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If patients take medications for an illness they have asked God to heal, does that constitute a breach of faith?

PROMOTING COMPLIANCE When Faith Gets in the Way

By Barbara Lodge Haynes

ABSRACT: *Sixty-six percent of U.S. Christians report they believe God can heal supernaturally, 68% have prayed for someone to be healed supernaturally by God, and 27% state they have experienced a miraculous physical healing. Christians who hold such beliefs may struggle with seeking and adhering to a prescribed healthcare regimen, as well as experience shame. A health education seminar assisting congregants to view healthcare as compatible with faith was implemented and evaluated in a Christian faith community.*

KEY WORDS: *Charismatic, Christian, compliance, faith community nursing, health education, prayer, supernatural healing*

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A large Christian congregation hears a moving sermon about how God heals. From the pulpit, an invitation to come to the front of the room for healing prayer has been given. Hands are laid on each person, and prayer is offered, requesting miraculously healing. People sense the Spirit of God moving; some experience a sense of healing, and some are healed.

But John and Mary do not experience healing. And, to avoid embarrassment, they fake it *and give a* good confession *(that they are being healed), while wondering if it is a lack of faith or some personal defect that prevented them from being healed (Keefauver, 2015). They ask themselves,* What did I do wrong?

Whether a healthcare professional believes that divine healing can occur, many patients *do* believe, and as such, find themselves in a dilemma: If they take medications for an illness they have asked God to heal, does that constitute a breach of faith? Although a healthcare professional may discount such a consideration, such scenarios are moral and ethical issues for *some* Christian believers, particularly those who believe in supernatural healing, such as charismatic, Pentecostal, and some evangelical Christians. A recent study revealed that 66% of Americans believe God can heal supernaturally, whereas 68% have prayed for someone to be healed supernaturally by God; 27% say they "have actually experienced a physical healing that could only be explained as a miraculous healing and not solely as a result of normal process, medical procedure, or the body healing itself" (Barna, 2016).

The purpose of this article is not to debate the validity of Christian beliefs about healing, but to help Christian nurses learn how to assist those who hold such beliefs in promoting their health through adherence to prescribed healthcare treatment. A project was developed and implemented in one charismatic congregation to assist congregants in viewing medical compliance, not as a lack of faith but rather as a blessing from God for health and healing. The goal was to help congregants adjoin faith and health (Pappas-Rogich & King, 2014).

CHRISTIANS AND COMPLIANCE

Many studies exist regarding causative factors contributing to noncompliance with the medical regimen. Such factors include medication costs, side effects, level of medical literacy, and fear of addiction (Brown & Bussell, 2011). Within the U.S. population, 60% of patients admit to being noncompliant with prescribed medical regimens, and the number is higher for those with mental illness (Corrigan, Rüsch, Ben-Zeev, & Sher, 2014).

Understanding two Christian ideas about healing may help faith community nurses (FCNs) more effectively understand congregational needs for health education. The first is a reluctance to seek professional healthcare. One study analyzed Protestant Christians' responses regarding whether it was acceptable to seek help for psychological problems, or whether those problems required only a spiritual/religious answer. The majority not only indicated a reluctance to seek professional help but felt it was doubtful that medical interventions would help (Royal & Thompson, 2012). Another concern is that some Christians tend to seek help from religious leaders, who may have skewed constructs of medication compliance and understanding of treatment, particularly regarding mental illness (Anthony et al., 2016; Royal & Thompson). However, Levin (2016) found that more than 75% of Americans (not charismatics) have used prayer for healing alongside regular healthcare, not as a substitution.

A second influencing idea is the use of complementary and alternative medicine (CAM) (Brown, 2013). Research links the use of CAM with noncompliance to a prescribed medication regimen (i.e., Krousel-Wood et al., 2011). As an FCN, I've heard, "What else can I do [that does not involve seeing a healthcare professional]?" The issue is so widespread in the congregation I serve, that I've sought advanced education and certification in holistic nutrition.

The exact reason for the use of CAM is unknown; however, one study indicated that: "Most [Christians] felt that herbals were safer than prescription medications and preferred their use" (Gray & Rutledge, 2013, p. 6). Brown (2013) argues that since the 1960s, CAM promoters subtly moved alternative therapies, especially energy-based therapies, from the realm of quackery and *New Age idolatry*, to scientific, nonreligious healthcare and fitness techniques. In other words, users believe CAM is scientifically supported and safe and has nothing to do with religion, all of which may not be true.

THE HEALTH BELIEF MODEL

An issue for health promotion is the question of *critical health literacy*, defined as the skill to "critically evaluate and use information to gain greater control over the situation" (Pender, Murdaugh, & Parsons, 2015, p. 267). The Health

> 66% of Americans believe God can heal supernaturally, whereas 68% have prayed for someone to be healed supernaturally by God.

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Belief Model suggests people must believe something is a personal threat to their health before they will treat, and that benefits of treating the threat outweigh barriers to treatment. The model, then, deals primarily with perceptions of an individual or, in a cultural sense, a group of individuals. Perceptions include how severe the person thinks the threat is, what the person thinks are the benefits of avoidance of treatment of the threat, how much the intervention will cost, and what psychosocial motivations are present to comply or not comply (Pender et al.). The influence of psychological motivations is reinforced by Lewin (2011), who postulated forces exist outside of the individual that either persuade the person toward or away from compliance. This can be particularly true of a close-knit religious community.

For example, one study among African American women noted the incorporation of "religious social capital" aided in enhancing compliance regarding sexual behaviors (Wingood et al., 2013, p. 2227). Religious social capital was defined as resources available to people through the faith community, where active involvement showed improved compliance with recommended interventions. The authors did not specify whether faith leaders played a specific role in the positive outcome. Lumpkins, Greiner, Mabachi, and Neuhaus (2013) found that helping faith leaders see themselves as health promoters may benefit the health of the community.

Another study investigated the relation of religious faith to CAM use in women with breast cancer. Women who had "unambiguous faith," defined as that which is certain about what it believes, were more likely to use alternative therapies to control symptoms (Pedersen, Christensen, Jensen, & Zachariae, 2013, p. 991). Those who hold a definite type of faith would be more likely to credit their concept of God with a positive outcome.

Religious faith is an important coping mechanism and should not be discounted. But, if faith discourages medical compliance to a degree that it interferes with health, it has become a detriment to the community. Healing beliefs can be beneficial to individuals who have a healthy paradigm—one in which God is an ever-present, loving, powerful being, who gives strength in all circumstances. But in some conditions, particularly for those who struggle with faith and health issues, a culture of shame can exist, which says, "If you have to take medicine, something is wrong with how you are believing." One theologian noted that the timing of one's healing rests on God's sovereign purpose (Keefauver, 2015). This would also be true of the means through which one is healed.

Understanding how to approach compliance with Christians who believe they should pray and wait for divine healing, is imperative. Mattox noted, "Even if the church has no specific teachings on these issues [of faith and health], patients may nevertheless use their religious belief as a template through which to view their relationship to healthcare professionals and recommended health practices" (2011, p. 22).

Some healthcare providers have brought God into the healing equation. Starting in 2000, physician Reginald Cherry wrote a book series, "God's Pathway To Healing" (Cherry, 2013). In his practice, Cherry prayed with Christian patients, providing the cultural care they needed. Incorporating God into the healthcare plan may assist providers in helping patients who believe in healing to embrace needed medical intervention.

FAITH-BASED HEALTH EDUCATION

The mandate of the FCN is to provide care for the spirit, soul, and body. It is not enough to persuade people to seek healthcare for a problem. If their spirit and soul aren't agreeing with the plan, the plan won't happen. One objective of *Healthy People 2020* is the collaboration of the healthcare community with other organizations to bring educational programs to unreached people. "Using nontraditional settings can help encourage information sharing… through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education" (*Healthy People* 2020, 2015, para. 5). *Healthy People* suggests that one potential partnership is with faith-based organizations (United States Department of Health and Human Services, n.d.).

Faith communities are close-knit, have a common belief system, and mutual trust among members (Mattox, 2011). Evidence shows that church-based programs are effective in producing positive outcomes in health behaviors, particularly in nutritional health and physical activity (Horton, Alvear, & Horton, 2014; Pappas-Rogich & King, 2014).

The population chosen for this health promotion project was a nondenominational, Christian charismatic congregation of 900. A *charismatic* is defined as someone whose beliefs could include direct communication with God and use of the spiritual gifts (the Greek word for this is *charismata*), as defined in Acts 2:1-4 and 1 Corinthians 12:1-11 (Strong, 1996, p. 725). A 2011 study found that 8.5% of the world's population report being charismatic or Pentecostal (79.5% of the U.S. population identify as Christian, 31.7% of the world population) (Pew Research Forum, 2011). Extensive research supports a growing global charismatic healing movement, substantiated by documented healing occurrences worldwide (Brown, 2011).

Some charismatic Christians believe that it is not God's will, under any circumstances, to be sick, although exceptions exist. For example, one charismatic ministry teaches that individuals can *receive* or *take* healing when they want. Popular speakers conduct miraculous healing services, lending credence to the idea that the right words, said the right way, can result in healing. This paradigm infers that illness is attributed to a spiritual attack of the devil and should be addressed spiritually (Charisma Media, 2015; Dvorak, 2015).

An educational activity was planned that would address the compatibility of charismatic faith, medical compliance, the use of medications from a biblical perspective, and the use of CAM. The seminar plan included teaching from healthcare professionals who are trusted members of the congregation and part of the church's health ministry team.

Having been an FCN for this congregation for nearly 15 years, I am familiar with many of the congregants' perceptions. One misconception is that taking medication for mental illness demonstrates a lack of faith. Little research has been done among charismatic Christians regarding the psychosocial dynamics that contribute to this view. One view is that mental illness is strictly a spiritual, rather than a biochemical, issue (Mercer, 2013). The lack of adequate coping skills in those diagnosed with mental illness adds to the desire to somehow fit in—and if that means stopping a medication viewed as unspiritual, then noncompliance may result.

Recently, a congregant who took medication for bipolar disorder went as a missionary to a foreign country. The local pastors suggested she was lacking faith for healing so she stopped taking her medications. In her words, she "had a complete meltdown," and returned stateside. I counseled her to revisit her healthcare provider, and we discussed how it was not a lack of faith to take medications. She resumed her missionary activities after medication compliance. This culture of shame, defined as "a culture in which conformity of behavior is maintained through the individual's fear of being shamed" (Oxford English Dictionary Online, n.d., expression 1), almost derailed her ministry. Physician Grant Mullen states about a culture of shame, "Medications and psychiatric treatment are often ridiculed as unnecessary, except for the spiritually weak or those who are disobedient to God's instruction" (2013, p. 66).

YOUR HEALTH AND THE BIBLE SEMINAR

A recent congregational survey, conducted in conjunction with the community hospital, provided evidence of the need and desire for health education. A seminar was planned with a general invitation to all congregants. Announcements were made by pastors and written in the church bulletin weekly for 3 weeks preceding the event, and a sign-up table in the church foyer was staffed after worship services to promote the seminar and answer questions. An announcement was placed on the church's website, Twitter, and Facebook pages, and in the local newspaper.


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Within the U.S. population, 60% of patients admit to being noncompliant with prescribed medical regimens.

Obtaining pastoral buy-in was imperative to program success. Since the beginning of health ministry in the church, pastors viewed health ministry as an outreach tool into the surrounding community, more than improving congregant health. Pastoral support developed slowly, as the health ministry team worked to convince pastors of the need for a more balanced approach to health promotion in the congregation. The pastoral staff agreed to a date in March 2016 for the seminar. Institutional Review Board approval was given by the author's educational institution. No incentives were offered for participation in this research project.

A search for a survey tool to measure medication compliance and religious beliefs yielded no results. The Self-Efficacy for Appropriate Medication Use Scale (SEAMS) (Risser, Jacobson, & Kripalani, 2007) was chosen, as this Likert-rating scale focuses on the person's confidence about taking medications independently. One yes-or-no question was added: *Does your belief or lack of belief in a higher power affect your confidence in the use of medications?* This gleaned information about whether participants perceived a conflict between their faith and medication compliance.

The primary goal of the seminar was to show that God heals miraculously, *and* through healthcare. Another goal was to show that, although CAM can be beneficial, it is not more spiritually acceptable than conventional therapies. Assisting congregants to see healthcare as compatible with their faith is to change a paradigm from that of shame (for needing to seek care) to a place of spiritual peace (that care is beneficial).

After obtaining informed consent and collecting the prequestionnaire, which included anonymous demographic information, such as age, race, and church membership/attendance, a presentation was made to participants (Table 1). A copy of the presentation was distributed to all attendees to assist in retention. Fact sheets about medications, alternative therapies, and nutritional aspects of health were made available. All participants were either members or regular attenders of the church. The presentation began with prayer. A question-and-answer group discussion followed each portion of the presentation. It was hoped that utilizing discussion as a modified motivational interview strategy would assist participants in a paradigm shift toward compliance, through empowering them to use discrimination in their choices and promoting self-efficacy (Corrigan et al., 2014). After the presentation, a time of prayer was included. Prayer is a necessary part of charismatic gatherings. Seeking God's guidance on pathways to health was a central theme of participants' prayers.

Upon completion of the seminar, a questionnaire was administered that

contained one statement with a Likert-type scale that included: strongly disagree, disagree, neutral, agree, and strongly agree. "This presentation has helped me to see that taking medications is part of God's plan for my health." Space was given for participants to write comments as desired.

DATA ANALYSIS

A convenience sample of seminar attendees was utilized for this project. From the congregation, 41 individuals expressed a desire to attend, and 21 attended the seminar, one of whom was Asian, and the rest were Caucasian. The church's congregants are primarily Caucasian, with a small minority of African American, Native American, and Asian members. Sixteen attendees ($N = 16$) signed consent forms to participate in the research evaluation.

Of the 16 questions on the SEAMS survey, a few questions were not completed (Table 2). It is unknown whether participants inadvertently or deliberately omitted responses. Thirty-seven percent (37.5%) of participants felt they would have no confidence in taking a medication, if they were not sure how to take it; 28% expressed a lack of confidence in taking a medication, if they were not sure when to take it, how it works, or if there was an issue regarding affordability. With few exceptions, the majority felt very confident or somewhat confident regarding taking their medications.

The final question added to the SEAMS survey asked whether a belief in a higher power affected the participants' confidence in the use of medications. Fifteen participants responded, with 80% answering yes. This question provided a baseline for the postseminar question "This presentation has helped me to see that taking medications is part of God's plan for my health." All 16 participants answered, with 15 choosing "strongly agree" or "agree." One participant chose "neither agree nor disagree."

REVEALING DISCUSSION

Participants' discussion during the question/answer periods was revealing. The first topic that emerged was the understanding of dietary intake with exertion. A light lunch was provided for attendees that included fresh fruit, raw vegetables with fat-free dips, turkey and low-fat cheese on whole wheat bread, and infused water. Following lunch and the presentation on nutrition, one woman said, "My husband couldn't survive on food like this. He does hard physical labor." This comment led to more discussion on healthy eating, portion control, the need for higher protein with exercise, and how different foods are metabolized.

TABLE 1. Your Health and the Bible Seminar Content

Part 1: Prevention—How to Care for our "Temple" (1 Corinthians 3:16-17, 6:19)	**Part 2: Treatments—Medicine and Alternative Therapies**	**Part 3: What About Mental Illness?**
What the Bible Says About Healthy Eating (Genesis 1:29, 9:2-4) • Understanding calories • Eating a variety of foods • Timing of eating • Using moderate portions • Including fruits, vegetables, legumes, whole grains • Drinking plenty of water • Limiting sugar/salt/refined products	Sowing and Reaping (Galatians 6:7) • Sickness can be the result of living in a "fallen world" or a result of our "bad choices."	How the Brain Works • Brain chemicals (norepinephrine, dopamine, serotonin, etc.) • Brain chemicals and mental disorders • Differences between mental illness and demons
What the Bible Says About Exercise (Isaiah 40:29-31; 1 Corinthians 9: 26-27) • Exercise guidelines • Maintaining healthy weight (calories in = calories out) • Get Active, Stay Active	Medicine • Pray for God's leading for your provider; discuss faith with provider • Medications: Revelation 22:2 • Many medicines come from plants; research is behind Food & Drug Administration-approved medicines	Treatment vs. No Treatment • Medication can balance chemicals • Jesus can heal illness of body and mind • Illness, including mental illness, is a curse, part of living in a fallen world (Deuteronomy 28:21-61)
What the Bible Says About Sleep (Psalm 4:8, 127:2) • Understanding Sleep (lighter, deep, rapid-eye-movement sleep) • Good sleep habits	Supplements and Alternative Therapies: • Are *not* regulated • Know what vitamins are needed and in what amounts • Ask a professional • Herbals are *not* regulated; can be dangerous • Understanding Yoga, Chinese Medicine	Jesus came to redeem us from the curse of sin and a fallen world (Galatians 3:13-14)
	Finding God's Pathway: • Pray (Philippians 4:6-7) • Prevent • Treat • Seek wise counsel • God's healing stands up to scrutiny/examination	

TABLE 2. Results of the Self-Efficacy for Appropriate Medication Use Scale (SEAMS) Presurvey ($N = 16$)

	How confident are you that you can take your medicines correctly:	Not at all Confident	Somewhat Confident	Very Confident	Totals*
1.	If you take several different medications each day?		1	15	16
2.	If you take medicines more than once a day?		2	13	15
3.	If you are away from home?		3	13	16
4.	If you have a busy day planned?	1	6	9	16
5.	If they cause some side effects?	3	7	6	16
6.	If no one reminds you to take the medicine?	2		13	15
7.	If the schedule to take the medicine is not convenient?	2	5	8	15
8.	If your normal routine gets messed up?	2	6	7	15
9.	If you are not sure how to take the medicine?	6	5	5	15
10.	If you are not sure what time of the day to take your medicine?	4	5	6	16
11.	If you are feeling sick (like having a cold or the flu)?	2	5	8	15
12.	If you get a refill of your old medicines, and some of the pills look different than usual?		5	9	14
13.	If a doctor changes your medicines?		7	9	16
14.	If you are not sure how it works, or what it does for you?	4	6	4	14
15.	How confident are you that you will be able to afford your medicines?	4	4	8	16
16.	How confident are you that you will be able to get to the pharmacy to get your medicines?	1	3	12	16

*Some values are <16 due to missing data.

A second discussion topic revealed confusion about what nutrients are best, how much of each nutrient is sufficient, and evaluating the quality of vitamins. This is not an unusual discussion. The United States Preventive Services Task Force (USPSTF, 2013) recommends 600 to 800 international units (IUs) of vitamin D per day. However, the American Association of Endocrinologists (2016) places that number at 1,500–2,000 IUs. Another source places daily intake requirement at 7,000 IUs (Veugelers & Ekwaru, 2014), stating that the mathematics used by the USPSTF were erroneous. How to evaluate information was discussed, along with one test for evaluating a multivitamin: place the vitamin pill in a glass of warm (not hot) water for 30 minutes. If it disintegrates, it will most likely do so in the stomach. If not, it may pass through the gut without being absorbed (Consumer Labs, n.d.).

The idea that God can use medication exposed another topic: how to help loved ones who stop taking medications, particularly in the case of mental illness. One participant stated, "I have had problems with a loved one who stops taking medication when feeling better, then behaviors get out of control until our family is disrupted." Another discussed a loved one who procrastinated getting prescription refills. Several expressed frustrations with loved ones regarding mental illness and drawing boundaries. Recommendations were made for communicating with healthcare providers regarding family members, as well as books available on dealing with loved ones with mental illness.

The fourth theme that emerged was fear about medications and a distrust of healthcare professionals. One attendee expressed fear about taking any medications: "My mother died of a bad drug interaction. All those chemicals scare me." The extensive research that goes into every medication before it reaches the consumer was discussed, along with the importance of establishing trust with providers.

Participants expressed fear that healthcare professionals would fail to notice side effects or interactions. One recommendation was to request to speak to a nurse in the provider's office or with the pharmacist about medications, particularly if a new medicine is prescribed.

Finally, participants relayed that they feel marginalized by providers who don't understand the significance of their faith. This was an adjunct to the general distrust of healthcare professionals. One participant stated, "I am not sure I want someone who cannot understand the importance of God in my life." The recommendation was made that participants discuss faith and ask the provider to pray with them, inviting God to inspire the provider to find the correct pathway to healing.

Three months after the presentation, a survey was mailed by post and emailed to all 16 participants; three responded. The three responses indicated the seminar had changed health behaviors on an ongoing basis. One married couple indicated they were taking vitamins. Another individual stated she had changed her nutritional habits, gaining better portion control. She also mentioned learning she needed to "take breathing meds on time" to avoid getting sick, instead of "trying to save money."

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There is evidence that church-based programs are effective in producing positive outcomes in health behaviors, particularly for nutritional health and physical activity.

Another indicated they used the information regarding exercise and alternative medicines since the presentation.

SEMINAR EFFECTIVENESS

The preproject survey indicated participants were confident in most circumstances that they could take prescriptions correctly. Most averred that their belief in God affected their confidence in the use of medications. Topics brought up by participants included concerns about getting weak with work or exercise, if eating a diet of more fruits and vegetables; confusion about what nutrients to take and how much; how to help loved ones who are noncompliant with medications; distrust of medications; and doubt in the faith of healthcare professionals.

The first topic was unexpected, considering it was not part of seminar content. The U.S. ranks highest in the world for percentage of population classified as obese (Public Health England, 2013). Participants expressed misconception of the amount of food required for an active adult.

The second topic was expected because public media is rife with conflicting reports about nutrients. In addition, members of the congregation sell health-related products, vitamins, and nutrients. Responses from participants indicated they felt better about taking vitamins than they had before the conference.

The third topic indicated concerns participants had about medications and healthcare professionals, and about loved ones taking prescribed medications. After the event, all participants indicated they felt that medications and healthcare are part of God's plan for health. One person stated she "felt much better about taking medications."

On the postpresentation survey, several participants requested future educational events. This suggests participants wanted to know more about healthcare being part of God's plan for health and wellness, a goal of the seminar.

PROJECT LIMITATIONS, FUTURE RESEARCH

The small sample size is a limitation of this project. Participants may have self-selected because they already believed healthcare is beneficial. Offering this program again to the congregation may help broaden the sample size and add information about what charismatic Christians believe about health and medical compliance.

Another limitation may be the familiarity and history of the researcher with the congregation, which may have influenced participant responses. Having someone from outside the congregation present the seminar would help eliminate possible response bias.

Finding a validated survey tool for assessing faith beliefs and medication compliance proved impossible. Research focusing on the development of a validated tool that would measure faith and compliance would be helpful. A longitudinal study investigating the long-term benefits of this type of educational event among Christians would provide helpful information for FCNs. Understanding the long-term effects of health education could facilitate planning for education in faith communities.

CONCLUSION

Understanding the root of medical noncompliance is beneficial in promoting compliance (Corrigan et al., 2014). For a faith community, this entails examining group culture, beliefs, and exploring how the healthcare professional can connect to bring about change. Faith community nurses are in an ideal position to reach those in a faith setting. By bringing the components of faith and belief into health, nurses can increase compliance and help create a healthier congregation.

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