CE 2.5 ANCC contact hours

# Prayer in Clinical Practice: What Does Evidence Support?

By YeounSoo Kim-Godwin

**ABSTRACT:** *A Korean-born U.S. nurse educator shares a perspective on prayer in clinical settings in South Korea and asks what appropriate, ethical prayer practice should be in the United States. A review of research on prayer for health and in nursing practice is offered, concluding with evidence-based suggestions for prayer with and for patients in clinical settings.*

**KEY WORDS:** *complementary alternative medicine (CAM), nursing, prayer, religion, spiritual care*

I am a Korean-born registered nurse who came to the United States as an adult. During my undergraduate clinical experiences in Korea, I shared my Christian faith with patients and prayed with them on many occasions. At times, my instructors expressed concern because they thought I focused on "spiritual care" more than clinical skills; however, I felt I was doing the right thing incorporating spiritual care. After completing the undergraduate nursing program, I started my nursing career at a remote island in Korea where over 3,000 leprosy patients stayed throughout their lives. Working with these patients for 3 years, I learned the most desired role of a nurse for this population was to be with them, eat with them, and pray for/with them. After I left the island, I worked as a staff nurse at a Christian hospital in Korea where all staff started the day with a prayer worship service, and were expected to pray for patients. As a result, it became natural for me to pray for and with my patients.

I did not experience any ethical or legal conflicts regarding prayer with patients during my brief hospital work experience in America. I had not considered negative implications of prayer in nursing until I read Taylor's 2011 article, "Spiritual Care: Evangelism at the Bedside?" in the *Journal of Christian Nursing*. It had not occurred to me that nurses could be reprimanded, penalized, or even suspended for praying with a patient. This led me to research prayer practices for health to discover suggestions for prayer for Christian nurses in clinical settings.

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## PRAYER IN THE UNITED STATES

Prayer is a common practice in the United States. The Barna Group, which has been conducting an annual tracking survey of religious behavior in the United States for over two decades, reported that 77% of respondents prayed to God during the past week in 1999, and 83% did so in 2004. Three out of four adults associated with non-Christian faiths reported they prayed in a typical week and even three of 10 atheists and agnostics admitted to praying (Barna Group, 2004). In 2005, in a Newsweek/Beliefnet Poll of 1,004 American adults, 64% of respondents prayed every day; only 8% of respondents reported they never prayed (Beliefnet, 2005). More recently, according to a USA TODAY/Gallup poll of 1,000 adults in May 2010, 92% believed in God and 83% said God answers their prayers; 57% of adults favored a National Day of Prayer (Grossman, 2010). Barna reported again in 2011

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that "slightly more than four out of five Americans pray during a typical week" (p. 172), or over 80%.

Prayer is a common practice for health. According to a national survey on use of prayer ($N$ = 2,055), 35% of respondents used prayer for health concerns; 75% of these prayed for wellness, and 22% prayed for specific medical conditions; of those praying for specific medical conditions, 69% found prayer very helpful (McCaffrey, Eisenberg, Legedza, Davis, & Phillips, 2004). According to the Centers for Disease Control and Prevention (CDC) and the National Center for Complementary and Alternative Medicine (NCCAM), prayer was ranked the most commonly used complementary and alternative medicine (CAM) among 31,044 adults in 2002; 43% reported they used prayer specifically for their own health during the last 12 months (ranked as first among the listed 10 CAM), 24% received prayer by others for their own health (ranked as second), and 9.6% participated in a prayer group for their own health (ranked as sixth) (Barnes, Powell-Griner, McFann, & Nahin, 2004).

Prayer was not included in the 2007 National Health Interview Survey by NCCAM and most likely will not be assessed again soon in national government surveys (2012). The rationale for this is the term "prayer" is widely used in multiple ways by diverse spiritualities and cannot be specifically measured, may falsely inflate reported CAM use, and may mask differences in CAM use by various racial and ethnic groups (Tippens, Marsman, & Zwickey, 2009).

Using a cross-sectional survey with a stratified random sample age of 40 and over, O'Connor, Pronk, Tan, and Whitebird (2005) found that among 4,404 survey respondents, 47.2% of respondents reported they pray for health, and 90.3% of these believed prayer improved their health. Those who prayed had significantly less smoking and alcohol use; were more likely to have a regular primary care provider; and had more preventive care visits, influenza immunizations, vegetable intake, satisfaction with care, and social support. Koenig, King, and Carson (2012) concluded from an exhaustive review of research that people of all faiths and walks of life use prayer in life, health, and illness with positive outcomes.

## DOES PRAYER WORK?

A variety of empirical studies have attempted to test the efficacy of prayer on health with little conclusive results (Krucoff & Crater, 2010; Narayanasamy & Narayanasamy, 2008). Some argue that it is beyond human research to prove God's response to prayer (Ahmed & Hall, 2008; Gaudia, 2007), if not inappropriate to "test" God. Others believe scientific design can reliably examine potential health benefits of prayer while simultaneously recognizing the methodological limitation of prayer research (Krucoff & Crater, 2010; Oliver, 2013; Peteet, 2010).

Cochrane Collaboration reviews in 2000, 2004, and 2009 of research on intercessory prayer to alleviate illness have shown no consistent or clear effects of intercessory prayer. However the reviewers suggest no changes be made in the provision of prayer for the sick, as well as better methodologies be used in prayer research (Oliver, 2013). In spite of the methodological concern and criticism of measuring the effectiveness of prayer, trends indicate the public believes there are positive health benefits of prayer (Choo, 2011; Denholm, 2008; Peteet, 2010; Vannemreddy, Bryan, & Nanda, 2009). Nursing reports also support the value of prayer for improvement of health and healing (Helming, 2011; Nance, Quinn Griffin, McNulty, & Fitzpatrick, 2010; Shelly, 2005).

The term, intercessory prayer (IP), goes beyond the basic definition of prayer. IP intercedes between God and human beings on behalf of someone else, trusting God will act for the good of that person (Strang, 2011). Although there is no contact between the individual praying or the person receiving the prayer in distance intercessory prayer (DIP), proximal intercessory prayer (PIP) refers to direct-contact prayer, frequently involving touch, by one or more persons on behalf of another (Brown, Mory, Williams, & McClymond, 2010; Nance et al., 2010). According to Hollywell and Walker (2009), private or personal prayer needs to be distinguished from DIP in which the individual is prayed for by an external agent, with or without the knowledge and approval of the recipient.

Although DIP is one of the types of prayer most studied and with controversial findings, PIP has been less studied, but has shown more positive effects on health. Brown et al. (2010) reported a statistically significant increase in auditory and visual function after PIP in rural Mozambique subjects. Masters and Spielmans (2007) analyzed the effects of DIP using 15 empirical studies and concluded there is no scientific discernable effect for DIP on health; the authors raised a methodological concern that the impossibility of a true control group presents a significant barrier in DIP research because researchers cannot assure that patients are not prayed for among the control group. Similarly, Roberts, Ahmed, Hall, and Davison (2009), who examined 10 randomized controlled trials of a total of 7,807 people in the United Kingdom, reported no overall significant difference in recovery from illness or death between those prayed for and those not prayed for. The authors concluded that IP is neither significantly beneficial nor harmful for those who are sick, and suggested better designed studies as necessary to draw firmer conclusions in further research.

In an attempt to counter previous methodological concerns, researchers and prayers were blinded as to what group patients were in (prayer vs. no prayer), and patients in both groups ($N = 999$) were blinded to the prayer intervention in a randomized study of DIP in cancer patients in Australia. Researchers reported the group prayed for by a Christian intercessory prayer team showed greater improvement in spiritual well-being as compared to the group receiving no prayer from the IP team. Although slight, the intervention group showed statistically significant improvements in peace, faith, emotional, and functional well-being (but not meaning) over a 6-month time frame as compared to the control group. The researchers concluded that DIP can assist cancer patients with spiritual well-being and impact quality of life (Oliver, 2013).

## PRAYER AMONG PATIENTS

A considerable number of studies have identified prayer as a frequent and favored coping method among patients. Coleman et al. (2006) analyzed an ethnically diverse convenience sample of 1,071 HIV-infected adults and found prayer was used for managing HIV-related anxiety, depression, fatigue, and nausea, regardless of ethnic groups. Specifically, older African Americans, Hispanics, and females were more likely to use prayer for the management of symptoms. The authors concluded that although not all ethnic groups rely on the use of prayer, for those who do, engaging in self-prayer may buffer the stress associated with HIV-related symptoms and healthcare providers need to be cognizant of prayer practices.

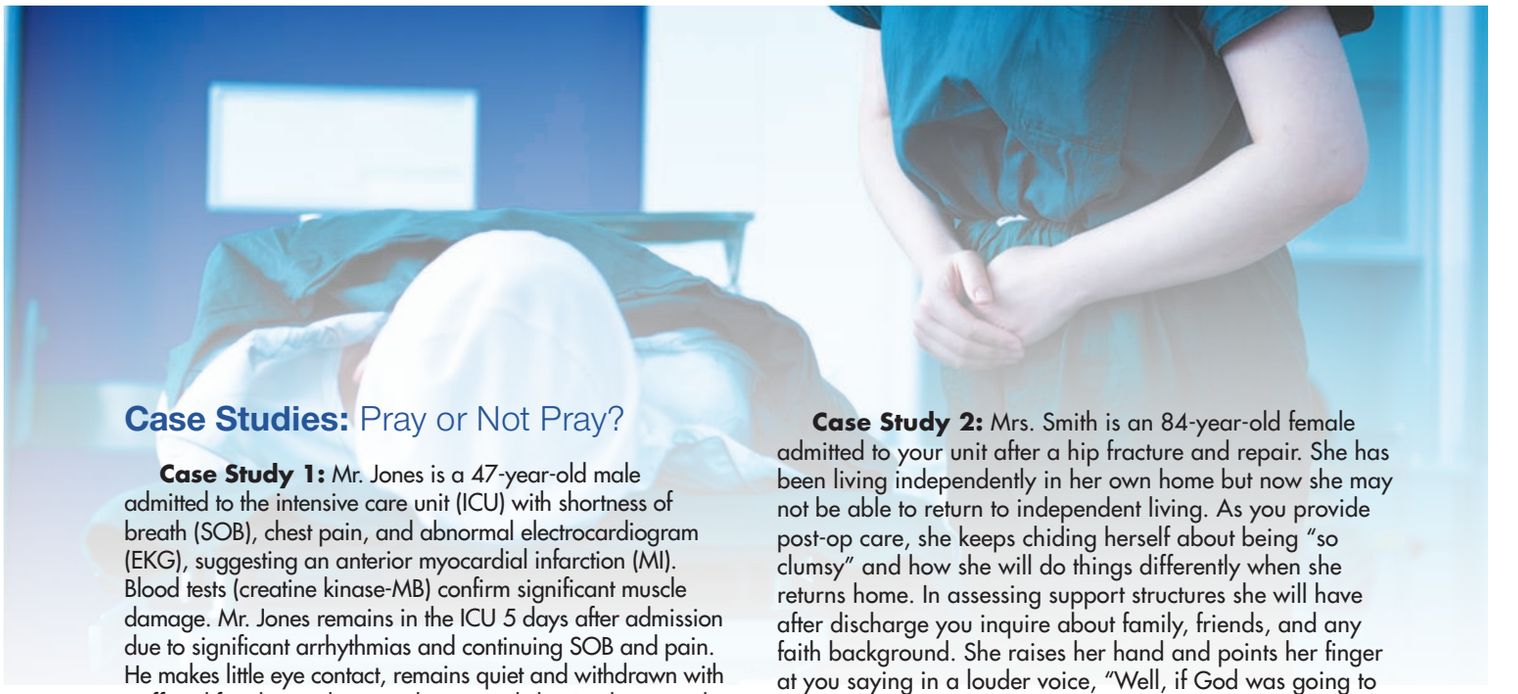
Prayer is an important coping mechanism among patients with cancer. Walton and Sullivan (2004) interviewed 11 men with prostate cancer identifying that prayer held a central importance in providing each participant with comfort and strength. Hefti (2011) reported that religious coping is highly prevalent among patients with psychiatric disorders. Surveys indicated that 70% to 80% use religious or spiritual activities (i.e., prayer and meditation, reading psalms or other religious/spiritual literature, attending religious services) to cope with daily difficulties and frustration.

Several studies conducted by Ai, Dunkle, Peterson, and Bolling (1998), Ai, Peterson, Bolling, and Koenig (2002), Ai, Tice, Peterson, and Huang (2005), and Ai et al. (2007) focused on prayer among hospitalized cardiac surgery patients. Researchers found that patients use prayer as a spiritual means to self-empowerment, discovering practical solutions for dealing with medical crises, and distancing themselves from distress and worry. The researchers suggested that nurses and physicians should give attention to encouraging patients' spiritual coping, regardless of the patient's religious tradition (Ai et al., 2002). As part of their analysis Ai et al. (2007) examined the role of optimism in explaining the relationship between prayer and well-being. They reported that prior to surgery, 88% of respondents expressed a belief in the importance of prayer and intended to use personal prayer to cope with difficulties related to surgery; however, the researchers did not distinguish between different types of prayer (Ai et al., 2007).

## PRAYER BY NURSES

A survey conducted by Taylor and Mamier (2005) indicated that the majority of patients prefer to receive prayer from their nurses. Among 156 adult cancer patients and 68 primary family members (most of whom were Christians), 60% of patients and 68% of family caregivers wanted nurses to offer private prayers for patients (i.e., the nurse prays for the patient later when he or she is alone); 41% of patients and 56% of family caregivers wanted nurses to pray for patients with the patients. Balboni et al. (2011) surveyed 70 advanced cancer patients, 206 oncology physicians, and 115 oncology nurses to assess attitudes toward the appropriate role of prayer. Eighty-three percent of nurses reported that patient-initiated patient–practitioner prayer was at least occasionally appropriate; clinician prayer was viewed as at least occasionally appropriate by the majority of patients (64%) and nurses (76%). Of patients who could envision themselves asking their physician or nurse for prayer (61%), 86% would find this form of prayer spiritually supportive.

Although these findings suggest that some patients or family members may not appreciate prayer, the majority of nurses are open to using prayer for their practice. Tracy and colleagues (2005) surveyed a random sample of 726 critical care nurses and found that prayer is one of the most commonly used therapies for patients in their practices (73.1%). In addition, 89.1% of nurses viewed the use of prayer as legitimate and 80.7% of nurses recommend the use of prayer for their patients; 79.4% of patients and families requested prayer as a common



## **Case Studies:** Pray or Not Pray?

**Case Study 1:** Mr. Jones is a 47-year-old male admitted to the intensive care unit (ICU) with shortness of breath (SOB), chest pain, and abnormal electrocardiogram (EKG), suggesting an anterior myocardial infarction (MI). Blood tests (creatine kinase-MB) confirm significant muscle damage. Mr. Jones remains in the ICU 5 days after admission due to significant arrhythmias and continuing SOB and pain. He makes little eye contact, remains quiet and withdrawn with staff and family members, and is eating little. On the second day of caring for Mr. Jones, you attempt to engage him in conversation, stating, "I have not known you for very long but your family tells me you normally are a talkative guy. I'm wondering what's going on inside." After some careful listening and questions, Mr. Jones says, "It doesn't matter… I'm going to die anyway." You note on the admission assessment form religion is listed as "none declared."

*Reflect:*

1. *What could be the next steps in offering spiritual support to Mr. Jones?*
2. *What additional information do you need to know about Mr. Jones before offering him prayer as an intervention?*
3. *Is silent prayer an appropriate nursing intervention? If so, what might you pray to God? If not, why not?*

**Case Study 2:** Mrs. Smith is an 84-year-old female admitted to your unit after a hip fracture and repair. She has been living independently in her own home but now she may not be able to return to independent living. As you provide post-op care, she keeps chiding herself about being "so clumsy" and how she will do things differently when she returns home. In assessing support structures she will have after discharge you inquire about family, friends, and any faith background. She raises her hand and points her finger at you saying in a louder voice, "Well, if God was going to help me, he shouldn't have let me fall!" After further exploration Mrs. Smith reveals she has attended church all her life but is only able to attend infrequently since she stopped driving. She remarks that maybe God is punishing her and then says almost imperceptibly, "I bet God doesn't even want to talk to me…"

*Reflect:*

1. *Is offering prayer for or with Mrs. Smith appropriate or not appropriate? Why or why not offer prayer as a nursing intervention?*
2. *If you decide to offer prayer, what would you say and do?*
3. *How will you assess if prayer was or was not a helpful intervention?*
4. *Is silent prayer appropriate? If so, what might you pray to God? If not, why not?*

therapy. Matthews (2012) surveyed 674 practicing nurses and reported that when nurses identify patients' spiritual needs, they provide prayer (ranked as first), followed by referral to chaplain, showing respect for religious and cultural beliefs, providing comfort, encountering barriers, and sharing their own faith beliefs. However, Matthews also noted that considerable numbers of nurses are afraid of overt prayer because of hospital rules.

Nurses also use prayer for themselves. Holt-Ashley (2000) reported a prayer group experience where over the years, a small group of nurses prayed daily for patients and for guidance in meeting work demands, meeting 15 minutes before work. Using a random national sample of 404 medical–surgical nurses, Cavendish, Konecny, Luise, and Lanza (2004) reported that nurses used petitionary prayer and preparatory prayer as spiritually related activities for guidance and support. The findings explicate the nurses' daily, silent use of preparatory prayer for professional performance enhancement, praying for confidence to make correct decisions, and that no harm would occur to patients in their care.

When nurses pray for patients, sometimes mysterious intervention from God occurs. For example, McCarver (2010) described her prayer experience for a mother whose newborn was placed in Child Protective Services at a postpartum unit, stating her prayer was part of the therapeutic nursing intervention. McCarver believed her prayer changed the outcome of how the baby was placed to a positive resolution for baby and mother.

In conclusion, although nurses' experiences with prayer vary, previous reports show the benefit of nurses'

personal prayer for patients as well as nurses' own needs. Prayer practices call on nurses' personal spiritual strength to help patients so they can provide better and richer support to patients and their families.

## PRAYER IMPLICATIONS

Although evidence from empirical studies remains inconclusive due to multiple factors, literature provides some evidence that prayer helps patients and has beneficial health effects. If nurses have a clear understanding of the benefits of prayer as a spiritual practice, they will feel more comfortable using prayer with their patients (DiJoseph & Cavendish, 2005). Strang (2011) stated a nurse offering prayer to patients is a valid expression of professional nursing care, as the professional desires to offer the "highest standard of care" (p. 95).

Nurses frequently are invited into the most private and intimate areas of patient's lives, providing them with opportunities to recognize and address spiritual needs (Hollywell & Walker, 2009). Patient–practitioner prayer involves some degree of shared experience of religion and/or spirituality, and a shared willingness to invite that experience into the patient–practitioner relationship (Balboni et al., 2011). It involves supporting the beliefs of the patient, praying with a patient if requested, and referring to pastoral care spiritual needs that require addressing. Because prayer entails careful respect of patient needs, wishes, and beliefs, prayer should not be done without prior spiritual history or assessment of patients' spiritual needs (Narayanasamy & Narayanasamy, 2008).

Nurses need to be educated about how and when to pray for/with patients. It is suggested that a nurse who desires to pray for a patient should ask for permission (Smith, 2011; Taylor, 2011). There is less risk of coercion if the patient makes the first move (Koenig, 2007). However, while it is always best to discuss beforehand what the patient wishes prayer for, many patients appreciate prayer for physical healing, so this should not always be ignored (Koenig, 2007). Koenig suggests that if healthcare professionals (HCPs) want to initiate prayer with patients, they should proceed with caution and only if the following conditions are met: (1) a thorough spiritual history has been taken, so that the HCP is certain the patient will appreciate and welcome such an action; (2) the HCP has the same religious background as the patient; and (3) there is a spiritual need present and the situation calls for prayer (2007, p. 67). There may be times, however, when the nurse will want to initiate prayer when he or she senses the need for prayer without a complete spiritual history or religious certainty. In those cases nurses should proceed with great caution. Nurses additionally need to understand their role in spiritual care is strictly supportive (DiJoseph & Cavendish, 2005) and make full use of the training, experience, and skills of spiritual care experts—chaplains and patient's spiritual leaders (clergy, spiritual directors). Nurses depend on hospital chaplains to take care of spiritual needs for which they don't have training or time to address, and should remember chaplains depend on nurses for referrals (Koenig, 2007). Finally, nursing should consider the importance of education at both nursing schools and work settings that focuses on best prayer practices.

## PRAYER IN PRACTICE

Given the extent of cultural and ethnic diversity in the United States, nurses need to recognize the different perceptions of prayer practices in different cultures and subcultures. Prayer for patients may be a natural practice in hospital settings in some non-Western countries. At the 2012 Korean American Missions Health Conference in New York, a plenary speaker Dr. Lee, a Korean surgeon, shared that he always prays for/with patients before surgery. He noted that all patients, including Buddhist monks or atheists, accept his prayer prior to their operation. He also prescribes Scripture readings for patients during their recovery period in the hospital, and his nursing orders include spiritual care (i.e., prayers) along with other medical orders. At a 1-year follow-up survey, he found that considerable numbers of patients who had been at the hospital had begun to attend a church. When listening to his report, I asked myself, "is this practice possible in the United States?" The plenary speaker at the conference is the chief director of a Christian hospital (literal name is "Gospel" hospital); therefore, the patients know they will be admitted to a Christian hospital and anticipate receiving Christian-style spiritual care during hospitalization. Dr. Lee's testimony might be an extreme case. Since I have not lived in Korea for two decades, I don't have current information on prayer practices in other hospitals in Korea. Nevertheless, I perceive that prayer practice among nurses in the United States is discouraged by over-emphasizing patient rights and autonomy and focusing on separation of church and state.

Conversely, nurses need to be aware that offering prayer (in sprite of good intentions) could cause discomfort for patients whose personal beliefs are not congruent with the nurse's beliefs. Balboni et al. (2011) noted there is no evidence that praying is likely to be beneficial in the absence of any kind of faith. Nurses should weigh potential negative consequences with a patient who may not share the same belief system and may be uncomfortable with prayer in the medical setting, or may feel that the nurse is imposing his or her religious belief. Strategies to mitigate negative consequences would be ensuring concordance in religious/spiritual beliefs or offering prayer in a manner that provides comfortable ways to decline, along with chaplaincy referrals (DiJoseph & Cavendish, 2005; Taylor, 2011).

Because the form and significance of prayer may be different for each patient, nurses need to accommodate patients' choices of a particular form of prayer across cultural and religious practices

(i.e., Christian, Judaism, Islam, etc.) (DiJoseph & Cavendish, 2005). Nurses can provide alternatives for beliefs and practices that may not be helpful, without trying to change the patient's underlying belief system. For example, if a patient wants to use prayer in place of treatment (denying treatment) or pray in a way that may not be helpful, the nurse could still pray with the patient for a sense of God's love and presence, while also bringing in chaplains, clergy, and others to support the patient (Taylor, 2003). Nurses should pray with patients in a way that is compatible with their personal beliefs. For example, if a patient wanted prayer, a Christian nurse could ask a non-Christian patient if she/he can pray to God (the patient's Universal Spirit, Life Force, etc.) as the nurse knows him.

Christian nurses need to employ best practices in praying for patients. Be cognizant of the spiritual crises illness can bring and carefully listen before responding as well as refer to chaplains or clergy. There may be some types of prayer that could be hypothesized as being universally beneficial. Voluntary prayer for the health of others may be one example (Masters & Spielmans, 2007), as well as prayer for guidance, God's presence, and so on (Taylor, 2003), or use form/ritual prayers found in every religion. Hollywell and Walker (2009) reported that private prayer, when measured by frequency, is usually associated with lower levels of depression and anxiety, and proposed private prayer as a suitable intervention for hospitalized patients. Balboni et al. (2011) stated that patient–practitioner prayer is more frequently considered appropriate in the setting of life-threatening illness.

Further research is warranted to identify acceptable types of prayers with positive health outcomes in healthcare settings. A recently published book by Harold Koenig, *Spirituality and Health Research: Methods, Measurement, Statistics, and Resources* (2012, Templeton) offers a comprehensive overview and resources for research in spirituality and health, including prayer. Table 1 summarizes suggestions from researchers and spiritual care experts for praying with patients in clinical settings. Nurses are encouraged to keep abreast of prayer literature and attend classes to learn how to best support patients through intervention with prayer.

### Table 1: Clinical Suggestions for Prayer With Patients

- Establish rapport; listen carefully as you offer presence
- Conduct a spiritual assessment, including assessment of prayer practices and needs
- Respect patient beliefs; some authors suggest it is best if the patient and the nurse have the same religious background
- Do not attempt to change patients' underlying belief systems; do offer support
- Always ask permission before praying with or for a patient
- Accommodate the patient's choice if a particular form of prayer is identified
- Offer to pray with patients when a spiritual need is present and it is appropriate (i.e., after spiritual assessment, patient indicates use of prayer, etc.)
- Offer to pray in a manner that provides comfortable/easy ways to decline
- When appropriate, ask the patient if you can pray for him or her silently on your own
- Pray with patients in a way that is compatible with your personal beliefs
- Pray for patients silently on your own as you feel the need (some authors suggest permission is required; others say silent prayer does not need explicit patient permission)
- Refer patients to spiritual care experts (chaplains, clergy, spiritual directors)
- Recognize different prayer practices in different cultures and subcultures
- Seek to know best prayer practices (read prayer literature, attend classes, seek out spiritual care experts)
- Attend to your own spiritual needs and growth

## INVOKING SILENT PRAYER

Considering current debate on the ethics of prayer, the use of silent prayer may be an appropriate starting place for most patient care situations. Although some suggest praying for a patient silently without their permission or knowing what they want prayed can be unethical (Puchalski & Ferrell, 2010), silent prayer by the nurse would eliminate most negative consequences of prayer. Silent prayer enables nurses to seek God's divine love and intervention for patients without coercing them.

According to Carson (2011), spiritual care consists of "three overlapping modalities—ministry of presence, ministry of word, and ministry of action" (p. 173). Ministry of word can include the use of prayer and prayer can be offered in silence as the nurse provides care to the patient. Providing spiritual care may be as simple as sharing the "gift of presence" during attentive listening (DiJoseph & Cavendish, 2005, p. 151). Silent prayer can be offered for God's involvement to increase healing or to help with test or surgical results (Carson, 2011). An introverted person may find it offensive to say prayers out loud and may prefer silent or meditative prayer (Taylor, 2003). Silent prayer also may be useful for nurses who wish to pray, but feel uncomfortable praying with patients for various reasons. Christian nurses should know that their prayers may still have positive outcomes even if the patient does not believe in prayer (DiJoseph & Cavendish, 2005).

## CONCLUSION

Prayer is a common practice among a large percentage of the U.S. population and many consider prayer relevant, even important for their health. Given the long-standing historical tradition in which prayer is embedded in nursing (O'Brien, 2003), and the prevalence of prayer among

the population, the relevance of praying for patients is likely quite high. When nurses understand the significance of prayer practices of their patients, they will achieve professional growth as spiritual care providers (DiJoseph & Cavendish, 2005).

O'Brien (2003) stated "it is only through prayer that nurses will truly be able to undertake a healing ministry of caring which incorporates the gifts of humility, peace, service, and salvation" (p. 120). Through prayer, nurses receive benefits on a personal level. In addition, nurses' prayer practice can support the nurse in a continued commitment to higher levels of professional practice.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