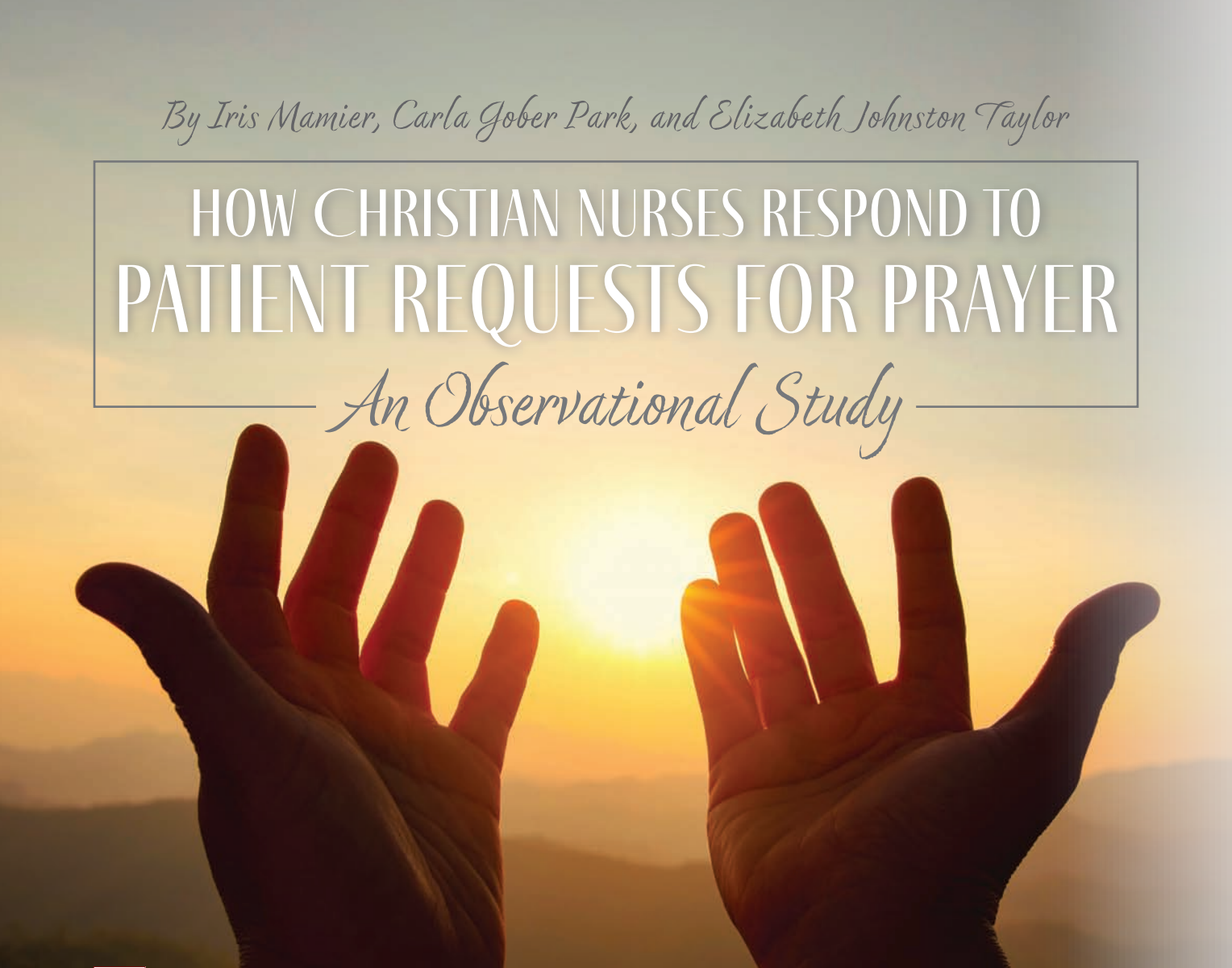
By Iris Mamier, Carla Gober Park, and Elizabeth Johnston Taylor

# HOW CHRISTIAN NURSES RESPOND TO PATIENT REQUESTS FOR PRAYER

## An Observational Study



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**ABSTRACT:** *Nurse-provided spiritual care includes support of patient spiritual practices such as prayer. However, limited evidence exists about how nurses respond when a patient requests prayer. A subsample of nurses (n = 381) from a larger study responded to two open-ended questions in an online survey in response to a prayer scenario. Among these mostly Christian nurses, 97% indicated willingness to pray. Content analysis revealed a five-component structure for praying: Open, Set the Stage, Request, Wrap-up, Close. The structure provides a template for future research and nurse prayer in clinical contexts.*

**KEY WORDS:** *nursing, nursing students, prayer, spiritual care, spirituality*

**Iris Mamier, PhD, RN,** an associate professor at Loma Linda University (LLU) School of Nursing, teaches in the graduate programs, maintains an interest in whole-person care, and engages in research on the spiritual aspects of the patients'/family caregivers' illness experiences and nurses' responses to them.

**Carla Gober Park, PhD, MPH, MS,** is Executive Director of Faith Community Strategy at AdventHealth Corporate and Assistant to the President for Mission at Adventist Health University, as well as an associate professor of the School of Medicine at LLU.

**Elizabeth Johnston Taylor, PhD, RN, FAAN,** a professor at LLU School of Nursing, Loma Linda, CA, has researched spiritual responses to illness and how nurses provide spiritual care for the past 25 years. She loves prayerful gardening and is re-landscaping her yard so it will use little water.

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According to the Barna Research Group, prayer is the most common faith practice among American adults (Kinnaman & Stone, 2017). In 2017, drawing on a nationally representative sample of over 1,000 American adults (87% were current or "past" Christians), the Barna researchers found that 79% prayed at least once in the last 3 months. Of this group, most prayed privately by themselves, silently (82%), or audibly (13%). Only 2% prayed collectively with a church or aloud with another person or group. Almost half of those who reported praying cited guidance in crises (49%) and requests for health and wellness (47%) as prayer content. Thus, it is conceivable that Americans facing a health crisis often pray in the context of illness or may want nurses to pray with or for them.

Support for nurses praying with patients comes from several sources. Prayer is captured in the nursing intervention classification (Butcher & Bulechek, 2018) as a spiritual growth facilitation intervention (Solari-Twadell & Hackbarth, 2010). It also is researched and documented in the nursing literature (e.g., Lekhak et al., 2020) and seen as an aspect of spiritual care that researchers classify as holistic and person-centered (Solari-Twadell & Hackbarth, 2010; Southard, 2020). In the past, some have challenged the notion of healthcare providers engaging with patients spiritually (e.g., Paley, 2009). However, recent qualitative interviews in the Netherlands with patients and mental healthcare professionals demonstrated that patients were less reticent to pray than were some of their providers (van Nieuw Amerongen-Meeuse et al., 2020). Exploring the reasons for and against prayer, the team found that providers who expressed concerns about their professional boundaries also cited feelings of vulnerability and lacking the right words.

*According to the Barna Research Group, prayer is the most common faith practice among American adults.*

## BACKGROUND

Carson and Koenig (2004) defined prayer as "an invitation to the Divine to enter into our lives in an active way" (p. 105). Thus, prayer is "soul talk" with the divine, a way of entering into a relationship and sharing feelings of love, awe, adoration, as well as fears and perceived needs. As many people turn to prayer to cope with the usual demands of everyday life (Kinnaman & Stone, 2017), it is not surprising that prayer is an important resource that helps some patients cope with a health crisis. However, illness can interfere with a person's ability to pray (van Nieuw Amerongen-Meeuse et al., 2020) and leave a person feeling anxious, vulnerable, isolated, or guilty. Prayer is the most well-known traditional spiritual nursing therapy (Barnum, 2010) and can be seen as a complementary therapy to foster healing or cope with an illness experience (Southard, 2020).

## LITERATURE REVIEW

While conducting a systematic review, Jors et al. (2015) explored the role of personal prayer in research studies of patients living with chronic conditions. Across 16 studies, they reviewed why and how people prayed. Study samples ranged from 10 to 360 participants suffering from a variety of diseases. Most frequently, researchers identified disease-centered prayer: praying for improvement, guidance in decision making and disease management, or seeking to find meaning or something positive in the illness experience. Use of lamentation prayer (complaining and expressing doubt and fear) was found least often. Other-centered prayers focused on the needs of friends and family, and physician providers. The use of God-centered prayers shifted the focus away from the illness to the person's relationship with God, his greatness and presence, and to worship and adoration. Both informal/conversational and formal (e.g., the rosary) prayers were used. The research team found that in addition to praying for healing, people pray to find meaning in their illness experience. This systematic review highlighted both the diversity of prayers as well as the function of prayer as a means for coping, meaning-making, source of strength, and to guide inpatient decision-making in chronic illness. More evidence for the relevance of prayer during illness comes from case studies documented by Green (2018), Shih et al. (2019), and Mulcahy (2007).

Religious patients often receive spiritual support, including prayer, through their faith community. South and McDowell (2018) explored the use of prayer as a complementary health practice in Christian adults in the U.S. Bible Belt. They documented that Christians often turn to prayer when facing illness and welcome prayer by clergy as well as friends, family, and healthcare professionals. Participants reported that prayer had a calming effect, increasing their well-being and decreasing their anxiety levels. Some also reported positive healing experiences.

Although some patients view spirituality as a private matter which they do not wish to discuss with their provider (Fowler, 2020), findings from a recent Korean study suggest that about a fifth of patients and family caregivers in the context of terminal care viewed their providers as a source of spiritual support (Kang & Choi, 2020). In a previous U.S. study that explored moderately distressed cancer patients and their family caregivers' preferences for spiritual support by their nurse, Taylor and Mamier (2005) found mixed responses: Whereas the majority of family caregivers affirmed a nurse's offer to pray (56%), less than half of the patients (41%) welcomed nurses offering prayer for them.



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However, 68% of the family caregivers and 60% of the patients agreed with a nurse offering to pray privately for them.

Mamier et al. (2019) assessed how often nurses used spiritual therapeutics in acute tertiary care at four hospitals within a faith-based health system. They found that out of 554 registered nurses, 326 (59%) indicated they had offered to pray with a patient/family in the past 72 to 80 hours at work. Taylor et al. (2018) surveyed a sample of registered nurses ($N$ = 445) and found that nurses scoring higher in personal prayer were 9% more likely to offer prayer. Taylor's team also found that those working in faith-based settings were 2.5 times more likely to offer prayer to patients than Christian nurses working for non-faith-based institutions. However, not all nurses are comfortable praying with patients, and some believe their workplace does not allow for nurse-initiated prayer as a complementary healthcare practice (Taylor et al., 2018).

In summary, though there is empirical evidence on prayer in the context of healthcare, studying prayer and observing prayer in clinical practice remains challenging. Limited evidence exists about how nurses respond in concrete situations when a patient requests prayer. What do they say? How do they pray, if they do? Do they assess the patient's request beyond the request itself? What guides how they pray? Is the prayer contextualized to patient needs, or is it, instead, more static and formulaic? There is also the question of how a nurse who is willing to pray responds when the patient has a religious background or beliefs that are different from his/her own. Finally, there is the question of how the nurse views the reason for the prayer: divine (miraculous) intervention, divine comfort to continue (maintaining peace and hope), and divine comfort to begin or strengthen (promoting increased peace and hope)? These questions led to the research questions: How do Christian nurses respond to a patient's overt requests for prayer, and how do practicing nurses pray in the context of delivering care?

## METHODS

### Design

This qualitative study was part of a larger quantitative, descriptive, cross-sectional, survey design study ($N$ = 445 nurses) on nurse perceptions about appropriate spiritual care practice (Taylor et al., 2018). The larger study was reviewed and approved by a university Institutional Review Board. Participants' voluntary consent was obtained before leading into an online survey system. Confidentiality was maintained by deleting the IP address after downloading the data from the online survey system.

### Sample

A subsample of nurses ($n$ = 381) from the total study responded to two open-ended questions at the end of a quantitative online survey. Participants included nurses from the United States and 40 nurses from other countries. Most worked in non-faith-based institutions (65%), identified with a Christian denomination (94%), and as both spiritual and religious (84%). Nurses represented diverse workplaces across the acute care spectrum (ED, ICU, CCU, OR, medical/surgical, perinatal, pediatrics, psychiatric) through the outpatient clinic, home health and hospice, inpatient hospice, and palliative care to long-term care, community-based workplaces, and academic nursing. See Table 1 as supplemental digital content (SDC) at http://links.lww.com/NCF-JCN/A105 for a detailed sample description.

### Recruitment and Data Collection

This study targeted Christian nurses. Data were collected from a geographically diverse convenience sample using an online survey accessed through the home page of the *Journal of Christian Nursing*. Two other nursing journals—*Home Health Now* and *American Journal of Nursing*—also linked to the survey on their websites. Participants were given a brief vignette: "P. J., age 72, is getting prepared for a surgery that will take place soon. You sense she is apprehensive and nervous. She asks, 'Nurse, will you pray for me?" Participants were then prompted to answer two questions: "What would you likely say or do?" and "If you agree to pray, how would you likely pray?" Space was given for typed responses.

### Data Management and Analysis

Data were downloaded from the online survey into an SPSS file. Demographic variables captured in the SPSS data matrix allowed for descriptive quantitative analysis to describe the sample. The qualitative part was then entered into a data management program (MAXQDA) used for coding and analysis.

Conventional descriptive content analysis (Hsieh & Shannon, 2005) was used to analyze nurses' self-reported prayers and descriptions of actions. Two researchers read the text for emergent codes. When no new codes emerged, the remaining data were analyzed using the codes identified. As coding proceeded, themes emerged which were captured by categories and subcategories until data saturation was reached. The researchers then reviewed for (sub-) categories that could be collapsed or consolidated. Ultimately, an emerging structure of categories and subcategories was described and summarized. Throughout the analysis, two researchers worked together discussing until reaching consensus while continually comparing categories with the data.

## FINDINGS

Eighty-six percent of the combined study sample (quantitative and qualitative parts) and 97% percent of the respondents to the open-ended questions were willing to pray with the patient in some fashion. These nurses either provided a written colloquial prayer or outlined prayer content, prayed silently, would ask the patient to take the lead, or referred to a ritual/formal prayer (like the Lord's prayer, Matthew 6:9-13) in response to the vignette. Out of the responding subsample, 12 did not pray but indicated they would find someone else to pray (a chaplain or colleague). At a minimum, they shared an empathetic response with the patient.



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FIGURE 1: *Conceptual Model of a Practice Theory on Patient-Initiated Nurse-led Prayer*

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Ten of these 12 participants also indicated they never prayed privately.

## How Nurses Pray

### *Phases*

When praying with patients, the nurses tended to formulate prayers that follow similar formats, made up of five phases, not all of which were included in every prayer:

- *Open* (identify divine listener)
- *Set the Stage* (connect with the here and now)
- *Request* (link perceived needs with how God can help)
- *Wrap-Up* (prepare for closing)
- *Close* (signal the end of prayer)

Table 2 offers an Emergent Structure of Nurses' Prayers (see SDC at http://links.lww.com/NCF-JCN/A105).

**Open.** Prayers opened in one of three ways: with 1) "Dear…"; 2) directly addressing the divine with various terms such as "Father," "God," "Jesus," or "Lord"; and finally, 3) with a descriptive adjective such as "gracious," "heavenly," "our Creator…" Almost none of the prayers began without one of these openings, which identified the divine listener by name and/or description.

**Set the Stage.** After the opening, many prayers set the stage. This was one of two phases that did not take place in all prayers. Setting the stage connects with the here and now and has a certain "warmth" to it. It does so by focusing on the immediate situation: how the patient feels, where the patient is in relation to God, how the patient perceives God to have been involved so far in his/her life, and so on. It builds a sense of connection and intimacy and seems to signal the arrival to God's presence—almost a metaphorical "we are here now." This is done in three ways: 1) focusing on God, 2) focusing on the patient, and 3) focusing on the activity of praying.

*Focusing on God* is one way to set the stage and includes focusing on God's attributes, God's actions, or thankfulness and praise. The nurse may identify God's attributes overtly with statements such as, "All-knowing God" or "you are the divine healer," or with statements such as, "You [God] know how she is feeling" or "We know that everything is in your control." Focusing on God's actions links God and the patient with statements like, "Thank you for how you have been good to her throughout her life," or "Thank you for the gift of life you have given her." Another way of focusing on God is by expressing thankfulness and praise, for example, "We come before you with thanksgiving and praise," or "We thank you for the opportunity to come before you."

A second way to set the stage is to *focus on the patient* or the patient's feelings. This occurs through thankfulness for the patient, expressed in statements such as, "Thank you for P.J." or "Thank you for the opportunity to care for Mrs. P.J." It also occurs through referring to the situation, with statements like, "P.J. is here to seek healing" or "You see your child, P.J., as she is getting ready for surgery." Identifying with the patient's feelings occurs in statements such as, "I lift the needs and concerns of P.J. to you" or "I can see that she is anxious and apprehensive about going into surgery." Many nurses identified the importance of actually stating the patient's name within the prayer itself.

A third and final way to set the stage included *focusing on the activity of praying*. This included an announcement of coming with or bringing the patient to God, expressed through "We come to you right now," or "We lift up P.J. to you," or "We come to you today with your dear child."

Some leave out this phase altogether and do not set the stage when praying with patients. Those who do not set the stage go straight from the open phase of the prayer to the phase of request. Moving from the opening to the phase of request without setting the stage results in a less personal request-seeking prayer.

**Request.** Request lay at the core of every prayer, likely due to the specific scenario used in the questionnaire item depicting a presurgery scenario. Although there was a variety of responses, all of the responses linked perceived needs with how God can be involved through 1) requests for God's qualities (peace, love, presence, strength, calmness, faith, knowledge, comfort); and 2) requests for God's action (through the healthcare professionals, divine action, preparing the patient, safe procedure, and/or providing good outcome/recovery).

**Wrap-up.** After request, there is either a wrap-up phase or a move directly to close. The wrap-up phase signals the leaving of requests and



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## TIPS FOR OFFERING TO PRAY WITH A PATIENT

| | |
|---|---|
| 1 | Be self-aware of what is prompting your desire to offer prayer. Remember the goal of therapeutic caring is to offer what is best for the patient. Also, remember that health-related crises can prompt a dark night of the soul when prayer may stir up anger—or bring peace. |
| 2 | Assess if the patient wants prayer with you. Ask: "Would a prayer be helpful?" which could be less forced than "Would you like me to pray for you?" |
| 3 | If the patient says yes, assess for what and how he/she would like prayer. For example, "Is there something you'd especially like me to pray about?" and "Do you have a way you prefer to pray?" |
| 4 | Pray according to patient preferences. (Their preferences likely reflect not only their religious tradition, but also personality, i.e., an introvert may prefer to share silent prayer from and/or with you.) |
| 5 | Be mindful that prayer is not magic; rather it is an encounter with the Holy. It is an occasion to orient ourselves towards God's will. |
| 6 | Prayer may launch a spiritually intimate conversation. Prevent yourself from running away if possible. Avoid using prayer to end an uncomfortable encounter; be prepared to offer referral to a spiritual care expert when appropriate. |

prepares for closing the prayer. It may include thanking/praising, such as "Thank you for hearing our prayer" and/or making a statement of faith: "We trust in You" or "You always hear our prayers."

**Close.** This last phase signaled the closing of the prayer. This was accomplished through wording such as "in the name of Jesus" or "in your name" and was sometimes accompanied by a statement about the will of God (e.g., "according to your will"). Almost all prayers ended with "Amen."

### *Emerging Prayer Principles*

The nurses drew on a variety of principles to guide their prayers. Nurses turn to their own beliefs and practices, using statements such as, "I would pray according to my beliefs," or "I would pray like I normally do in my own prayers" or "how I was taught" and/or will ask permission to pray in a way that is comfortable for the nurse.

Others seek to contextualize their prayers. Some neutralize their prayers by making them "nondenominational" or by praying "without specific reference to a title" (not identifying the name of the divine). Second, they purposefully hold back parts of their tradition. For example, the nurse may choose not to use the wording "in Jesus' name" if this is thought to be more acceptable to the patient. Third, some nurses adjust their prayers in ways that do not contradict their own beliefs (e.g., praying to "God" instead of "Jesus"). Fourth, some nurses simply choose to wait quietly while the patient or someone else prays.

Finally, a few nurses indicated that they prayed in a way that was congruent with what they understood the patient to believe, suggesting that it is "not necessarily how I would personally pray." Other nurses stated that, instead of praying with the patient, they would pray privately to themselves or they would let the patient "lead." The following reasons were identified for allowing the patient to lead: respect for religious differences, nurse comfort level, and patient comfort level.

There was no evidence that nurses prayed contrary to their own beliefs; however, there were suggestions that nurses sometimes contextualized. The following illustrates:

> If I see that there is a Bible nearby, or know that they are Evangelical or Pentecostal, I will pray verbatim with Bible verses. If the patient is Catholic and clutching a rosary, I will recite the rosary with or for them. In any case, I try to remember to first seek the Holy Spirit in my silent prayer to ask to be shown the best way to pray for and/or with the patient.

This quote illustrates the significance of cues and observations made in the patient interaction leading up to the prayer.

### *Other Observations of Nurse Prayers*

There was variability in how nurses prayed with patients. Many nurses asked permission to pray even though the patient requested prayer. Others began by asking how the patient wanted to pray (e.g., considering their religious tradition, name of the divine), whereas others simply proceeded to the prayer.

Several nurses recognized the need for privacy, stating "I'd draw the curtain" or "provide for privacy as able" or "I would pray softly." Many identified a need for physical touch during prayer, with some stating that they would ask permission "to hold hands," whereas others described themselves as "gently putting my hand on their shoulder or arm."



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A few identified praying with family members who might be present. Several also identified sitting with the patient during the prayer. Of interest is that many nurses discussed the quality of the prayer itself in terms of voice, attitude, and characteristics of the prayer. For example, "saying the prayer sincerely, confidently and quietly" or "with reverence for the patient" or "with authenticity" or "short and to the point." The nurses used a variety of ways to offer presence in the process of praying.

### *Outliers*

In coding almost 400 prayers, 5 fell outside the general pattern of the rest. One nurse suggested a "one size fits all" prayer that is addressed to angels:

> I always say the same prayer and people love it. "Angels guide this day. Angels guide the doctors and nurses. Angels guide P.J. today as she goes through this procedure. Thank you, angels, for your protection and guidance. Amen." I do this upbeat and happy.

It should be noted that not all patients pray to angels. Patient preference should guide the decision.

In another example, a nurse wrote, "Pray specifically for surgical area, patency of vessels and speedy healing." This prayer uses medical jargon and detail that potentially speaks from the perspective of possible complications.

A third outlier:

> Jesus, we know you came and defeated death. You came to free us from our fear of death. We once had reason to fear it, but no longer. Jesus, I know that P.J. will awaken from this surgery—either in her bed here surrounded by her friends, or in your arms, gazing up into your face. I ask you to comfort and calm P.J. now. In your name, we pray.

This prayer introduces the notion of dying even though the vignette does not identify this as a patient concern. The prayer also makes assumptions about the patient's spirituality.

This prayer introduces battle metaphors that may not be comfortable for every patient. "Send forth the covering of the blood of the lamb, ministering angels, and angels with their swords drawn to defend and protect."

Finally, this fifth prayer, an "authority prayer," may go beyond what the patient wants. This suggests a need to confirm that the manner of prayer fits with the patient's expectations:

> In obedience to what Jesus has commanded me to do and in the authority of his name, I command this body to be whole and well. I command you to recover. Sickness, disease, weakness, malfunction, abnormality--I command you to go. Be well and be whole in Jesus' name.

## DISCUSSION

This study provided rich prayer data representing the diverse perspectives of mostly Christian nurses. The predominately Christian nurses practicing in U.S. healthcare represented a purposive sample of nurses who may be more at ease to respond favorably to patient-initiated prayer (Minton et al., 2016). Prayers offered by a subsample of international nurses' prayers exemplified the same themes and willingness to pray, which was documented by Minton et al. (2016) in a regional study. Although created in response to a hypothetical clinical situation with limited context information, these data are likely the closest representation of a real-life clinical prayer situation that researchers can capture.

From the aggregate of prayers, a five-phase structure emerged that has not been previously described. *Short-and-to-the-point prayers* included the phases of open, request, and close. These prayers typically jumped to the task at hand without exploring faith tradition or specific requests. Although these succinct prayers "check the box" and consume less time, they were matter of fact and felt less personal.

By contrast, more developed prayers included all five phases and went deeper; the prayers set the stage before presenting requests and wrapped up the prayer before closing, connecting with the individual patient and with the divine. Some of these prayers drew in the person prayed for, making him/her feel "heard" and "seen" as the nurse's words connected with the patient's experience and situation as well as with the divine. Koenig (2002; 2013) recommended emphasizing the love of God for the person during prayer when the patient believes in a personal God, which is fitting in phases 2 and 4. During these phases, God's presence was invoked through faith statements, reflecting on God's attributes, praise, and thanksgiving. Worship of the divine was also identified by Jors et al. (2015) in "God-centered prayers" reflecting similar themes which shifted the focus from the illness to the divine. This may well be key to the transformative part of the prayer experience.

How the nurse prayed depended a lot on the nurses' perceptions of the situation, their regard for the patient's belief system, and their awareness of their own beliefs. Nurses drew naturally on their spiritual heritage when praying with patients, sometimes asking permission to do so. Other times they were actively trying to neutralize or contextualize the prayer to fit the patient. Some nurses explored first how to refer to the divine and did not assume that the patient referred to the divine in the same way the nurse did. In light of the Barna finding (Kinnaman &

### *Web Resources*

- **American Nurse: Prayer with Patients**
  https://www.myamericannurse.com/prayer-proselytizing-or-providing-comfort/
- **FAQs in Spiritual Care Collection**
  https://journals.lww.com/journalofchristiannursing/pages/collectiondetails.aspx?TopicalCollectionId=21
- **Spiritual Care Resources**
  https://ncf-jcn.org/resource/spiritual-care-resources



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Stone, 2017) that most Americans pray to God (90%), there may be enough common ground to share a prayer when requested. However, half of the Barna sample also addressed Jesus, and 23% addressed the Holy Spirit in their prayer. Given that the Barna research also found that people pray to a lesser degree to an unidentified higher power, saints, the divine in themselves, the universe, ancestors, nature, Yahweh, Allah, or another deity, an additional step of clarifying with the patient before praying appears warranted. Although nurses have been asked to include a short spiritual assessment using a brief spiritual history tool (e.g., Carson & Koenig, 2004; DiJoseph & Cavendish, 2005), the overt prayer request led nurse clinicians to develop more specific assessment questions relevant to the situation at hand, like, How would you like me to pray? Is there any specific way you want me to pray? or What would you like me to pray about? Is it okay if I hold your hand/touch your shoulder during prayer? Prayers that were labeled outliers demonstrated how important it might be that the nurse has a good understanding of what fits with individual patients.

Whereas nurses, both in faith-based hospitals as well as secular settings, sometimes pray with their patients (Mamier et al., 2019; Taylor et al., 2017), this study demonstrated that the majority of predominately Christian nurses were willing to grant a patient's request for prayer by providing a colloquial or formal/ritual prayer. Nurses' overall willingness to pray aloud with a patient matches Minton et al.'s (2016) findings. This finding may be explained by the fact that the nurses in this study identified as spiritual (96%; Taylor et al., 2018), and higher nurse spirituality has been linked to higher levels of providing spiritual care (Mamier et al., 2019).

Conversely, respondents who declined to pray did not engage in prayer privately (Taylor et al., 2018). Minton et al. (2016) also found that the majority of their nurse participants granted patient prayer requests willingly. Likewise, as in Minton et al.'s study, those who were not comfortable praying were willing to find someone else. Alternatively, they provided a therapeutic response to the request, which can be interpreted as respect for patients' spiritual needs. This matches what has previously been demonstrated in nurses' prevailing positive attitudes toward spirituality and spiritual care (Ross et al., 2018). The Barna study (Kinnaman & Stone, 2017), however, explains why nurses who practice in a culture where most people who pray typically do so silently and alone may find it difficult to respond to a patient's overt request for prayer, especially if prayer is not addressed in one's nursing education.

Individual elements of prayer identified in this study matched prayer themes outlined by Barna (Kinnaman & Stone, 2017): Prayer centered on gratitude and thanksgiving followed by petitions for the needs of the family and the person's immediate community. Specifically, people asked for personal guidance in crisis and presented their needs for personal health and wellness in their prayers. Likewise, nurse prayer requests mirrored what Koenig (2002; 2013) proposed: to ask for peace, comfort, and strength as the patient and family walked through the illness experience, and prayer for the healthcare team asking for wisdom and skill.

The findings of this study have the potential to contribute to theory-building on nurse-led prayer in response to a patient prayer request. Although the three-point prayer structure [Open, Request, Close] represents a quick and straight-forward response to a patient's prayer request, the more elaborate five-point structure [Open, Set the Stage, Request, Wrap-up, Close] shows ways in which a nurse-led prayer can become personal, potentially connecting with the patient's situation, the lament of the soul, and the yearning for the presence of the divine. Christian nurses in this study suggested many insightful aspects to consider before moving into the prayer situation. For clinicians who feel shy and who do not habitually pray with another person but who want to learn how they can respond positively to the invitation to pray for a patient, the findings of this study provide a structure and reflection points that may help them craft a colloquial prayer which they can adapt as the situation arises.

## Limitations

The study was both enabled and limited by the researchers involved, and by their situatedness as practicing Christians. Familiarity with the topic did not prevent the researchers from discovering new aspects about nurse prayer. The online-survey design did not allow for interactions with the participants. Thus, there was no undue participant influence; yet, member check-in with the nurses to validate the findings was not possible. Researcher reflexivity was cultivated through an iterative process of



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working through the data, a team approach, and notes kept while working through the qualitative analysis. Based on the large diverse sample, findings are likely transferable to other Christian nurses at least in the United States.

## CONCLUSION

Every practicing nurse will encounter being asked to pray by patients. This study provides an emerging practice theory on nurse-led prayer that can be useful for future research, clinicians, nursing students, and nurse educators who believe that praying in a professional context is a skill that can be acquired and taught.


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