

‘Prayer and Medicine, a healthy alliance? A multi-faith, multi-cultural perspective’

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Prayer is described in one dictionary as a solemn request or thanksgiving to God or an object of worship. Another describes it as an earnest request or devout wish. Taylor (2003) describes prayer as the mechanism for petitioning an omnipotent divinity to grant healing, which frequently sustains coping and brings comfort. Studies (McCullough 1995, Levin 1996, Dossey 1996, Paloma 1993) have shown that prayer is beneficial for patients and it can be argued that prayer in the clinical setting forms part of holistic care. Taylor suggests that prayer should be incorporated into nursing practice and reported an experience when a patient requested her nurse to pray with her and the nurse answered ‘No, I don’t do that’. On the other hand, a nurse who was unfamiliar with a patient, without a word, placed a card with a written prayer on it in his hand and was thought to be disturbingly brazen. These contrasting true stories illustrate how erroneously the place of prayer in medical care can be viewed. The questions that arise are *how, when, why and with whom to pray*. Winslow and Winslow (2003) recommend careful reflection about the meaning and purpose of prayer in the clinical setting before engaging in prayer with patients.

Shelly and Fish (1995) describe it as an intimate conversation between a person and God. God is not universally accepted, and it can be difficult to know how to address the ‘Supreme Being’ without causing offence. In a richly multicultural and religiously diverse society, it feels more comfortable talking about spirituality than religiosity because spirituality is often viewed as a universal human trait which people often profess having, while denying any religious affiliation. However, as well as being spiritual, many are affected by their religious culture and therefore some understanding of religious practice is beneficial. A theme that occurred from a multicultural multifaith group is that prayer can be helpful because it presents an opportunity to offload responsibility for dealing with ones troubles onto God (Cinnirella and Loewenthal 1999). This study also demonstrates that religious affiliation intertwines with ethnic origin to result in some important differences in the beliefs prevalent in different ethnic and religious communities in Britain, which affect use of health care. People are not always prepared to share their spirituality with others for fear of being labelled as mentally ill (Naranayasamy 2002).

A number of studies have identified faith and prayer as frequent and favoured coping strategies among patients and carers (Johnson and Spilka 1991, Pargament 1997, Koenig 1998, Ai et al. 2002, Meriviglia 2002, Picot et al. 1997, Stolley et al. 1999, Steele and Fitch 1996, Cinnirella and Loewenthal 1999). Prayer is employed for different reasons which include: moving closer to God and staying connected for someone who already believes; first awareness of God because of threat to ones existence through illness; questioning ones existence and searching for the meaning of life; hoping to get better; preparing for the ‘hereafter’; to find relief in suffering; and as a Confidant or Counsellor. Afro-Caribbean Christian and Pakistani Muslim participants in one of these studies showed a preference for private coping strategies that include prayer, because of the stigma associated with mental illness. They believe more in private prayer, demonstrating very high levels of confidence that prayer works and also providing little chance of being misunderstood or discriminated against by God.

There is a growing evidence of a large body of religiously based beliefs and practices in different cultural groups, which may complement or conflict with those of orthodox medicine and psychiatry. For example, patients may use a range of religiously endorsed coping strategies and beliefs alongside orthodox psychiatric or

similar help, without telling practitioners for fear of being misunderstood. Some have argued for ethnic specific mental health service provision (Cinnirella and Loewenthal 1999). A survey of patients one day prior to cardiac surgery showed 96% used prayer to cope and 70% gave prayer the highest possible rating on the Likert scale for helpfulness (Saudia et al. 1991). A deep desire to find comfort motivates people to pray (Hawley and Irurita 1998, Lewis 1996). Spiritual well-being is said to be a central component of psychological health (McCulloch and Larson 1999).

Religious-cultural communities tend to foster stereotypical lay beliefs and the nature and effects of religiously based beliefs about the causes and cures of illness need to be understood and taken into account in formulating appropriate care. Up to one third of participants in a multicultural study felt that lack of faith and failure to pray regularly could actually play a causal role in mental illness while the remaining two thirds did not believe that religion had any causal role. However, up to 80% of this same group believed that prayer could play a useful role in treatment (Cinnirella and Loewenthal 1999).

It can be difficult to judge accurately if it is at all appropriate, and if so, when to introduce prayer into patient management. Prayer is an intervention therefore we must always be mindful of potential for intrusion and abuse. Illness makes a person vulnerable and the increasing interest in including prayer in patient care makes the need for ethical consideration imperative (Taylor 2002, O'Conner 2001). There are a number of viewpoints that include seeking informed consent (Dagi 1995), or else obtaining permission when possible, or that if done as an act of love would not require consent (DeLashmutt and Silva 1998). Post et al. (2000) argued that when a request for prayer is received, the request should be referred to spiritual leaders if possible. Winslow and Winslow (2003) suggest that while prayer should never be prescribed and a patient should not be pressured into adopting or relinquishing it, their expressed wish for prayer should be followed. Do practitioners have a 'duty of care' to urge people to pray?

Various studies, mostly American, show that 70%-90% of people surveyed believed in prayer for a number of reasons to do with ill health (Gallup 1996, Meisenhelder and Chandler 2000, Meriviglia 2002, Poloma and Gallup 1991, Woodward 1997, Richards 1999, Taylor and Outlaw 2002). Subtle cues about the patient and how they perceive that staff relate to them might reveal whether the subject of prayer can be broached. Castro et al. (2000) found a high predictive value of whether a patient would want prayer by how important to them they rated spirituality on a 9-point Likert scale. If how frequently one prays, self-perception of ones spirituality or spiritual need is an indicator of who may desire to receive prayer, then elders, Blacks, Hispanics and women may be more interested compared to men and Caucasians.

In their study of groups of White Christian, Pakistani Muslim, Indian Hindu, Orthodox Jew and Afro-Caribbean Christians, Levin et al 1994. Levin and Taylor 1997, Connell and Gibson 1997, Picot et al 1997, McDonald et al.1998, Shahabi et al. 2002, Moadel et al. 1999) Cinnirella and Loewenthal (1999) found that the degree to which religious coping strategies were perceived to be effective varied across the groups, with prayer being perceived as particularly effective among Afro-Caribbean Christian and Pakistani Muslim groups. Among all non-white groups and the Jewish group, there was fear of being misunderstood by outgroup health professionals. However, the fact that patients pray does not mean that they want to pray with practitioners.

When it has been established that a patient would like to be prayed with, it becomes important to establish the form of prayer most suited to a patients needs. Prayer can be petitionary, meditative, intercessory, liturgical, transactionary, conversational, private or an act of supplication. Also psychological and physiological conditions have an impact on praying (Hawley and Irurita 1998). On one hand, illness can increase the frequency and intensity of prayer. On the other hand, it can also

produce challenges to one's customary prayer experience (Taylor 2003). The challenge could be due to one's physical state, psychological adjustment to the illness and conflicts about prayer, or the physical environment of being in hospital. It then becomes necessary to recognise and address these issues with the patient before prayer can become helpful for coping.

Prayer is seen as a helpful part of one's spirituality and search for meaning. What is the solution if a patient's beliefs or practices are considered detrimental to their health or healthcare? With a richly diverse cultural composition, there are increased varieties of factors to consider ethically which may lead to ethical compromise while preserving integrity. Practitioners need to be flexible in their participation while maintaining harmony between their personal convictions and their professional and social roles.

Practitioners must be mindful of their own limitations and refer to a spiritual care expert when necessary. Sometimes not knowing how other practitioners would respond to a request for prayer affects us. Taylor (2003) reported significant percentages of practitioners used prayer in patient care; however, it rarely involved an overtly shared experience. Barriers to providing spiritual care alongside health care include lack of time, personal discomfort, lack of knowledge or experience, lack of private space and difficulty ascertaining if it is appropriate to pray with a patient (Kuuppelomaki 2002, Taylor et al. 1995). Winslow and Winslow (2003) point out that in fact a practitioner's spirituality may be challenged and spiritual weakness highlighted. Also a practitioner's personal beliefs may be betrayed. The practice of prayer should be congruent with their beliefs. Nor should it contravene the values of the employing health care institution.

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