

© 2012 by the Oncology Nursing Society. Unauthorized reproduction, in part or in whole, is strictly prohibited. For permission to photocopy, post online, reprint, adapt, or otherwise reuse any or all content from this article, e-mail pubpermissions@ons.org. To purchase high-quality reprints, e-mail reprints@ons.org.

How Women With Advanced Cancer Pray: A Report From Two Focus Groups

Amy Rex Smith, DNSc, RN, ACNS, BC, Susan DeSanto-Madeya, PhD, RN, John E. Pérez, PhD, Elizabeth F. Tracey, PhD, RN, Susan DeCristofaro, MS, RN, Rebecca L. Norris, MA, and Shruti L. Mukkamala, MS

The relationship among religious and spiritual factors and well-being in patients with cancer has been well-established (Brady, Peterman, Fitchett, Mo, & Cella, 1999; Gall & Cornblat, 2002; Levine, Aviv, Yoo, Ewing, & Au, 2009; Prince-Paul, 2008); however, the mechanisms of the relationship are not yet understood. One particularly salient religious and spiritual factor is prayer. Prayer is a central practice across many religious traditions, but it also is practiced by those who consider themselves spiritual without following any specific faith tradition. McCullough and Larson (1999) reported that prayer also can be practiced by those who do not consider themselves religious or spiritual. According to a survey of more than 30,000 adults in the United States, prayer used specifically for one's own health was the most common form of complementary and alternative medicine (Barnes, Powell-Griner, McFann, & Nahin, 2002).

Generally, prayer is thought of as a deliberative communication between a person and a supreme being, God, or something outside oneself (Levine et al., 2009; Meraviglia, 2002). However, prayer can also be an intimate and personal inward process. Ladd and Spilka (2002) suggested that prayer is best understood as making connections in three ways: inward prayers (self-examination), outward prayers (strengthening human-to-human connections), and upward prayers (focusing on the human-divine relationship). Prayer may either use words or be wordless, and requires concentration and focus to keep a detachment from other thoughts (McCullough & Larson, 1999).

Research shows that prayer is used at various points throughout the cancer experience. Based on a secondary analysis of qualitative interview data, Taylor, Outlaw,

Purpose/Objectives: To explore the meaning, function, and focus of prayer for patients with advanced cancer, and to identify the effects of prayer on their coping.

Research Approach: Qualitative, descriptive design using focus groups.

Setting: Three cancer centers that are part of a university-affiliated comprehensive cancer network in the northeastern United States.

Participants: 13 adult, female outpatients receiving active treatment for ovarian or lung cancer.

Methodologic Approach: Two semistructured, focus group interviews were conducted. Audiotapes were transcribed verbatim. Data were coded and analyzed using standard content analysis procedures.

Main Research Variables: Prayer and coping.

Findings: Four themes emerged: finding one's own way, renewed appreciation for life, provision of strength and courage, and gaining a stronger spiritual connection. In addition, praying for others, conversational prayer, petitionary prayer, ritual prayer, and thanksgiving prayer were used most often by participants to cope.

Conclusions: The findings support prayer as a positive coping mechanism for women with advanced ovarian or lung cancer.

Interpretation: The study provides knowledge about prayer as a source of spiritual and psychological support. Oncology nurses should consider the use of prayer for patients coping with advanced cancer.

Bernardo, and Roy (1999) suggested that some types of prayer may enhance well-being, where as other types may exacerbate distress. They identified several spiritual conflicts that arose when participants prayed about their cancer: unanswered prayer, hesitancy about petitionary prayer, conflicts around control, and questions about

the nature of God and theodicy. Those spiritual conflicts caused additional distress for the patients with cancer. In other qualitative studies, prayer has been identified as providing comfort, assurance, guidance, strength, and meaning for patients with cancer (Gall & Cornblat, 2002; Holt et al., 2009; Levine et al., 2009; Walton & Sullivan, 2004). Patients also have reported a sense of God's presence during prayer (Gall & Cornblat, 2002; Narayanasamy, 2003). Among African American women, prayer was identified as being essential to coping with cancer (Henderson, Gore, Davis, & Condon, 2003). Despite attempts to label, describe, and differentiate between types of prayer (Laird, Snyder, Rapoff, & Green, 2004; Meraviglia, 2002), research is limited on the associations between different types of prayer and the well-being of patients with advanced cancer.

The current article is a report of a qualitative study that explored the meaning, function, and focus of prayer for patients with advanced cancer. The report was part of a larger pilot study to examine which type of prayer was associated with positive emotional and physical health outcomes among adult outpatients. The quantitative part of the study has been reported previously (Pérez et al., 2011).

Purpose and Design

A descriptive, qualitative design using focus groups was selected to explore the research question posed in the qualitative component of the study, "How do patients with advanced cancer pray?" More specifically, the objectives were to identify and describe themes on using prayer to cope with cancer, and to identify the positive and negative effects of prayer.

Focus group interviews provide an opportunity to gather detailed information from a group of people who have lived through a shared experience (Creswell & Plano Clark, 2007). For this study, the shared experience was active treatment for advanced ovarian or lung cancer. The participants were given an opportunity to respond to specific research questions and, in return, receive a supportive environment, empathetic listening, and an opportunity to validate their experiences with others who have had similar experiences. Although group dynamics and time limits affect the data collected, focus groups are considered an optimal way to collect exploratory qualitative data efficiently (Creswell & Plano Clark, 2007).

Methods

Participants

Study participants were recruited from three hospitals that are members of an urban, university-affiliated comprehensive cancer center. The institutional review

boards (IRBs) at the Dana-Farber Cancer Institute and the University of Massachusetts, Boston, approved the study protocol. Patients with stage III–IV lung or ovarian cancers were eligible for the study. In addition, participants had to be 18 years or older, able to read English, and in active outpatient treatment (e.g., radiation, chemotherapy, hormone therapy). Participants were recruited into the study by three methods: (a) brochures providing a brief overview and purpose of the study, eligibility criteria, and study team contact information were distributed in the waiting areas of the hospital cancer centers; (b) an introductory letter, signed by the primary oncologists, was mailed out or given to identified patients informing them of this study by a member of their healthcare team; or (c) previously screened, eligible outpatients were approached by a member of the study staff after being introduced by a member of their healthcare team. Participants provided consent that included having their medical charts reviewed to obtain relevant health information (e.g., type and stage of cancer).

Patients who met eligibility criteria and were able to attend a focus group meeting were invited to participate in the qualitative component of the study. Patients who were not interested or able to participate in the focus group were offered an opportunity to participate in the quantitative component of the study instead. The focus groups were scheduled based on participants' availability and convenience. Participants were provided lunch during the focus group meeting and received a \$25 gift card as compensation for their participation.

Two focus groups, consisting of 13 participants total, were held in conference rooms at two of the hospitals' cancer centers. The ovarian cancer focus group ($n = 8$) was held at the Dana-Farber Cancer Institute in July 2008, and the lung cancer focus group ($n = 5$) was held at the Massachusetts General Hospital in April 2009. All participants were women and their ages ranged from late 30s to early 80s. The majority of participants self-identified as Caucasian.

Data Collection and Analysis

Each focus group met for two hours and followed the following format.

Introduction (10 minutes): The facilitator welcomed participants, discussed the purpose of focus group, reviewed the procedure for the session, and reviewed the rules (e.g., respecting opinions, letting others have a chance to talk).

Focus group (100 minutes): Five to six of the research questions were posed by the moderator to coordinate a discussion. The number of questions addressed depended on the quality and length of responses.

Wrap up (10 minutes): Participants were asked, "Is there anything else that you would like to tell us?" and "Is there anything that we missed?"

The original schedule of research questions approved by the IRBs was ambitious. The research questions were modified from a previously published study (Taylor et al., 1999), which used in-depth qualitative interviews as the methodology. Considering the number of participants who wanted to respond to each question and the time limits imposed by the focus group, the following topics were covered: the meaning and importance of prayer, what specifically the prayers were for, if the ways participants prayed had changed after diagnosis, and if they felt that their prayers had influenced their health care or impacted their cancer treatments. In the lung cancer group, which was smaller, the facilitator also asked whether prayer had ever caused distress. As is standard with focus group methodology, an observer was in the room with the facilitator to take field notes (i.e., record behaviors and body language). Data from the field notes were incorporated into the data analysis.

The session was tape recorded and transcribed verbatim. Any identifiable information was removed during the transcription process. The transcripts were reviewed, verified by the primary author, and then entered and saved in the qualitative software program, QSR NVivo, version 8.0. Content analysis procedures of "identifying, coding, and categorizing the primary patterns in the data" (Patton, 1990, p. 381) were used to analyze the transcripts. The authors read the transcripts twice and independently hand-coded the data by placing a substantive code, using the participants' own words, next to the lines of the transcript. Then, the authors met regularly to review, discuss, and modify their coding to ensure reliability. During this process, a code book was developed that defined and described each code. The codes then were clustered together on the basis of similarity and dissimilarity of content. After hand analyses, all codes and exemplars were entered into QSR NVivo, version 8.0. Electronic coding mirrored hand coding.

Subsequent analysis identified four broader themes: finding her own way, renewed appreciation for life, provision of strength and courage, and gaining a stronger spiritual connection. The types of prayer described by the participants also were identified. An electronic decision trail of the abstraction process from raw data to significant statements, categories, and themes was sent to the moderator and to a master's-level oncology nurse to confirm that the data and findings were internally consistent.

Results

The themes that emerged are presented in descending order of the frequency with which they were described.

Theme 1: Finding One's Own Way

This theme was expressed by every participant and was defined as the process of the individual patient making spiritual sense of and moving forward through her cancer diagnosis and cancer treatment experiences. A definite sense of a time trajectory was present in the participants' statements and, for some, a sense of a spiritual pilgrimage. Each participant had found a unique way through the cancer experience that extended beyond her usual religious or spiritual practices. As one participant with ovarian cancer described,

The last year when I had my third [cancer] bout in three years, I was in the hospital and a female rabbi came into my room. . . . I really, in talking to that rabbi, I really discovered that there was a spirituality, but it was my own way of, you know, I had to find my own niche. And I think that's what everybody has to do. I don't think you have to have organized prayer or . . . I, I think it's just you, whatever makes you feel better.

Another patient with ovarian cancer explained,

So, um, prayer is finding peace, I did learn to meditate in a support group I went to, a local support group. And, um, we laid on the floor and they talked about a white light, healing light coming down through your body and run down your part of the body and then. When I'm really stressed, that's what I do. I lay down on the floor sometimes and I think, close my eyes, and I think about this light, which I think of as God. I don't really know what I, you know God is a power to me and I see, when I see something beautiful like today, it's a beautiful day. To me, that's God.

Theme 2: Renewed Appreciation for Life

This theme was expressed by the majority of participants in both groups, and was defined as ways that the participant looks at life with new priorities. Many of the participants had experienced their cancer diagnosis as a signal, even a sign from God, and were now focusing on the central issues of value in their lives and letting go of the rest of their concerns. A participant with lung cancer described,

I just pray, I pray every morning. I pray every morning, and thank Him for . . . either your cup is half full or your cup is half empty. When I get up, I thank God because I have another day. I don't say, "Is this the day I'm going to die?" To me, that is as simple as that.

A participant with ovarian cancer expressed a renewed appreciation in her love for and received from her family.

Everything feeds into it . . . the beauty of the little babies in the family as they run across the floor, “Oh, Jesus, how did anything that beautiful happen?” And it happens, it happens all the time. . . . It’s just a positive response to life.

Theme 3: Provision of Strength and Courage

Expressed by all of the participants with lung cancer and a majority of the participants with ovarian cancer, this theme was defined as using prayer as a source of strength and courage throughout the cancer experiences. Many participants described their cancer experience and focused in on how it affected their other family responsibilities and the exasperation with long days. This theme focused on how prayer enabled them to endure those difficult experiences. A participant with lung cancer stated, “Prayer and meditation was my saving grace,” and described,

I ask the Lord to let me lean on Him when I can’t just, just can’t seem to go on anymore, you know? . . . Things seem so, so dire, and so terrible, and so I ask, “Let me lean on You. And the only thing that is in me to support, help me get through this time.”

A participant with ovarian cancer noted,

Prayer gives me the strength. And uh, before I had the cancer, I’ve always been very religious and went to church once a week. . . . But now I go daily, and I do the rosary, and I light candles.

Theme 4: Gaining a Stronger Spiritual Connection

Expressed by most of the patients with lung cancer and two of the patients with ovarian cancer, this was the least frequent theme. However, it was a powerful and significant theme for the participants who reported it. Defined as growing in one’s faith and growing closer to God, participants who reported this spiritual growth identified themselves as religious people and cited membership in monotheistic traditional religions. Those faith traditions identified paths that provide spiritual growth even when no other type of growth seems possible. A participant with lung cancer described reconnecting to her spiritual roots.

You know, as a child, you learn certain things . . . from the Bible and all of the little scriptures that I learned in school and in Sunday school, um, came back to me and it made me a lot calmer, made the process very easier for me. And, um, grew me closer, I think.

Another participant with lung cancer identified herself as a Catholic from a devout family, and her comments reflected a change in her illness based on her

praying. She talked about her initial bout of cancer and its recurrence five years later.

But my praying, again in between the five years, I probably prayed, but not with the same intensity that I prayed with when I was sick. And I used to say, like gosh, I wish I was connected to God like I was when I was sick and maybe that was one of those things. Now I am connected to God the same way I was when I was sick the first time. You know your prayer is different, like it’s more, um, I’m just so in tune with my prayer and praying for my family and my kids.

Types of Prayer

Five types of prayer were described by participants from both groups. By frequency, the types of prayer described were prayer for others, conversational prayer, petitionary prayer, ritual prayer, and thanksgiving prayer.

Praying for others: Prayer in this category was defined as instances where the participant identified another person for whom they prayed. Many of the participants stated that they did not pray for themselves, but preferred to pray for others. The others they prayed for varied, specifically mentioned, however, were family members, doctors and healthcare providers, other patients, and other focus group members. Praying for others in the focus group was exemplified within the ovarian cancer group, when a dominant participant, along with the participation of all group members, ended the group meeting with a verbal prayer for the group members.

A participant with lung cancer described, “I know when you have an illness, you have the focus of just praying, not only for yourself, but for your family and the people you love and the people that need you.” Another lung cancer participant explained, “I pray for my doctor; I pray that he keeps his strength.”

Conversational prayer: Talking to God throughout the day was categorized as conversational prayer. Participants called this “talking prayer” and “when you talk, he listens.” McCullough and Larson (1999) identified this as colloquial prayer differentiating from petitionary prayer. Although both contain requests, they state that, in colloquial prayer, “the petitionary elements are less concrete and specific than in petitionary prayer” (p. 96). Conversational prayer was defined as an internal running conversation that went on over time throughout the day while the participant was awake. A participant with ovarian cancer described, “During the day, I have a conversation going on, which sounds a little weird, but I do.”

Petitionary prayer for self: Asking for specific things for oneself is the basis for this category. However, the petitions themselves were quite unique and diverse.

- To die in her home
- For guidance and direction

- To live long enough for her children to grow up a little more
- To be able to get a message back to earth to her loved ones after she is dead
- For the chemotherapy to work

Ritual prayer: This type of prayer is defined as using structured, written prayers; this formal way of praying is referred to as liturgical prayer in some faith traditions. Examples of these included using structured prayers from an interfaith prayer book given out by the hospital oncology chaplain, the St. Jude Prayer and St. Jude novena, praying the Rosary (e.g., Hail Mary, use of rosary beads), the Lord's prayer (Our Father), the Gloria Patri (Glory be to the Father), and praying the 23rd psalm (the Lord is my shepherd).

Thanksgiving prayer: These prayers were expressions of gratefulness to God, and used the word "thank" when the participant was describing their prayer. As an ovarian cancer participant explained, "The best thing you can do in your life is to express thanks for what you have experienced and enjoyed and loved." A participant with lung cancer described, "I prayed to Him and thanked Him that I was able to do that."

Discussion

The findings from this qualitative study support prayer as a positive spiritual and psychological coping mechanism for people with advanced cancer. Although not exhaustive, the findings provide the foundation for additional exploration of the role of prayer in coping with cancer. Because of the nature of prayer as a discrete behavior and its widespread use, this line of inquiry is worth pursuing. The four themes that emerged from the data can be used to generate several research ideas, for example, that people with advanced cancer develop their own, unique spiritual pathways as they journey through the cancer experience; that prayer provides direct psychological and spiritual support for people as they go through difficult treatments; and that prayer provides a positive potential for growth throughout the cancer experience, including reprioritizing and appreciating life and deepening one's own spirituality. A unique feature of this study was that all of the participants had advanced cancer and were in active treatment, which may suggest that people with advanced cancer place a greater emphasis or importance on prayer as the illness progresses. Therefore, oncology nurses should consider assessing the role of prayer and developing individualized plans of spiritual care as they accompany patients throughout the cancer journey.

The identification of five types of prayers used by people with advanced cancer also is helpful as the ef-

fects of specific types of prayer are examined. In the current study, prayer was only portrayed as helpful. Also, prayer for others was identified as the most frequent type of prayer used. Lambert, Fincham, Stillman, Graham, and Beach (2010) found that prayer for others increases feelings of forgiveness and increases selfless concern. Thanksgiving prayer provides an example. If one conceptualizes thanksgiving prayer as an expression of gratefulness directed toward God or a power outside of one's self, a link can be made to the gratefulness literature. In a comprehensive review of gratitude and well-being, Wood, Froh, and Geraghty (2010) described gratitude as a "life orientation towards noticing and appreciating the positive aspects of life" (p. 891). Gratitude interventions are most often lists of what the person is grateful for; therefore, it might be reasonable to consider thanksgiving prayer as a form of gratitude intervention. In a quantitative study of prayer types and well-being, Pérez et al. (2011) found that thanksgiving prayer was associated with lower depressive symptoms mediated by lower levels of rumination. A need for additional qualitative studies remains, as identification and knowledge of the type of prayers occurring in the natural environment is essential in the development of targeted interventional research.

Pilot intervention studies have examined the effect of prayer on well-being among patients with cancer. For example, Johnson et al. (2009) published a pilot study of the use of centering prayer during chemotherapy treatments. Built on the meditation literature, centering prayer replaced meditation in women with recurrent ovarian cancer. Findings indicated that centering prayer was beneficial and led to improvement in the women's emotional well-being, anxiety, depression, and faith.

Prayer also has been associated with quality of life (QOL) for patients with cancer. The inclusion of spiritual well-being has become incorporated in QOL research (Brady et al., 1999). A phenomenologic study of self-care strategies to promote QOL in patients with lung cancer identified prayer as an important self-care strategy (John, 2010), emphasizing that the role of prayer in promoting QOL in patients with lung cancer has not been explored. Prince-Paul (2008) conducted a phenomenologic study of the meaning of social well-being at the end of life for eight adult, Caucasian, Christian patients with terminal cancer in hospice care. Six themes emerged, including gratitude and the meaning of relationships with God. For all of the patients, prayer was central, and their relationship with God was personal, positive, and directive. Linking studies of types of prayer to the extant body of knowledge about QOL may help to understand the mechanisms of how prayer affects the well-being of patients with advanced cancer.

Limitations

Purposive sampling was used for participant recruitment to gain information from participants who shared a common experience and had a similar illness trajectory, in this case, advanced lung or ovarian cancer. In an effort to recruit men, lung cancer was selected. Despite this effort, the sample was limited to women. Male participants with lung cancer were scheduled to be a part of the lung cancer focus group; however, they did not attend. Although a same-gender group may have led to a more open dialogue, the lack of the male perspective is a noted limitation. Similarly, the small focus group sizes facilitated more discussion among the participants, but may have limited the richness of the findings. Study criteria included that participants be in active treatment for their cancer diagnosis. Although the focus groups were reconfigured and rescheduled multiple times to maximize the number of participants, it remained difficult to obtain an adequate number of participants who were well enough to attend a focus group session on any given day.

The ovarian cancer group had a dominant participant who had a strong religious commitment and was verbal in her beliefs; consequently, she would often comment on others' contributions from her religious perspective. This may have hampered others' ability to fully express their opinions, particularly if they were not as open about their spirituality. Participants also may have been less willing to disclose negative effects of prayer in a group setting. Both groups expressed strong emotions and had participants who cried during the group sessions. However, none felt the need to leave or meet with the social worker or chaplain—accessible during and after the focus group sessions. Participants' emotions were handled effectively by the facilitator and by the support provided in the group.

For future studies, individual interviews are recommended to allow for a more ambitious schedule of interview questions. Individual qualitative interviews may provide greater scheduling flexibility, a more open environment, and a better opportunity for in-depth descriptions, including any negative effects. Interviews could be conducted until data saturation have occurred, which did not happen with the focus group data.

Conclusions

The themes identified by this study emphasize the importance of spirituality in coping with advanced cancer. Prayer for others was the most frequent type of prayer identified by the participants. Thanksgiving prayer, with its links to the gratitude literature, may prove to be an important focus for future studies with patients with cancer. The current study provides

knowledge about prayer as a source of spiritual and psychological support.

Implications for Nursing

Based on the results of this research, several recommendations for nursing practice are suggested. Oncology nurses should assess the role of prayer for patients with cancer and develop personalized plans of spiritual care as they accompany these patients throughout the cancer journey. Although the initial spiritual assessment is a critical aspect of nursing care, the need remains for nurses to move beyond the initial spiritual assessments. Spirituality is not a static and often changes as the cancer experience unfolds. Close surveillance of patients is necessary to ensure that cues indicating spiritual needs are not missed.

Nurses who identify spiritual needs do not need to feel total responsibility for spiritual care. Spiritual care is an interdisciplinary team effort and nurses should be encouraged that referring patients to chaplaincy is a valid, and often necessary, nursing intervention. For some of the patients in this study, prayer provided considerable emotional assistance. Cultivating thanksgiving prayer and prayer for others for patients that do pray may help to decrease depressive symptoms and promote well-being. Oncology nurses can support patients with cancer through comprehensive and continual spiritual assessments and by ensuring that spiritual support systems are in place to enhance coping and QOL.

The authors gratefully acknowledge the contributions of Sarah Ahmad, Esteban Barreto, Katia Canuguez, Laurel Radwin, Geraldine Sanon, Max Stewart, and the participants in this research. They also thank Karen Emmons, PhD, and Adán Colón-Carmona, PhD, for their leadership of the U56 collaboration.

Amy Rex Smith, DNSc, RN, ACNS, BC, is an associate professor in the College of Nursing and Health Sciences at the University of Massachusetts in Boston; Susan DeSanto-Madeya, PhD, RN, is a clinical associate professor in the Connell School of Nursing at Boston College in Massachusetts; John E. Pérez, PhD, is an associate professor in the Department of Psychology at the University of San Francisco in California; Elizabeth F. Tracey, PhD, RN, is the hospice director at Masonicare Partners Home Health and Hospice in Wallingford, CT; Susan DeCristofaro, MS, RN, is a clinical education specialist at the Dana-Farber Cancer Institute in Boston; and Rebecca L. Norris, MA, and Shruti L. Mukkamala, MS, are doctoral students, both in the Department of Psychology at the University of Massachusetts in Boston. This study was funded by a National Cancer Institute U56 Comprehensive Cancer Partnership Program Grant between the Dana-Farber/Harvard Cancer Center and the University of Massachusetts, Boston (U56 CA118635). Smith can be reached at amyrex.smith@umb.edu, with copy to editor at ONFEditor@ons.org. (Submitted March 2011. Accepted for publication September 28, 2011.)

Digital Object Identifier: 10.1188/12.ONF.E310-E316

References

- Barnes, P., Powell-Griner, E., McFann, K., & Nahin, R. (2002). *Complementary and alternative medicine use among adults: United States, 2002* (No. 343). Centers for Disease Control and Prevention Advance data report. Retrieved from <http://ncam.nih.gov.ezproxy.lib.umb.edu/news/report.pdf>
- Brady, M.J., Peterman, A.H., Fitchett, G., Mo, M., & Cella, D. (1999). A case for including spirituality in quality of life measurement in oncology. *Psycho-Oncology, 8*, 417–428. doi:10.1002/(SICI)1099-1611(199909/10)8:5<417::AID-PON398>3.3.CO;2-W
- Creswell, J.W., & Plano Clark, V.L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.
- Gall, T.L., & Cornblat, M.W. (2002). Breast cancer survivors give voice: A qualitative analysis of spiritual factors in long-term adjustment. *Psycho-Oncology, 11*, 524–535.
- Henderson, P.D., Gore, S.V., Davis, B.L., & Condon, E.H. (2003). African American women coping with breast cancer: A qualitative analysis. *Oncology Nursing Forum, 30*, 641–647.
- Holt, C.L., Caplan, L., Schulz, E., Blake, V., Southward, P., Buckner, A., Lawrence, H. (2009). Role of religion in coping among African Americans: A qualitative examination. *Journal of Psychosocial Oncology, 27*, 248–273. doi:10.1080/07347330902776028
- John, L.D. (2010). Self-care strategies used by patients with lung cancer to promote quality of life. *Oncology Nursing Forum, 37*, 339–347. doi:10.1188/10.ONF.339-347
- Johnson, M.E., Dose, A.M., Pipe, T.B., Petersen, W.O., Huschka, M., Gallenberg, M.M., . . . Frost, M.H. (2009). Centering prayer for women receiving chemotherapy for recurrent ovarian cancer: A pilot study. *Oncology Nursing Forum, 36*, 421–428. doi:10.1188/09.ONF.421-428
- Ladd, K.L., & Spilka, B. (2002). Inward, outward, and upward: Cognitive aspects of prayer. *Journal for the Scientific Study of Religion, 41*, 475–484.
- Laird, S.P., Snyder, C.R., Rapoff, M.A., & Green, S. (2004). Measuring private prayer: Development, validation, and clinical application of the multidimensional prayer inventory. *International Journal for the Psychology of Religion, 14*, 251–272. doi:10.1207/s15327582ijpr1404_2
- Lambert, N.M., Fincham, F.D., Stillman, T.F., Graham, S.M., & Beach, S.R.H. (2010). Motivating change in relationships: Can prayer increase forgiveness? *Psychological Science, 21*, 126–132.
- Levine, E., Aviv, C., Yoo, G., Ewing, C., & Au, S. (2009). The benefits of prayer on mood and well-being of breast cancer survivors. *Supportive Care in Cancer, 17*, 295–306.
- McCullough, M.E., & Larson, D.B. (1999). Prayer. In R.W. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp. 85–110). Washington, DC: American Psychological Association.
- Meraviglia, M.G. (2002). Prayer in people with cancer. *Cancer Nursing, 25*, 326–331. doi:10.1097/00002820-200208000-00010
- Narayanasamy, A. (2003). Spiritual coping mechanisms in chronic illness: A qualitative study. *Journal of Clinical Nursing, 13*, 116–117. doi:10.1046/j.1365-2702.2003.00834.x
- Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
- Pérez, J.E., Rex Smith, A., Norris, R.M., Canenguez, K.M., Tracey, E.F., & DeCristofaro, S.B. (2011). Types of prayer and depressive symptoms among cancer patients: The mediating role of rumination and social support. *Journal of Behavioral Medicine, 34*, 519–530.
- Prince-Paul, M. (2008). Understanding the meaning of social well-being at the end of life. *Oncology Nursing Forum, 35*, 365–371. doi:10.1188/08.ONF.365-371
- Taylor, E.J., Outlaw, F.H., Bernardo, T.R., & Roy, A. (1999). Spiritual conflicts associated with praying about cancer. *Psycho-Oncology, 8*, 386–394.
- Walton, J., & Sullivan, N. (2004). Men of prayer: Spirituality of men with prostate cancer. A grounded theory study. *Journal of Holistic Nursing, 22*, 133–151. doi:10.1177/0898010104264778
- Wood, A.L., Froh, J.J., & Geraghty, A.W.A. (2010). Gratitude and well-being: A review and theoretical integration. *Clinical Psychology Review, 30*, 890–905. doi:10.1016/j.cpr.2010.03.05