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Transpersonal Healing: Assessing the Evidence from Laboratory and Clinical Trials

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Transpersonal or distant healing intention (DHI) is one of the most commonly used forms of complementary and alternative healing. While it is popular, its efficacy is uncertain and the mechanism of action unclear. This article provides an overview of both the laboratory research and clinical trials of DHI, summarizing the state of the field. There appears to be support, based on controlled laboratory studies, for a transpersonal dimension to DHI. Results of randomized, controlled clinical trials are more equivocal. While results do not offer clear evidence to support DHI as an evidence-based modality, this provocative field reveals important epistemological and ontological implications for bridging science and spirituality.

Keywords: *transpersonal, prayer, healing, intention, science*

Transpersonal or distant healing intention (DHI) may be “defined as a conscious, dedicated act of mentation attempting to benefit another person’s physical or emotional well-being at a distance” (Sicher, Targ, Moore, & Smith, 1998, p. 356). Terms used to describe DHI interventions include transpersonal imagery, intercessory prayer, spiritual healing, non-directed prayer, intentionality, energy healing, shamanic healing, non-local healing, non-contact Therapeutic Touch, and Reiki (Braud, 2003; Schlitz & Braud, 1997). Each of these methods involves a distinct theoretical, theological, cultural, or pragmatic approach toward healing through the application of one person’s intention toward another. In each case, there is an assumption that healing can take place under conditions that transcend conventional sensory communication. This assumption is a challenge for both the epistemology of research as well as the ontological assumptions about causality that appear to be violated if healing can occur at a distance and under conditions that preclude conventional mind/body interactions.

DHI, especially in the form of prayer, is one of the most commonly used complementary and alternative medicine (CAM) healing modalities. A government survey of adult Americans by the United States National Center for Health Statistics showed that of the top ten CAM practices, the first was prayer for oneself and the second was prayer for others (Barnes, Powell-Griner, McFann, & Nahin, 2004). Among social workers, a survey found that 28% of over 2,000 respondents had

engaged in verbal prayer with their clients, while 57% privately prayed for their clients (Canda & Furman, 2009). In a survey among 1,900 cancer survivors, 62% reportedly prayed for their own health, 39% had others pray for their health, and 15% participated in group prayer (Mao, Farrar, Xie, Bowman, & Armstrong, 2007). Further, based on general population surveys from 2002 to 2008, the use of prayer for health concerns has continually increased in the United States after taking into account demographics, socioeconomic status, health status, and lifestyle behaviors (Wachholtz & Sambamoorthi, 2011). These surveys indicate the widespread prevalence of belief and utilization in DHI related practices.

The use of personal prayer in healing has shown measurable positive effects (Dossey, 1997). For example, a study of religious and spiritual coping strategies among women newly diagnosed with breast cancer found that the subjects experienced distinct benefits: 91% said that their faith gave them the emotional support necessary to deal with their cancer, and their levels of prayer activity either remained the same or rose during their cancer experience (Feher & Maly, 1999). These findings strongly indicate that self-prayer can provide a psychoemotional benefit for healing. But what is the evidence that there is a measurable effect of distant intention for mental and physical health and healing?

An Overview of the Evidence

Laboratory evidence for the possibility of DHI efficacy has focused primarily on physiological outcomes in

randomized controlled trials. These include changes in the autonomic nervous system of one person in response to the intention of another person (Schlitz et al., 2003; Schmidt, in press). These findings offer a proof-of-principle for a distant healing effect, but do not speak directly to a healing response. Other laboratory studies focused specifically on the healing of wounds. In the first, Grad, Cadoret, and Paul (1961) studied the effects of a noted healer, Oskar Estebany, on surgical wounds in 48 mice as compared to a non-healed control group. Estebany used his hands around the mice to send healing “energy.” Grad et al. controlled for possible artifacts such as possible warmth from the hands and found a significant healing effect in the treated group as compared to the controls. In a later study, successfully replicated, mice exposed to the healer showed significantly enhanced wound healing, suggesting a DHI effect not attributable to placebo effects (Grad, 1965). More recent studies by Bengston (Bengston & Krinsley, 2000) also showed significantly enhanced healing in mice when DHI was directed towards healing of injected, mammary cancer (rather than surgical wounds).

In a meta-analysis, Hodge (2007) reviewed 17 randomized controlled studies of DHI and concluded that the outcomes produced small, but significant, effects for intercessory prayer under both random and fixed effect models, and with and without inclusion of one controversial study (Cha, Wirth, & Lobo, 2001). Masters, Spielmans, and Goodson (2006) focused on 14 studies involving only intercessory prayer and found a positive, but not significant, outcome. In an updated meta-analysis with one additional study, Masters and Spielmans (2007) again found a positive, non-significant outcome. Their data also showed that the DHI effect size, while small, was nearly 15 times larger for unhealthy subjects than for healthy controls, suggesting that need or motivation may play a role in DHI efficacy. Nevertheless, because the overall results were not robust, Masters and Spielmans recommended that further resources not be allocated for this type of research. In the most recent meta-analysis, a Cochrane systematic review, Roberts, Ahmed, and Davison (2009) found fewer deaths in an intercessory prayer condition as compared to standard care controls. The results were again significant for high risk, thus highly motivated, subjects as the object of prayer intentions ($p < 0.00001$). Yet, their conclusion was similar to that of Masters and Spielmans: “The evidence presented so far is interesting enough to support further

study. However, if resources were available for such a trial, we would probably use them elsewhere” (p. 24). While significant effects were reported for DHI, the researchers remained cautious, contributing to a general lack of enthusiasm within mainstream science to continue this line of research, perhaps due to the lack of a theoretical or ontological basis for DHI. Such a stance indicates a general unwillingness on the part of mainstream science to take on topics that pose fundamental challenges to the prevailing worldview.

Recent Clinical Studies in Critique

Several recent studies, conducted in leading medical centers in the United States, suggest that distant prayer for others offers useful insight into the design and challenge of bringing DHI into randomized, controlled, clinical settings. In one study out of Harvard Medical School, Benson et al. (2006) found that a group of cardiac patients, who received intercessory or distant prayer without knowing they were in the treatment group, showed no improvement. For the group who knew they were the recipients of distant prayer, the results were actually significantly worse than the control group. Such a counterintuitive finding brings up an important question. Can knowing one is the object of DHI be harmful? In part, this issue reflects a lack of data and theoretical understanding on what is occurring in DHI. For example, is it important to have an alignment between the intention of the healer and the healee? In addition, these findings reveal the methodological challenges of this research. Are researchers using the correct intervention in these studies? And have they identified the most appropriate outcomes to evaluate? These challenges need to be addressed in future research.

The Monitoring and Actualisation of Noetic Trainings (MANTRA) randomized study, conducted by Dr. Mitch Krucoff and his colleagues (Krucoff et al., 2005) at Duke University Medical Center, is another example of a null result on the primary health outcome. Participants ($n=748$) were divided into two groups, an assigned prayer group ($n=371$) and a control receiving no prayer ($n=377$). The assigned prayer group was then divided into a participant group ($n=189$) receiving bedside noetic intervention (MIT therapy; a combination of therapies utilizing music, imagery, and touch) and prayer, and a group that received prayer only ($n=182$). Of the no prayer group, 185 received bedside MIT therapy only, and 192 received only standard care. The data showed no significant difference for the primary

composite endpoint in any treatment comparison, although mortality at 6 months was lower with MIT therapy than with no MIT therapy. In the final year of participant recruitment, an additional 12 prayer groups were added, and a two-tiered prayer therapy method was established. The second-tier prayer group was not given any patient information (first-tier groups received the name, age, and illness), other than notification that a patient had been enrolled, and was told to pray solely for the group of prayers of the primary-tier congregations. For this portion of the study, a suggestive healing effect was observed in patients when a group of people prayed for the first tier of prayers. This kind of additive effect leaves researchers intrigued and eager to learn more, even when the primary outcome does not support the distant-healing hypothesis.

Further, in an NIH-funded clinical trial conducted by Astin (2007) at California Pacific Medical Center, distant intention had no effect on outcomes for AIDS patients. Interestingly, however, Astin discovered that people in the distant healing treatment group were able to guess to a statistically significant degree (even though they were kept blinded) which group they were in, as opposed to the control group, which did not demonstrate this capacity. The treatment group seemed to “feel” something transpersonal; this feeling just did not correlate with the clinical outcomes that were measured.

In another recent study, Schlitz, Hopf, Eskenazi, Vieten, and Radin (2012) examined the potential variables of expectation and belief. They focused on the effects of DHI on objective and psychosocial measures associated with surgical wounds in 72 women undergoing plastic surgery. Participants were randomly assigned to one of three groups: blinded and receiving DHI (DH), blinded and not receiving DHI (Control), and knowing that one was receiving DHI (Expectancy). Outcome measures included collagen deposition in a surrogate wound and several self-report measures. Experienced distant healers provided DHI. No differences in these measures were observed across the three groups. However, participants’ prior belief in the efficacy of DHI was negatively correlated with the status of their mental health at the end of the study ($p = 0.04$, two-tailed), and healers’ perceptions of the quality of their subjective “contact” with the participants were negatively correlated both with change in mood ($p = 0.001$) and with collagen deposition ($p = 0.04$)—a result consistent with the Ben-

son et al. (2006) study that suggests that while there may be an effect in these studies, it has yet to be established that this effect is in the direction of healing. A post-hoc analysis found that among participants assigned to receive DHI under blinded conditions, those undergoing reconstructive surgery after breast cancer treatment reported significantly better change in mood than those who were undergoing purely elective cosmetic surgery ($p = 0.004$). This analysis again supports the potential role of need or motivation on the part of the patient in DHI studies. If future DHI experiments confirm the post-hoc observations, then some of the ambiguity observed in previous DHI studies may be attributable to interactions among participants’ and healers’ beliefs, expectations, and motivations.

Conclusions

Based on these studies, can one conclude that transpersonal healing and DHI do not impact healing? More controversially, can one conclude that knowing what someone is intending for them can actually cause harm? If so, what about all the people who testify to the healing powers of prayer? Indeed, the popular literature is filled with such stories. Could they all be wrong?

Overall, laboratory studies suggest that there might be some modest efficacy for DHI (Braud, 2003; Schmidt, 2012; Schmidt, Schneider, Utts, & Walach, 2004). However, the clinical application of DHI has yet to be established. Lack of a clear consensus and uncertainty about the key underlying variables has led most analysts to recommend that research funding be directed toward more tractable problems. From a pragmatic viewpoint, such advice may seem warranted. However, if DHI effects are genuine to any extent, even if they manifest only as a small magnitude, high variance phenomenon, or can have negative consequences, then the scientific and medical consequences are profound and additional research is justified. In particular, exploring the extent to which effects of DHI may be attributable to or modulated by patient expectations and resulting placebo effects offers the potential to shed light on the mind-body healing process in general. Investigating how patient beliefs or motivations might interact with DHI may also provide an avenue to answer these questions as well.

There are many difficult epistemological and ontological questions that face researchers who want to do scientific studies on prayer, intention, and

transpersonal healing. Some of the most significant, and unresolved, questions such as what type of intention to use, how often to intend, how to describe what is done so that others can reproduce the results, and how to match the belief system of one person with that of the healer's, have yet to be addressed in the clinical trials.

Does it make sense that healing intentions can be effective independent of any personal relationship between the healer and the healee? Again, existing research simply does not reveal enough to reach firm conclusions based on a dozen studies that have mixed results and that did not control for these factors. What is apparent is that none of the clinical trials made use of *ecological validity*. In other words, the clinical trials were not designed to model what frequently happens in real life, where people may know the person they are praying for and may have a meaningful relationship with that person.

Interestingly, in the Benson et al. (2006) study, the prayer groups were instructed to use a standard prayer that was different from their normal practice. The study did not actually test what the healers claimed had worked in the past for them. It is also clear from the existing studies that very little attention was given to the inner experiences of either the healer or the patient.

Maybe it is time to look at the way questions are asked and methods are employed. Indeed, these factors may be the key to unlocking the mystery of transpersonal healing. For people faced with the trauma of life-threatening illness, learning how to tune in to the extended resources of spiritual care may provide a helpful complement to professional medical care, regardless of clinical research outcomes. The questions remain: Where would newly designed research lead? Should something so meaningful to so many people be given up, or should researchers rethink the assumptions that guide the research? These questions await answers.

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