The Effects of Prayer as a Coping Strategy for Nurses

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Purpose: *To determine the effects of prayer as a coping strategy for nurses.*
Design: *Quantitative descriptive design.*
Methods: *The population was the 15,000 members of the American Society of Perianesthesia Nurses. Twelve hundred fifty nine subjects completed a demographic questionnaire and the Prayer Functions Scale. The surveys were available on SurveyMonkey.com for 2 weeks in the fall of 2014.*
Findings: *Results indicated at $\alpha = 0.05$ that the nurses surveyed experienced the effects of prayer, providing assistance, providing acceptance, providing calm, and deferring as benefits of use of prayer as a coping strategy.*
Conclusions: *Reduction of nurses' stress through prayer is one way to ameliorate the ill effects that can impact nurses through stress. Nursing administration, nursing organizations, and academics could consider use of prayer as an effective coping mechanism in teaching, studying, and exploration of methods to help nurses cope with the inherent stressors of their profession.*

Keywords: *appraisal, coping, prayer, nurse, psychological stress, stressors.*

NURSES ARE ONE of the most important resources in a health care organization. Therefore, assisting the nurse in staying healthy is vital for any health care organization to maintain and improve the standard of patient care delivery.[1] Nursing is a stressful profession with high energy demands at the mental, emotional, and physical levels.[2-4] Many simultaneous tasks of the nurse are required that consist of high-level skills, continuous quality care of patients, and team work with many different disciplines.[5-8] Additional stressors include, but are not limited to, role stress, death of patients, emergency situations, staffing shortages, personal stressors, and a rapidly changing health care environment.[9-15] Even new nursing graduates feel the stress of the clash between "professional values of patient-oriented nursing care and organizational value of task-oriented nursing care."[16] Such events push one past his or her ability, requiring the implementation of coping strategies.[14,15] A nurse with intentions to remain in the nursing profession for many years must find effective methods to cope with the stressors associated with the role of a nurse.

Many coping methods, including self-help, stress management training, meditation, taking a break, emotional support, and personal belief systems, have been examined in the research.[2,17-19] Prayer is an additional coping strategy identified in literature. As a coping strategy, prayer provides context and social connection, keeping a person's perceptions of stress well managed,[20,21] thereby making prayer a part of the class of significant coping mechanisms.[22]

Prayer, as used in this study, is defined as communicating with one's God or higher power and can

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include talking, listening, and meditating.[22-26] A widely accepted definition of prayer is from William James. In lectures given at Harvard in 1901-1902, he defined prayer as "every kind of inward communion or conversation with a power recognized as divine."[27]

Review of the literature substantiated nursing as a stressful profession.[2,28-32] Unmanaged stress contributed to nurses not only leaving the profession but also having health issues.[11,33-36] Nurses have reported high levels of stress; studies demonstrated associations between stress and compromised health, increased sick leave, less job satisfaction with attrition, and decreased job performance.[1,37,38] In addition, other outcomes are an increase in mistakes made in medication administration; a decrease in ability to connect with patients, patients' families, and coworkers; and a higher turnover rate.[39,40] Stress experienced by nurses have surpassed many nurses' ability to cope, causing illness and burnout.[2,28,40] Decreasing nurses' stress through prayer may help alleviate such issues, including improving mental health.[39] The coping method(s) the nurse chooses to use can determine if his or her stress is decreased. Individual studies have shown prayer to decrease stress.[29-32] However, minimal research was found in the literature determining the effectiveness of prayer as a coping strategy for nurses.

Despite research results which showed that the majority of people prayed and were comforted by prayer, conflicting beliefs still existed as to whether or not prayer belonged in health care.[41] Conversely, studies were found that encouraged nurses to assess a patient's spirituality and need for prayer.[39,42,43]

Research studies revealed that prayer served many functions, such as providing acceptance, assistance, and calm or deference, for the one who prayed.[14,44-46] These functions have the potential to benefit a nurse at work.[25] Bade and Cook[47] reported that one of the most effective functions of prayer was guidance. Dehghani et al[48] identified a statistically significant reduction in anxiety for mothers of children with cancer who prayed. Hollywell and Walker[49] stated that "devotional prayers involving an intimate dialogue with a supportive God appear to be associated with improved optimism, wellbeing and function" (p. 637). Similarly, a study regarding effects of intercessory prayer (prayer on behalf of oneself or another) on the one prayed for showed the highest levels of optimism, even accounting for the benefits of social support alone.[50] Prayers of adoration, thanksgiving, and reception were reported to be associated with improved measures of well-being including self-esteem, optimism, and meaning in life.[51,52] Prayer was also found to decrease stress.[30] These identified effects have the potential to positively benefit a nurse at work.

Purpose

The purpose of this research study was to determine the effects of prayer as a coping strategy for nurses. Do nurses use prayer to help them cope with the stresses of working as a nurse? What are some of the ameliorating effects of prayer on the stress of the nurse?

Ethical Considerations

Every effort was made to protect the confidentiality and anonymity of the research subjects. Approval was obtained through the Institutional Review Board (IRB) of Southern Nazarene University and approval of the American Society of Perianesthesia Nurses (ASPAN) before initiating the research study.

The statement of participation (SOP) explained to the potential subjects that participation in the research study was voluntary, all responses were confidential, and the subjects could skip an item or withdraw from the research study at any time without penalty. The researcher-developed demographic questionnaire included five items, and the Prayer Function Scale (PFS) included 58 items. The SOP also informed potential subjects that completion and submission of the demographic questionnaire and PFS was considered consent. No personal identifiers were requested. The researcher and the statistician were the only individuals to view the data. The potential research subjects were informed that the demographic questionnaire and PFS were available online at SurveyMonkey.com for 2 weeks and would take approximately 10 minutes to complete. The researcher had no personal contact with the subjects. Risks were minimal and

within accepted research limits for potential subjects.

Methods

Once approval was obtained from the ASPAN, the invitational mailing developed by the researcher discussing the opportunity to participate in the study was sent out via blast email to ASPAN members (15,000) by a representative of the organization. A hyperlink was attached to the email by the researcher which directed potential subjects to SurveyMonkey.com where the SOP, a copy of the demographic questionnaire, and PFS were available for 2 weeks during the fall of 2014. The SOP described to the reader the name of the researcher, title of the research study, and purpose of the research study. Also included in the SOP were that all responses were confidential, no identifying information was requested (because demographics are insufficient for identity analysis and no IP address or similar location information was provided to the researcher), and the subject could skip the item or discontinue the study at any time without penalty if an item made the subject feel uncomfortable; risks were minimal and within accepted research limits for potential subjects. The subject was informed that completing the demographic questionnaire and PFS was considered consent to participate in the research study. The research study was available on SurveyMonkey.com for 2 weeks and took approximately 10 minutes to complete both the demographic questionnaire and PFS.

Design

This study used a quantitative descriptive design, which examined the effects of prayer as a coping strategy for nurses. Descriptive study design is vitally important in gaining new knowledge regarding a topic on which little research exists. One-way descriptive design does this is by giving an accurate picture of an event.[53]

Sample

The population for this study was the approximately 15,000 registered nurses (RNs) and licensed practical nurses (LPNs) who were members of the ASPAN, had access to a computer, and possessed email addresses. The sample consisted of the 1,259 members who voluntarily responded to the blast email initiated by a representative of the ASPAN and completed the PFS and the researcher-developed questionnaire. The demographic questionnaire included in the research study consisted of the following items: gender, birth range, marital status, years in nursing, and highest level achieved in nursing education. The sample was primarily female subjects (96.2%), subjects in the birth ranges of 1964 and before (73.53%), subjects who were married (77.2%), subjects with 21 years or more of experience in nursing (78.68%), and subjects with Bachelor of Science degrees in nursing (54.80%).

Setting

The study was conducted in the setting of the subject's choice. Natural, true-to-life environments are settings uncontrolled by the researcher.[53]

Instrument

The PFS was used to determine the effects of prayer as a coping strategy for nurses.[54] The PFS was developed by Bade and Cook[54] who noted that prayer functioned in various ways as a coping strategy and also noted that in most studies, only one measure of prayer was taken (frequency of prayer). By doing so, most research studies regarding prayer failed to capture the complexity of prayer, overlooking a broader spectrum of potential benefits (Table 1).[54]

The PFS was a 58-item measure that focused on four concepts: Provided Acceptance, Provided Calm, Deference, and Provided Assistance.[47] Subjects ranked the items on a Likert scale from frequently (5) to never (1).[54] A Cronbach's alpha of 0.86-0.95 has been reported to demonstrate the validity and reliability of this instrument.[54]

Results

A total of 1,259 nurses who were members of the ASPAN in the fall of 2014 answered the demographic questionnaire and the PFS. The demographic questionnaire included five items: gender, birth range, marital status, years of nursing experience, and the highest level achieved in nursing education. Please note that variances from the 1,259 total indicate the number of subjects that responded

Table 1. Prayer Function Scale Sample Questions

	Never	Sometimes		Frequently	
Questions	**1**	**2**	**3**	**4**	**5**
Provides acceptance					
29. Pray that God's will be done in the situation.	1	2	3	4	5
31. Pray that the difficulty will lead me to a closer relationship to God.	1	2	3	4	5
33. Pray for the strength to endure.	1	2	3	4	5
Provides calm					
21. Allows me to reflect on the issues.	1	2	3	4	5
40. Meditate.	1	2	3	4	5
56. Keeps me focused.	1	2	3	4	5
Provides assistance					
1. Ask God to help me through the difficult times.	1	2	3	4	5
4. Seek God's will.	1	2	3	4	5
5. Ask for guidance	1	2	3	4	5
Provides deference					
16. Pray for God to change the situation.	1	2	3	4	5
17. Pray for things to get better.	1	2	3	4	5
53. Pray for difficulties to be taken away.	1	2	3	4	5

The following items describe ways that people might use prayer to deal with personal difficulties. As you answer these questions, think of the ways that you personally use prayer when coping with difficulties. Please rate each item by circling the most appropriate number indicating **how often** you use the item when dealing with personal difficulties.

to that particular item. The demographic characteristics were tested by the overall mean of the PFS.

Gender

For the demographics of gender, there were 1,251 responses. Of the 1,251 responses, 1,203 (96.2%) were female and 48 (3.8%) were male. A between-subjects analysis of variance (ANOVA) was calculated. There was significant evidence at $\alpha = 0.05$ level to conclude that gender resulted in different scores of prayer coping strategy. Because there were only two groups, a post hoc test was not performed.

Birth Range

The birth range options were 1945 or before (n = 17, 1.4%), 1946 to 1964 (n = 922, 73.6%), 1965 to 1980 (n = 258, 20.6%), and 1981 or after (n = 56, 4.5%). A between-subjects ANOVA was calculated which showed a significant difference of level of birth range, F (3, 1203) = 4.853, $P = .002$. Post hoc analyses indicated nurses in the birth ranges of 1945 and before and 1946-1964 indicated statistically more significant use of prayer for acceptance, assistance, calm, and deference than nurses in the birth range 1981 or after.

Marital Status

There were five categories of marital status: single (n = 99, 7.9%); married (n = 966, 77.2%); divorced (n = 147, 11.8%); other, defined as any status that was not married, divorced, widowed, or single (n = 13, 1.0%); and widowed (n = 26, 2.1%). A between-subjects ANOVA was calculated which showed a significant effect of marital status, $F(4, 1200) = 5.233$, $P = .000$ on the scores of prayer coping strategy. The Tukey tests were conducted on all possible pairwise contrasts. The following pairs of groups were found to be significantly different ($P < .05$): group 1 (single; M = 3.63, standard deviation [SD] = 1.13) and group 2 (married; M = 3.98, SD = 1.04), group 2 (married) and group 4 (other; M = 2.93, SD = 1.46), group 3 (divorced; M = 3.91) and group 4 (other), and group 4 (other) and group 5 (widowed; M = 4.06, SD = 0.91). There were statistically significant differences between nurses who were married, divorced, or widowed and nurses who reported "other" showing

more use of prayer as a coping strategy in the former group than the latter.

Years of Nursing Experience

There were four categories of nursing experience: 1 year or less (n = 3, 0.2%), 2 to 10 years (n = 88, 7.0%), 11 to 20 years (n = 177, 14.1%), and 21 or more years (n = 985, 78.6%). A between-subjects ANOVA was calculated which showed a significant effect of years of nursing experience, F (3, 1202) = 3.57, $P = .024$. Use of the Tukey test found that the following pairs of groups were found to be significantly different at $\alpha = 0.05$: group 2 (2 to 10; M = 3.68, SD = 1.14) and group 4 (21 years or more; M = 3.98, SD = 1.03). Nurses with 21 years or more of experience in nursing indicated statistically more significant use of prayer for acceptance, assistance, calm, and deference than nurses with less years of experience.

Highest Level in Nursing Education

There were five categories of level of education: diploma (n = 146, 11.6%), associate (n = 231, 18.4%), bachelor (n = 688, 54.8%), master (n = 178, 14.2%), and doctorate (n = 12, 1.0%). There was a significant effect of level of education, F (4, 1203) = 2.599, $P = .035$. Tukey Honestly Significant Difference (HSD) tests were conducted on all possible pairwise contrasts. The following pairs of groups were found to be significantly different at $\alpha = 0.05$: group 1 (diploma; M = 4.04, SD = 1.01) statistically varied from group 2 (associate; M = 3.98, SD = 1.09) and group 2 (associate) from group 3 (bachelor; M = 3.94, SD = 1.03). Nurses with diploma degrees in nursing statistically varied in use of prayer for acceptance, assistance, calm, and deference from nurses with associate degrees in nursing. Nurses with associate degrees in nursing statistically varied in use of prayer as a coping strategy from nurses with bachelor degrees in nursing.

PFS Four-Concept Analysis

Table 2 presents the descriptive statistics associated with the measures of assistance, deference, acceptance, and calm. Valid sample sizes were found to be 1,147 in all cases, with 149 missing cases associated with all four measures. The mean was highest with respect to assistance, followed by acceptance, calm, and, finally, deference. Standard errors of the mean were found to have a very small range, from a minimum of 0.032 with respect to assistance to a maximum of 0.036 with respect to deference. Regarding median

Table 2. PFS Four-Concept Analysis

Measure	Assistance	Deference	Acceptance	Calm
N valid	1,147	1,147	1,147	1,147
N missing	149	149	149	149
Mean	4.261	3.465	3.800	3.714
SE of the mean	.032	.036	.034	.033
Median	4.833	3.000	4.000	3.857
Mode	5	3	5	5
SD	1.096	1.214	1.162	1.101
Variance	1.201	1.473	1.349	1.213
Skewness	−1.669	−.462	−.852	−.735
SE of the skewness	.072	.072	.072	.072
Kurtosis	1.950	−.546	−.054	−.079
SE of the kurtosis	144	.144	.144	.144
Range	4	4	4	4
Minimum	1	1	1	1
Maximum	5	5	5	5
Sum	4,887	3,974	4,359	4,260
Percentiles: 5%	1.248	1.000	1.163	1.200
Percentiles: 95%	5.000	5.000	5.000	5.000

SE, standard error; SD, standard deviation; PFS, Prayer Function Scale.

values, this was found to be lowest with respect to deference and highest with regard to assistance. Mean and median values were found to be similar in all cases, suggesting that all four measures do not have substantial skew. Next, deference had a mode of three, with all remaining measures having a mode of five. All SDs were found to be slightly above one, with variances also found to be slightly above one. With regard to skewness and kurtosis, values below -2 or above +2 indicate substantially low or high skewness or kurtosis. All measures of skewness and kurtosis were found to be within this range, indicating the lack of substantial skewness or kurtosis. Next, all measures were found to have a minimum value of one, with a maximum value of five, producing a range of four in all cases. Sums of all values were found to range from close to 4,000 to close to 4,900. Finally, with regard to the fifth and 95th percentiles, the 5th percentiles were found to be equal to one or slightly above one, with the 95th percentiles all found to be equal to five.

As shown in Table 3, Pearson's correlation provided significant, positive, and strong correlations in all cases. These results indicate that a higher value on any one of these measures is associated with higher measures on any other of these measures. The mean for the items in the PFS varied from 4.261 for assistance to 3.465 for deference. All had a range from 1 to 5. With the Pearson correlations finding very little difference, correlating at the 0.01 level, the PFS may be limited in its ability to detect differences in functions of prayer.

Discussion

Results were consistent with previous findings.[25] Findings indicated that the majority of nurses surveyed used prayer as an effective coping mechanism. Results at $\alpha = 0.05$ indicated that female subjects; subjects in the birth ranges of 1964 and before; subjects who were married, divorced, or widowed; subjects with 21 years or more of experience in nursing; and subjects with diploma or associate degrees in nursing significantly statistically reported more use of prayer for assistance, acceptance, calm and deference than the nurses from the other identified demographic groups. Results indicated at $\alpha = 0.05$ that the nurses surveyed experienced the effects of provides assistance, provides acceptance, provides calm, and deferring as benefits of use of prayer as a coping strategy.

Limitations

Because there was scant information in the literature found regarding prayer as a coping strategy for nurses, this can be viewed as a preliminary study. This research study measured the effects of prayer as a coping strategy for nurses using the PFS. There were several limitations to the research study. For example, the study did not

Table 3. Correlations

	Assistance	Deference	Acceptance	Calm
Assistance				
Pearson correlation	1	.674*	.858*	.782*
Sig. (2-tailed)		.000	.000	.000
N	1,147	1,147	1,147	1,147
Deference				
Pearson correlation	.674*	1	.671*	.654*
Sig. (2-tailed)	.000		.000	.000
N	1,147	1,147	1,147	1,147
Acceptance				
Pearson correlation	.858*	.671*	1	.817*
Sig. (2-tailed)	.000	.000		.000
N	1,147	1,147	1,147	1,147
Calm				
Pearson correlation	.782*	.654*	.817*	1
Sig. (2-tailed)	.000	.000	.000	
N	1,147	1,147	1,147	1,147

*Correlation is significant at the 0.01 level (2-tailed).

address the questions of how and where prayer took place or what the praying as coping actually looked like. In addition, valid questions for future studies would be the frequency of the nurse praying and whether the subjects prayed at all, did prayer relieve the subjects stress, and did the subject receive the desired results. Another question that could be asked would be if the demographics captured in this study accurately represented the population of nurses. This was a self-reported study, with the limitations inherent in the process. Finally, only one health care profession and one nursing organization were included in the study.

Conclusion

Multiple research studies have indicated that stress was identified as occurring when environmental demands exceeded the individual's resources.[12,55,56] Not surprisingly, nurses reported high levels of psychological stress.[1,28,57] Studies demonstrated associations between stress and compromised health, increased sick leave, less job satisfaction with attrition, and affected job performance.[13,28,57] In addition to other stress-related variables, there was a reported increase in mistakes made in medication administration, higher turnover rate, and decrease in ability to connect with patients, patients' families, and coworkers.[1,37-40]

A nurse with intentions to remain in the nursing profession for many years must find effective methods to cope with the stressors associated with being a nurse. As a strategy to cope with stress, prayer provides context and social connection, keeping a person's perceptions of stress well managed.[18,58-63] Reduction of nurses' stress through prayer is one way to affect the preceding list of ill effects that can impact nurses through stress.

Numerous studies reported that prayer was shown to reduce stress.[19,25,29,30,40,52,64,65] Results of this research study are consistent with those of previous studies.[25] Research instruments located measured goal-oriented thinking, frequency and type of religious thinking used to cope, the use of relationships to cope with stress, and features of religion which contributed to coping.[66-68] The PFS measured the effects of prayer: acceptance, assistance, calming, and deferring.[47] The increased complexity of items measured by the PFS, in addition to the measuring of effects of prayer, identified the PFS as a better fit for this research study.

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