

## THE ORERE SOURCE

Abstracts from the Pastoral Care and other Healthcare Journals

### *Some Thoughts about the Dynamics of Hoping*

Until I was a teenager, my parents, my brother and I lived in the home of my grandmother, Jean, my mother's mother. She was a rather quiet but strong woman who had weathered the storms of life mainly on her own after the early death of her husband. He had died as a result of the "great flu" which swept the western world after World War I. Jean was Scottish through and through, and it would not be until I was grown and married with my own family that I realized what a strong influence she had had on my life. Basic values and attitudes had been inherited from her, almost as if they had come to me in my genes.

For all of her life, there was a small embroidered saying in a frame which stood on the left side of the mantelpiece above the living room fireplace. It had a saying which always intrigued me but which even my grandmother could not explain terribly well, except to say that it was for encouragement. The saying was an aphorism which seems to have been common in both Great Britain and the U.S. since some time in the 1800's. "Don't worry, it may never happen." These were the words of counsel that I saw every day and often wondered about.

I have never been able to place the words securely within my own faith because they only seem to go so far. There is something truncated about their counsel. I don't have a problem about worrying. My problem is - what to do and believe after "it" does happen? When I visit patients in the hospital, "it" has already occurred, the painful diagnosis disclosed, the life-altering surgery already completed. The question then becomes, what hope is there beyond the advice of my grandmother's aphorism?

Within the religious community, we and the people to whom we minister can draw upon the resources that come from our faith. It is from within our faith that, at one level, our hope is rooted. To oversimplify, most people of faith engage in the task of reframing an "it" in order to cope with the problem that has entered their lives. Within the Christian tradition, we speak of all things happening within the providence of God. (Romans 8:38-39) We see things in life in this way, because we are assured that nothing can tear us out of that relationship. All that we are called to do is to believe that this is so in order to be hopeful, in order not to worry beyond "it." Donald Capps encouraged this approach in his 1995 book *Agents of Hope: A Pastoral Psychology* (Minneapolis: Fortress Press). He suggests that the central task of the chaplain or pastor is to be "a provider of hope". He ranges trust, patience and modesty over against the despair, apathy and shame in parishioners and clients. He highlights the value of reframing, and it is the dimensions of time that he highlights: future time by the use of "future visioning", and past time by "revising the past." I think that Capps was right about our needing to be agents of hope. Unfortunately, he has too few arrows in his quiver.

As most chaplains know, for some people this is impossible for them to do. Try as hard as they can they seem unable to be hope-full. They don't always tell this to the chaplain or the health care team in as many words. So their behaviours speak for them. They appear uninterested in their future or their health care. They appear un-motivated to learn about their self-care. They may report that they have no reason to live. It was because of patients like this who became stuck and unable to hope, and because my own pastoral training had not effectively prepared me for such situations that I looked to another field of study of help. If as a chaplain I was to be able to help people hope again, I needed to understand the "active ingredients" in the process of hoping. Perhaps such ingredients could be cultivated in order to better prepare me to help the "hopeless." Martin E.P. Seligman first helped me unravel some of the factors that explain such behaviour. He began with the questions: why are some people unable to

be hopeful? What do they bring to a place in their life that leaves them either demoralized, or spiralling downwards out of control? Why do some people act as if they are helpless, while others in the same situation do not? (See Helplessness: On Development, Depression and Death. NY: W.H. Freeman 1975 and Learned Optimism: How to Change Your Mind and Your Life. NY. A.A. Knopf 1991) It was he who taught me a central lesson about hope; people who feel unable to hope can be helped to change. Feeling hopeless is not a life sentence.

For the past 20 years, Rick Snyder has been exploring the nature of hope and how people are able to remain hope-full. Snyder is the Wright Distinguished Professor of Clinical Psychology at the University of Kansas-Lawrence. How his own thinking developed helps us understand his theory. As a young psychologist he decided to try to understand how people make excuses when they make mistakes or perform poorly in something they have tried to accomplish. As he listened to people describe how they talked with themselves about such incidents or those where they felt like failures, he discovered that everyone, without exception, reported that they had goals. Not only that, people want to achieve positive goals. He came to the conclusion that led him to believe that hope was “the other side” of the process of making excuses. It was a rather simple, but profound discovery. It was the central idea in his first paper on hope. (C.R. Snyder. (1989) “*Reality negotiation: From excuses to hope and beyond*” in the *Journal of Social and Clinical Psychology* 8, 130-157) This research and the work of others convinced him that people seek goals, positive goals for themselves.

Not only did people have goals, people told him they looked for ways to reach those goals. At this same time there was a development in the field of psychology which came to be called the “cognitive revolution”. People in psychology were emphasizing pathways-like thinking, a development that placed thinking and the brain prominently in Snyder’s effort to understand hope. By happenstance, he paid a visit to Karl Menninger (an active churchman) who was an important figure in the behavioural sciences and in the field of mental health. In 1959 as president of the American Psychiatric Association he had titled his presidential address “*The academic lecture on hope.*” Menninger encouraged Snyder to place thinking at the core of hope rather than emotions. Menninger always maintained that emotions were too reactive and slippery to be central. This confirmed Snyder in the place he had already arrived at concerning the centrality of thinking in hope. Hope, as Snyder was starting to define it was primarily a way of thinking, with feelings playing an important but only a contributory part.

There was one final issue that Snyder had to clarify for himself, and that was whether hopeful thinking would be found in particular situations that a person entered, or was it found in something nearer the consistent characteristic (a trait) that each person brings into the situation? Or was it some mix of both? He did more interviews and became convinced that hope involved more than a person’s thoughts about the specific issue or situation. He found that people carried within them a basic and fairly enduring kind of self-assessment about their ability to accomplish tasks or handle crises in life. He called this “agency;” a person’s ability to energize themselves to accomplish a goal.

By 1991, Snyder had joined all of these insights together, and gave his definition of hope, a definition that only psychologists could love: “Hope is a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy), and (b) pathways (planning to meet goals).” (Snyder, Irving and Anderson (1991) in “*Hope and health: Measuring the will and the ways,*” in Snyder and Forsyth (Eds). Handbook of Social and Clinical Psychology: The Health Perspective. Elmsford, NY: Pergamon Press. P. 287) He had a three-legged stool: goals, pathways, agency. In other words, he had concluded that being hopeful involves believing one can set goals, figuring out how to achieve them, and motivating oneself to accomplish them. To identify whether a person was essentially hopeful or not he devised a short questionnaire, the Hope Scale. It has been widely used and tested in many different types of groups. A child’s test has also been developed. You can even do your own test. For reasons that are not yet fully understood, pain and hope are correlated. To test your own hopefulness, put your hand up to your wrist, in water which is at 32 degrees F. and time yourself as you

keep it there as long as you can. High-hope people leave their hands in the water for an average 120 seconds, low-hope people average just 65 seconds.

Snyder had also become clear about what hope is not. For many people, hope and optimism seem to be similar, if not identical. However, even though they are related, they are different in that optimism involves expectations that one will get to their desired goal but that expectation may not be accompanied by the necessary planning about how to get there. In fact, being a Pollyanna is a good example of a person who may appear hopeful but who is expected not to succeed. Hope is also not “type-A behaviour,” where the person is driven and time-conscious about what they are doing. But above all, hope according to Snyder is not simply an emotion, a state of feeling confident. Nor is it a matter of self-esteem, intelligence or previous accomplishments, even though all of these qualities are related to hope. Snyder defines “being hopeful” as: believing you can set a goal, figuring out how to achieve it, and motivating yourself to accomplish it.

How does religious faith relate to hope in Snyder’s model? It is only in recent years that he has written about this question in depth. In his first book (*The Psychology of Hope: You Can Get There From Here* (1994) NY: Free Press) he noted that hope and meaning should be companions. He believed that it is through self-reflection on personal goals, and the progress one perceives one in making toward those goals that meaning is created in a person’s life. In his subsequent work he has tied meaning to hope in his own (unpublished) research and it has been confirmed by the research of others. It is also surely confirmed by those of us in our ministries. When a person is challenged by their circumstances in life, issues of meaning and hope appear together.

Snyder’s recent paper, co-authored with Amber Gum “*Hope and terminal illness*” (*Journal of Palliative Medicine* (2002) 5, p.883-894) is perhaps our clearest look at how he thinks hope impacts people who are ill or dying. In this paper he suggests how his model includes religion and faith, and there are several features of his model that I have found of practical value in my ministry. In his thinking about pathways, he reminds us of the necessity of assessing and affirming spiritual goals; of the importance of life review; and of the importance of referral to another spiritual advisor if we cannot be that for a person. Again, we need to note his valuing of the place of thinking in his model. For me as a minister and chaplain, I am reminded of the value of words, stories and images that come from religious books, our own communal heritage. In pastoral training, in the U.S. at least we have tended to de-emphasise these in favour of an emphasis on feelings. Snyder’s model restores the place of thinking and remembering.

But we should not stop there, though that is the stopping place for ineffective chaplains and ministers. If we accept Snyder’s model, we have much more to offer people than words and stories and images. By being actively engaged with patients, we can help build and sustain hope in a number of different ways. Snyder offers a number of suggestions. Snyder suggests that ways to help people strengthen their goals include: helping a person mourn the loss of valued and now unattainable goals (which may include helping a person find meaning and benefit in their situation); helping a person recognize their worth in spite of goal losses; and helping the person recall past goal achievements and important relationships. Hope can also be strengthened when a person is helped to develop alternative goals, which may include choosing those goals that are truly important to themselves, rather than settling for the goals others have imposed or suggested; telling others about these goals; enlisting the help of others so that accomplishment can be seen when the goals have been achieved. All of these activities have been described in the pastoral care literature by various writers. Snyder’s contribution is to bring them together and reminding us that each contributes to the strengthening of hope-fullness in our patients.

Finally, there is the matter of agency. Identifying alternative goals and ways to achieve them should automatically increase a person’s sense of power and ability, which affects their hope-fullness. So even a dying person who can find alternatives should experience a greater sense of agency. It is fairly common however that some agency (personal power) is needed to undertake the initial task of identifying

new and different goals. So how can a very sick person increase their sense of mastery, or competence (Snyder's agency) to start with? Snyder has several suggestions. Find the time of the day when a person's physical energy is at its peak so that they have the necessary energy to engage in conversation. Encourage them to get good rest. Exercise as much as possible. Because for some people it is a religious issue, encourage the person to make sure that pain or troubling symptoms are controlled. If these matters are not attended to, they work against the person being able to function as their own "agent", which in turn works against them being able to be hopeful.

I wonder what my grandmother would have thought about having a different aphorism for her mantlepiece. One possibility comes from the Talmud: "Hope for a miracle, but don't depend on one." I would prefer these words, part of the title of one of Snyder's books: **You can get there from here**. People can be helped to hope again, and to maintain their hopefulness. By unpacking this complex behaviour, Snyder has made concrete a familiar yet abstract concept. His work offers us a clearer understanding of the dynamics of hope and hoping, which means that we can find a greater variety of pastoral interventions, allowing us to be able to minister more effectively.

(A copy of the Hope Scale test may be obtained by contacting [oreresource@rocketmail.com](mailto:oreresource@rocketmail.com) )

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The Rev. W. Noel Brown is a Chaplain and ACPE Supervisor, Northwestern Memorial Hospital, Chicago, and editor of THE ORERE SOURCE, a bi-monthly compendium of his abstracts from the pastoral care and healthcare literature. The following summaries have been selected from recent additions to the 13,600 in the database.

Contact: [oreresource@rocketmail.com](mailto:oreresource@rocketmail.com)

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#### **Joe Barody**

##### **Should clinical pastoral education and professional chaplaincy become more scientific? It's a matter of salt**

**Journal of Health Care Chaplaincy**  
**Vol. 12 # 1/2 (- 2002) pp. 1-10**

In considering whether or in what ways science should relate to professional chaplaincy and Clinical Pastoral Education, Barody turns to the past for guidance. He describes the work of Anton Boisen, and Elwood Worcester. Perhaps the better known of the two, Boisen, a Congregational minister relied on both psychology and medical science to illuminate and expand his vision of ministry. He combined his evangelical faith with Freudian theory to create a new method of healing. Worcester, an Episcopal priest who organized the Emmanuel Movement, reacted to the impersonal nature of the Social Gospel and also to the healing claims of Christian Science, and sought to "recover Christ's healing ministry". His response was to develop a "scientific psychotherapy." Because both these men found insights and knowledge outside their own field of ministry, Barody also finds permission to utilize science as a means for "continuing the priestly, healing ministry of Jesus...".

However, he warns against the uncritical use of some of the recent scientific studies which claim that faith leads to better health. "Accepting the so-called scientific faith claims of medical researchers like Dr Koenig may help professional chaplaincy survive health care reform, but in doing so, they will have traded the evangelical, liberal faith proclaimed by Elwood Worcester and Anton Boisen for an identity based on the pseudo-faith created by science." (pp. 9-10)

Barody's essay is the first of 24 which address from a variety of perspectives the question stated in the title of his work. (6 refs)

#### **Judith H. Blanchard**

##### **Covenanted companionship: assessing spiritual needs with the open heart patient** **Chaplaincy Today**

**Vol. 19 # 2 (Autumn/Winter 2003) pp. 10-15**

Blanchard reports on a research project she headed, which developed and tested a spiritual assessment form for pre-operative open heart surgery patients. Ten chaplains and 169 patients took part in the project.

There are a number of noteworthy features about this paper. First, Blanchard is aware of and describes

the work of others who have themselves developed spiritual assessment tools. Second, she describes very clearly her methodology of data gathering, especially two areas where other researchers could raise questions about the validity of some of her assumptions. The assessment questions are included. The results are clearly presented, and followed by discussion. One area of need identified by the project: 42% of the patients had suffered a significant personal loss in the previous year. One unexpected finding: the data gathering process itself led to very significant opportunities for ministry.

Comment: This study is an excellent example of the way in which a hospital chaplain can combine pastoral care and research. (16 refs.)

**Anna Bradshaw, George Fitchett**

**"God, why did this happen to me?": three perspectives on theodicy**

**Journal of Pastoral Care & Counseling**

**Vol. 57 # 2 (Summer 2003) pp. 179-189**

A careful examination of the ways used by three persons - all long-term diabetics - to make sense of their illness within the framework of their religious faith. Each person was interviewed to understand their beliefs and activities - past and present. The interview transcripts were then analyzed to learn each person's religious resources, to locate their statements about their theodicy, and their overall mental functioning. The implications of the findings for pastoral care are discussed.

From the stories, six themes emerged about the nature of the human struggle concerning theodicy. The first was that the struggle with theodicy takes place over a life-time. Second, each person's process unfolds and changes as they work at the issues. Third, the journey of each person is highly individualized. Fourth, a person's pre-existing resources play a crucial role in any crisis. Fifth, it was discovered that anger can be a key feature of the process and may be an ongoing element. Sixth, it may be that the theodicy struggle sometimes includes times of conflict and withdrawal. Each of these themes is discussed in some detail.

**Elizabeth Broadbent, Keith J. Petrie, Patrick G. Alley, Roger Booth**

**Psychological stress impairs early wound repair following surgery**

**Psychosomatic Medicine**

**Vol. 65 # 5 (Sept/Oct 2003) pp. 865-869**

Lab studies have suggested that a person with a surgical incision will heal more slowly when they have been experiencing psychological stress.

A hard-science study now shows what had been known in laboratory studies is also true in the clinical setting. The surgery was with adult patients having an inguinal hernia repair.

The conclusion of the authors: "These results suggest that in clinical practice, interventions to reduce the patient's psychological stress level may improve wound repair and recovery following surgery."

Comment: Hard-data research with direct implications for the work of the chaplain in pre-operative care, confirming the value of interventions which lead to stress reduction.

**Daniel Callahan**

**Too much of a good thing: how splendid technologies can go wrong**

**Hastings Center Report**

**Vol. 33 # 2 (Mar/Apr 2003) pp. 19-22**

Callahan was stuck in traffic, and he got to thinking about how both the automobile and medical technology have built within them the capacity to endlessly raise our desires and also raise the baseline of acceptability of certain consequences that flow from either. (Of course, the same applies to any technology for that matter; it is just that some consequences have greater impact.) However, there is a problem associated with such developments: how do we limit the desires that flow from new technology?

"Even if in some literal sense technology is neutral, in the important sense of the way it affects human lives it is anything but neutral. When the technology is ubiquitous, when it serves important human values and ways of life, and when it is all but impossible to avoid using, then it has captured our lives." Callahan describes how this has happened in the cases of the auto and medical technology.

Is Callahan hopeful that the situation can be different? He offers a maybe. "... for those of us looking for a change, probably the best we can hope for is a nasty crisis that will force a change. But it's not likely to happen. As those of us who have longed for universal health care for many decades long ago learned, the capacity of this country to muddle through what in other places would seem a crisis is formidable." (p. 22) (0 refs)

**Donald Capps**

**Youthful visitors and hospitable hosts: exercises in misunderstanding**

**Journal of Pastoral Care & Counseling**  
**Vol. 57 # 2 (Summer 2003) pp. 153-166**

When they were young, Gordon Allport visited Sigmund Freud in his office in Vienna. Milton Nauss, a Lutheran minister visited Albert Einstein in his home in Princeton NJ. Both of the young men subsequently wrote about their experiences. The visits made a lasting impression on each and shaped their later lives.

However, because both seemed to have misconstrued what happened during their visits, Capps felt that an essay could identify lessons that might be learned from them, especially for the benefit of those today who are learning about pastoral visitation. For Capps, there are two main lessons. Visitors should be clear about the motivation for their visit. Second, the visitor needs to be clear about the desired outcome of the visit.

**George F. Flannelly, Andrew J. Weaver, George F. Handzo**

**A three-year study of chaplains' professional activities at Memorial Sloan-Kettering Cancer Center in New York city**

**Psycho-Oncology**

**Vol. 12 # 8 (Dec 2003) pp. 760-768**

There have been few published reports on either the number or kind of interventions that chaplains perform over a period, or on the number and kind of referrals made to chaplains by other health care professionals. The purpose of this study was to fill this gap by finding answers to the following questions: What are the relative numbers of referred to non-referred visits to patients? What are the patterns of referrals to and from chaplains, families, and staff? What are the reasons for the referrals? What type of pastoral activities do chaplains engage in? Do the lengths of chaplain visits vary under different circumstances? Are there patterns which develop over the course of a person's hospitalization?

Data was gathered for two-week periods in each of three consecutive years. The participants included three full-time certified chaplains (a Roman Catholic sister, a Lutheran minister, and a rabbi), a part-time certified imam, and a number of chaplain-residents - five in 1995, four in 1996, and six in 1997.

Among the findings: almost 20% of all chaplains' visits in this center originated from referrals. Most staff referrals came from nurses, very few from doctors; and the percentage of referrals from nurses increased significantly within the three-years of the study. More than 1/3 of all chaplain contacts were

with family/friends of the patients. Pastoral visits were much shorter when the patient was not present. Interventions provided by the chaplain varied according to the patient's religious faith. Pre-op visits were usually much shorter than were post-op visits.

The most frequent intervention provided by the chaplain, more even than prayer or Scripture reading was "emotional enabling", which they define as "to facilitate the expression of feelings." (28 refs)

**Stan Gerard, Blair H. Smith, Julie A. Simpson**  
**A randomized controlled trial of spiritual healing in restricted neck movement**

**Journal of Alternative and Complementary Medicine**

**Vol. 9 # 4 (Aug 2003) pp. 467-477**

This paper, from three researchers in Aberdeen Scotland describe a pragmatic, randomized controlled trial to evaluate the effect of visiting a spiritual healer to obtain help with a medical problem, restricted neck movement. The details of the research project are clearly spelled out in non-technical language. There were 34 persons in each of a treatment group and in a control group. The persons in the treatment group each had three weekly sessions of spiritual healing treatment lasting about 30 minutes at a time. The treatment involved the laying on of hands, but with no actual touching. The healer was Stan Gerard who has had 14 years experience and has a diploma in spiritual healing.

The outcome? Patients who were treated by this healer had less neck stiffness after the healing sessions than previously, both objectively and compared to the control group. The authors, who are very modest in their claims, suggest that additional study needs to be done in order to better understand what is happening in these treatments. (22 refs)

**Jerome Groopman**

**The grief industry**

**The New Yorker**

**Vol. - # - (26 Jan 2004) pp. 30-38**

Critical-incident stress debriefing (CISD) has become a widely-used method of helping people in the immediate aftermath of crises. Chaplains and clergy have been trained in its use. After the collapse of the World Trade Center, some people predicted that 1.5 million would be traumatized and probably need such help and it was anticipated that CISD would be required for a large number of persons.

As background, Groopman describes how Jeffrey Mitchell developed CISD. It is a 7- step debriefing

regimen, reports how it has been used after 09/11, or rather, how it has often been misused, and why it is probably unnecessary. The Depts. of Defense, Justice, Veterans Affairs, the American Red Cross and the Dept of Health and Human Services have all abandoned it as a therapeutic intervention.

Groopman suggests that for the vast majority of persons exposed to a traumatic event, most people recover quickly and without help. "The most helpful approach is to employ a public-health model, using people in the community who aren't diagnosing you." (p. 34) He proposes that counseling is not really necessary, and that people be guided by how they respond (and what they need) when they themselves have lost a loved one.

He also reports what is being learned about true Post Traumatic Stress Disorder (PTSD), suggesting that rather than using critical-incident debriefing, that ways to restore resiliency be used. Foa's work to help rape victims is described as one way of doing this.

**Wayne B. Jonas, Cindy C. Crawford**  
**Science and spiritual healing: a critical review of spiritual healing, "energy" medicine, and intentionality**

**Alternative Therapies**  
**Vol. 9 # 2 (Mar/Apr 2003) pp. 56-61**

The evidence to date - and there is less reliable evidence than is often realized - suggests that some healing therapies based on spiritual or mental techniques really are effective. However, more and better-quality research is needed.

These are the main findings of Jonas and Crawford based on their summary and analysis of the reports of 12 researchers who had presented papers reporting their own survey findings in 6 areas of spiritual and mental healing at a conference in October 2000. At the conference, critical reviews were presented covering six areas of study: 1. The health impact of spiritual and religious practices. 2. Intercessory or healing prayer. 3. "Energy" healing approaches. 4. Therapeutic qigong (Chinese energy healing). 5. Direct mental interaction with living systems. 6. Mind-matter interaction studies.

To prepare their analysis of the presentations at the conference, Jonas and Crawford asked the following questions: 1. Are the effects of healing "real" when assessed by high-quality, independently reproduced experiments? 2. How extensive are the effects of the healing interventions? 3. What clinical impact does healing have in "real-life clinical situations? They

rated all of the studies on a scale of A to F with evidence levels and quality measures for assessing each one.

Their conclusions are cautious. "There is evidence to suggest that mind and matter interact in a way that is consistent with the assumptions of distant healing. Mental intention has effects on non-living random systems and may have effects on living systems."

Their assessment can be read in greater detail in their book *Healing, Intention, and Energy Medicine: Science, Research Methods and Clinical Implications*. (2002) London: Harcourt. (12 refs)

**Harold G. Koenig, Linda K. George, Patricia Titus, Keith G. Meador**

**Religion, spirituality, and health service use by older hospitalized patients**

**Journal of Religion and Health**  
**Vol. 42 # 4 (Winter 2003) pp. 301-314**

Do religious or spiritual beliefs or practices have any effect on the length of stay (LOS) or other health services during hospitalization? This commonly asked question has been discussed by a number of researchers in the past decade. Here a widely known and well-respected group of researchers report their findings about this question.

A group of consecutively admitted inpatients (n=812) 50 years of age or older who were admitted to a university medical center in the south of the U.S. were assessed using measures of religiousness and spirituality. Counted were the frequency of listening/ watching to religious radio/TV (RTV), self-rated religiousness (SRR), observer-rated spirituality (ORS), and daily spiritual experiences (DSE). The findings were then associated with length of stay, though the project did allow the authors to look at use of medical services while hospitalized.

The findings: RTV and self-rated religiousness were associated with longer LOS. But observer-rated spirituality and daily spiritual experiences predicted shorter LOS. The effects of daily spiritual experiences on LOS were stronger among non-whites. The effect of RTV on LOS was stronger among women, but this could have been explained as being due to their worse health status admission.

The study concludes: religious activities, attitudes and spiritual experiences are weak predictors of LOS. Whether the prediction is positive or negative depends on the religious or spiritual activity practiced. (28 refs)

**Alan K.L. Lai**

**Dragon talk: providing pastoral care for Chinese immigrants**

**Journal of Pastoral Care & Counseling**

**Vol. 57 # 1 (Spring 2003) pp. 45-52**

A Chinese pastor in British Columbia, Canada describes the inappropriateness of using the model of pastoral care he was taught in Clinical Pastoral Education for his ministry to indigenous Chinese, or even persons of Chinese descent who have lived in the west for an extended period. He calls the pastoral care education processes "barriers" to providing good pastoral care to such persons. He shows how attempting to focus on a Chinese patient's feelings and needs can be unproductive.

He concludes by offering some suggestions for more effective care, including the fact that all pastoral care with Chinese patients and their families must begin with superficial matters, so that - possibly - in time, there may be more openness to deeper concerns.

**Wilfred McSherry, Keith Cash**

**The language of spirituality: an emerging taxonomy**

**International Journal of Nursing Studies**

**Vol. 41 # 2 (Feb 2004) pp. 151-161**

The word "spirituality" is in danger of becoming meaningless; or so these authors argue. They suggest that the word now implies many different things depending on each person's interpretation or worldview. McSherry and Cash are concerned that the result will be that this word will lose any real significance in discussions about the health care of patients. They do not wish this to happen so they have searched the nursing and health care databases and reviewed the many uses of the term. They have identified numerous definitions each with several layers of meaning, and out of their review they have developed what they call a "spiritual taxonomy" that clarifies the different meanings, and how they exist alongside each other. At one end of the taxonomy is a spirituality based on religious and theist ideals; while at the other end there is a spirituality based in secular, humanistic, existential elements. They suggest there is also a middle way which contains elements from each end, but which is not as fundamental or radical as either extreme.

Having completed their taxonomy and examined its implications for both practice and education, they come to the conclusion that there can be no such thing as a universal definition of spirituality, and the theoretical probability of being able to create one is

"virtually impossible." They found this conclusion unsatisfactory and propose that one way forward would be not to focus on the restrictive arguments of the matter of definition. Instead, they propose that through qualitative research, and discussion of concepts, by examining "the reciprocal interactions" of persons and patients, practitioners, and diverse cultures" they hope the discussion could move from the "cognitive" and "academic" to a place that embraces social practice. (60 refs)

**Thomas St J. O'Connor**

**Pastoral counseling and pastoral care: Is there a difference?**

**Journal of Pastoral Care & Counseling**

**Vol. 57 # 1 (Spring 2003) pp. 3-14**

Is there a difference between pastoral care and pastoral counseling? What is it? These questions have been discussed, often with great passion and at great length over the past 50 years. Now O'Connor provides us with a historical review of ideas and events which lead him to conclude: "For 1900 years, there has been no distinction between pastoral care and pastoral counseling in the Christian tradition. The difference developed in the twentieth century, and became embedded in history with the formation of AAPC and ACPE." (p.13)

To reach this conclusion, he reports what various pastoral theologians have written: McNeill, Clebsch and Jaekle, Kemp, Gerkin, Stokes, Clinebell, Hiltner, Browning, Hunter, Oden, Purves, Glaz and Moessner, Stone. It is a careful assessment of the ideas of these thinkers, supplemented with O'Connor's experiences in ministry and in teaching.

**Barry Quinn**

**Exploring nurses' experiences of supporting a cancer patient in their search for meaning**

**European Journal of Oncology Nursing**

**Vol. 7 # 3 (Sept 2003) pp. 164-171**

Quinn reports his study of nurses in which he examined what it was like for them to support cancer patients in their search for meaning. The research process followed by Quinn was Benner's model of data analysis. (P. Benner in *Interpretive Phenomenology: embodiment, caring, and ethics in health and illness*. Sage Publications. 1994)

The main themes which Quinn distilled out of his interviews were that these nurses: valued the experience from their own lives; understood the search for meaning; recognized the value of time; understood the nature of the relationship they had with their

patients; recognized that the skills they used to support patients were often intangible and hard to describe; reported that they had been changed by their caring for patients.

Comment: Before he was a nurse, Quinn was a hospital chaplain. This may explain, at least in part, why this article reads as if a chaplain could have written it. And written well in the sense that we are provided with a clear description of ministry to the terminally ill.

**Oakley Ray**

**How the mind hurts and heals the body**

**American Psychologist**

**Vol. 59 # 1 (Jan 2004) pp. 1-12**

Health care is changing, as we all know. There have been rapid changes in every corner of health care, and medical intervention. Psychologist Oakley describes the changes in the field of traditional psychology and health issues. He provides evidence for a new perspective for understanding health and disease, life and death. In order to do this, he reviews some of the social and behavioral factors which act on the human brain that influence health, illness and death. Supported by data from several areas of research, he presents a proposal that provides both the concepts and the mechanisms for studying and explaining mind-body relationships.

This particular mind-body approach incorporates ideas, belief systems and hopes (all of which are within a chaplain's ken) as well as biochemistry and anatomy. As he points out, "Changing (a person's) thoughts imply a changing brain, and thus a changing biology and body." (p.1)

In his discussion of stress (or allostatic load, as he terms it) he discusses spirituality as an important coping skill, about which "psychologists have both much to offer and much to learn."

Comment: Not overly technical, this is a paper which will stimulate the thinking of those chaplains interested in the relationship between faiths, beliefs and health. (102 refs)

**Tony Sheldon**

**Doctors' "end of life" decisions vary across Europe**

**British Medical JOURNAL**

**Vol. 327 # 7412 (23 Aug 2003) pp. 414**

The just completed Ethicus study into end of life medical practices in European intensive care units looked at matters such as religion and culture. It was found that limiting life treatment is common, but the

practice varies among countries. The researchers found that religion, culture, and geography all influence the decisions by European doctors when it comes to limiting "life sustaining treatment" in intensive care units. For example, life sustaining treatment was more often withdrawn if the doctor was Protestant, Roman Catholic or had no religious affiliation than if they were Muslim, Jewish or Greek Orthodox.

**Eric E. Smith**

**Assessing the bottom line impact of a hospital pastoral care program**

**Chaplaincy Today**

**Vol. 19 # 2 (Autumn/Winter 2003) pp. 22-25**

Smith maintains that chaplains are of "tremendous benefit" to a health care institution, and that people who consider them "nice, but not necessary" are not seeing the full picture. He argues that spiritual care services both directly and indirectly impact the "bottom line" of an organization. Specifically, he describes shortened length of stay, staff care as a factor in staff retention, end-of-life issues, derailed lawsuits, increased admissions and referrals, physician recruitment, endowments and gifts.

He concludes by noting that some may argue that by looking at such issues, chaplains are adopting a business-oriented mindset, and so "trading our birthright for a mess of pottage." He disagrees. "By claiming our value to the organization and its mission using the terms and concepts which drive the decisions of administrators and governing boards, we are reclaiming our birthright, not giving it up." (p. 25)

Comment: Unfortunately, the evidence that Smith presents to support his claims is not strong, even though we would wish that it were. (4 refs)

**Klaas Spronk**

**Good death and bad death in ancient Israel according to biblical lore**

**Social Science & Medicine**

**Vol. 58 # 5 (Mar 2004) pp. 987-995**

This paper is a survey of the Hebrew bible to identify the ways in which the people of ancient Israel reacted to death. In short, it was something to fear, but in some respects as something also to be welcomed. Death was seen as good or at least acceptable (1) after a long life, (2) when a person dies in peace, (3) when there is continuity in the relation with ancestors and the heirs, and (4) when one will be buried in one's own land. Death was experienced

as bad when (1) it is premature, (2) violent, especially when it is shameful, (3) when a person does not have an heir, and (4) when one does not receive a proper burial. (13 refs)

**Leigh Turner**

**Bioethics and religions: religious traditions and understandings of morality, health, and illness  
Health Care Analysis**

**Vol. 11 # 3 (Sept 2003) pp. 181-197**

Although contemporary medical ethics does not overtly draw upon religious values when deliberating ethical issues, religion continues to play an important role in both the moral reasoning of patients, and in public debate about ethical issues. Turner looks at the connections between religious traditions and understandings of morality, medicine, illness, suffering, and the human body which are rooted in those traditions. Leigh does not provide an analysis within the constraints of one particular religious tradition, setting out instead to address how various religious traditions ought to relate to bioethics, or, more broadly, to contemporary liberal political and social theory.

Leigh's fundamental question is this: how do religious cosmologies provide interpretive horizons of understanding for many patients, family members, social activists, and health care providers? Following Weber, Geertz and Berger, Leigh suggests, "religions provide individuals and communities with "sacred canopies" of meaning and order." Under that rubric she examines such matters as: the tensions between philosophical reason and spiritual moral insight, and then the tensions between religious attitudes towards health and illness, and more secular

understandings of medicine, disease and there body. (53 refs)

**Sue Wintz, Earl P. Cooper**

**Developing learning modules to address cultural and spiritual sensitivity**

**Chaplaincy Today**

**Vol. 19 # 2 (Autumn/Winter 2003) pp. 3-6**

The authors, both hospital chaplains, describe how they developed educational materials on cultural and spiritual sensitivity which could be used in different ways, including to help chaplains increase their competencies in these areas, for CPE curricula, and for seminars with medical and nursing staff.

The stated goals of the learning are for learners to 1) identify and acknowledge their individual cultural and spiritual heritage and how this impacts their attitudes in providing care; 2) describe the various components and culture and sensitivity; and, 3) identify and demonstrate appropriate cultural and spiritual sensitivity in their approaches to providing care. They suggest that the chaplain is the most appropriate person in interdisciplinary teams to assume the role of "cultural broker." The in-service, which lasts approximately 50 minutes, has been trialed in 27 different facilities throughout the U.S. as well as in Australia.

The study materials themselves are available on-line at [www.professionalchaplains.org](http://www.professionalchaplains.org) select Professional Resources, then select, Reading Room.

Comment: The editor saw an earlier version of these materials and considered them valuable and would encourage their use.

The above abstracts were selected from the 455 abstracts entered in the database since the last issue of this Journal.