

THE ORERE SOURCE

Abstracts for the Pastoral Care and Other Health Care Journals

Every week this semester, I am meeting with a group of colleagues to talk about some questions that are stretching my knowledge and my beliefs. It is the continuation of a project which four of us here in the hospital and medical school began two years ago. A physician (an Episcopalian) two psychologists (a Buddhist and an Episcopalian), and myself (Presbyterian) started to examine issues concerning compassion and altruism in the training of medical and divinity students. In 2002, we published a paper outlining the start of our theoretical underpinnings. (Contact me for a copy.) This year we have been joined by two physicians (a Catholic internist and a Jewish psychiatrist) who oversee the training of 2nd and 3rd year medical students. Together we have been working to devise a way of measuring altruistic behaviour in these students. It is a challenging task, as others who have gone down this road before us have discovered.

We are almost ready to make the video-vignettes that will be the basis for our test instrument. In due course, we hope to publish the results for others to critique and to build on. The important realization for me as a chaplain from all of this is the realization that the field of science is now reaching into my world of ministry in a way that has never previously been true. Compassion, altruism, love - these have been qualities which the religious community has spoken of, encouraged and sought to understand for centuries. But now, for the first time, the theologians and philosophers (and the occasional sociologist) are being joined by biologists, psychologists, physicians, public-health analysts, educators and economists in a broad push to understand the nature of these important inner qualities from secular perspectives.

Consider some of the research now being undertaken in various places in the U.S.:

"What has love got to do with it: Altruism, generativity and spirituality in the aftermath of 9/11/01; Love, emotion and empathy: infancy to early childhood; Effects of compassionate/loving intention as a therapeutic intervention by partners of breast cancer patients; Cultivating adolescents' other-regarding virtues: the developmental pathways to unlimited love.

These are just a few of the projects which I know are now in progress. Behind the work of each project lies the belief that unlimited love is ultimately the love that God has for each one of us, without exception. Spiritual traditions have always affirmed that the effects of such love are transforming and healing. But can we understand that love more clearly? How does such love enter our lives? Can a person be trained to communicate such love more fully - say in their training as chaplains? Can we learn how such love is resisted? We might be more effective chaplains if we understood how people do that.

One of the early pioneers in this field was Pitrim A. Sorokin who in 1954 published his major work The Ways and Power of Love. It was really the first modern attempt to deal with the concepts of human and divine love within the research literature describing altruism. Unfortunately, his work lay largely forgotten for half a century. There were several reasons for this. His financial support was always marginal. He did not train someone to keep the momentum of the research going, and he was not able to start a lively dialogue between his own field and persons in other disciplines. There is every reason to believe that this last matter will not be an issue because the projects referred to above are already under way, and like our own they are strongly multidisciplinary.

But where does this kind of research leave those of us who are chaplains? The challenge is to accept that there are people who are interested in concepts and beliefs we in the religious community have always considered our own and not be threatened by them. These "outsiders" speak languages that may appear to be from another world. Yet I believe that if we talk to them, or better, work with them, they will benefit from our insights, as subjective and "unscientific" as they may be. After all we have been thinking about these aspects of human life for a very long time.

It has to be acknowledged there are real dangers related to their interest in "our" territory. The major concern is that the methods and the language used may import meanings and signifiers that will have unintended consequences for us both theologically, and practically. The scientific method, when it has been practiced in its historic, reductionist way has usually stripped context away from what was being studied. Not only can this do violence to the subjects being studied, it can impoverish the values to which we in the faith community are committed. It is for this very reason that I think we have to be involved if we can in work on such subjects.

In his now mostly forgotten book Sacred and Secular, Philip Micklem described four basic ways in which the inter-relationship of the sacred and the secular may be understood by persons of faith. It is a cautionary book, warning us of the dangers inherent in attempting to have the sacred and the secular interpenetrated in ways that this kind of research requires. Nevertheless, I believe that in these efforts to better understand values such as compassion, altruism, or love, we as clergy should be as involved as much as possible, in order that we can speak both to the secular world where such study is taking place, but also to the world of religious faith where we can interpret and encourage our colleagues in parish ministry to understand and benefit from whatever new insights will come from the exploration of this new world of study and research.

A second danger arising from our involvement in this world of research could be that we will begin to think that we fully know what we are examining, and in assuming that we may begin to believe that we are god. The power of knowledge can be seductive, especially when it is caught up into the world of religious faith.

I did not tell you about the last person in our research group. He is a Jewish film critic. He has a teaching position in medicine and the humanities. More importantly, he does not believe that what we are doing can be done! How stimulating it is to have someone who forces us to go back to first principles in order to examine issues we have perhaps accepted too easily.

The scientist who lives laborious days in the disinterested pursuit of truth, the artist who will starve in a garret if only he may express the beauty he has seen, the martyr who will obey God in the scorn of consequence, are all religious men or, at least, are men who illustrate that principle which lies behind religion. Truth, Beauty, Goodness -- these are sacred, the object of man's true love and reverence. He to whom nothing is sacred, all questions are open, and the distinction between right and wrong is blurred, is an enslaved, not an emancipated, spirit. ... Nathaniel Micklem, *The Theology of Politics*

I prefer to run the risk, and to be an emancipated spirit.

Rev. W. Noel Brown, Chaplain and ACPE Supervisor, North-western Memorial Hospital, Chicago, and editor of the ORERE SOURCE, a bi-monthly compendium of his abstracts from the pastoral care and healthcare literature. Contact: orerresource@rocketmail.com

Ingrid Bolmsjo, Goran Hermeren
Meeting existential needs in palliative care - who, when, and why?
J of Palliative Care
Vol. 18 # 3 (Autumn 2002) pp. 185-191

Who should take care of the existential needs of the terminally ill? That is the focus of the work reported in this article. The authors use the phrase "existential issues" to refer to end-of-life issues relating to

autonomy, meaning, guilt, relationships, dignity and communication.

The paper reports the discussions of a Swedish focus group in which people talked together about this subject. There were 7 persons in the group (including a chaplain). All had had personal experience of palliative care. The authors began by asking two questions: why should health care staff take care of the existential needs of patients? And if that ques-

tion is answered satisfactorily in the affirmative, who in the health care team should do so?

The consensus was that there are no general solutions to the above questions. The seven agreed however that if a palliative care unit is going to provide good care, the staff should pay attention to all of the constraints that would prevent staff from responding to the existential needs of patients. They identified some of the constraints that have to be watched are: continuity and time constraints; competent organizations, and personal qualities. All of these are important realities which need constant attention if a unit is going to provide quality care for the dying.

Bernie Carter, Karina Lambrenos, Jonathan Thursfield

A pain workshop: an approach to eliciting the views of young people with chronic pain

J of Clinical Nursing

Vol. 11 # 6 (Nov 2002) pp. 753-762

This study explores the ways in which chronic pain impacts on the lives of teenagers. The paper describes the processes of a day-long workshop in which five adolescents talked together about a range of different types of pain they were suffering - abdominal, headache, bone pain, back pain. Of potential interest to chaplains is the language they use to describe what they are experiencing, and how they experience it. There are five interlinking themes in their talking: "no one's pain's the same; getting on with it; 'it's hard 'cos; keeping with the dream; and, it depends ... some are ok." Pain was experienced as if it was both a separate entity as well as an intrinsic part of them, and, to a degree, they saw it blighting their future.

E.A. Catlin, J.H. Guillemin, Mary Martha Thiel, Sheila Hammond, M.L. Wang, J.

Spiritual and religious components of patient care in the neonatal intensive care unit: sacred themes in a secular setting

J of Perinatology

Vol. 21 # 7 (Oct/Nov 2001) pp. 426-430

NICU's are demanding and stressful places to work in. At times, the work can be agonizing as staff struggle to keep new-borns alive.

There has been little research to identify the extent to which NICU staff rely on religious or spiritual frameworks to help them cope with what they are doing. So the authors, an interdisciplinary group of chaplains and neonatologists hypothesized that spiritual distress might be a common and unrecognized

reality for NICU care-providers. They present the results of their search, which was based on an anonymous, computed-based questionnaire survey.

There are some startling findings. There was found to be a "large undercurrent of spirituality" in the ICU (located in a large secular teaching hospital in Boston). It was also nearly unanimous that nursing staff prayed privately for the babies in their care. When asked "What theological sense do you make of the suffering of the babies in the NICU?" over 1/3 replied that it was part of God's plan. The vast majority of this staff group had a religious framework within which they "made sense" of what was happening to the new-borns.

Marc P.H.D. Cleiren, Ad A.J. van Zoelen
Post-mortem organ donation and grief: a study of consent, refusal and well-being in bereavement

Death Studies

Vol. 26 # 10 (Dec 2002) pp. 837-849

When a family member is a post-mortem organ donor, does the decision regarding donation affect the grieving of the bereaved family members? In this Dutch study, (95 bereaved - 36 were organ donors, in 23 cases consent was refused, in 36 cases no request was made) there was no identifiable difference in levels of depression or difficulty in grieving. However, it was found that dissatisfaction with hospital care was associated with depressive and grief symptoms.

Consenting to organ donation appears to be neither a hindrance nor a help in the grief process.

Angela Coulter

After Bristol: putting patients at the centre
British Medical J

Vol. 324 # 7338 (16 Mar 2002) pp. 648-651

The so-called Bristol Report came from a public enquiry into the failures in the performances of surgeons involved in doing heart surgery on children at the Bristol Royal Infirmary between 1984 and 1995. There were 198 recommendations on how to prevent such failures in the future. The main ones were to: Involved patients (or their parents) in decisions; keep patients (and/or parents) informed; improve communications; provide patients (or parents with counselling and support; gain informed consent for all procedures; elicit feedback from patients (patients) and listen to their views; be candid and open when adverse events occur.

Coulter, the chief executive of the Picker Institute Europe (which organizes feedback from the NHS) considers whether the recommendations can be made into a reality. She discusses each of the main points above, she believes the changes recommended are achievable.

The original report can be accessed from: <http://www.bristol-inquiry.org.uk> (accessed 5 Jan 2003)

John Ellershaw, Chris Ward

Care of the dying patient: the last hours or days of life

British Medical J

Vol. 326 # 7379 (4 Jan 2003) pp. 30-34

The skills of many British doctors to care for their dying patients, especially outside palliative care settings, are not as sharp as they should be, according to Ellershaw and Ward. They claim that too many patients are still dying undignified deaths with uncontrolled symptoms. The very task of diagnosing that a person is dying, for example, is a complex process that many are not handling well.

This paper describes what the authors believe will be involved in correcting this situation. They include a number of issues where the knowledge and expertise of chaplains may be called upon. For example, "Describe an ethical framework that deals with issues relating to dying....." Or, "Appreciate cultural and religious traditions related to the dying phase." Included in the goals of care is: "Goal 6 - Religious and spiritual needs assessed with patient and family."

Not a road map, but at least in the eyes of these two English physicians, a clear indication that the trained chaplain has an important role where comprehensive care is to be provided for the terminally ill.

Veronica English, Gillian Romano-Critchley, Julian Sheather, Ann Sommerville

Ethics briefings

J of Medical Ethics

Vol. 28 # 3 (Jun 2002) pp. 205-206

The ethical issues in this briefing are concerned mainly with questions about the nature of families, and relationships between parents and children when those children are born of surrogate-parents.

Who is a parent? Families are increasingly complex groupings, raising new questions about parental rights and responsibilities. (Who are the parents of the 18-month-old boy whose mother is in a commit-

ted lesbian relationship, and whose biological father is a gay man, with conception being via IVF?)

Ease of travel to get medical assistance for reproductive problems has created a situation in which there are new issues for the legal system. An English woman enters into a surrogacy contract with an American couple. But when the English woman learns that the surrogate woman is expecting twins, she asks the surrogate to have a selective abortion. The pregnant woman refuses, and the twins are born safely, in the U.K. This case is currently being sorted out in a California court.

Another issue is that of payment. In the U.S. it is acceptable to pay a surrogate mother. Not so in the U.K. except for expenses, and that matter gets cloudier with each new case.

Finally, there is the issue of promise-keeping and truth-telling. This matter seems destined to be on-going with several court decisions overturning consent agreements previously entered in to. Should a child be told that their birth mother is not their biological relative, and never intended to be? A Dutch community has had to sort out how to handle a situation in which the parents of 18 children were conceived through artificial insemination (between 1989 and 1995), only to find out that the sperm donor has now started to develop the symptoms of a progressive brain disorder. The children have a 50% chance of developing the same disorder. Should they be told? To make matters even more difficult, their potential off-spring would also be at risk.

Richard G.A. Feachem, Neelam K. Sekhri, Karen L. White

Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente

British Medical J

Vol. 324 # 7330 (19 Jan 2002) pp. 135-141

A comparison of the costs and the relative health care performances of the NHS and Kaiser Permanente in California. In many ways these two systems are remarkably similar, as the authors show.

The results are interesting. The widely held belief that the NHS is efficient is not supported. Kaiser was found to achieve better performance at roughly the same cost as the NHS because of integration through the system, efficient management of hospital use, the benefits of competition, and greater investment in information technology. "Kaiser's superior performance is mainly in prompt and appropriate diagnosis and treatment." (p. 141)

Bruce D. Feldstein

Toward meaning

J of the American Medical Association

Vol. 286 # 11 (19 Sept 2001) pp. 1291-1292

Feldstein describes his experience when, as a physician in his emergency department, he had to care for an 86-year old woman who is critically ill, and who asks him, point-blank, to tell her the results of her brain scan. He had hoped to pass her back to her oncologist, but she wants to know, now.

He has to tell her that her cancer has spread to her brain. They continue to talk and seeing a crucifix around her neck, he asks her if she is a prayerful person. She says she is, and he awkwardly offers to pray with her. "Now what? We were from different worlds. She was Catholic, originally from Mexico. I am Jewish, originally from Detroit and, at 43, half her age. We had only just met. She prayed to Jesus. I do not pray to Jesus. What would I say? I certainly had not been prepared in medical school for a situation like this."

Feldstein describes what then took place, the marvellous unfolding of faith, for both of them. Then he reflects on the ethical aspects of what he had done.

Feldstein is now a full-time hospital chaplain, though this career change is not recorded as being linked to this encounter.

R Gatrad, A. Sheikh

Palliative care for Muslims and issues after death

International J of Palliative Nursing

Vol. 8 # 12 (Dec 2002) pp. 594-597

In this paper, Gatrad and Sheikh focus on bereavement and death customs for Muslims in the U.K. They describe issues relating to the immediate handling of the body after death, the washing of the deceased, and reasons for early burial. Muslims views concerning organ transplants and post-mortems are also presented.

The article also provides some practical advice on the day-to-day issues that can arise when caring for a recently deceased Muslim patient and his/her relatives.

There is probably little new in this article for the trained chaplain. However, for those chaplains who supply nursing colleagues with recent articles of interest, this one may contain information of value.

Claire Hilton

Religion beliefs and practices in acute mental health patients

Nursing Standard

Vol. 16 # 38 (5 Jun 2002) pp. 33-36

What is recorded concerning religious affiliation, beliefs and practices of older persons in their admission and assessment notes when they are admitted to a facility because they are experiencing mental health problems?

Because no "audit standards" for this issue could be located in the mental health literature, the author engaged patients, medical and nursing audit committees in establishing a "gold standard" for what she considered an important clinical care issue.

Their agreed standard states that staff should be "aware of their patient's religion and their level of commitment to it." In the standards setting meetings, various indicators were named which would be the markers for determining whether the standard was being observed. These included documentation of the religious group; denomination or sect on admission sheets; whether religious practices were identified as being practiced at their usual level of activity; whether specific religious requirements were noted; and, whether or not the patient had concerns regarding the stigma associated with mental illness and if members of their religious group would have negative attitudes toward them.

After the audit standards had been agreed to, Hilton reviewed the case notes for 23 consecutive admissions. (18 female, 5 male). Data on the patients is provided.

The audit standards were not met. While religious affiliation was generally recorded - incorrectly in several cases - the level of religious activity was not adequately addressed.

The paper represents an attempt by a psychiatrist to consider seriously the place and value of religion in the lives of persons who are seriously mentally ill. Her "gold standard" seems worthy of further consideration by chaplains in the field of mental health.

Ewan Kelly

Marking life and death: co-constructing welcoming and funeral rituals for babies dying in utero or shortly after birth

Contact (monograph)

Vol. 12 (2002) pp. 4-39

The journal "Contact" is co-sponsored by 5 major pastoral care and counselling organizations in the U.K. It has been published for almost 50 years. Their monograph is published annually and this is the 12th in the series.

Kelly, a former hospital chaplain and now a lecturer in practical theology at the University of Edinburgh

explores some of the theological and theoretical considerations, as well as the emotional needs that are addressed in the creation of rituals to mark the life and death of babies dying in utero or soon after birth.

As traditional expressions of religious faith have weakened across western societies, the task of creating appropriate and meaningful rituals to mark such deaths has become increasingly difficult. Kelly provides some principles, with the help of two case studies from his own ministry. Whether it is a welcoming (baptism, blessing or non-religious naming) or a funeral ritual, the theological perspectives which the chaplain brings are crucial in the process of creating the ritual, its content, how it may be facilitated, and the significance of the event for both the parent(s), family and the chaplain.

Harold G. Koenig

An 83-year-old woman with chronic illness and strong religious beliefs

**J of the American Medical Association
Vol. 288 # 4 (24/31 Jul 2002) pp. 487-493**

Some chaplains, for a variety of different reasons, have become alarmed at the thought of doctors starting to discuss religious beliefs and practices with their patients. In this article, Harold Koenig, who has published widely in this area, provides a very clear example, using a case history, of what he believes are the appropriate boundaries and behaviours for doctors who do so.

His remarks are made in the context of a grand-rounds presentation where an 83-year old woman who has multiple medical problems manages to cope with her illness, which was causing chronic progressive pain and weakness, but who was able to cope remarkably well, aided in large part by her religious faith.

We are given the patient's medical history, the views of the patient herself about her life and suffering and the place of her faith. Koenig then answers questions put to him by other physicians. In this section, he addresses such matters as: do religious beliefs make a difference in terms of health and coping? (unambiguously, yes); how does religion facilitate coping with chronic pain, disability and serious illness; and the major questions currently being asked by physicians about; taking a spiritual history, religious beliefs influencing medical decisions; religious beliefs that conflict with medical care; the role of a supportive community; the patient who has additional religious needs.

His concluding comment is about "professional boundaries" in which he points out that while more than half of the US medical schools now have courses on religion and medicine "a couple of lectures or even a more intensive course throughout a semester or 2 is no match for the training a chaplain receives. Whenever anything but the most simple and uncomplicated spiritual issues come up, chaplains or pastoral counsellors should be consulted." (p. 490) Seventy-four references and a box with five questions for taking a spiritual history are appended.

Jill Main

Management of relatives of patients who are dying

**J of Clinical Nursing
Vol. 11 # 6 (Nov 2002) pp. 794-801**

Approximately 60% of deaths in the UK occur in a hospital setting. Previous studies about staff attitudes towards relatives of dying patients have suggested that staff do not always handle these situations well. This article reports a study to examine the issue both from staff perspectives as well as from the perspective of relatives. Staff (18) were interviewed in focus groups and relatives (7 of 10 approached) were interviewed individually.

The themes of the staff discussions were: being uncomfortable, being left to cope; relatives are the problem; patients before relatives; and, managing death and dying. Each of these themes is examined in turn. The themes from the relatives' interviews were: closing the book; and, the dark and the light.

It appears that staff often felt ill-equipped to deal with issues around death and dying, suggesting there continues to be a place for the pastoral support of the chaplain. Both qualified and unqualified staff thought that training to help them in this area is generally not available. They felt uncomfortable and unsupported when working with dying patients and their relatives.

This was a small study done in the South Birmingham area. Chaplains will have to determine whether these findings would also be true where they work.

Maria Merritt

Emotional Reasoning - review

**Hastings Center Report
Vol. 32 # 5 (Sept/Oct 2002) pp. 45-46**

This is a review of Jodi Halpern's book From Detached Concern to Empathy: Humanizing Medical Education. (Oxford University Press 2001. 165 pp.) While the book is intended for persons involved in

medical education, Halpern has a potentially valuable contribution to make to chaplaincy because of her description of the nature of empathy, what it is, how it develops, and how it is related to rational thought and professional caring. The major focus of her book is her understanding of what she calls "emotional reasoning," which she believes is the core skill of clinical empathy. She describes empathy as "reasoning" in that it is the mental process meant to correct and make more specific one's understanding of another person's experience. It is emotional in that one's own feelings, as evoked by another person's situation are what organize and guide that process.

Emotional reasoning can start from curiosity (more cognitive than emotional), or from listening to and being moved by another's story (more emotional than cognitive).

The process of empathy involves taking the starting point, whichever it may be, and their imaginative associations and holding them not as conclusions, but as cues to seek further information in dialogue with the other person.

To be empathic involves several steps in a reflective process: 1. Acknowledging the feelings. 2. Recognizing our automatic way of responding to those feelings. 3. Resisting the automatic path. 4. Reconsidering the feelings from a standpoint centred in imaginative curiosity about the other person. "To empathize is to overcome the compulsion to turn away, and instead to open your imagination to the specific reality of how another person suffers."

Thomas St. J. O'Connor, Fred Koning, Elizabeth Meakes, Kelly McLarnon-Sinclair, Katherine
Quantity and rigor of qualitative research in four pastoral counselling journals

J of Pastoral Care

Vol. 55 # 3 (Fall 2001) pp. 271-280

Presents the results of their study on the quantity (limited) and rigor (overall fairly weak) of the qualitative research published from 1993-1997 in the Journal of Pastoral Care, Pastoral Sciences, the Journal of Religion and Health, and Pastoral Psychology. There are a total of just 26 studies altogether.

This article is of value for any chaplain who wishes to do some research concerning their ministry, because the methodology used to evaluate the articles is spelled out in a clear and detailed manner. In effect, their criteria are a potential road-map for doing good research

However, before the methodology, they describe the overall field of qualitative research, providing an introduction to the various approaches that are now in use, how they differ from one another, and citing examples of each.

The article is a gold-mine for any chaplain considering doing some research.

R.M. Perkin, D.B. Resnik

The agony of agonal respiration: is the last gasp necessary

J of Medical Ethics

Vol. 28 # 3 (Jun 2002) pp. 164-169

Chaplains are familiar with the gasping breathing of a patient who is about to die. It may be only one or two breathes. It may go on for minutes or even hours. For relatives, it is a distressing time, often provoking their question: "Isn't there anything you can do to stop his/her suffering like that?"

Yes, there is. There are drugs that will stop such activity. The ethical question is: should they be used? Perkin and Resnik here make a case for their use. They base their reasoning on the argument that they are relieving suffering, suffering which is being experienced in the face of imminent death.

They anticipate that some will object because they are arguing for active euthanasia. They disagree, arguing that such interventions can be justified in the same way that other practices are justified when they reduce suffering, sometimes hastening death as a result, even though that is not the intent of the intervention. "We propose that there is an ethical basis, in rare circumstances, for the use of neuromuscular blockade to suppress prolonged episodes of agonal respiration in the well-sedated patient in order to allow a peaceful and comfortable death."

Maj-Britt Raholm, Lisbet Lindholm, Katie Ericksson

Grasping the essence of the spiritual dimension reflected through the horizon of suffering: an interpretative research synthesis

The Australian J of Holistic Nursing

Vol. 9 # 1 (Apr 2002) pp. 4-13

In the past 20 years, there have been unprecedented efforts outside the world of organized religious thinking to define and understand spirituality. Nowhere has this been more true than within the nursing profession from which have come dozens of articles reporting reflection and research seeking to

clarify the nature of spirituality, and its place in health care.

This paper describes the authors' efforts to describe the essence of the spiritual dimension reflected through the horizon of suffering. Their method involved careful reading of 18 articles published between 1989 and 2000 in nursing journals, followed by the task of relating the studies in order to identify different aspects of spirituality, always as reflected through the horizon of suffering. Their examination of the articles led to the identification of four different major themes. Undemanding communion (with the sub-themes: experiencing comfort; experiencing love: experiencing faith.), as confirmation of dignity (with the sub-themes: being with the patient; showing compassion; being touch; listening authentically.), the dialectic of suffering (with the sub-themes: experiences of being abandoned; experiences of punishment; experiences of guilt; experiencing a new opportunity.) and the creation of coherence of meaning (with the sub-themes: experiencing meaning; experiencing a personal calling; experiencing peace; experiencing reconciliation.). Each of the themes and their sub-themes is discussed and illustrated. 43 refs

Martin E.P. Seligman
And then God created man
Science & Spirit

Vol. 13 # 6 (Nov/Dec 2002) pp. 28-33

Truly God works in mysterious ways. Only time will tell whether this article will be an account of such an occasion. Seligman is a past president of the American Psychological Association, and has a long and distinguished career working to understand human behaviour. He has been a driving force in a new wave in psychology which has become known as "positive psychology," the push to understand and to develop interventions which will strengthen the positive aspects of human personality.

In this biographical article, Seligman describes being invited to meet with Sir John Templeton along with ten other scientists, philosophers and theologians. Apparently the 89-year-old philanthropist regularly brings people together to encourage cross-fertilization of the best minds in different fields. Seligman says that a few years ago he would have immediately rejected such an invitation. In fact, he was very worried by Templeton's known religious involvements. However, after talking with Templeton's people, and being assured that he was not going to the object of proselytizing, he agreed to

accept the invitation. Furthermore, he had recently read NonZero: The Logic of Human Destiny by Lyford Cay, (Pantheon Books:1999) who had also been invited, and he wanted to meet Cay.

The article is Seligman's account of what transpired at the conference. After Cay's lecture (Cay's religious views are unstated), Seligman talks privately with him. Cay says to him: "I thought you were a non-believer." Seligman replies: "I was. I've never been able to choke down the idea of a supernatural God who stands outside of time, As much as I wanted to, I've never been able to believe there was meaning in life beyond what we choose to adopt for ourselves. But I am beginning to think I was wrong." (p. 32)

What follows is a personal theology in the process of being born. It makes for thoughtful reading.

Hans-Christoph Steinhausen

The outcome of anorexia nervosa in the 20th century

American J of Psychiatry

Vol. 159 # 8 (Aug 2002) pp. 1284-1293

Has the outcome of treatment for anorexia nervosa improved in the last 50 years? Having looked at 119 studies of 5, 590 patients, Steinhausen answers, no, he can find no convincing evidence that it has. The mortality rate is still 5%. In surviving patients, just under half (47%) fully recover, 33% improve, and 21% go on with the problem as a chronic one.

Larry VandeCreek

Tragic events and the benefits of "cognitive processing" and "finding meaning"

The APC News

Vol. 5 # 6 (Nov/Dec 2002) pp. 15

Chaplains "know" that patients appear to be more at peace within themselves when they have been listened to, helped to come to a place of acceptance about issues they trouble them. The paper VandeCreek highlights in his column describes how this inner peace has been measured in objective terms.

He describes and comments on a paper which reports the effect of "cognitive processing" in HIV positive men. After they had been actively listened to, their blood cell counts, specifically their CD4 T-cell counts were measured. The men had typically experienced the recent loss of a confidante they had known for many years, and now they were being treated for HIV infection, but having no one they felt they could share closely what was happening to them.

VandeCreek describes the original paper (J.E. Brower et al., "Cognitive processing, discovery of meaning, CD4 decline, and AIDS-related mortality among bereaved HIV-seropositive men" in the *J of Consulting and Clinical Psychology* 66(6), 979-986.) and comments on its implications for chaplaincy. From his reading, the main implication is that with these HIV- positive men, pastoral visits will be helpful when the visits help persons find meaning in whatever they are experiencing.

Kiri Walsh, Michael King, Louise Jones, Adrian Tookman, Robert Blizard

Spiritual beliefs may affect outcome of bereavement: prospective study

British Medical J

Vol. 324 # 7353 (29 Jun 2002) pp. 1551- 1555

"Does religious belief affect the grieving process?" is the question these authors set out to answer. Their method was to interview people who were about to be bereaved, and then to do follow-up interviews 14 months later. A total of 135 close friends and relatives participated; they live in or near London.

The authors used 5 instruments to gather data: the Royal Free (what a name!) interview for religion

and spiritual beliefs which accesses the nature and strengths of beliefs and practices (*Psychological Medicine* 1995; 25: 1125- 1134); a core bereavement items scale which measures intensity of grief (*Psychological Medicine* 1997; 27: 49-57); a hospital anxiety and depression scale (*Acta Psychiatrica Scandinavica* 1983: 67: 361-370); the Close Person's Questionnaire (Society Science and Medicine 1992; 35: 1027-1035); The Locus of Control of Behaviour Scale which measures the extent to which a person perceives events as being a consequence of their own behaviour and under personal control (*British J of Medical Psychology* 1984; 57: 173-180).

The results showed that persons who reported no spiritual belief had not resolved their grief at 14 months. Participants with strong spiritual beliefs resolved their grief progressively over that same period. People with low levels of belief showed little change in the first nine months but after that resolved their grief. The analysis found that strength of belief does affect the course of bereavement, independent of any psychological status for the person.

Scottish Association of Chaplains in Healthcare (SACH)

The Association seeks

- To be a professional body representing the interests of chaplains in Healthcare
- To promote, set and maintain high standards of chaplaincy and provide a Code of Practice to further them
- To provide support and fellowship
- To provide training and educational opportunities
- To develop and promote special interest groups
- To promote theological reflection
- To establish and promote good working relationships with religious and other organisations concerned with the promotion of healthcare
- To keep and publish a list of members

Further details of the Association are available from the SACH website:

www.sach.org.uk