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Rethinking Prayer and Health Research: An Exploratory Inquiry on Prayer's Psychological Dimension

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A brief literature review of cancer survival trials is employed by the author to raise questions on their design and to bring speculatively into discussion concepts such as “worldview”, “intentional normative dissociation”, and “psychosomatic plasticity-proneness”. Using prayer’s psychological dimension as a way to unite such elements opens new fertile perspectives on the academic study of prayer and health. In this context, it is suggested that a consistent interdisciplinary research agenda is required in order to understand those biopsychosocial factors interconnected within the process and outcome of prayer before attempting to decipher the big answers laying dormant probably within the transpersonal and spiritual layers of human experience.

Keywords: prayer, worldview, intentional normative dissociation, psychosomatic plasticity-proneness, cancer survival, spirituality and health, subjectivity, embodiment, biopsychosocial, spiritual capital, transpersonal capital

The last 20 years have been challenging for those researchers asking the question, “Can psychological interventions promote survival in cancer?” Starting with two promising experiments (Fawzy et al., 1993; Spiegel et al., 1989) interpreted widely as encouraging the possibility that psychological intervention might promote cancer survival, today the academic literature presents a different picture. A collection of recent studies failed to replicate earlier positive results (Cunningham et al., 1998; Edelman et al., 1999; Goodwin et al., 2001, Kissane et al., 2007), while meta-analyses and associated commentaries (e.g., Chida et al., 2008; Coyne, Stefanek, & Palmer, 2007; Coyne et al., 2009; Kraemer, Kuchler, & Spiegel, 2009) signaled the need for more rigorous methodological standards in this research area. Though some published papers outline promising avenues of research (e.g., Andersen et al., 2008; Cunningham et al., 2000; Cunningham & Watson, 2004; Kissane, 2009; Lengacher et al., 2008; Lutgendorf, Sood & Antoni, 2010), from a physiological standpoint, Greer (1999) has drawn attention to the claim that it is highly improbable for psychological processes to play a significant role in the course of most cancers. Still, psychological interventions might contribute theoretically to homeostatic control in those cancers where hormonal and immunological factors may be important (e.g., in breast, gynecological, and prostate,

renal cell, melanoma, and similar cancers). Due to the complexity of processes and cascading events that take place in the lives of cancer patients, it is currently very difficult to attribute causal influence in medical outcomes to any specific psychological intervention when so many variables are implicated. Until consistent progress will be made in this regard (e.g., Gorin, 2010), some of the claims linking psychological states and health outcomes might be critically labeled as “Unproven Medicine” (Coyne & Tennen, 2010; Coyne, Tennen, & Ranchor, 2010).

The above-mentioned situation encourages attention to the methods used to investigate such an intricate subject (Cunningham, 2005; Stephen et al., 2007), especially the reasons why psychological therapies have not robustly addressed the potential “psychogenicity” of some cancer types; this notion refers to the ability of a psychological intervention to elicit significant and permanent changes on key psychosocial factors that are demonstrably linked with biological variables known to determine favorable biomedical outcomes (Temoshok, 2002). Assuming that one’s psycho-emotional life could often play a consistent role in the regulation of many hormonal and neurological events in the body, a major difficulty—one that particularly concerns psychoneuroimmunology researchers—is the identification of the key ingredients

and conditions that activate those pathways related to health-disease outcomes (Kiecolt-Glaser, 2009; Miller, Chen, & Cole, 2009; Walker et al., 2005). For example, in order to exceed the medical prognosis regarding one's cancer survival expectations, that patient would need to change by psycho-emotional means his or her current homeostatic equilibrium, equilibrium already corrupted by the advanced cancer which has by that time adapted successfully to the internal milieu of its host (Cunningham, 1999). This complex but presumably achievable task might require some fundamentally different approaches than those employed by conventional psychotherapeutic interventions. It should be taken into account that self-preservation of humans as a species could be a major reason for which in daily life an individual cannot usually influence, significantly and with ease, his or her own physiology to the point of radically altering the existing homeostatic equilibrium (as in that stance, even a short lasting inability from one's part to consciously control this process would induce instantly severe health problems upon one's body).

Changing Magnification and Perspective

In order to find relevant answers to key questions pertaining to cancer survival, it is necessary to take into consideration the degree of detail and complexity required by this particular topic of inquiry within the general context of cancer research (Mukherjee, 2010), an operation corresponding metaphorically to a significant change of a microscope's magnification factor. Changing magnification and perspective could reveal a different level of detail that implicitly will ask for customized approaches and adequate research tools. Hypothetically, there might be some discrete and insufficiently understood factors that, within specific individual and social constraints, could interact synergically in order to activate or accelerate some body healing processes.

To take a relevant analogy (Reich, 2009), the situation of the person seeking healing from cancer might be comparable to that of that of a professional basketball player, whose success depends on both "nature and nurture": as much on natural endowment (e.g., height, efficient use of oxygen) as on abilities developed during years of training (e.g., speed of running, precision of throws). Recovering from such a serious illness is a feat that requires maximizing all resources, and that tests the limits of human capabilities, just as world-class sports events do. Research in this area thus needs to do more than simply look for norms within health-care-as-usual. As

Abraham Maslow once stated, "If we want to know how fast a human being can run, then it is of no use to average out the speed of the population; it is far better to collect Olympic gold medal winners and see how well they can do" (as cited in Hoffman, 1988, p. 185). Healing cancer is a matter of the extraordinary. If psychological and social life is viewed as a sort of "game" within a Bourdieusian framework of athletic competitions (Calhoun, 2003, p. 275), then taking on the work of attempting to positively influence cancer survival expectations with the assistance of certain psychological interventions implies an Olympic-level effort: putting oneself on the line, being passionately engaged in a struggle with one's own limits, and being aware of the larger picture while remaining deeply committed to valuable personal goals.

If this sports parallel remains credible, some questions will need to be debated in the academic forum. Among them:

Would it be possible to consider as a suitable trial-participant any cancer patient that has been immersed most of his or her life in a variety of mundane activities, rarely related to systematic culture-bound rituals of healing?

Would it be ethical to provide specific and intensive training only to some cancer patients?

Would it be in any way acceptable to put implicit pressure on the trial participants, as improvements in their long-term health status would depend presumably on their personal implication in the training process (though such a supposition has not been previously clinically validated)?

After taking these aspects into consideration, a potential clinically significant result that might emerge following a specific training program should deserve to be considered as comparable with the performance of breaking a world sports record, with the time and effort dedicated to achieving such a goal playing a large contribution in the outcome. Such an approach to cancer survival research shares not only similarities with sports (e.g., it might be hard but not impossible to duplicate high levels of performance) but also significant differences. For example, there is the challenge of assessing participants' ability to follow successfully an intensive training program within a very limited timeframe (added to the general challenging context of one's health status) and the problematic matter (not

detailed in this article) of designing and validating what is “adequate” content for such training activity.

Hypothesis and Terminology

In light of the perspective described above, I suggest that it is improbable for current trials designed to examine the effects of psychotherapeutic interventions on cancer survival to fully succeed or to go beyond statistically significant results. I recognize that any type of intensive training might be a very challenging or even an almost impossible task for those patients with a low level of stamina due to the progression of cancer. Still, assuming that some patients would be willing to join such a training program, I propose three key elements that should be relevant to the health progress of any participant to psycho-oncology trials or possible even to other trials exploring mind-body connection: one’s worldview, intentional normative dissociation (IND), and psychosomatic plasticity-proneness (PPP).

I hypothesize that these factors might significantly impact the final results of such a trial especially if they operate together in using Christian prayer as a vehicle of the intervention. Although such an approach appears to be accessible only to patients acknowledging their Christian beliefs, future research could probably find constructive ways to incorporate its core content into those trials designed to explore the potential health benefits associated with a variety of spiritual paths (e.g., Carlson & Speca, 2011; Didonna, 2009).

The concepts detailed to some extent in the present paper will certainly have diminished relevance if they are not related to a larger theoretical framework (e.g., Atkinson, 2010; Bottero, 2010; Burkitt, 2002; Dillon, 2001; Gerrans, 2005; Harvey, 2010; Hilgers, 2009; Ignatow, 2009; Kontos & Naglie, 2009; Lizardo, 2004; Lo & Stacey, 2008; Pickel, 2005; Vaisey, 2009) that explores from different angles notions such as habitus (i.e., the social world incarnated in individuals through a set of internalized structures or assumptions, often taken for granted and engaged upon without any great deal of prior reflection) and tacit knowledge (i.e., knowledge not consciously articulated by a person but which significantly regulates one’s activities).

In the context of this article, while acknowledging that the definition of terms such as “illness” and “disease” is rather fluid (e.g., Craffert, 2011), illness refers to the way in which people experience a disease or any biophysiological state that is an object of inquiry for the current medical science (e.g., Kleinman, 1988;

Vellenga, 2008). Also, curing (clinical recovery from disease) is not considered a synonym for healing (how regained health is subjectively experienced by the former patient). As objective measures alone often cannot record adequately the emotional and social costs of a disease, the ruptured lives unable to cope with the pain and with the memories of a possibly forever lost health, healing should be seen as a fundamental aspect of human well-being and a necessary part of an authentic state of health. So, “healing” is here preferred to “curing” because no curing is complete without healing, and healing might precede curing.

It is also important to note that three terms repeatedly mentioned in this paper (religion, spirituality and transpersonal) have different meanings despite their significant overlaps. Though it would be acceptable to conceptualize religion at the level of an organized socio-cultural system and spirituality at the level of individuals’ personal quests for meaning and fulfillment (Koenig, McCullough, & Larson, 2001), the examination of these terms within a transpersonal framework might be relevant (Hartelius, Caplan, & Rardin, 2007; Pappas & Friedman, 2007) if salient questions pertaining to the transpersonal experiences in which the sense of identity extends beyond the individual to encompass wider aspects of life and cosmos are to be addressed (e.g., how can we bridge the divide between the consensual world of religiosity and the uniquely private world of spirituality that relates to what might be viewed as the sacred?). While the analysis of these broader concepts and their substantive and functional distinctions is beyond the purpose of this article, the extensive academic literature provided at references may offer readers various definitions and details suitable for their particular interests (e.g., psychology, sociology, anthropology, theology).

Worldview

A patient’s worldview could be loosely defined as a set of beliefs and assumptions that describe reality and define the boundaries of what possibly can be done towards healing by the patient himself or herself with and without additional support (medical, spiritual, etc.). Underused until now as a construct within the mainstream psychological literature (Johnson, Hill, & Cohen 2011; Koltko-Rivera, 2004), worldview encourages attention towards the way patients perceive disease and healing, according to their cultural and social frameworks (Good, 1994; Hughner & Kleine, 2004). Taking into consideration the recent academic literature exploring

from different perspectives the placebo phenomena (e.g., Ader et al., 2010; Benedetti, 2008; Benedetti, Carlino, & Pollo, 2011; Colloca & Miller, 2011a, 2011b; Enck et al., 2011; Finniss et al., 2010; Flaten et al., 2011; Harrington, 2008, 2011; Hyland, 2011; Jonas, 2011; Kaptchuk, 2011; Kihlstrom, 2008; Kirsch, 2008; Kohls et al., 2011; Linde, Fässler, & Meissner, 2011; Meissner, 2011; Miller & Brody, 2011; Moerman, 2002; Mora, Nestoriuc, & Rief, 2011; Myers, 2010; Price et al., 2008; Raz, 2008; Thompson et al., 2009; Vase et al., 2011; Vits et al., 2011; Walach, 2011), it appears that the culture-constructed lenses through which one learns how to interpret the world often influences to various extents many medical conditions otherwise rooted in objective reality.

Though patients are free-willed and autonomous persons, their attribute as relational beings (Gergen, 2000) could shape their personal convictions about healing to such a point that they essentially could be viewed as mere outgrowths of social processes. However, culture seems to be embodied by human beings in ways that are distinct from those encountered in everyday experience as objectified cultural forms (Lizardo, in press) and narrative remains the conventional form of organizing experience and defining identity through the interpretation and reinterpretation of life events (e.g., Bruner, 1987, 2008; Hyvärinen et al., 2010; McAdams, Josselson & Lieblich, 2006; McLean, Pasupathi, & Pals, 2007; Ochs, 2009; Sirota, 2010; Swinton et al., 2011; Whitsitt, 2010). It could be said that as humans, we live in and we are shaped by the stories of our culture or, as one researcher noted, “we lead our lives as stories, and our identity is constructed both by stories we tell ourselves and others about ourselves and the master narratives that consciously or unconsciously serve as models to us” (Rimmon-Kenan, 2002, p. 11). The stories that are told in being lived and lived in being told (Carr, 1986) contribute to the way a person comes to define the limits and possibilities of the world “as it is,” including one’s potential ability to influence psychologically the evolution of a disease such as cancer.

Stories do not appear in a vacuum but within the framework of a culture that is dynamic and never still, and that represents “what we make of the world, materially, intellectually and spiritually” (Gorringe, 2004, p. 3). An interdisciplinary examination is thus required for an authentic understanding of the extent to which meaning is shaped by the nature of our individual human bodies (e.g., Johnson, 2007), of the interaction

between personality traits and culture in shaping human lives (e.g., Hofstede & McCrae, 2004), and of the processes through which the dominant cultural models have instilled to varying degrees in humans many implicit assumptions regarding healing and illness (e.g., Achterberg, Dombrowe, & Krippner, 2007; Garro, 2003; Koss-Chioino, 2006). As illness experience is mapped onto a symbolic space created by the models and metaphors of the medical system (Kirmayer, 2004), the patient’s perceptions and representations give rise to multiple levels of interpretations that may reinforce each other, giving experience profound depth, or may contradict each other, leading the patient into ambivalence (e.g., Watson-Gegeo & Gegeo, 2011), illuminating often the workings of the everyday symbolic violence (Bourdieu, 2002) embedded in the modes of action and structures of cognition belonging to dominant social agents.

Sick people often became patients with terrible suddenness, so personal narratives of illness experience are ways of linking body, self, and society (e.g., Bury, 2001; Feder-Alford, 2006; van de Berg & Trujillo, 2009). It might be that these narratives represent one’s efforts to regain the ability to respond effectively to given challenges gaining increased self-efficacy (Bandura, 1994) by understanding and modifying some of the perceived toxic beliefs. Still, due to the convergent pressure of external and internal forces that can make the patient reluctant to engage confidently with the outside world, questions should be raised on how these narratives are impacted by the cultural customs in oncology wards (e.g., Broom & Adams, 2010; Carr, 2010; Mulcahy, Parry, & Glover, 2010; Speraw, 2009), by the religious function of modern medicine (Wardlaw, 2011), by the inadequate theorizing of health and illness (e.g., Conrad & Barker, 2010; Murray, 2004; Stam, 2000), by the moral dimensions of stigma (e.g., Jackson, 2005; Yang et al., 2007), or by the extent to which health professionals consciously provide “narrative care” to their patients (e.g., Coulehan, 2003; Frank, 2007; Henoeh & Danielson, 2009; Kirmayer, 2003; Löyttyniemi, 2005; Mattingly & Lawlor, 2001). As both literature and psychology involve not only a conception of language and what it does (Jones, 2007; Wear & Jones, 2010), but also adopt as one of their goals the better understanding of individual and social behavior (e.g., Contarello, 2008; Moghaddam, 2004, 2006), realist fictional works about illness (e.g., Moore, 1998) are often able to provide imaginative access to

lived events, deserving to be explored in depth within a suitable academic context (e.g., Ratekin, 2007; Schaff & Shapiro, 2006).

Maintaining psychological well-being during serious illness is both challenging and difficult for the patient (Folkman & Greer, 2000; Lepore & Revenson, 2007), so the illness narratives of cancer survivors should stimulate further exploration of their worldview and of the related inner resources one could use to create order and coherence in the face of a threatening disease (e.g., Broom, 2009; Cantrell & Conte, 2009; Coulehan, 2011; Drew, 2007; Frank, 1995, 2003; Killoran, Schlitz, & Lewis, 2002; Little et al., 1998; Radley, 2002; Richins, 1994; Röing et al., 2009; Sarenmalm et al., 2009; Schilder et al., 2004; Willig, 2009). It would not be unreasonable to hypothesize that, most often unspoken and taken for granted, one's worldview might be shaped by key factors such as subjectivity (e.g., Biehl, Good, & Kleinman, 2007; Crapanzano, 2006; Csordas, 2008; Jahn & Dunne, 1997; Layton, 2008; Ortner, 2005; Willig, 2000; Zahavi, 2005) and self identity (e.g., Hall, 2007; Manzi, Vignoles, & Regalia, 2010; Maslow, 1976; Quinn, 2006; Schwartz, Luyckx, & Vignoles, 2011; van Huyssteen & Wiebe, 2011; Vignoles, Chrysochoou, & Breakwell, 2000; Zahavi, 2009), themselves embedded in a silent web of social constraints and inter-subjective creation (e.g., Baerveldt & Voestermans, 2005; Cohen & Barrett, 2008; Csordas, 2004; Gillespie & Cornish, 2009; Hollan, 2000; Jenkins, 2001; Kabele, 2010; Laughlin & Throop, 2009; Martin, 2000; Moore & Kosut, 2010; Nolan et al., 2008; Pachucki, Pendergrass, & Lamont, 2007; Slocum-Bradley, 2009; Strauss, 2006; Vaisey & Lizardo, 2010).

Intentional Normative Dissociation

A second possible factor in healing is what I will refer to as intentional normative dissociation (IND). As dissociation theorists have noted (Bernstein & Putnam, 1986; Ludwig, 1983; Putnam, 1989), dissociative experiences fall along a continuum ranging from everyday events involving absorption—especially in daily recreational activities (e.g., listening to music, reading novels, watching movies, daydreaming)—to the extreme and relatively rare conditions belonging to pathology (e.g., disorders of memory and identity). Current academic literature (e.g., Butler, 2004) considers that non-pathological dissociation known also as normative dissociation (both terms indicating the presence of normal dissociative processes) implies a change in the

state of consciousness that is not induced organically, does not occur as part of a psychiatric disorder, and involves the alteration or separation of what are usually experienced as integrated mental processes lasting a limited amount of time. Most dissociative experiences are not pathological and allow the individual to disengage from the tension of their present situation, the key ingredient being absorption (Tellengen & Atkinson, 1974); this construct is seen as involving a state of “total attention,” of complete engagement in experiencing and modeling the attentional object. Considered as positive dissociative experiences (Pica & Beere, 1995), they occur during a non-traumatic event when perception of an individual narrows during an intense situation of personal relevance and blocks out the background.

While the ubiquity of non-pathological dissociation in the life of human beings seems to be an accepted fact (e.g., Alvarado, 2005; Budden, 2003; Butler, 2004; de Ruiter, Elzinga, & Phaf, 2006; Hunt et al., 2002; Krippner, 1999; Seligman & Kirmayer, 2008; Somer, 2006), the mechanisms and functions hidden behind the surface of this phenomenon are not clearly identified. Keeping in mind normative dissociation's complexity and its underestimated importance for one's daily life—even when it is just about the pursuit of recreational enjoyment (Butler, 2006), it seems possible to suggest (without clinical evidence) the existence of a normative dissociative experience that is intentionally, if often unconsciously, cultivated: IND.

If ordinary, normative dissociative events that most people experience could be defined as brief, usually uncontrolled, and superficial (in terms of the depth and stability of attention focus), the participants in search of deeper personal transformation deliberately train themselves to partake in IND activities that eventually lead to significant identity transformations, reflected also into one's experience of the external world. Although I am aware of the “Singlestate Fallacy,” briefly defined as “the erroneous assumption that all worthwhile abilities reside in our normal, awake mind/body state” (Roberts, 2006, p. 105), IND may be relatively unrelated to the known spectrum of altered states of consciousness. The IND process shares similarities with the institutionalized forms of trance (Bartocci & Dein, 2005; Castillo, 1995; Krippner, 2009; Vaitl et al., 2005) only to the extent that it requires a conscious practice of controlling attention in order to disengage oneself to the desired degree from the surrounding environment.

As here defined, IND is usually accompanied by an increase in the cognitive and emotional functioning, inducing positive consequences on one's consensus consciousness—a general label for the state in which one spends most of the time, an active, semi-arbitrary construction shaped fundamentally by the culture one is raised in (Tart, 2001). One's habitual state of consciousness might be consistently influenced by the collective assumptions and cultural values of the society one lives in, thus allowing the dissociation to become a central element in some types of healing processes performed mostly in certain areas of the world (Cardena & Cousins, 2010; Cardena & Krippner, 2010; Chapin, 2008; Schumaker, 1995; Seligman, 2010; Winkelman, 2004). Such a concept, if empirically verifiable, might be of help in clarifying the relation between dissociation, cultural variability, and religion (e.g., Dorahy & Lewis, 2001).

Psychosomatic Plasticity Proneness

A third dimension related to healing process, psychosomatic plasticity proneness (PPP), is proposed here as a way to conceptualize the psychosomatic potential possessed to various degrees by each human being and used, often in an implicit manner, to turn personal psycho-emotional content into a bodily reality. Psychosomatic is, of course, a term widely accepted as referring to the inseparability and interdependence of psychosocial and biologic aspects of human beings (Engel, 1977; Lipowski, 1984). If this proposed construct is in some measure valid, it would then follow that without the discrete mediation of PPP, psychosocial factors cannot contribute significantly to the progression of a disease or to the regaining of health.

If PPP's existence as a catalyst can be validated empirically, future research may well show that it has a strong connection with transliminality, a perceptual-personality construct referring to a hypersensitivity to psychological material originating in the unconscious, and/or the external environment (Thalbourne & Maltby, 2008). As with dissociation, PPP falls presumably along a continuum, its impact ranging from discrete subjective and physiological changes (visible as the mild forms of placebo and nocebo effects) to extreme physiological manifestations (e.g., Jawer, 2006; Seligman, 2005). I suggest that PPP can perhaps be stimulated or inhibited to a large extent by the complex and multi-layered interaction between one's identity and social forces,

thus playing a significant role in the incorporation of the social body into the physical body (Kleinman & Kleinman, 1994).

Prayer Brings Together

Worldview, IND, and PPP in Promoting Health

The act of prayer is usually understood as one's way of communicating with a divine power and, while the activities involved in it vary widely, it can be considered as perhaps one of the most remarkable culturally-mediated forms of normative dissociation and a ubiquitous religious phenomenon. Due to its intentional dimension and its large acceptance in various cultures as part of social narratives across an extended period of time (Crook, 2007; Geertz, 2008; Janssen & Bänziger, 2003; Levine, 2008; McCullough & Larson, 1999; Neyrey, 2001), the sustained practice of prayer might be able to piece into a single whole the three previously discussed elements pertaining to healing: worldview, IND, and PPP. Often used by Christians as a way to build a personal relationship with God (Luhmann, 2005), investigating prayer's place within the process through which supernatural order is known and experienced by believers could offer a glimpse into the trained absorption skills shared by those lay people manifesting significant spiritual and transpersonal experiences (Luhmann, 2004). A recent hypothesis (Luhmann, Nusbaum, & Thisted, 2010, p. 67) proposed that "learning to experience God depends on interpretation (the socially taught and culturally variable cognitive categories that identify the presence of God), practice (the subjective and psychological consequences of the specific training specified by the religion: e.g., prayer), and proclivity (a talent for and willingness to respond to practice)."

In Christian scripture, the intentional practice of dissociation as a learned behavior is stated explicitly: "Therefore I tell you, whatever you ask for in prayer, believe that you have received it, and it will be yours" (Mark 11:24). Framing this verse in relation to the previously presented psychological elements might mean, for example, that for a meaningful prayer, one should dissociate oneself from the present condition of illness by seeing it as fragile and volatile against the general cultural conditioning and often against objective medical proofs. Simultaneously, one should live in the grateful habitual assumption of the wish fulfilled until relief is felt and a deep conviction in an active healing process is installed, as one cannot longer yearn for something that has been already granted. It thus appears

that prayer, in order to be effective to a greater degree, requires a devoted believer. In this context, religious devotion might be understood as representing a believer who is psychologically endowed with a high ability to become absorbed, to reach a flow state of energized and habitual focus, being able to direct with ease its stream of attention towards internal, mental stimuli (making more lively and natural the representation of fulfillment) while simultaneously disconnecting themselves from those palpable evidences that at least temporarily deny the possibility of one's predictable healing.

As one acts everyday according to a complex system of references and justifications, each human being could be considered, psychologically speaking, a believer in his or her own worldview. Within a cultural perspective (Ward, 2005), what might separate a devoted believer from an individual without a strong religious and spiritual credo is whether his or her worldview is fundamentally shaped and reinforced both by a religious tradition and personal spiritual experience. In the case of Christianity, this might require a familiarity with relevant Christian scripture and the conviction that God is permanently present in his or her life, thus providing a sense of existential security. If a devoted Christian believer accepts as truth the above mentioned scriptural verse and decides to act according to it, then it might entail embodying the desired wellness by assumption, suspending disbelief to such extent that he or she is able to "imagine" his or her own health or, according to this word's Latin roots, to "conceive" it within, to become pregnant with it. At a cognitive and emotional level, this embodiment might happen through a sequence of epiphanies (McDonald, 2008) culminating with a radical ontological shift towards a spiritual identity. As such identity is often defined by how the individual ego relates to and incorporates spirituality into its personal sense of self (MacDonald, 2009, p. 90), in the devoted believer's case a spiritual identity should fundamentally rewrite one's illness narrative and offer a release from psycho-emotional, internalized constraints that are non-conducive to healing.

The psychological act of conceiving the desired state of health is neither superficial nor easily duplicated. Still, it is an act as essential to a prayer for health as physical conception is for giving birth to a child. Though locus of control is external in a God-centered worldview, following the metaphor of the sailboat aligning itself with the wind (Ellens, 2010), such alignment may

involve a great deal of activity by the sailor; the task of habitual dissociation from one's illness while gratefully assuming the sensory vividness of the desired health state is a challenging task that may require an extensive adjustment of one's identity and lifestyle. According to this perspective, God is not factored out of the healing, nor is God manipulated to do one's will (e.g., Pretorius, 2007; Pretorius, 2009). While it is not the purpose of this paper to engage in theological debates regarding the relationship between human beings and a Christian God, or any kind of divine power, it must be stated that a prayer-based approach is necessarily based on the presumption that God, however understood, will always grant some form of healing to any believer who expresses in his or her identity and spiritual practice a stable constellation of elements (some of which are tentatively explored in this article).

Various hypothesis involving God are for obvious reasons often impossible to test empirically; however, for experimental purposes it could be suggested that a devoted believer is better at praying than a non-devoted believer, to the extent that one deliberately uses the available personal freedom in order to choose not just to believe in a Divine Power but to transform that decision into a starting point for a profound and long-term engagement in the delicate construction of a healing-prone spiritual identity. Following this path, one might be more likely to benefit from whatever as-yet scientifically unknown healing mechanism that may have given rise to traditional beliefs in divine healing (e.g., Breslin & Lewis, 2008; Levin, 1996). Anchored in the general assumption—with significant moral ramifications—that health is a desirable state of being for any individual, prayer for health might have a higher level of congruence with one's worldview and with the general support that a family or a community could provide to a patient, in contrast with prayers for attaining other goals that might be more or less ethically and socially acceptable.

All Prayers Are Not Equal in Faith

Beyond understanding prayer as a way of fostering connectivity with the self, with others, and with the Divine (e.g., Ladd et al., 2007), at its very core it remains a petition (Capps, 1982) structured according to one's worldview (Cadge & Daglian, 2008; Levine et al., 2009; Ridge et al., 2008). From a psychological perspective, for the devoted believer, prayer might be a meaningful path that will help reincorporate health into one's life.

Still, to various degrees, prior to actually performing the embodiment of health, the inner transformations related to the healing outcome could be cognitively processed by any believer as an alien, inaccessible experience of radical otherness.

The Christian Bible can be seen as the most important religious book for a Christian believer, a book whose words are intended presumably to form and shape that person's life. A Christian re-appropriates the biblical text by engaging its testimony and probably by including those passages that they find relevant and resonant with prior life experience into a very personal and profound psychological drama, eventually changing their identity to various extents in the pursuit of healing and fulfillment. Its statements and transformation stories repeatedly underline the idea that prayer is meaningless and ineffective without faith (e.g., Mark 11:24, "Therefore I tell you, all things whatever you pray and ask for, believe that you have received them, and you shall have them"; Mark 9:23, "Jesus said to him, 'If you can believe, all things are possible to him who believes.'"). Besides the various interpretations that one might give to these verses, faith could psychologically be assimilated with a vividly-experienced, healing-conducive worldview.

To a certain extent, faith is "hermeneutical" (Brümmer, 2010; Schutte, 2011) and could be viewed as a specific adjusted filter, performing a radical interpretation of one's human experience. This means much more than just accepting at the cognitive level some type of religious convictions while at a closer look significant emotional ambivalences might await to surface. Religious faith appears to be for Fowler (1981) an "orientation of the total person" involving an "alignment of the will" and "a resting of the heart" compatible with "a vision of transcendent value and power, one's ultimate concern," faith serving "to give purpose and goal to one's hopes and strivings, thoughts and actions" (p. 14). Though such process of interpretation takes place according to a heritage of religious metaphors and often activates even some desirable role-taking conduct (e.g., Capps, 1982; Kuchan, 2011), one's personal way of responding to "transcendent value and power as perceived and grasped through the forms of the cumulative tradition" (Fowler, 1981, p. 9) could go deeper into the cultural reality of some specific state of consciousness resonant with biblical phenomena (Pilch, 2004; Craffert, 2010; Bowie, 2011).

The power of one's prayer-ritual language needs to reverberate and evoke one's faith, thus granting an

essential performative dimension to any prayer act, but especially to one's prayers for health. Praying implies a relationship of trust and dependency with a Divine power (Levin, 2009), a relationship manifested through the absence of anxiety, so that faith seen as worldview should be a deeply inhabited aspect of one's life. If this very difficult step that requires a trained ability to habitually dissociate in a normative way from the sensorial aspects of a disease is successfully accomplished, then from the psychological point of view it will make redundant any expectation of gratification; in the assumed identity of the devoted believer, emotionally saturated with devotion and gratitude, health has already been restored at a subjective level and with persistent confidence will grow objectively visible according to the strength of one's faith and the discretion of divine grace.

It might not be an exaggeration to claim that any paradigmatic worldview of the 21st century is, globally speaking, a scientific-prone one, the hegemonic influence of the media shaping even the ambiguities of one's narrative. Implicitly, for research purposes, faith cannot be conceived as being a standardized and identically shared component of most believers' life. Beneath the seemingly naturalness of any type of worldview, be it religious, spiritual, or secular, lies an intricate web of constructed meanings, individual-specific elements blending fluidly with those that are socially-enforced and perpetuated (Csordas & Lewton, 1998). While the rationalization of suffering has radically increased in the last decades (Davies, 2011; Youll & Meekosha, in press), the threat of a disease such as cancer could still restructure one's worldview in a short period of time and to a significant extent, for better or for worse. For this reason, some consideration should be given to the idea (Cavanagh, 1994) that the cancer counterpart to the dictum "there are no atheists in foxholes" might be, "there are no atheists in oncology and bone-marrow transplant units." In this context, if suitable help is given to patients who are open to new therapeutic approaches, the radical inner transformations required for health embodiment might be achieved in cases where worldview, IND, and PPP are blended adequately.

The Production of Healing Requires Capital

In the last decade, a large number of researchers (e.g., Berry, 2005; Chiu et al., 2004; de Jager Meezenbroek et al., in press; King & Koenig, 2009; Zwingmann, Klein, & Büssing, 2011; see also the field analysis on www.metanexus.net/tarp) advocated that a sustained

interdisciplinary effort must be made in order to identify and clarify the ambiguity of definitions and the inadequacy of measurements that make problematic many discussions on spirituality. For example, according to a general sociological perspective on spirituality (e.g., Flanagan, 2008; Knoblauch, 2008), this concept is related to spiritual capital, a type of capital embodied in the knowledge, abilities, and dispositions an individual has amassed in the field of spirituality (Verter, 2003; Guest, 2007). Within this framework, it could be said that in the childhood period, the complex acquisition of spiritual capital is probably influenced by the child-rearing process through which culture gets internalized (Bloom, 2004; Quinn, 2005, 2010; Seymour, 2010; Sirota, 2010) and implicitly by the availability of emotional capital, a resource essential for the adequate psycho-social development of any individual (e.g., Reay, 2004; Turner, 2010).

Later in life, depending on the development taking place in adolescence and emerging adulthood (Barry et al., 2010; Dean, 2010; King & Roeser, 2009), the initial stock of tacit knowledge one possesses could suffer a complex process of cultural disempowerment (Büssing et al., 2010), reducing one's capacities to cope meaningfully with illness, suffering, and death (Oman & Thoresen, 2003). Such depreciation, related probably to individual secularization (Spickard, 2007; Wood, 2009) and to the hidden expressions of the secular body (Asad, 2011; Hirschkind, 2011), is a consequence of various complex processes, a highly significant one being the extent to which postmodern subjectivity is shaped by media consumption (e.g., Marsh, 2006, 2007; Meyer, 2009; Milford, 2010; Scharen, 2006; Turner, 2008) more visibly through the particular relationship developed in recent times between the viewer and the TV (e.g., Winston, 2009; Ott, 2007a, 2007b). Though religious involvement appears to be the product of both genetic and social-environmental influences (Bradshaw & Ellison, 2008), it may be that transliminality is more related to genetic factors while, especially in secular societies, a child inherits religious and spiritual capital mainly from family.

Researching transpersonal and spiritual aspects of human existence involves not just abstract theoretical endeavors but practical matters also, some of them related to health issues (e.g., Ellens, 2009; Elmer, MacDonald, & Friedman, 2003; Louchakova & Warner, 2003). The speculative perspectives on prayer for health proposed in

this article sometimes share similarities with mystical practices (e.g., Hunt, 2006; Daniels, 2003; Ellens, 2009), making challenging the process of testing them within a secular setting. In this fluid context, what could be seen as a "production of healing" through the mediation of prayer may be fundamentally dependent upon and enhanced by one's ability to transcend the dense rational and emotional ceiling derived from and enforced by the normative cultural patterns of secular societies.

Though the concept of transpersonal capital is not novel within the academic literature and it relates to the connection between the corporeal and the social (Kleinman & Kleinman, 1994), I choose to loosely redefine it in a different manner and within a specific psychological framework, hoping to make more clear the speculative network of arguments presented in the paper. Assuming that one's spiritual worldview is constructed with the help of brief but profound transpersonal experiences which provide penetrating, transforming insights into one's identity, I suggest that acquiring transpersonal capital requires at a primary level a conscious individual effort to inhabit and maintain a credible spiritual worldview, found to be largely congruent with the person's own mediated and unmediated life experiences.

Building such congruence while living mostly in a secular environment could be compared to some extent with the acquisition of a muscular physique (which cannot be done at second-hand, but entailing personal costs and life choices). The formative transpersonal experiences resulting from daily spiritual practice are difficult to generate at will and although in many cases such life events are rare and eventually turn into background memories, it might not be unusual for the people who have them to consider themselves as belonging to a so-called cognitive minority, defined as "a group of people whose view of the world differs significantly from the one generally taken for granted in their society ... a group formed around a body of deviant knowledge." (Berger, 1963, p. 18). The upgrading of brief transpersonal insights and peak experiences into enduring understandings and stable plateau experiences (Walsh, 2011, p. 121) is probably mediated to a large extent by IND and it represents a fundamental part of the embodiment process through which transpersonal capital is gained.

Such a challenging endeavor of self-fashioning leading to a robust spiritual worldview offers a new

relevance to one's level of committed implication in its own governance through the selection and usage of appropriate technologies of the self, technologies seen as forms of knowledge and strategies that make possible the construction of one's identity (e.g., Nielsen, in press), allowing "individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault, 1988, p. 18).

As contemporary miraculous healings seem to imply enormously accelerated natural healing processes (Nichols, 2002), a spiritual worldview might stimulate not just existential and psychological wellbeing (Ellison, 1983; Ryff, 1995) but also those practices dependent of specific states of consciousness (Tart, 2001) and probably involved in gaining access to exceptional inner resources. Deepening the supposition, these resources might become physiologically active following transformations in the mechanisms of human plasticity, recent research on epigenesis suggesting that sustained experiences could be able to affect both brain structure and function (e.g., Belsky & Pluess, 2009; Cole, 2009; Kitayama & Uskul, 2011; van IJzendoorn, Bakermans-Kranenburg, & Ebstein, 2011; Masterpasqua, 2009; Park & Huang, 2010; Roberts & Jackson, 2008; Wessel, 2009).

Conclusion

This speculative article should be viewed more like a minoritarian manifesto calling for increased communication within and across diverse research fields, a gentle provocation for a conceptual boldness derived from cross fertilization of ideas and sources of empirical evidence with the aim of nurturing theoretical integration and tangible applications. As such, exploring the psychological dimension of prayer in health research is not an attempt to find support for some kind of religious ideological agenda. Though prayer should not be crippled by the daunting task of exploring the ineffable in a positivistic manner (Ellens, 2009), it also should not be conceptualized a priori as just a one-way transmission (a form of monologue with oneself) or as a communication without a verifiable closure (missing some sort of evidence that God heard one's prayer).

In order to gain a more elaborate understanding of the prayer phenomenon, exploring in depth its role in one's healing process requires constructive scholarly conversations particularly within the boundaries of social

science. A coordinated academic effort to identify and conceptualize the key psychosocial factors involved in the human healing process might provide in a decade a refined perspective and even some encouraging empirical results (Ellens, 2009). The designs used in the various empirical experiments of the last decades on prayer and health (most recently reviewed in ap Siòn & Francis, 2009) might need substantial refinement, at least with regard to the "prayer" and "faith" concepts. Keeping in mind that prayer practices might differ significantly within Christian communities, researchers involved in the academic study of such complex subject should create new interdisciplinary methodologies, sensitive to the intricate facets that prayer entails before claiming a definitive answer regarding its impact on health and wellbeing. As different forms of religious praying are defined also by diverse cognitive features (e.g., Schjoedt et al., 2009), a more accurate conceptual understanding of what prayer is and how it might work within a biopsychosocial framework should be developed. Renewed sociological interest in prayer research (Mason, 2011; Giordan, 2011) suggests that prayer might be re-theorized as the most fundamental religious act and conceived as a profoundly social activity (even the so-called "private prayer").

Though the research on the formation of identity and subjectivity in relation to health (e.g., Whyte, 2009) should be integrated into the larger framework of individual and collective worldviews, the researchers should not chase for an ever-increasing complexity that will inevitably lead to the entrapment within specification, in a futile effort to record the fluid territory of human experience. The parallel with sports intensive training suggested in the cancer survival section of this article should be considered as useful also in the empirical research on prayer and health. As humans, we enculture ourselves through the formative aspect of training and this deliberate and performative practice will not only recontextualize implicitly prior experiences but it might also offer in time an accurate feedback on how to design suitable trial experiments. At a time when secular societies are diving into a new age of acute anxiety and "ecstasy deprivation" (Bourguignon, 2003), inner authenticity appears to become an essential part of a postsecular spirituality (van Aarde, 2009). For a potentially successful health embodiment, faith as worldview—that sharp and habitual awareness of the "nearness" which empowers—would definitely require a lot of intense and persistent preparation, probably close

to the extent of those rites of passage explored usually in ethnographies on spirituality (e.g., Turner, 2006).

It is beyond the purpose of this paper to correlate in detail its content to related areas of inquiry such as:

religion, spirituality and health (e.g., Hefti, 2011; Hill et al., 2000; Koenig, 2010; Koenig, McCullough, & Larson, 2001; Levin, 2010; Levin, Chatters, & Taylor, 2011; McCullough & Willoughby, 2009; Miller & Thoresen, 2003; Lee & Newberg, 2005; Oman & Thoresen, 2002; Park, 2007; Stefanek, McDonald & Hess, 2005; Thoresen & Harris, 2002)

gratitude (e.g., Emmons & McCullough, 2003; Lambert et al., 2009; McCullough, Kilpatrick, Emmons, & Larson, 2001; McCullough, Kimeldorf, & Cohen, 2008; Sheldon & Lyubomirsky, 2007; Wood, Joseph, & Maltby, 2008; Polak & McCullough, 2006)

intercessory prayer (e.g., Cadge, 2009; Dossey & Hufford, 2005; Hodge, 2007; Masters & Spielmans, 2007; Schjoedt et al., 2011; Schlitz & Radin, 2007).

To minimize such limitations, the references provided by this article may help interested readers grasp the current state of research in these promising areas.

While the psychological process of praying for one's health considered here lacks detailed explanations based on experimental data and thus might be controversial in the larger communities, I hope that the present article will at least increase awareness not only of the immense potential that lies ahead, as yet unexplored, but also to the difficulties implied by a rigorous interdisciplinary research on human nature and experience (e.g., Ammerman, 2006; Belzen, 2009; Belzen & Hood, 2006; Bender, 2010; Cadge, Levitt, & Smilde, 2011; Chamberlain, 2000; Chibeni & Moreira-Almeida, 2007; Cromby, 2011; Crammer et al., 2011; Cunningham, 2007; Davis, 2003; Edgell, in press; Gergen, 2010; Goertzen, 2008; Henrich, Heine, & Norenzayan, 2010; Hickey, 2010; Horneber et al., in press; Jones et al., 2009; Lengacher et al., 2003; Louchakova & Lucas, 2007; Newberg & Lee, 2005; Notterman, 2004; Ray, 2004; Salsman et al., in press; Schroll, 2010; Slife & Richardson, 2008; Stenner et al., 2011; Taves, 2009; Walach, 2007a, 2007b; Walach & Reich, 2005; Walsh & Vaughan, 1993; Valsiner, 2009).

It should be generally recognized that past and present endeavors in the field of prayer and health

have only marginally explored the complex aspects involved in those intensely intricate phenomena associated with the field, so it will take some time to crawl before walking. From such perspective, more substantial attention should be given to understanding those biopsychosocial factors interconnected within the process and outcome of prayer before attempting to decipher the big questions lying dormant within transpersonal and spiritual layers of human experience. In other words, extending the sailing metaphor, social science researchers should pay special attention to the way lived socio-cultural meanings are shaping the sailor's human development. Under the pressure of a persistent and implicit enculturation process, previously learned and often unchallenged meanings are binding the sailor firmly to the collectively sedimented assumptions about the sailing experience. Inevitably, these meanings will end up shrinking the sailor's independent choices, leading to a predictable but possibly unsatisfactory chance of reaching the desired spiritual horizon and/or health outcome (Ellens, 2010).

Past medical and social science research has failed to offer to the academic community the clinically significant results that would have supported beyond doubt the idea that prayer can improve to a large extent, in a relatively predictable manner, one's physical and mental health. In such context, concluding that further trials of this type of intervention should not be undertaken (using the resources available for the investigation of other questions pertaining to health care) might seem like a reasonable idea to many researchers. Contrary to this line of thought, the present article claims that stopping the research on prayer and health or even continuing it while using conceptually unsuitable designs could delay valuable academic progress.

Pursuing emergent paths to new knowledge on prayer and health issues should imply trying first to describe accurately one's individual experiences confined within the margins of an apparently mundane consensual trance and latter carefully identifying the possible healing-prone patterns. Such a complex task would probably require a persistent, stimulating and unsettling search for new forms of theorizing about lived experience (Good, 2010), but in time some of the laws that govern the ineffable will eventually become clearer and arguably easier to integrate into the mainstream paradigms of the future academic endeavors (as they might be currently beyond scientific understanding not by definition, but by

virtue of remaining at the frontier of that understanding). In the end, the study of prayer-mediated healing should become an opportunity towards a deeper reflection on what it means to be human, a chance for the academic community to explore respectfully but inquisitively the deep Inner Space, the ultimate Final Frontier.

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