaving 20 participants for inclusion in the statistical analysis. All of the participants lived in

the Central Virginia region, and during the time of the study were receiving counseling for depression. Table 1 summarizes relevant demographic information.

Therapists

All participants in this sample were actual clients receiving counseling for depression, thus all had therapists. Six therapists agreed to participate in the present study and all except one were licensed in Virginia – there was no mortality for this group. The one therapist who was not licensed was a Master’s level university intern under the supervision of a faculty member who was licensed. All therapists worked in Christian counseling clinics, except for the intern who was under the supervision of a faculty member who worked at a Christian university. Table 2 summarizes relevant therapist information.

Intercessors

Seven intercessors participated in the present study and there was no mortality for this group. Five of the seven intercessors stated that they prayed the amount of time required for the study (at least 10 minutes per day). The remaining two intercessors either missed a day, or prayed less than the required 10 minutes during certain days. Table 3 presents a summary of relevant intercessor demographics. The “Length of Time as a Christian” is indicated in years. The “Type of Faith” indicates the broadest of denominational categories (E=Evangelical, F= Fundamentalist, NA=No answer). Scale of belief indicates how intercessors rated themselves with regards to how much they believed prayer could effect change, from 0 (no belief) to 10 (maximum belief).

Table 1

Participant Demographics

	<u>Experimental</u>	<u>Control</u>
<u>Gender</u>		
Male	2	5
Female	8	5
<u>Marital status</u>		
Married	4	3
Single/never married	1	2
Divorced (currently)	4	5
Separated	1	0
<u>Age</u>		
13-30	1	4
31-40	0	1
41-50	5	1
51-60	3	3
61-70	1	1
<u>Religious belief</u>		
Christian	6	4
Jewish	0	1
Spiritual/unspecified	3	2
"No belief"/Atheist	0	1
No answer	1	2

Table 2

Therapist Demographics

<u>Therapist</u>	<u>Years of Experience</u>	<u>Therapeutic Modalities</u>	<u>Homework</u>
A	25	CBT, Bowenian, Client-Centered	Bibliotherapy Prayer
B	13	CBT, Existential Family systems	Bibliotherapy Journaling
C	15	CBT, Interpersonal	Relaxation exercises Journaling, Bibliotherapy
D	10	REBT Solution-focused	Skill-building worksheet
E	9	CBT, Existential, Client-Centered	Journaling
F	6 weeks	CBT, Experiential	Journaling Thought replacement Bibliotherapy

Table 3

Intercessor Demographics

<u>Intercessor</u>	<u>Length of Time as a Christian</u>	<u>Type of Faith</u>	<u>Belief Scale</u>
A	30	E	10
B	30	N/A	10
C	22	E/F	10
D	19	E	10
E	17	E	10
F	6	“Don’t know”	10
G	19	E/F	8

Descriptive Statistics

Table 4 provides a summary of the descriptive statistics for the experimental and control groups.

Table 4

BDI-II Group Scores: Means and Standard Deviations

	<u>Prayer</u>	<u>Mean</u>	<u>S.D.</u>	<u>N</u>
Pre-test BDI-II	Yes	25.30	11.05	10
	No	31.30	11.80	10
	Total	28.30	11.54	20
Post-test BDI-II	Yes	17.40	13.32	10
	No	23.00	16.06	10
	Total	20.20	14.64	20

The Relationship between Prayer and BDI-II Cut Scores

Based on cut off scores outlined in the BDI-II manual (Beck et al., 1996), the BDI-II mean pre-test group scores for the experimental and control groups respectively were 25.3 (moderate) and 31.3 (severe). Post-test scores were 17.4 (mild) and 23.0 (moderate) for the experimental and control groups respectively. The experimental group ended the study in the “mild” depression category, while the control group finished in the “moderate” depression category.

Comparing Means and Assessing Change

Due to the difference between the experimental and control groups in mean pre-test BDI-II scores, a repeated measures ANCOVA was utilized. The covariate (pre-test mean BDI-II group scores) was used to statistically control for pre-treatment differences in depression, after randomization. Results are given in Table 5.

Table 5

Analysis of Covariance

Source	df	SS	MS	F	Sig.
Intercept	1	.46	.46	.006	.940
BDIAC	1	3540.21	3540.21	45.494	.000
Prayer	1	3.29	3.29	.042	.840
Error	17	322.89	77.82		

Summary of All Findings

The results of the present study indicate that the difference between the experimental and control groups after the post-test was not significant. BDI-II mean group scores did improve for both groups between pre-test and post-test measures. Although scores for the experimental group were not significantly improved compared to the control group ($F=.042$, $df=1,17$, $p=.840$), the experimental group did score lower during the post-test measure – the only group to score in the “mild” depression category, according to the BDI-II manual (Beck et al., 1996). The control group’s mean score was in the “moderate” category. The implications of this study, as well as this study’s findings, among other factors, will be explored in the following chapter.

CHAPTER V: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter presents a brief summary of the present study, as well as a discussion of the results and what can be concluded from the findings. A review will be made of how these conclusions interact with the study's hypothesis. Additionally, there will be conclusions given about the study's design, measurements, and other methodological considerations. Finally, this chapter will conclude with recommendations for future research.

Summary

A variety of studies and related literature suggest that remote intercessory prayer may be an effective intervention for a range of physiological and biological ailments in humans, as well as plants and animals (Astin et al., n.d.; Byrd, 1988; Dossey, 1996; Harris et al., 1999; Leibovici, 2001; Matthews et al., 2000; Miller, 1982; Nask, 1982; Sicher et al., 1998; Snel & van der Sijde, 1995; Solfin, 1982; Weisendander et al., PIB). Only a few studies have explored the effect of prayer on mental health (Connerly, 2003; O'Laoire, 1997; Tloczynski & Fritzsich, 2002). The present study is unique in that it is one of the few that has explored the effect of remote intercessory prayer on mental health, and more specifically, depression.

To study the effect of remote intercessory prayer, 20 participants were petitioned in several clinics throughout central Virginia. The participants were active clients receiving counseling for depression, which may or may not have been comorbid with other DSM-IV diagnostic categories. Participants were randomly assigned to either a group that would receive remote intercessory

prayer, or not receive prayer. Group admission was determined for each participant by the researcher randomly drawing from a pool of 20 numbers. Those participants who received even numbers were assigned to the prayer group, while those who received odd numbers were assigned to the group that did not receive prayer. Since participants were receiving counseling during the time of the study neither they, nor their respective therapists, knew which group they were assigned to.

As participants were assigned to their groups they took the first Beck Depression Inventory (BDI-II). Information about the participants in the prayer group was recorded on a list, and as they joined the study the information of those in the prayer group (only initials and ages) was sent to intercessors who prayed for those on their list for 28 days. After the required 28 days had ended intercessors returned their required prayer journals, which documented their prayer activity throughout the 28-day period. Participants in the prayer and no-prayer groups were then asked to take the BDI-II for a second time.

Discussion of Findings

Although the group that received prayer finished in the “mild” depression category, and the group that did not receive prayer finished in the “moderate” depression category, the differences between the two group means was not significant ($F = .042, df = 1, 17, p = .840$). Thus, the null hypothesis was upheld.

How Findings Interact with the Hypothesis

The findings show that by the end of the study there was not a statistically significant difference between the group that received prayer and the group that did not receive prayer. However, this does not necessarily mean that prayer did not effect positive change for a variety of reasons. First, although prayer was controlled as much as possible through randomization, complete control of the prayer was not possible. It is unrealistic to assume that only those in the prayer group received prayer and those in the no-prayer group received no prayer. It is possible, and even probable, that participants in both groups prayed for their own recovery, or others, such as family and friends, prayed for them. In fact, this could account for some of the improvements seen in the no-prayer group. Thus, findings may not necessarily counter the hypothesis, that prayer can affect a decrease in depression level, since prayer by collaterals may have been part of the reason for the improvement in mood of those in the no-prayer group.

A second reason the non-significant findings may not counter the hypothesis is due to the nature of change, or “healing” itself. Some literature supports the idea that productive change may result in more dysphoria before there are noticeable improvements in mood (Miller & Rollnick, 2002; Prochaska et al., 1994). Millon (1996) offers this view stating, “Real change cannot be produced unless [the mechanisms that tend to resist change] are suspended, producing anxiety” (p. 13). An increase in depression may not necessarily indicate ineffective prayer – in fact it may indicate that the prayer has been effective in moving the intercessee (the one prayed for) through the painful

stages of change (Prochaska et al., 1994), which in the long term would lead to the most complete change.

Prayers are usually answered in the manner that is most beneficial to the object of the prayer (Dossey, 1993; Sweet, 2004), and for reasons mentioned above, simple improvement in mood may not be the “best” answer for a particular prayer. Thus, when the intercessors in this study prayed not only for “an alleviation in depression and improvement in mood”, but also for God’s “will to be done”, it is possible that they could have been praying for two different things, and the best answer (which did not involve an immediate improvement in mood) was the end result.

Conclusions from the Findings

The first conclusion that can be made from the findings is that prayer may benefit those across religious and spiritual viewpoints. If any of the improvement that participants experienced was due to remote intercessory prayer then the effect occurred across religious affiliation. Half of the participants did not express a Christian worldview on their questionnaires, and they were divided between prayer and no-prayer groups. Participants improved regardless of religious affiliation. This finding is consistent with the literature that proposes the non-discriminatory effects of prayer across religious affiliation (Dossey, 1993). However, all of the intercessors in this study defined themselves as Christian.

A second possible conclusion can be drawn regarding the difference between the prayer and no-prayer groups at the beginning of the study – an explanation made possible by the concept of retroactive prayer, an idea

advanced by Leibovici (2001), and later by Olshansky and Dossey (2003).

Retroactive prayer proposes that the effects of some prayer can be seen before prayers are given, thus lending support to the idea that prayer, like other aspects of the metaphysical, is not subject to the limits of time. Leibovici's study demonstrated a clinically significant result for retroactive prayer in patients treated at a hospital for a bloodstream infection, four to ten years after treatment.

In the present study participants in the prayer group began the study less depressed ($M = 25.30$) than those participants who received no prayer ($M = 31.30$). At post-test it was shown that both groups improved at equivalent amounts, which resulted in the prayer group ending less depressed ($M = 17.40$) than the group that did not receive prayer ($M = 23.00$): This occurred despite randomization. Ultimately, there should not have been a sizeable difference between the mean depression levels of each of the groups before the introduction of the prayer. Thus it may be possible, according to Olshansky and Dossey's (2003) proposal, that the prayers offered by the intercessors in this study could have effected change in the depression levels of those in the prayer group before the study began (and before they prayed), thus explaining the above-stated findings, and showing congruence with Dossey's proposed concept of prayer not being limited by time. However, given the fact that retroactive prayer has received very little attention in the research, more clinically controlled trials are necessary to verify this concept.

Relevant Conclusions about the Present Study's Design, Measurements, and Methodological Considerations

This researcher believes that the double-blind, randomized, pre-test/post-test design was necessary for this study. Using the BDI-II as the tool for measurement was also appropriate, given its respectful consideration in the literature for its ability to measure depression and its clinical utility (Arbisi, n.d.; Barroso & Sandelowski, 2001). The BDI-II was used as the sole tool to measure depression. Perhaps an additional measure of depression level would have provided another level of measurement for comparison, however, given the researcher's desire to make the study as least intrusive as possible in the in vivo clinical arena, using only the BDI-II seemed sufficient. To measure true improvement, factors (mentioned later in the present chapter) other than depression could have been measured.

A consideration must be made regarding the present study's dependent variable. The researcher chose to measure depression, but in the broadest sense. As long as the participants were outpatient clients receiving counseling for any type of depression they were permitted to participate in the study. There were no requirements for a specific depressive diagnosis (e.g., Major Depressive Disorder, Recurrent, Mild; or Adjustment Disorder with Depressed Mood.) Due to the extreme difficulty the researcher had in securing a large number of participants it was necessary to broaden the criteria for depression. Perhaps requiring more specific dependent variables would give insight into which depressive diagnoses, if any, are more affected by remote intercessory prayer.

Another methodological consideration is in regards to the endpoint that the post-test measurement took place. There was only one point at which a post-test measure was taken – 28 days (or as soon as possible) after the first administration of the BDI-II. Perhaps additional post-tests measurements after the 28-day period (say six months and one year) may have indicated additional changes that were not captured at the 28-day point.

Recommendations for Future Research

As it was mentioned in Chapter Three, the researcher encountered significant difficulty in securing a large number of participants for the present study. The only clinics that agreed to participate in the present study were those that described themselves as having a “Christian” orientation. This occurred despite the researcher’s desire and attempt to engage clients from counseling clinics that were philosophically and theologically diverse. Many clinics that claimed to have a respect for comprehensive treatment approaches, and advertised themselves as honoring a holistic view of recovery (including spirituality and prayer), declined to participate.

One of the most significant hindrances to previous prayer research has been bias and ignorance (Sweet, 2004). It is likely that this could have been one possible reason why the researcher encountered such difficulty in obtaining a sizeable number of participants for the present study. Bias was most likely not due solely to potential therapists and agency managers, but also to potential participants. Sweet highlights the challenges researchers face in conducting remote intercessory prayer research on human participants, as opposed to other

subjects, such as plants and biological organisms. Many people are resistant to the study of prayer because they believe it to be sacrilegious, placing God in a “test tube.” Concerning the prayer research Sweet has done on human participants he notes that even though many were deeply religious and firmly believed in the potential for prayer to effect positive change, yet “few volunteered immediately” (p. 57). Thus, one of the most significant questions that must be addressed in regards to future research on remote intercessory prayer is how to address the concern and/or bias of others who either may disagree with the concept of remote prayer outright, or may at least disagree with the particular prayer proposed in a study.

Future researchers may consider copying the abstracts of journal articles on remote prayer (following all copyright guidelines) and sending them, along with a petition letter (similar in format to Appendix A), to potential therapists or agency managers. This would provide them with succinct empirical evidence that would demonstrate that prayer has been an effective and non-harmful object of study. Showing potential, hesitant therapists that prayer studies have previously occurred, without harm to participants, may help to ease the minds of those therapists who believe in the power of prayer but fear that Christian prayer would somehow be detrimental to their client’s health (considering that the most referenced studies on remote intercessory prayer have involved Christian prayer). For other therapists who may be more resistant to the concept of integrating any spiritual themes into research, giving them copies of, or references to, journal abstracts would show them that well-designed, empirical

prayer studies have been conducted, and may help to demonstrate to them the validity of including spiritual themes into research.

For potential participants who may have concerns about participating in prayer research abstracts from research articles may be helpful for some. However, a more helpful solution may be to schedule individual interviews with each potential participant before they choose to participate. This would allow the researcher the opportunity to thoroughly explain the study, and would give potential participants the chance to ask any immediate questions they may have. A friendly and respectful demeanor by the researcher may possibly serve as an assurance to the potential participant of the researchers' intentions and professionalism, and thus possibly make his or her decision to participate more likely.

There is clearly a need for further studies that examine the relationship between remote intercessory prayer and mental health issues. The only study other than the present one which examined the relationship between remote intercessory prayer and depression is by Connerly (2003), which concluded with significant findings in favor of the use of intercessory prayer for depression for 20 participants. Future research should vary the independent variable (prayer) in regards to the number of minutes of prayer per day, the number of days prayed, and the number of intercessors used. In fact, comparing how differences in these amounts of prayer affects depression may provide useful information in answering the question of how much prayer is necessary to establish various degrees of change. Conversely, future studies may demonstrate that these

variables are unimportant, and that other factors may be more important, such as genuine concern or compassion for example.

The need for larger scale studies is also apparent. In order to increase the number of participants in prayer studies, and thus increase the power of statistical tests, it may be necessary to move outside of local areas. The present study petitioned for participants only within the Central Virginia region. Despite this geographic area being located in a part of the country often referred to as the “Bible Belt”, it was still difficult to secure a high number of clients. Future researchers may consider looking at broader geographic areas, such as specific states, regions (e.g., New England states), or even nationally. International studies will also be necessary in order to assess how remote intercessory prayer affects participants in other cultures; these cultures may be significantly different from any culture within the United States.

The present study focused on those receiving outpatient counseling. Although there is still a significant need for additional studies that explore the effects of remote intercessory prayer in outpatient settings, future studies should also give attention to those clients receiving inpatient treatment. Although some of the most referenced studies of remote prayer on physiological illness have been conducted in inpatient settings (Byrd, 1988; Harris et al., 1999; Leibovici, 2001), there have been no known remote prayer studies that have given attention to mental health inpatients.

Future researchers should consider narrowing the criteria for participation in remote intercessory prayer studies in which the dependent variable is

depression. Assessing how remote intercessory prayer affects specific depressive diagnoses (e.g., Dysthymic Disorder; Major Depressive Disorder, Recurrent, Severe with Psychotic Features) is necessary to learn which depressive diagnoses, if any, are more responsive to prayer. Additionally, future research should also examine the effects of remote intercessory prayer on other commonly diagnosed mental health issues, such as anxiety or schizophrenia, given the paucity of research in these areas. Clinically controlled trials for remote intercessory prayer that focus on its effects on substance use disorders should also be considered given the prevalence of substance use in the United States and throughout the world.

Considering what was stated in the conclusions section of the present chapter, mental health issues such as depression may not be the best indicators of true improvement. Since pain can often intensify as one moves through the stages of change, increased depression may occur as one heals. Thus other factors may serve as better indicators of truly effective prayer. Future research may consider measuring factors such as the following to assess true change: A client's insight into their problems, acceptance of responsibility for their behavior, behavioral change, and motivation for change, to name a few. These are some of the characteristics in which Prochaska et al. (1994) and Miller and Rollnick (2002) identify as indicators of true change.

Given that prayer in some manner is practiced in many, if not all, religious and spiritual denominations, another area of future research on remote intercessory prayer may compare the prayer methods of these various traditions

and assess their effects. Blocking together intercessors of specific religious/spiritual traditions and studying their effects, compared to other traditions, may provide insights into the strengths of other prayer styles and traditions.

Intercessors in the present study were required to utilize two types of prayer – both goal-directed (praying for a specific outcome) and non-goal-directed (“Thy will be done”). The literature indicates that these two types of prayer may result in different effects (Dossey, 1996, Sweet, 2004). Future research should focus on exploring the effectiveness of goal-directed and non-goal-directed prayer by isolating each type of prayer and studying their effects separately.

Although prayer may be a controversial topic of study in some academic settings (Dossey, 1993), there is enough support in the literature to warrant additional research. Despite a non-significant difference in pre-test and post-test means between the prayer and no-prayer groups at the end of the present study, the prayer group did conclude with a lower BDI-II score than the no-prayer group – indicating less depression. Perhaps a greater number of participants would have resulted in significant results. There was also a sizeable difference between the two groups at the outset of the study, despite randomization. Although the difference in group mean BDI-II scores between both groups was considered as a covariate in the repeated measures ANCOVA, it can conversely be seen as a possible indication of retroactive prayer effects, which have been

suggested earlier. Given these results, and the support received in the literature, there is justification for continued research on remote intercessory prayer.

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APPENDIX A: INVITATION LETTER TO THERAPISTS

*Remote Intercessory Prayer and Depression: Invitation
Letter to Therapists*

Dear Colleagues:

I am currently involved in a dissertation project exploring the relationship between remote intercessory prayer (Person A praying for Person B outside of Person B's presence) and depression. This study is performed as partial fulfillment of the requirements for my Ph.D. degree in counseling at Liberty University. I am seeking counselors who would have an interest in a study such as this. Results from other studies on remote prayer have been very encouraging and I am looking forward to contributing to this exciting body of knowledge with your help.

Should you choose to participate in this study the only requirements on your part would be to: **1.** Ask those of your clients (age 13 and above) suffering from depressive symptoms if they would be willing to participate in a study exploring the effects of remote prayer on depression; **2.** At the beginning of the study (announced by me) give clients a packet containing an **Informed Consent form, Client Questionnaire,** and **Beck Depression Inventory (BDI-II)**, which your clients may complete in the office (waiting room or available office) and I can be present to pick up (or I can administer at a more convenient time if that is a better option for you); **3.** Administer the BDI-II once again during the end of the study, 28days later; and **4.** Fill out a brief **Therapist Questionnaire** and either place it in my box at Light or send in the provided SASE. Clients qualify if they are suffering from any combination/severity of depressive

symptoms (e.g., Dysthymic D/O, Major Depressive D/O, Bipolar D/O, Depressive D/O NOS, simply numerous depressive symptoms without a diagnosis).

Clients who are already participating in a prayer study will not be eligible for participation in this study.

Clients will be randomly selected to either receive prayer, or not receive prayer. Neither the client, nor you the counselor, will know who has been assigned to which group. Intercessors (those outside the office doing the praying) will receive a list of initials with corresponding ages that will represent those who will be prayed for. Thus, intercessors will not be given any information that would violate the confidentiality of those in the group they pray for.

There are no foreseeable risks to the participant. There will be no sharing of confidential information with anyone, and you the counselor will be asked to do nothing different with your clients beyond what is stated above (administering the BDI-II). An instruction sheet is included with this letter breaking down the general steps in this study.

If you would be interested in participating in this study, or have any questions, please contact me at either of the numbers listed below or simply leave the attached page in my box at Light Counseling, Inc. I am looking to start the study immediately.

Thank you for your assistance!

Jason Wright, LPC, LMFT

*Identifying phone numbers and e-mail addresses have been removed from this version.

APPENDIX B: INSTRUCTION SHEET

Instruction Sheet

The steps to be taken for this study are as follows:

1. Counselors willing to participate will ask their clients suffering from depressive symptoms if they would be willing to participate in a study examining the effectiveness of remote prayer on depression.
2. Counselors will complete a **Therapist Questionnaire** and place in my box. at Light Counseling, Inc., or send in provided SASE.
3. Counselors will give willing clients a packet of information containing instructions explaining the study, **Informed Consent form**, **Client/Participant Questionnaire**, and **BDI-II**.
4. Clients will read the information and if still willing to participate will sign the **Informed Consent form**, fill out the **Client/Participant Questionnaire**, and complete the **BDI-II**. Participants will fill out information in the office and give to the Lights Counseling receptionist.
5. Randomly, participants will be assigned a number between 1 and 20. Those assigned a positive number will be included in the prayer group. Those assigned an odd number will be assigned to the no-prayer group. I will contact the intercessors and ask them to begin praying for the clients who are assigned a positive number (indicated on a list containing only initials and ages – **no identifying information**).

6. After the conclusion of the prayer, in 28 days, I will ask counselors to administer the BDI-II again with the same instructions as previous.
7. Results will be analyzed and the study will be concluded.

APPENDIX C: THERAPIST QUESTIONNAIRE

Therapist Questionnaire

Name: _____

Name of Mental Health

Clinic: _____

1. How long have you been practicing psychotherapy?
2. What therapeutic modalities do you utilize? (e.g., cognitive-behavioral, client-centered, existential, eclectic [if eclectic, what particular therapeutic modalities?])
3. Do you utilize homework? If so, what types of homework?
4. Do you utilize bibliotherapy? If so, what books do you commonly prescribe?

Thank you!

APPENDIX D: INVITATION LETTER TO POTENTIAL PARTICIPANTS

Treatment Effectiveness on Depression: Invitation Letter to Potential Participants

I am currently involved in a research project that examines the effectiveness of remote intercessory prayer (Person A praying for Person B outside of Person B's presence) on depression. The study is performed as partial fulfillment of the requirements for my Ph.D. degree in counseling at Liberty University.

Your participation in this project will provide useful information on this topic. You qualify for participation if you are at least 13 years of age and are currently experiencing any level of depression. **You do not qualify for the study if you are currently participating in another prayer study.**

You will be asked to complete one depression inventory called the Beck Depression Inventory (BDI-II) to assess your depression severity. The BDI-II contains 21 multiple-choice questions and can typically be completed within 5 to 10 minutes. This will be completed once at the beginning of the study, and once at the conclusion of the study, twenty-eight days later. Also, you will be asked to complete a brief questionnaire.

Participation in this study is strictly voluntary. You may withdraw from the study at any point without penalty. All data from the study are confidential and will be used for research purposes only. There are no foreseeable risks to you if you choose to participate. If you have any questions please do not hesitate to contact me at the number listed below.

Please complete the **Informed Consent** form (included in this packet) and leave it with the receptionist (**PLEASE PRINT AND SIGN YOUR NAME IN THE "PARTICIPANT" SECTION OF THE INFORMED CONSENT FORM.**)

Also please fill out the **Client Questionnaire** (included in this packet) and leave with the receptionist. An instruction sheet is included to show you the steps of the study.

In the near future your counselor will be giving you the first BDI-II, which can be taken in the waiting room or in an available office in the clinic: Please leave this with the receptionist.

Thank you for your time!

Jason Wright

*Contact phone numbers have been removed from this version.

APPENDIX E: INFORMED CONSENT FORM

Informed Consent Form

This study analyses the effectiveness of remote intercessory prayer on depression. It is performed as a partial fulfillment of the requirements for the Ph.D. degree in counseling at Liberty University.

There are no foreseeable risks with this research. The main benefit of this research is in contributing to the scientific knowledge on this topic. No costs or payments are associated with participating in this study. You qualify for participation in this study if you are suffering from any form of depression. Twenty counseling clients will participate in this research.

I, the “participant”, agree to participate in this research project and I understand that:

1. The total time required for this study on my part is approximately 15-30 minutes.
2. The nature of my participation includes signing this **Informed Consent form**, filling out the **Client/Participant Questionnaire**, and completing of the **Beck Depression Inventory (BDI)**, once at the beginning of the study and once at the end, 28 days after I take the first **BDI**.
3. My participation is completely voluntary. I may terminate my involvement at any time without penalty. There are no risks to my physical or mental health beyond those encountered in everyday life.
4. All my data are confidential, and only the researcher will have access to my identifying information. All research measures will be destroyed within five (5) years after completion of the study.
5. All data are for research purposes only.
6. I may decline to answer any specific question asked of me.

- 7. If I have questions about this research I may contact the researcher, Jason Wright, by calling (*Contact phone number has been removed from this version).
- 8. Should I have any questions about my rights as a participant in this research I may contact either Dr. Ron Hawkins or Dr. Fred Milacci at the Liberty University Office for Research Protection (*Contact phone number has been removed from this version).

By signing this form as a participant I agree that I am 18 years of age or older. If I am not at least 18 years of age my parent must also sign in the "Parent" section below my name.

PARTICIPANT:

Print name: First _____ Middle _____ Last _____

Age: _____

Signature _____ Date _____

PARENT:

I, _____, as the parent of the above-signed, acknowledge that I understand the steps of this study and agree to the terms stated above.

Parent signature _____ Date _____

Please do not write below line

=====

RESEARCHER:

I certify that the informed consent procedure has been followed and that I have answered any questions from the participant as completely as possible.

Signature _____ Date _____ Case Number _____

APPENDIX F: CLIENT/PARTICIPANT QUESTIONNAIRE

Client/Participant Questionnaire

(Please remember that all identifying information will be kept confidential)

Name:_____ Marital Status:_____ Age:_____

Sex:_____ Race:_____ Occupation:_____

Education:_____

Name of Mental Health Clinic/Therapist_____

1. How long have you been receiving services?
2. Have you noticed any improvements in your mood since starting therapy?
3. Are you taking medications? If so, please give the name(s) and dosage(s) of your medications.
4. Have you ever been admitted to a hospital for depressive symptoms? If so, how many times and for approximately how long on each admission (if more than one)?
5. Do you have any particular religious or spiritual beliefs/practices that you find helpful?

Thank you!

APPENDIX G: SUMMARY SHEET

<i>Summary Sheet</i>				
<i>Participant #</i>	<i>Initials</i>	<i>Age</i>	<i>BDI-II a</i>	<i>BDI-II b</i>
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

APPENDIX H: MODIFIED SUMMARY SHEET

<i>Modified Summary Sheet</i>		
<i>Participant #</i>	<i>Initials</i>	<i>Age</i>
2		
4		
6		
8		
10		
12		
14		
16		
18		
20		

APPENDIX I: LETTER TO INTERCESSORS

Letter to Intercessors

The purpose of my request for intercessory prayer is to analyze the effects of remote intercessory prayer on people receiving counseling for depression. This study is in partial fulfillment of the requirements for the completion of the Ph.D. degree in counseling at Liberty University.

Included with this letter is a Modified Summary Sheet, which includes the initials and age of participants in the study who have been chosen by random sampling to be included in the group receiving remote prayer. Please pray, at minimum, for “the alleviation of depression and improvement in mood” for the participants indicated on this list. Also, praying for God’s will “to be done” for those on this list is also recommended.

Please pray for the participants on this list for 28 days, at least 10 minutes per day. At the end of the 28 days the intercessory prayer may be discontinued. You may receive more than one list, so it will be 28 days for the client(s) indicated on each list respectively.

Additionally, please complete the included prayer journal daily and at the conclusion of the study return this, along with the Intercessor Questionnaire, to me in the included SASE.

Thank you very much for your participation in this important study. Your contribution of time and energy will be a very valuable contribution to this study. If you have any questions or concerns, or at any time wish to stop participating in this study, please call me at one of the two numbers listed below.

APPENDIX J: PRAYER JOURNAL

Intercessor Prayer Journal

Name: _____

Day	Number of Minutes in Prayer	Prayed at Least as Outlined in Letter Yes/No
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
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APPENDIX K: INTERCESSOR QUESTIONNAIRE

Intercessor Questionnaire

Name: _____

1. Do you consider yourself a “born again” Christian (John 3:3)? If not please describe.
2. How long have you been a Christian?
3. Please indicate how strongly you believe in the power of prayer (the potential for prayer to have a positive effect on the one prayed for) by circling a number on the following scale (0=Not at all to 10=As strong as possible):

0 1 2 3 4 5 6 7 8 9 10
4. Are you willing to pray in the manner described in the letter included with this questionnaire?
5. How would you describe your Christian faith? Please circle one, or write out below:

Evangelical Fundamentalist Catholic