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To Pray or Not to Pray: Considering Gender and Religious Concordance in Praying with the Ill

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Analysis of Covariance was conducted on quantitative data collected by chaplains from January 2005 to December 2008. Data from 82 Catholic, Jewish, and Protestant chaplains, consisting of 53 CPE students and 29 professional chaplains were used in this study. Overall, chaplains exhibited a statistically significant higher rate of prayer with patients from their own religion (religious concordance) than they did with patients of different religions (religious discordance). There was also an interaction of chaplain religion and religious concordance wherein Protestant chaplains were 50% more likely to pray with Protestant patients than with

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patients of other religions, and Catholic chaplains were 20% more likely to pray with Catholic patients than with other patients. Chaplains were also significantly more likely to pray with patients of their own gender (gender concordance) than with patients of the other gender (gender discordance).

KEYWORDS chaplain, gender, pastoral care, prayer, religion

INTRODUCTION

A national survey of U.S. adults found that 35% of respondents prayed for their own health concerns (McCaffrey, Eisenberg, Legedza, Davis, & Phillips, 2004). Of those who said they prayed, 75% said they prayed for wellness and 22% said they prayed about specific medical problems. Another national survey found that prayer was much higher among cancer patients, nearly 70% of whom said they prayed for their health (Ross, Hall, Fairley, Taylor, & Howard, 2008). Other research shows that many patients would like their physicians to pray with them (King & Bushwick, 1994) and most patients expect prayer to be part of their spiritual care (Mako, Galek, & Poppito, 2006).

Yet, relatively little has been written about prayer in chaplaincy journals. A systematic review of articles published in journals about chaplaincy and pastoral care over the last 30 years located just one study specifically about prayer. Many articles were found that mentioned praying with patients, but only a few of them focused on prayer.

The *Bulletin of the American Protestant Hospital Association*—the precursor of *The Care Giver Journal*, and *Chaplaincy Today*—had special issues on chaplaincy in 1979–1984. Although some of the articles in these issues mentioned prayer in passing, such as its use in memorial services (e.g., Earhart, 1980), and the importance of praying with dying patients and grieving family members (e.g., Mudd, 1981; Schoup, 1983), only two articles discussed prayer at length.

The first of these two articles presents general guidelines for when and how to pray with terminally ill patients (Lucas, 1979). Lucas' main point is that prayer should be used to affirm the presence of God and to inspire hope in patients who are worried, anxious, or feeling guilty, and in families who are grieving. The other article similarly discusses when and how to pray with patients, but it provides more specific advice (Keidel, 1983). Keidel provides ten answers in response to the question: Why pray? These include alleviating patients' anxiety and sustaining them through the crisis, sharing their concerns with God, and activating the "faith process." Keidel perceives prayer as an instrument of healing, and offers recommendations about when to pray and how to pray with patients.

We found only five articles in *The Care Giver Journal* during its lifespan (1984–1997) that discussed prayer. Three of them described the use of prayer

in memorial services (Lamb, 1990), intensive care units (Saylor, 1984) and pain management (Stratton, 1987), and a fourth urged clergy to not only pray with their patients, but to practice the laying on of hands (Udell, 1987). The fifth article was one of only a few articles in the chaplaincy literature that provided a comprehensive discussion of prayer and its use in pastoral care (Evenson, Goodell, Handzo, & Shulman, 1993). Its authors view prayer as an integral part of a chaplain's visit, in which discussing prayer with patients can be used to obtain a spiritual history and to assess "their spiritual state of affairs." As they see it, prayer enhances the connection between the chaplain and patient, and reconnects or strengthens the patients' connections to their religious traditions. They state: "This awakening of religious ties may work best when the chaplain and the patient share the same faith group" (p. 43).

Several articles about prayer appeared in the *Journal of Pastoral Care* in the 1980's and 1990's, yet only three addressed prayer as a pastoral care intervention. One discussed the importance of prayer to nursing home residents (Simmons, 1991), one discussed the use of healing prayer by chaplains and other clergy (Furniss, 1984), and the third was a qualitative study examining the nature of prayers written in a chapel prayer book by patients, families, and staff (Grossoehme, 1996).

The *Journal of Health Care Chaplaincy* devoted an entire issue to intercessory prayer in 1998. Most of the commentaries in that issue explored the findings and implications of research on intercessory prayer, but some tried to relate this research to their practice of pastoral care. Since then, prayer appears to have received more attention as a pastoral care intervention in the chaplaincy literature, in that nearly every issue of *Chaplaincy Today* between 1998 and 2008 contained an article that mentions prayer in some fashion. Still, most of these articles do not address prayer at length.

Although we identified just one study specifically about prayer in the chaplaincy literature, a large scale study of pastoral care in hospital settings reported that prayer is one of the most widely used interventions (Handzo, et al., 2008). That study, which documented more than 30,000 chaplain visits, found that prayer was the most common religious intervention used with patients of virtually all religious faiths (>45% of visits). Since it has been suggested that prayer awakens religious ties in that it "may work best when the chaplain and the patient share the same faith group" (Evenson et al., 1993, p. 43), the present study was conducted to examine the degree to which chaplains are more likely to pray with patients of their own religious faith.

METHODS

The data used in the study were collected from January 2005 through December 2008 by 34 professional chaplains and 118 students enrolled in Clinical Pastoral Education (CPE) courses (collectively referred to as

chaplains) who participated in the Metropolitan Chaplaincy Study. The data were collected on a daily basis throughout the study period as each of 14 hospitals began to use a computerized data system (Chaplaincy Counts®). There were a total of 122,808 chaplain visits, of which 116, 913 were visits with patients.

Information recorded for each chaplain visit included: (1) who was visited (patient, family, staff, or other); (2) the religious affiliation or faith of the patient; (3) the gender of the patient; and, (4) interventions performed by the chaplain during the visit (e.g., presence, grief support, prayer, religious ritual). The gender and religious faith of chaplains were also recorded, and their level of professional experience was coded (see as follows).

Since this study specifically examines chaplain visits with patients, visits with family, staff, or others were excluded from the analyses. The sample of visits was further restricted since the study focused on chaplain prayer with (1) patients whose religious faith was the same as (concordant), or different from (discordant) the chaplain; and, (2) patients whose gender was the same as (concordant), or different from (discordant) the chaplain. This immediately excluded those visits for which data on the patient's gender and/or religious faith were not available, or the patient's religious faith was listed as "none," "unknown," "atheist," "agnostic," or "other." The majority of the remaining visits were with patients who identified as either: Roman Catholic, Jewish, or Protestant. Other less common patient religions in the dataset included: Christian Scientists, Hindus, Friends/Quakers, Muslims, Orthodox Christians, Latter Day Saints (Mormons), and Sikhs.

To assure the percentages used in the statistical analyses were based on a reasonable number of visits, chaplains who had fewer than 100 patient visits, and/or fewer than 10 visits in each of the four cells of the analyses, were excluded (see Table 1). The 100 visits criterion excluded a large number of students, whereas the 10 visits per cell criterion excluded a small number of Buddhist, Muslim, and Unitarian Universalist chaplains.

TABLE 1 Basic Research Design Used to Analyze the Percentage of Patient Visits in which Chaplains Used Prayer as an Intervention (Covariates Used in the Analysis Are not Shown)

	Between factor		With-in factors (repeated measures)	
Chaplain religion	Patient of the same religious faith		Patient of a different religious faith	
Catholic Chaplain	Cell 1 Patient of the Same Gender	Cell 2 Patient of a Different Gender	Cell 3 Patient of the Same Gender	Cell 4 Patient of a Different Gender
Jewish Chaplain	Cell 1 Patient of the Same Gender	Cell 2 Patient of a Different Gender	Cell 3 Patient of the Same Gender	Cell 4 Patient of a Different Gender
Protestant Chaplain	Cell 1 Patient of the Same Gender	Cell 2 Patient of a Different Gender	Cell 3 Patient of the Same Gender	Cell Patient of a Different Gender

The final sample consisted of 82 Catholic, Jewish and Protestant chaplains, of which 53 were CPE students, and 29 were professional chaplains. The participants were classified into six levels of experience. The six levels were: (1) novice or beginning students, who were taking their first CPE class; (2) intermediate students, who had taken 1–3 CPE units; (3) advanced students, who had at least 4 CPE units, most of whom were Supervisory Residents; (4) beginning chaplains; (5) chaplains with intermediate experience; and, (6) advanced chaplains. Chaplain gender was coded: 1 = female and 0 = male.

The dependent variable used in the analyses was the percent of visits in which chaplains prayed with patients. The independent variables included: (1) whether the patient's faith was the same as, or different from, the chaplain's faith; and, (2) whether the patient's gender was the same as, or different from, the chaplain's gender. Many of the patients in the study were not Catholic, Jewish or Protestant, so a large proportion of chaplain visits were with patients of a different religion than their own.

Analysis of Covariance (ANCOVA) was conducted on the percentage data in a 3 (Between) × 2 (Within) × 2 (Within) factorial design (see Table 1). The chaplain's religion (Catholic, Jewish, Protestant) served as the between-subject factor, while patient's religion (same as chaplain, different from chaplain), and the patient's gender (same as chaplain, different from chaplain) served as within-subject factors. Level of professional experience and chaplain gender were used as covariates.

RESULTS

The ANCOVA revealed no main effects for chaplain religion, gender, or level of professional experience. However, main effects of religious concordance and gender were found, as well as some interaction effects.

Table 2 presents the mean percentage of visits in which Catholic, Jewish, and Protestant chaplains prayed with patients of the same and different religious faiths. The bottom row of Table 2 (labeled "All") indicates that chaplains prayed more with patients of their own religion regardless of the chaplain's religion. In all, chaplains prayed during roughly 31% of their visits

TABLE 2 Mean Percentage of Visits in which Chaplains Prayed with Patients of the Same and Different Religions

	Different		Same	
Chaplain's religion	*M*	*SD*	*M*	*SD*
Catholic	35.37	23.37	42.47	25.16
Jewish	20.59	18.50	29.99	27.36
Protestant	31.27	21.75	46.77	21.76
All	30.82	21.88	43.83	23.53

TABLE 3 Mean Percentage of Visits in which Chaplains Prayed with Patients of the Same and Different Genders

	Different		Same	
Chaplain's religion	*M*	*SD*	*M*	*SD*
Catholic	34.61	23.04	39.34	22.12
Jewish	22.83	22.52	26.10	22.96
Protestant	30.94	20.68	39.13	22.27
All	30.71	21.38	37.59	22.46

with patients of different religions, whereas they prayed during roughly 44% of their visits with patients of their own faith. This represents a statistically significant increase in prayer with patients of their own faith, $F(2,77) = 20.58$, $p < .001$. A marginally significant effect of chaplain religion by patient religion (i.e., same or different religion) was also found, $F(2,77) = 2.61$, $p < .08$, with Protestant chaplains exhibiting a 50% increase in prayer during visits with Protestant patients. Catholics, on the other hand, exhibited only a 20% increase in the likelihood they would pray with patients of their own faith. Jewish chaplains prayed less with all patients, but they tended to pray more with patients who were Jewish.

Table 3 shows the results with respect to gender similarity. Overall, chaplains prayed less frequently with patients of a different gender (approx. 31% of visits) than with patients of their own gender (approx. 38% of visits), and this difference was statistically significant, $F(1,77) = 26.37$, $p < .001$. A significant interaction of chaplain religion and patient gender (i.e., same or different gender) was also found, $F(2,77) = 4.05$, $p < .05$, in which Protestant chaplains were more likely than other chaplains to pray with patients of their own gender.

Tables 4 and 5 present the same results as those shown in Tables 2 and 3, except the values given in Tables 4 and 5 were calculated by subtracting the mean percent of visits in which each chaplain prayed from the mean percent of visits in which each chaplain prayed with patients who were (a) similar or different in religion, and (b) similar or different in gender. Thus,

TABLE 4 Mean Differences in the Percent of Visits in which Chaplains Prayed with Patients of the Same and Different Religions Relative to All Visits in which Chaplains Prayed

	Different		Same	
Chaplain's religion	*M*	*SD*	*M*	*SD*
Catholic	−1.67	9.23	5.24	11.91
Jewish	−4.15	5.98	6.08	11.29
Protestant	−5.19	3.86	10.23	8.36
All	−4.33	5.72	8.69	9.68

TABLE 5 Mean Differences in the Percent of Visits in which Chaplains Prayed with Patients of the Same and Different Genders Relative to All Visits in which Chaplains Prayed

	Different		Same	
Chaplain's religion	*M*	*SD*	*M*	*SD*
Catholic	0.01	6.83	3.55	4.32
Jewish	−0.43	5.44	2.36	7.34
Protestant	−1.27	6.02	6.31	4.28
All	−0.90	6.08	5.25	4.93

Table 4 indicates that all chaplains were nearly 9% more likely to pray with patients of their own religion and roughly 4% less likely to pray with patients espousing a different religion, relative to the total percentage of all visits in which they prayed with patients. This more clearly illustrates the interaction effect of chaplain religion and religious concordance, with Protestant chaplains praying about 5% less frequently with patients of a different religion and over 10% more frequently with patients of the same religion relative to the percentage of all visits in which they prayed with patients. Post-hoc tests found the interaction effect between chaplain religion and patient religion (i.e., same or different) was mainly due to differences in prayer among Protestant chaplains, $F(1,78) = 4.94$, $p < .05$. Further post-hoc analyses found that the higher rates of prayer of Protestant chaplains with Protestant patients was mainly attributable to Episcopal, Lutheran, and Presbyterian chaplain practices. Prayer among these three groups was particularly high when chaplains visited patients of their own respective denominations: Episcopal chaplains (Episcopal patients = 67.8%, other patients = 32.2%); Lutheran chaplains (Lutheran patients = 70.5%, other patients = 29.5%); Presbyterian chaplains (Presbyterian patients = 54.6%, other patients = 45.4%).

As noted previously, significant interactions were found between chaplain religion and patient gender (same or different). Subsequent analyses found that this interaction is mainly associated with differences in prayer by Protestant chaplains, $F(1,78) = 7.76$, $p < .01$. As depicted in Table 5, Protestant chaplains were about 1% less likely to pray with patients of a different gender, and were 6% more likely to pray with patients of the same gender, relative to the total percentage of all visits in which they prayed with patients.

DISCUSSION

This study is unique in examining differences in chaplains' use of prayer with hospitalized patients who are similar or different from them in terms of gender and religious affiliation. The study's findings indicate that chaplains exhibit a statistically significant higher rate of prayer with patients who share the same religion as opposed to patients who ascribe to different religions.

This greater propensity for chaplains to pray with patients of the same faith is consistent with the view that prayer can help reconnect patients to their religious communities and that doing so may work best when the chaplain and patient share the same religious faith (Evenson et al., 1993).

Moreover, there was an interaction effect of chaplain religion and patient religion, in which Protestant chaplains exhibited a 50% increase in prayer during visits with Protestant patients, compared to a 20% increase for Catholic chaplains with Catholic patients. Post-hoc tests revealed that this interaction was mostly accounted for by differences in prayer among Protestant chaplains with patients of the same or different religions. Jewish chaplains were less likely to pray with all patients, but they were more likely to pray with Jewish patients than with other patients.

Explanations for the different rates of prayer with patients of the same or different religions can be approached from several different perspectives. One explanation may be that the variation in rates, result from variations in the quality and assessment of chaplain training programs. Chaplains included in this study have completed or are engaged in Clinical Pastoral Education (CPE) that emphasizes pastoral ministry across diverse populations. Although educational objectives and outcomes exist for CPE programs, there are no standards of practice to guide CPE instructors to assure accountability and fidelity with the delivery of educational services.

Another explanation, related to social identity, aligns with some of the findings. Social identity theory asserts that individuals have multiple social identities derived from perceived group memberships (Stets & Burke, 2000). The self-categorization of chaplains and patients as members of a particular faith group may enhance their in-group ties and preferences. The particularly high rates of prayer of Episcopal, Lutheran, and Presbyterian chaplains with patients of their own religious denominations suggest that these chaplains and patients have a strong social identity with their own faith groups.

Another way of looking at the question is to examine why chaplains pray less frequently with some patients. This might simply be due to the fact that: (a) these patients do not request prayer and/or (b) the chaplain's assessment of the patient indicates the patient is not interested in prayer.

There are a number of reasons why chaplains might not pray with patients of different religions. For instance, it is quite possible that chaplains may be reluctant to pray with patients of different faiths than their own because they are concerned it may cause the patient discomfort. The patient might feel uncomfortable: (a) with respect to his/her role in relation to the chaplain (perhaps feeling inferior) or (b) fear of being proselytized by the chaplain.

There can be a somewhat awkward cultural and religious dance when a chaplain visits a patient of a different faith, since patients may not know how to respond to a clergyperson of a different religion: Should the patient or chaplain kneel, sit, hold hands, close his/her eyes, pray extemporaneously

or read from a book? Negotiating these questions and issues can cause discomfort and vulnerability in a patient from a different religious faith as opposed to a patient who is familiar with practices of their own faith.

Patient role confusion may stem, in part, from the power dynamics of the patient-chaplain relationship. For instance, a patient may feel that he/she cannot participate in a prayer if a chaplain from a different faith initiates a prayer that is non-inclusive of the patient's own religious faith. Such a prayer may actually hurt rather than heal the patient (Resnicoff, 1987). To demonstrate respect for a patient's diverse religious practice, a chaplain may encourage a patient to initiate a prayer; the chaplain may initiate a general, inclusive prayer; or allow the patient to end the prayer according to his/her religious faith. Nevertheless, a chaplain may fear that a patient of a different faith will feel that he/she is being proselytized.

Lastly, some of the differences in rates of prayer may arise from differences in the ways chaplains recorded their interventions. For instance, chaplains in this study may not have recorded "prayer-like" practices commonly used by pastoral practitioners in the category of prayer. At some point in the pastoral visit—often near the end—chaplains will share a (conversational) prayer, blessing, hope, or wish with patients and their families.

Despite the differences in the rates of prayer that were found, there was a relatively high rate of prayer use among most chaplains, regardless of their personal faith or the faith of their patients. This result is unsurprising based on previous findings indicating that prayer is one of the most widely used interventions of chaplains, and the most common religious intervention employed with patients of virtually all religious faiths (>45% of visits) (Handzo, et al., 2008). Similarly, Evenson et al. (1993) viewed prayer as an integral part of a chaplain's visit since it reconnects or strengthens the patient's ties to his/her religious traditions.

Finally, with respect to gender, chaplains were significantly more likely to pray with patients of their own gender (38% of visits) than with patients of the opposite gender (31% of visits). Protestant chaplains were also more likely to pray with patients of their own gender compared to Catholic and Jewish chaplains.

Although these results and other studies show that prayer is frequently used by chaplains as a pastoral care intervention, this has not always been the case during the relatively brief history of professional pastoral care (Evenson et al., 1993). It was common at one time for all clergy to pray when visiting the sick. However, the clinical training movement recognized that prayer might be an imposition on the sick, so it de-emphasized praying with patients. "Unfortunately," according to Evenson and his colleagues, "rather than finding ways to integrate prayer, it was too often abandoned as a pastoral care tool" (Evenson et al., 1993, p. 40). Yet, prayer can be a very valuable tool that can serve a variety of functions, which likely accounts for its high rate of use by most of the chaplains in this sample.

Limitations

Although the number of visits available for analysis was considerable, the final sample size was smaller than we would have liked. The initial sample size was reduced because religion and gender data were not available for some patients. Additionally, chaplains with fewer than 100 patient visits were also removed from the study. These requirements significantly reduced the total number of chaplains in the final study. Incorporating data from chaplains with a lower volume of visits (fewer than 100 visits) would have significantly increased the sample size of chaplains in the study, but undermined the integrity of the percentage measures. Including a qualitative dimension to the study would help researchers discriminate chaplains' preferences for utilizing prayer with same-faith and/or same-gender patients.

Future Directions

Future research should consider augmenting the current quantitative research findings with qualitative research which would better parse out why chaplains may be more likely to recite prayers with same-faith patients rather than with patients of a different faith. To bolster the current research findings, future research, whether qualitative or quantitative, should examine which types of prayers (liturgical, custom-made or other forms of prayer) chaplains most commonly employ with patients.

A qualitative dimension to questions pertaining to reasons for higher rates of prayer among same-faith chaplains and patients would help to further illuminate these findings.

Additionally, inclusion of qualitative response items may also afford researchers a perspective into which types of prayer and in which context (bedside, religious institution, outside) prayer is typically recited. These qualitative dimensions could better distinguish among forms of prayer and elucidate why certain chaplains are more likely to pray with patients of their own religious faith.

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