‘Beyond Boundaries or Best Practice’ Prayer in Clinical Mental Health Care: Opinions of Professionals and Patients

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Abstract: The use of prayer in mental health care is controversial. Several scholars in the field have emphasized possibilities, whereas others have expressed clear disapproval. The aim of the current study was to describe opinions about prayer of mental health professionals (MHPs) and patients in a Christian (CC) and a secular (SC) mental health clinic. Content analysis was applied to 35 patient interviews and 18 interviews with MHPs. Most of the nurses in both clinics were open to the possible use of prayer, frequently argued by assisting patients in case of inability, but also by personal belief in its potency. Practitioners in both clinics were sometimes reticent or reluctant towards prayer. In the CC the nurses practiced prayer regularly, but all of them mentioned preconditions (like a similar outlook on life) and patients were stimulated to pray themselves. All patients in the CC and most of the patients in the SC had no objections against prayer and tended to focus on the benefits, like tranquility and relief. Prayer in mental health care could be practiced, especially by nurses, in cases of inability of patients, when considered beneficial and when a similar religious background is present.

Keywords: religion; spirituality; mental health; prayer

1. Introduction

The use of prayer in mental health care is controversial. Several scholars in the field have formulated deliberate advices for professionals. “Doctors and clinicians should not initiate prayer without knowledge of the patient’s religious background and whether the patient would appreciate such activity” (D’Souza 2007, p. S58). Dein and colleagues acknowledge prayer to be contentious, but state that prayer for certain patients might be helpful and could potentially strengthen the therapeutic alliance (Dein et al. 2010). They refer to the following statement of Koenig in the psychiatric bulletin:

“Prayer with a religious patient can have a powerful positive effect and strengthen the therapeutic alliance. This, however, can be a dangerous intervention and should never occur until the psychiatrist has a complete understanding of the patient’s religious beliefs and prior experiences with religion. Prayer should only be done if the patient initiates a request for it, the psychiatrist feels comfortable doing..."
so, and the religious backgrounds of patient and psychiatrist are similar. Even if all the right conditions are present, there will be some patients for whom prayer would be too intrusive, too personal and may violate delicate professional boundaries. Prayer should never be a matter of routine. The timing and intention must be planned out carefully with clear goals in mind”. (Koenig 2008, p. 203).

This recommendation was written, with knowledge that 20% of psychiatrists in the USA used to pray rarely with patients and 6% did it regularly (Curlin et al. 2007). Nevertheless, several colleagues were alarmed by Koenig’s statement about prayer. They argued that the introduction of a completely nonclinical activity carries a grave danger of blurring therapeutic boundaries and creates ambiguity over the nature of the relationship (Poole et al. 2008; Poole and Cook 2011).

Many definitions of prayer circulate, and most of them have in common that they mention a movement from within a person as well as God, the Divine or the sacred. “Prayer is the simple act of turning our mind and our heart to the sacred” (Ameling 2000). “In the broadest sense, prayer describes thoughts, words or deeds that address or petition a divine entity or force” (Andrade and Radhakrishnan 2009). Spilka and Ladd (2013) have pointed at difficulties in defining prayer, suggesting that: “the best definition of prayer envisages a direction—in fact, many directions—into the pray-er’s cognitions, motivations, personality, and social behavior” (p. 13). The current study uses the following definition: prayer is “the typically intentional expression of one’s self in an attempt to establish or enhance connectivity with the divine, with others in a religious or spiritual framework, and with the self” (Ladd and McIntosh 2008, p. 29). Though the connection with others is no necessary element of prayer, when (mental) health professionals pray together with patients this element is always present.

Different authors distinguish various types of prayer. Foster (1992) mentions seven types: petition (asking something for one’s self), intercession (asking something for others), confession, lamentation, adoration, invocation and thanksgiving. Poloma and Gallup (1991) distinguish four main types of prayer: ritual, conversational, petitionary and meditative prayer. Another type of prayer that more frequently is described in the context of nonwestern cultures is the so-called ‘authority prayer’, or ‘prayer on command’ (Währisch-Oblau 2011, p. 67). Prayer can also be grouped in active or passive, communal or private. Passive prayer is related to meditation. The more active prayer is, the more words are involved. Communal prayers involve formal religious liturgy and/or public rituals (Foster 1992). However, people usually spend more of their prayer time in a private way. In private prayer several of the mentioned types can also be combined.

Prayer in health care settings has been topic of study and debate. For example, a meta-analytic review describes the lack of effect of intercessory prayer, intended as intervention, in various health care settings (Masters et al. 2006). Another study describes that private petitionary prayer among Christian adults has a negative association with mental health, whereas ritual prayer shows a positive relationship (Black et al. 2015). In studies describing the concept of health care professionals praying with patients, types of prayer are not always mentioned, but in western, predominantly Christian societies, prayer during a face-to-face contact between caregiver and patient would likely be either ritual, conversational or sometimes petitionary (intercessory according to Foster 1992). With respect to petitionary or intercessory prayer, mental health professionals may realize that patients could see prayer as a supplement or as a substitute of regular treatment (Gallagher et al. 2002; Ouwehand et al. 2018). In cases of a substitute, different explanatory models could make patients merely to trust prayer instead of regular treatment.

A complicating factor with regard to prayer in (mental) health care, could be the presence of a ‘religiosity gap’. This term has been used to describe differences in outlook on life between mental health professionals and patients, the first group being less often religiously involved (Lukoff et al. 1992). Patients tend to prefer a ‘religiosity match’ when religion/spirituality (R/S) is discussed during treatment (Stanley et al. 2011; van Nieuw Amerongen-Meeuse et al. 2018) and their preference may extend to the issue of prayer. Koenig (2008) has formulated a similar background between caregiver and patient as requisite.
The different types of prayer, the different motivations of a prayer-er, as well as the differences in outlook on life all may be elements reinforcing the variety of opinions about prayer. Furthermore, the presence of different disciplines in (mental) health care may play a role. The conflicting statements described earlier, are mainly made in the context of psychiatrists and psychologists—i.e., practitioners. At the same time, the nursing discipline has an important function in (clinical) mental health care. In general nursing care, prayer with patients seems to be more accepted. Ameling suggests that nurses should “understand potential uses of prayer as part of holistic nursing practice” (Ameling 2000, p. 46). Another study offers guidelines to assist nurses in their ethical decisions about prayer with patients, elaborating that spirituality and spiritual care are considered concepts of central importance in the practice of nursing (Winslow and Winslow 2003). DiJoseph and Cavendish (2005) state that nursing is a caring profession, advocating a basic interpersonal relationship that connects at the spiritual level. Several review articles point out whether and how prayer can be used by nurses (Durfee-Fowler 2003; Lo 2003; Taylor 2003). At the same time prayer for nurses is certainly not a matter of course. An article in the context of nursing states that it is imperative that healthcare providers await the request of prayer by the patient, before prayer is initiated (Green 2018) and even then nurses regularly experience a sense of uneasiness (Minton et al. 2016). Prayer of mental health nurses with patients has not specifically been worked out, but in mental health care nurses still may have a more holistic view than their colleagues from other disciplines.

In the question whether or not (mental) health professionals could pray with patients, the opinion of patients is a matter of importance. It is known that part of the inpatients appreciates prayer by health professionals. A study in the United States among hospitalized patients, found that 88% accepted the offer of colloquial prayer by massage therapists after a massage, 85% found it helpful and 51% wanted prayer daily (McMillan and Taylor 2018). The authors conclude that patients may welcome prayer, as long as clinicians show ‘genuine kindness and respect’. Another study however found that hospitalized patients tend to prefer prayer from chaplains as compared with nurses (Martinuz et al. 2013). Patients preferences concerning prayer in the context of mental health care have less often been described. A recent Dutch study found that 24–62% of mental health patients would appreciate prayer with a nurse during their clinical stay, whereas at least half of them reported that it did not occur (van Nieuw Amerongen-Meeuse et al. 2020a). Unmet religious/spiritual (R/S) care needs are frequently present in mental health care (Pennybaker et al. 2016) and may hamper treatment alliance (van Nieuw Amerongen-Meeuse et al. 2020b).

Opinions and preferences of professionals and patients are culturally determined and likely to be related to their own life view. Furthermore they may relate to different definitions of prayer, and to different contexts in which prayer is practiced. Western countries like the Netherlands, are more and more plural with regard to R/S. Traditional Christianity is present, but other religions and spirituality without religion are also represented. In general R/S is far less institutionalized compared with several decades ago (Pew Research Center 2018). It may be relevant to investigate opinions about prayer in a plural society. Following on from this, the question is whether a difference in outlook on life indeed is a threshold making prayer of a mental health professional with a patient not desirable. Should a nonreligious mental health nurse accept a request for prayer by a patient? Furthermore, one may question whether mental health professionals indeed should await patients’ requests and why. Additionally, different disciplines may consider the issue from different stances, having differing educational backgrounds. And it would be relevant to know whether professionals and patients have similar opinions or whether their view is different.

The aim of the current study therefore was to explore opinions of inpatients and mental health professionals of various disciplines about the use of prayer in individual patient-caregiver contacts in clinical mental health care. We propose to address the following research question: What are opinions, possible reasons, objections or conditions of mental health professionals and inpatients about the use of prayer in mental health care in a Christian and a secular clinic in the Netherlands?
2. Methods

A qualitative approach was used in the current study, which was performed in a cooperation between the University of Humanistic Studies, Utrecht; the Center for Research and Innovation in Christian Mental Health Care, Eleos/De Hoop, Amersfoort; and Altrecht Mental Health Care, Utrecht; the Netherlands. The study was approved by the science committees of the Center for Research and Innovation in Christian Mental Health Care and of Altrecht Mental Health Care (CWO no 1525).

We analyzed existing in-depth interviews with inpatients and their mental health professionals (MHPs) about R/S in mental health care on the topic of prayer. Several questions were dedicated to the idea of or the experience with a mental health professional of any discipline praying with a patient during an individual patient-caregiver contact. These prayers could occur spontaneously, either following a patient’s request or an MHP’s initiative. The interviews originally were conducted to assess R/S care needs among mental health patients and to explore their view of a different outlook on life between themselves and MHPs. The MHP interviews focused on their way of managing R/S in mental health care and on their views on the so-called ‘religiosity gap’. Based on these interviews two articles have been published, on the topic of R/S care needs (van Nieuw Amerongen-Meeuse et al. 2019) and on the topic of a religiosity gap (van Nieuw Amerongen-Meeuse et al. 2018). Part of the method section is similar. The current study differs from the previous publications by its specific focus on the topic of prayer, zooming in on one of the mentioned R/S care needs.

2.1. Sample/Participants

We aimed to include both professionals and inpatients identifying themselves as Christian believers, as well as professionals and patients without a specific religious orientation. Therefore, two different clinical settings were involved in the study: a specialized protestant Christian clinic (CC) in which Christian professionals and Christian patients participated; and a regular, secular clinic (SC) in which professionals and patients of various life views took part. Both clinics do not have a statement in their policy about prayer of MHPs with patients, and in the CC, MHPs praying with patients in individual patient contact is not uncommon. Patients in the age of 18–65 with a range of diagnoses took part in the study. All of them had a clinical stay, ranging from a couple of days to several months. Patient characteristics have been described earlier (van Nieuw Amerongen-Meeuse et al. 2019). Patients with severe manic or psychotic states, serious communication problems, and patients admitted involuntarily because of a short-term civil commitment (<3 weeks) were excluded. The MHPs had various disciplines: in a mental health clinic in the Netherlands, care is provided by a multidisciplinary team consisting of psychiatrists, physicians, nurses, peer support workers and sometimes a chaplain. The participants received detailed information about the study and provided written consent.

Patients were approached in the clinics by their practitioner, one of the nurses, or the interviewer (JN). Professionals of various disciplines were approached by e-mail. Of those who were invited to be interviewed all professionals and approximately 70% of patients from both clinics agreed to participate. The main reason cited for non-participation was lack of energy due to illness and treatment.

2.2. Data Collection

All participants received a face-to-face semi-structured interview in the clinic by JN, between September 2015 and August 2016. No other persons were present during the interviews and no repeat interviews were conducted. In each interview, the participant was asked what term he or she preferred to use for R/S: e.g., faith, spirituality or ‘meaning making’ (‘zingeving’; common Dutch expression of the search for meaning in life).

The patient interview focused on the role of R/S during their mental illness and treatment. The interview for MHPs concentrated on their own view of and way of managing R/S in treatment. In the course of the data collection, the topic of prayer became more and more visible and a question about prayer was added to the topic list. Therefore this subject was not present in all the interviews.
The interviews were undertaken in Dutch and varied in length (30–60 min). All but one were audio recorded and transcribed verbatim. One of the patients reported uneasiness about recording the interview; the interviewer noted down as much of the interview as possible. In reporting the study the COREQ-checklist was followed (Tong et al. 2007).

2.3. Data Analysis

With help of the qualitative analysis program Atlas.ti, content analysis was performed, using a conventional approach (Hsieh and Shannon 2005), by which inductive categories were developed (Elo and Kyngäs 2008). Analysis started when data collection was going on and the interviews were analyzed and coded independently by JN and a research assistant. The first step was a process of open coding, in which units of text were coded, remaining close to the data. Secondly, the open codes were categorized and classified, by developing axial codes. A memo was written when distinctive results were found or new themes emerged. The topic list was adapted when new themes were detected. The topic of prayer was not present on the semi-structured questionnaire from the start of the study, but has been added after three patient interviews as a new emerging theme. For the current study selective coding has been applied by two of the authors (AB and JN) for all parts of the interviews that concerned ‘prayer in the context of mental health care’. In this way we identified relevant themes with respect to the research question and made various diagrams to map the selective codes and their interrelation to one another, resulting in two final code trees (Figures 1 and 2).
2.4. Characteristics of the Sample

Thirty-five patients and eighteen MHPs took part in the current study. In the two clinics combined, 36% of the patients and 28% of the professionals was male. Patients in the age of 18–65 were included. The mean age of the patients was 45.3 years (SD 12.6). Professionals on average were younger, having a mean age of 38.0 years (SD 11.6).

Religious affiliation of participants differed between the two clinics (van Nieuw Amerongen-Meeuse et al. 2019). In the CC, all patients and professionals were pietistic reformed (emphasis on individual piety, personal faith and a biblical tradition, related to Calvinism), orthodox reformed (emphasis on biblical tradition, covenant and conservative Protestant theology) or evangelical (e.g., Pentecostal denominations and/or Baptist churches). The R/S orientations of patients and professionals in the SC were more diverse and the various Christian denominations were less represented.

The patients agreed that the interviewer took note of their DSM-5 diagnostic classification. The psychiatric diagnoses showed considerable variation and many patients had more than one diagnosis. The most common diagnoses (both clinics combined) were: depression 51%, anxiety disorders (46%), personality disorders (46%) psychotic disorders (23%), and autism spectrum disorders (11%).

The MHP population consisted of 6 psychiatrists/physicians (3 CC), seven nurses (3 CC), 4 social workers (3 CC) and 1 chaplain (SC). See for extra information about sex, age and religious denominations: van Nieuw Amerongen-Meeuse et al. (2018).

3. Results

Mental health professionals of both involved institutions had different answers on the question whether MHPs could or could not pray with patients. Compared with their SC colleagues, MHPs in the CC had more elaborate opinions. Several nurses in the CC used to see patient assistance in prayer as their task. In both clinics however also MHPs were present who thought it to be inappropriate that they themselves or their colleagues would pray with patients. Furthermore, most of the MHPs mentioned preconditions in case they did not disapprove this.

Patients on the contrary, tended not to give many thoughts on the ethics of MHPs praying with them. Most of them agreed with the possible use and emphasized the reasons for instead of the reasons against. Furthermore, they often mentioned benefits of prayer, especially in the CC, where the experience was more common. A similarity with the view of the MHPs was that many patients also mentioned preconditions. Results below are described for MHPs and patients separately, starting with the most prominent results per group.

3.1. Mental Health Professionals

3.1.1. Reasons for and against Prayer with Patients

MHPs in both clinics had various opinions about the appropriateness of prayer with a patient. A first group of MHPs—equally represented in both clinics—thought praying with patients could be appropriate. They brought up several reasons, that could be divided into two main motives. Some—mainly nurses—regarded prayer as part of treatment (1), especially in cases when a patient would be unable to pray. In praying with patients they aimed to assist them. Praying with patients for several MHPs also was a way of aligning treatment with patients’ expectancies. Prayer could make a bridge between patients’ values and regular treatment, and may align different explanatory models.¹

¹ On the one hand, prayer can be expected to help due to direct intervention by God—this expectation could be regarded as religious (and hence related to a religious explanatory model of mental disease). In contrast, there is the biomedical and psychological approach, as required and expected in a mental health clinic (this is a secular, scientific or naturalistic explanatory model).
Other motivations to pray with patients, were more colored by the personal conviction of MHPs regarding the importance of prayer (2). MHPs illustrated their belief in the potency of prayer and/or the usefulness of bringing a patients’ problems together to God. Prayer in this way could function as sharing issues with a ‘Third party’ where all problems could be brought. These MHPs could imagine that prayer might help patients:

“I can imagine that it may give some relief . . . to give words to it, pronounce it and bring it to God in this way. That may be facilitating and releasing”. (CC8, social worker)

At the same time, prayer for MHPs themselves in this regard was sometimes supportive, in cases of a lack of certainty about the situation and about treatment. The MHP experiences a certain degree of helplessness and feels inclined to address the ‘broader picture’ in a framework of faith.

Another motive was the feeling of connectedness: praying together as brothers and sisters in faith could emphasize equality. In the SC regularly was added that prayer with patients was not usual and many MHPs had never heard it occurred. Most of the MHPs who favored to pray with patients, illustrated their feelings of compassion, mentioning that prayer in their view was appropriate at the difficult moments of patients.

A second—smaller—group of MHPs, disapproved prayer in all cases, argued by transgressing boundaries of professionalism. Someone explained that prayer would not be appropriate for professionals who are expected to provide regular mental health care and another called prayer with patients ‘manipulative’ towards patients.

“I think prayer is like . . . well I am going to express to God . . . No, I think this is manipulative, I would never do such a thing”. And when asked about colleagues practicing prayer with patients: “Deep inside my heart, I think, they ought not to do so”. (CC4, social worker)

A third group of MHPs were less strict in their disapproval, but stated they would rather not pray with patients themselves (mainly psychiatrists/physicians). They explained to feel uneasy about praying with patients, for example because of trouble in finding the right language, but also because of a feeling of vulnerability.

“As a practitioner, I think it to be very complicated. Because it is very personal . . . So when a patient asks me to pray, well ( . . . ) You are making yourself vulnerable and that would hinder me. Prayer is so much colored by personal convictions, I think that can be very delicate”. (CC2, practitioner)

Most of the MHPs in both clinics that approved prayer, mentioned preconditions and several participants thought prayer to be mainly a task for nurses.

3.1.2. A Role for Nurses?

Practitioners with reticence towards prayer for themselves regularly emphasized that praying with patients would be a task for nurses. They reasoned that nurses are more close to patients and more involved in daily routine issues.

“They are more close to patients, because they are with patients during the whole day and use to join their daily routine. Like someone having a need for much care, heading off to bed and then a nurse present and saying a prayer, well I think that suits in the nursing plan. When someone is unable to pray or has a need for it”. (CC2, practitioner)

Several nurses in the CC confirmed this, seeing prayer as one of their tasks, advocating with the earlier described reason of inability of patients.

“There is a man, being very depressive. To pray is impossible for him ( . . . ). In such a case I consider it to be my task to do it. It’s not that his faith depends on his prayer, but I can imagine his relief to have things expressed, to have words that can be brought to God”. (CC9, nurse)
3.1.3. Conditions

Most of the MHPs that did not disapprove prayer, mentioned preconditions. In the CC it was regularly noticed that an MHP should have the ‘feeling’ that the moment was appropriate to offer prayer. A few MHPs stated that they would await a patients’ request. In both clinics MHPs shared the opinion that they should have the idea that patients would benefit from prayer and several MHPs in the CC tended to ask patients praying themselves when they thought that would still be achievable. They mentioned to be willing to prevent overdependence of patients, which could for example occur in case of personality disorders.

“Well, when I entered the clinic she was ready with a list of points to pray for. At a certain moment I said: well, now you can do it yourself. Right, so she did”. (CC6, nurse)

MHPs in the SC often pointed at the necessity of a similar religious background, accompanied by sincerity of the MHP.

“It’s about . . . either or not evangelize, you know. Imagine, you are of a protestant church and so is the patient, and it happens that you could pray together when things are so hard. I am not against it. However, I always say: you should be able to find it in the daily report ( . . . ). The practitioner may question it and estimate whether or not it would be beneficial for the patient, or that the patient would get more feelings of guilt from it”. (SC9, nurse)

Furthermore several MHPs noted that a different explanatory model of patients who only believed in the potency of prayer, as opposed to regular treatment, would make them reluctant to pray with patients.

3.2. Mental Health Patients

3.2.1. Importance and Benefits

Patients favoring prayer with MHPs tended to focus on personal aspects: the conviction of importance and experienced benefits. They mentioned the same facets as the MHPs: belief in its potency and a ‘shared Third party’. Many patients added the benefits they experienced by prayer; feelings of tranquility, blessing and relief.

“Possibly the knowledge you bring things to God. Aloud. And you ask God to join, really. You may know it by heart, but when you express it . . . it’s more substantial. Someone else expressing things for you. And I must say, often I experience tranquility and blessing by it. Not always, but often. Whether that is psychological . . . I don’t know, but it helps”. (Pt CC12)

“I really could imagine that it would help... when you’re down and that there happens to be someone with you, who in a safe atmosphere prays with you, or talks . . . ” (Pt SC15)

Like the MHPs, patients in the CC had more thoughts about prayer and reported more experience in the context of mental health care. Some thought prayer would ‘break their walls’ of untouchability down, giving an opening for further contact with the MHP. Sometimes prayer clarified issues for them. The interviewed patients regularly thought MHPs could help them in formulating their needs to God and some mentioned their own inability. One of the CC patients said that MHPs were far more able than himself to express his needs to God.

“I think smart people are working here and they can pray very well, so express things in a good way. I think there is a power in that”. (Pt CC3)
Several CC patients had no experience with an MHP praying with him or her, and regretted that.

“Just what I say, starting a clinical stay for example, it would be very good when someone else will pray with you for it. Like, we are here now, You are seeing us, will You help us during the coming months. I would have appreciated that. Someone approaching you, saying well it’s terrible for you being here alone, knowing nobody else. It’s like being thrown in the deep water and I want to bring that to God, together with you. Really, I would have very much appreciated that”. (Pt CC10)

That quote illustrates that many patients in the CC appreciated initiative by MHPs. One of the participants could not believe that nurses in a Christian care setting would refuse to pray with patients when they requested that.

3.2.2. Conditions

Patients in the CC did not mention many preconditions, but several patients in the SC stated that a similar religious background would be an important precondition. One of the patients pronounced that MHPs should ‘stay close to themselves’, and could not be forced to pray. Another patient also thought a confidential relationship necessary.

“You cannot haphazardly do such a thing, I mean, you should know each other quite well, at least that is what I think, before you start doing so (praying together, JN)”. (Pt SC16)

One of the CC patients who was somewhat reticent towards prayer mentioned that much depended on the type of prayer.

“It depends on how they pray, you know. If it is very heavy . . . you may bring patients further in the dark (laughs), but if the prayer is full of hope ( . . . ). Look, ( . . . ) you can pray for healing, you can bless somebody, it’s really a different type of stuff, what you are going to pray. You bring your own vision over ( . . . ). It’s no church here”. (Pt CC15)

Some CC patients implicitly seemed to see prayer more as task for nurses than for other MHPs, but this view was less strongly present among patients as compared with MHPs.

3.2.3. Possible Objections

For one of the CC patients, the diversity of religious denominations in the CC for her was a reason to be reticent towards prayer in the context of mental health care, though she tended to let others free in their choices. One of the SC patients stated that he thought prayer not to be appropriate mental health care.

“They did not pray with me or so . . . and I did not think that appropriate in this place”. (Pt SC8)

Another thought prayer to be distracting from her mental problems where she came for.

“I found it kind of a distraction, from what really mattered (experience in the CC, JN). I never dared to say something against it, because I thought that would have been extra sinful. At least it did not go about my real problems, what I really was thinking. ( . . . ) It was kind of ‘double’, the atmosphere was familiar”. (Pt SC17)

One of the CC patients could imagine the objections, but thought prayer would be possible.

“Because, despite my doubts and cares, I am a motivated Christian. And the practitioners as well, at least I may expect that. So it should be possible. But I understand that . . . well maybe a special board should consider it, but I do not rule it out. ( . . . ). At the same time there are snags. Whether it is good, professionally, with regard to distance, reticence, relationship. I don’t know. But I don’t say it should not happen”. (Pt CC14)
4. Discussion

MHPs in the current study represented various perspectives on the issue whether or not prayer with patients could be appropriate. With regard to the well-known variety of opinions, this is not surprising (Koenig 2008; Poole et al. 2008). The variety of disciplines that were interviewed will also have played a part in this regard. However, our study may add some new insights into the reasons for and against prayer, as well as in possible conditions. Furthermore the fact that patients on average were much less reticent towards prayer in the context of mental health care is noteworthy and could influence MHPs’ opinions.

Scholars stated that MHPs should not pray with patients, because the ‘completely non-clinical activity carries a grave danger of blurring of therapeutic boundaries and creates ambiguity over the nature of the relationship’ (Poole et al. 2008, p. 356). The same authors mention that patients could regret afterwards, even when they requested prayer themselves. Praying with patients leads to duplicity of the psychiatrist’s role and erosion of the purpose of treatment, they argue. From all these arguments, in the current study some MHPs mainly denoted the fear of boundary blurring. They sustained the viewpoint that it is the regular care that should work, and that prayer would be limited to spiritual caregivers. Placing prayer opposite to regular treatment, might relate to see praying with patients as intercessory prayer. Two patients mentioned prayer ‘not appropriate’ and ‘distractive’ from the mental problems, but in general the patients did not seem to care about professionality of MHPs. Furthermore, in the current study no patients were present who regretted prayer; on the contrary several patients in the CC regretted that prayer was absent in their care.

Another argument of MHPs against prayer that has been established in the current study is a sense of uneasiness (Minton et al. 2016). This has also been described to be present in case of addressing R/S issues (Huguelet et al. 2011) and could be even stronger when a patient requests prayer. In the current study MHPs motivated their sense of uneasiness by the delicate area when entering the ‘religious world’ of the patient. The ‘right vocabulary’ for example can matter a lot and MHPs seemed to doubt their own capacities in this regard. The sense of uneasiness might be associated with the boundaries of the professional role, but also with feelings of vulnerability as a consequence of a more horizontal relationship when praying together. The latter objection seemed to be more personally colored in comparison with the ‘moral’ statement about professionality. MHPs argued: ‘I do not feel comfortable, others may know for themselves’. Meanwhile, some nurses regarded the horizontality of the relationship (as compared to the ‘vertical’ caregiver-patient relationship) as a benefit: they appreciated the experience of equality and connectedness. Possibly, nurses are better equipped to collaborate with the patient in a more horizontal relationship, and need less professional distance.

One of the arguments favoring prayer in the context of mental health care, also related to professionality. Some MHPs mentioned that prayer could be a task—mainly for nurses—in case of patients’ inability. In addition, nurses and patients recognize this possibility for assistance in prayer for the patient. Advocates of prayer in this way may see more diversity in possible types of prayer as compared to opponents. Nurses seem to disapprove prayer less often as compared with psychiatrists and physicians. This is sustained by nursing literature, advocating holistic care (Ameling 2000) and speaking about the duty of nurses to meet patients’ R/S needs (Ledger 2005). Furthermore in nursing education more attention is given to spiritual issues, for example illustrated in the bio-psycho-spiritual Neumann Systems Model (Aronowitz and Fawcett 2016). On the other hand, in nursing practice also critical comments and caution with prayer have been articulated (French and Narayanasamy 2011). Though patients in the current study did less specifically mention prayer as a task for nurses, in general they seem to feel more comfortable in addressing R/S themes with nurses as compared with practitioners (van Nieuw Amerongen-Meeuse et al. 2019). Nurses are available for 24 h a day and are also present on tranquil moments, like late shifts.
Some patients regarding prayer mentioned to prefer the capacities of MHPs, but in general patients tended to focus more on the personal importance they attached to prayer and the benefits they experienced by prayer. The difference between MHPs and patients in this regard may not be surprising, since MHPs might feel the need to justify why they choose to pray with patients. The fact that many patients, especially those who were religiously involved, approved and preferred prayer, indicates that earlier described wishes of patients to pray with their health professionals, are still actual in contemporary society, especially among patients with high R/S involvement. The function and benefits of prayer however may deserve some extra consideration.

MHPs and patients showed similarities in the personal importance they attached to prayer: belief in its potency and the advantage of sharing troubles with a Third party. Patients also added the benefits they experienced: tranquility, blessing and relief. Sharing issues with someone else could be seen as making a third party partaker of the troubles, and several patients stated that even that would help them: God knows. Belief in the potency of prayer was mostly argued by the hope that God would bless regular treatment, but one of the patients as well as some MHP’s mentioned another option: that patients would merely trust the potency of prayer. Types of prayer could play a role in this regard. In the current study two of the mentioned types were most clearly visible: conversational and petitionary prayer. Conversational prayer was articulated as expressing things to God, involving Him to treatment. Patients argued that prayer could break walls and give opening for further treatment. Petitionary prayer was illustrated by asking for help and blessing of the (regular) treatment. Conversational prayer may have some overlap with ritual prayer—especially when related to patients habits and their inability due to the illness. Possibly, MHP’s assistance in this regard could be least influenced by personal convictions of the MHP, when prayer is practiced in a way the patient is used to.

The type petitionary prayer deserves some extra attention, since MHP’s mentioned the experience that patients could see prayer as a substitute of treatment. Different explanatory models might influence the expectations of patients (though that will be stronger visible by authority prayer). MHPs can decide to try align the different models by agreeing to pray and also trying to motivate patients to follow regular treatment. Some however considered praying with patients under such conditions difficult and possibly not helpful. At the same time, belief in the potency of prayer and belief in the usefulness of regular treatment do not necessarily fight each other and many patients mentioned both. Most of MHP’s favoring prayer also mentioned ‘belief in the potency of prayer’ as a motivation to pray with patients and for them that would also not fight regular care. This argument ‘pro prayer’ however has not been described by scholars, probably it could combat professionality and the medical view. Simultaneously it is the question whether prayer for a patient would be helpful when an MHP clearly does not believe in God. That may fight genuineness as one of the factors for a good treatment alliance (Nienhuis et al. 2018).

The same point may be a basis of the condition that many participants mentioned: a similar outlook on life. A ‘religiosity gap’ for some patients is a reason not to prefer R/S care in a secular context (van Nieuw Amerongen-Meeuse et al. 2018). The condition of a similar outlook on life in the current study was brought up by more or less all participants. In our study in the CC this condition was more or less present, which may be a reason that praying with patients is not uncommon there. MHPs also brought up the condition that patients may not misuse prayer, stating that it should be beneficial for the patient. In cases of personality disorders for example, patients could make too much an appeal on MHPs, who could experience pressure in the treatment relationship. A few patients also mentioned the precondition that prayer should be beneficial, but they linked that to the type of prayer: the vocabulary and the content used.

Conditions, as mentioned above, are quite new to describe as study results. Scholars have debated preconditions, but sustaining literature from patient and MHP views is scarce. Studies describing the preference of prayer by patients were by and large quantitative (McMillan and Taylor 2018; Martinuz et al. 2013). In the current study, preconditions were frequently present, both among MHPs and patients. However, one of the preconditions that are mentioned in literature (Green 2018), was not
present in the current study: a patient request. Both patients and MHPs did not see this as necessary, though a few practitioners stated they would for themselves only consider prayer in case of a patient request. The question could raise why a patient request was not brought up as a strict precondition. In the current study some nurses initiated prayer because to their own estimation it was appropriate. They felt compassion with patients, seeing their struggle at difficult times. Inability of patients may be something that should be noticed by MHPs; patients are not always able to express their needs (van Nieuw Amerongen-Meeuse et al. 2019). And on the other hand, patients with a different explanatory model might more soon request prayer whereas possibly it would be better rejected in such cases.

Conditions of prayer can be compared with the ethics of medical care. The whole discussion whether or not prayer could be appropriate, could be linked to the four commonly accepted principles: respect for autonomy, nonmaleficence, beneficence and justice (Beauchamp and Childress 2019). The principle of autonomy may inspire MHPs to the viewpoint that a patients' request for such a controversial aspect of care like praying together at least is necessary. Beneficence was regularly brought up, both by patients and MHPs, but is likely to be differently estimated by different individuals, also by different MHPs. Poole (Poole et al. 2008) seems to fear maleficence in case of praying together, but many patients in the current study experienced benefits. Justice may be the hardest principle to follow: how to decide when to offer prayer (and estimating it beneficial) or to refuse praying together because it does not seem helpful? With respect to these ethics, MHPs should reflect carefully about the meaning and purpose of prayer before engaging in prayer with patients (Winslow and Winslow 2003).

4.1. Limitations

Results of the current study are obtained from general in-depth interviews with MHPs and patients concerning the integration of R/S in mental health treatment. The interviews therefore were not specifically carried out to obtain opinions about the use of prayer in mental health care, and not in all of the interviews the topic was touched. At the same time, data could be more authentic in this way, as opinions might have been given more spontaneously. Participants in the CC were more used to prayer in the context of mental health care compared with participants in the SC. That is not strange since prayer is regularly practiced in the CC whereas almost all SC MHPs and patients had no experience with it. As in all qualitative research generalizability of the results is uncertain.

4.2. Recommendations

The current explorative study mainly offers directions for future studies. In addition we can make a few conclusive remarks. Possibly the inability of patients could be a reason for MHPs—mainly nurses in clinical setting—to pray with patients, in cases of a similar religious background. However, they are recommended to be cautious, acknowledging the delicateness of themes and the possibility of different explanatory models. It may in some cases be useful to investigate patients’ expectations when considering to pray.

All in all more focused research is needed to be able to formulate directly clinical applicable advices. Different disciplines in mental health care could be questioned about their ethical approach towards prayer (1). Types of prayer in the context of mental health nursing could be mapped (2), and therapeutic benefits and/or possible adverse effects, as suggested by Poole et al. (2008) may be empirically studied (3). Furthermore, possibilities of integration in or alignment with a biopsychosocial approach in mental health care could be investigated (4), which may especially prove useful in the field of transcultural psychiatry. Finally, it may be relevant to examine the feasibility and desirability of patients’ preferences that MHPs take the initiative (5).

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