

THE ORERE SOURCE

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Mark Bartel

What is spiritual? What is spiritual suffering?

J of Pastoral Care & Counseling

Vol. 58 # 4 (Fall 2004) pp. 187-202

Within the past four or five years, there have been a number of attempts to clarify what is meant by the words "spirit" and "spirituality", and also the problem of how to recognize "spiritual suffering." Bartel's article is a timely and useful contribution to these efforts so that we can then proceed with the task of making better spiritual assessments.

Bartel begins by asserting that persons have five spiritual needs: love, faith, hope, virtue, and beauty. He then unwraps each of the five concepts in turn, examining the meaning given to them by 18 other thinkers, including meanings in the Hebrew and Christian Scriptures. Other than Galen (129-200 CE), all are from the modern era, and all except one are male. He reconstructs his examination in the form of a four-page table with the concepts from each thinker associated with each of the five spiritual needs.

Bartel then takes each of the five concepts in turn, states the classical term for each, states its more contemporary synonym and then associates with it a number of other terms/phrases which seem to fall under the umbrella of the word/need. For example, Hope has a more modern term - Vision, and the words that fill out an understanding of this need include: meaning and purpose, courage, perseverance, perspective, and vision.

He then turns to the problem of spiritual suffering. Here he correlates the positive spiritual themes in his first section with what he believes are the indicators of spiritual suffering. Ranging over against hope he sees: despair, anguish, depression, discouragement, disappointment, meaninglessness, pointlessness, aimlessness, emptiness, drifting confusion, lack of goals or vision, helplessness, powerlessness,

giving up, surrender, passivity, procrastination, fear, cowardice, worry pessimism, negativity, anxiety, catastrophising.

While this is by no means the final word, Bartel has given us a conceptually slim and accessible model to discuss and respond to in order to better understand a concept that is central to the practice of pastoral ministry. (46 refs)

Alvin J. Clark

Forgiveness: a neurological model

Medical Hypotheses

Vol. 65 # 14 (- 2005) pp. 649-654

Many chaplains and counsellors continue to believe that forgiveness is a major and sublime idea which is owed to the Judeo-Christian tradition.

Forgiveness did not originate in the minds of humans. The fact that monkeys, apes as well as humans all engage in reconciling behaviour means that forgiveness goes back many million years. As Frans de Waal has written: "... it is probably over 30 million years old, preceding the evolutionary divergence of these primates... instead of looking at reconciliation as a triumph of reason over instinct, we need to begin to study the roots and universality of the psychological mechanisms involved. It is time for science to enter the scene." (See [Peacemaking Among Primates](#). Cambridge Press (1989) p. 271.)

And that is what Clark is reporting in his article. He offers a definition of forgiveness that emphasizes its biological and neurological components, namely the cessation of emotions connected with the memories of a hurtful act. The experience of forgiveness is analyzed into seven separate steps and each step is associated with a neurological basis.

The method Clark uses to present his proposed model of forgiveness is anecdotal. An experience of forgiveness is described in a story and is then ana-

lyzed into a series of seven steps. Each step is associated with a proposed neurological basis.

The central difference between standard definitions of forgiveness and the one suggested by Clark is that in the former way of thinking, the emotions felt by the victim and the perpetrator are connected to the offender or an act. In Clark's definition, the emotions are connected to the memories of the offender or the offending act.

For Clark, forgiveness involves ceasing feelings that are traditionally associated with being wronged and forgiveness - the victim feels anger and resentment; the offender feels guilt, and possibly the fear of consequences. In his model, both offended persons and offenders can experience forgiveness similarly "as a cessation of their respective emotions."

For non-medically trained readers, the article is challenging but readable. For chaplains and therapists, the concepts are an invitation to consider forgiveness in a new and potentially more helpful way. (14 refs)

Jack Coulehan, Patrick Clary
Healing the healer: poetry in palliative care
J of Palliative Medicine
Vol. 8 # 2 (Apr 2005) pp. 382-389

The authors, both medical doctors, assert that "Practicing medicine with too many facts and not enough poetry leads to dissatisfaction, disappointment, and impaired healing, especially in the care of the terminally ill." In their paper they describe three aspects of healing that are fostered by poetry: the power of the word as instrument to heal (or harm); the skill of "negative capability" (John Keat's phrase "to describe the ability to hold and cherish opposites in one's mind at the same time") that enhances effectiveness; and empathic connection, or compassionate presence - the relationship that heals without words.

The authors start with the words of physician-poet William Carlos Williams who wrote:

"It is difficult
to get the news from poems
yet men die miserably every day
for lack
of what is found there."

The article ends with four poems, which alone are worth your precious reading time. My favourite is "Five tasks taught by hospice nurses" by P. Clary. (17 refs)

Mary T. DesCamp, Eve E. Sweetser
Metaphors for God: why and how do our choices matter for humans? The application of contemporary linguistics research to the debate on God and metaphor

Pastoral Psychology
Vol. 53 # 3 (Jan 2005) pp. 207-238

How do we speak about God? The theologians and philosophers of the past quarter century have rightly warned us of the complexities of this question. Now into an already complex discussion, we are presented with the insights of two new fields. The authors of this article describe "an explosion" in the amount of research done in cognitive psychology and in cognitive linguistics. They are fields which have obvious implications for the question how may we speak about "God."

DesCamp and Sweetser argue that cognitive linguistics research must now be a part of the theological debate concerning metaphors for "God." They begin with an introduction to the concept of "metaphor" and a number of issues which surround this concept. They then turn to their central discussion: cognitive linguistics and metaphors for God.

As part of their discussion, they report their analysis of the metaphors for God in the Bible: 44 in the Hebrew scriptures, and 50 from the Christian. Their analysis broadens our understanding of the meaning and use of metaphors; why some speak convincingly to us while to other people the same metaphors appear meaningless. (21 refs)

Paul N. Duckro
Religious factors in health care
<http://www.ihpnet.org/med3.html>
Vol. - # - (Fall 2004) pp. 1-6

This is the syllabus from the Saint Louis University School of Medicine for their course where religion/spirituality and medicine intersect. The director of pastoral care in the university hospital, Mary Lou Bennett is an instructor in the course.

The contents of the 10-session course are described, and the bibliography is also included. (16 readings) Downloaded 01/10/2005.

Martha J. Farah
Neuroethics: a guide for the perplexed
Cerebrum: the Dana forum on brain science
Vol. 6 # 4 (Fall 2004) pp. 29-38

Neuroethics is a word starting to appear in many places in the ethics literature. It is a trend that will continue, and this article provides background for

those who have not met the concept before. Neuroethics is most commonly understood to be a subcategory in bioethics that is concerned with neuroscience.

There is as yet, no specific definition of Neuroethics which is universally accepted. Writer William Safire probably coined the term itself, and he defined it as "the field of philosophy that discusses the rights and wrongs of the treatment of, or enhancement of, the human brain." Dartmouth College Center for Cognitive Neuroscience Director Michael S. Gazzaniga believes that a better definition would be: "It is - or should be - an effort to come up with a brain-based philosophy of life." He argues that neuroethics concerns "how we want to deal with the social issues of disease, normality, mortality, lifestyle, and the philosophy of living, informed by our understanding of underlying brain mechanisms."

Farah, an early thinker in this new field, writes in order to bring some greater order to the conceptual confusion. She believes that neuroscience may one day explain in terms of neural tissue virtually all aspects of human emotion and cognition. If indeed mental processes prove to result from purely physical events, it opens for renewed discussion questions concerning the meaning of consciousness, spirituality, free will and moral responsibility.

For now, some more immediate questions: If I fall in love with someone who is on Prozac and then I find that the person is difficult and temperamental off the drug, who was it I loved? Did I cheat if I studied better with Ritalin, and can I take credit for the improved work? (10 refs)

Pat Fosarelli

Illness and children

Walking Together: Physicians, Chaplains, and Clergy Caring for the Sick - monograph (Summer 2004) pp. 13-22

A description of the needs of sick and dying children, and how chaplains and clergy can provide pastoral care in this time of their life.

Fosarelli provides a clear description of the suffering of children, and the factors which can shape that suffering. She describes how to comfort the child, and their family members. She also addresses issues of pain, emotional distress and spiritual issues. "By virtue of our professions, we cannot, and must not try to escape the pain involved in ministering to seriously ill children and their families. These are our congregants, our sisters and brothers in the family of God." (p. 13)

In her final section she briefly addresses the problem of bereavement, both for parents and for children.

She concludes: "as with the care of any dying patient, adult or child, it is important to respect children, listen to their needs, and be present to them in the midst of their dying." (p. 22)

This article is a paper in the monograph titled Walking Together: Physicians, Chaplains, and Clergy Caring for the Sick edited by Christina Puchalski and published by the George Washington Institute for Spirituality and Health. The publication is the result of a 1999 conference "Clergy and Physician Partnerships in End-of-Life Care."

Larry W. Foster, Linda J. McLellan, Lisa A. Rybicki, Deborah A. Sassano, Amy Hsu, Brian J. Survival of patients who have undergone allogeneic bone marrow transplantation: the relative importance of in-hospital lay care-partner support

*** **J of Psychosocial Oncology**

Vol. 22 # 2 (- 2004) pp. 1-20

Some studies concerning patient care simply confirm what health care professionals already know. This is one of those studies, but the confirmation is a truly dramatic one, with life and death consequences.

The medical records of a consecutive series of adult bone marrow transplant (BMT) patients (n=131) were reviewed and each record was checked to see whether or not the patient had someone who stayed with them at least 5 hours a day from the day of transplant until their discharge from the hospital. In the study, such a person is called a "lay care-partner"; it might have been a spouse, friend, or parent.

After controlling for important variables such as: primary diagnosis, disease status, source of donor marrow etc, it was discovered that: one year after transplant, 3 out of 4 patients who had had a care-partner were still alive, while only 1 out of 4 who had no care-partner were still alive.

There is a degree of understatement in the authors' summary: "It seems clear that the absence of a care-partner is deleterious to a patient's outcome."

The authors do not address the question of the mechanism at work, suggesting only that additional research is needed in order to understand this life-affording effect. (23 refs)

Janice S. Goldfein
Reclaiming the self
Psychotherapy Networker

Vol. 28 # 1 (Jan/Feb 2004) pp. 47-55

Goldfein describes how she put her life back together after being raped. She describes the rape itself, her reactions, and then her recovery - including the use she made of several religious rituals from her Jewish faith tradition. "The attack never became my life; nor does it define who I am. Most of all, I learned that recovery is made possible by shifting focus from the pain of the attack to what gives life meaning and purpose." Goldfein is a clinical social worker. (0 refs)

Ronald M. Green
Last word: Imagining the future
Kennedy Institute of Ethics J

Vol. 15 # 1 (Jan 2005) pp. 101-106

The Eloi are a gentle, herbivorous people who live on the park-like surface of the planet. Below them, in a dark world are the Morlocks, a grotesque mole-like species. The Morlocks seem to maintain the planet's mechanical life-support systems. Their price for doing so is to capture and eat an Eloi now and then.

This is the world of The Time Machine (1895) by H.G. Wells. The two species are not the result of genetic engineering. They have evolved naturally over time from the extreme class divisions of nineteenth century British society.

Well's book was a warning to his contemporaries of the danger of allowing economic injustices to become so acute that they could transform human life. Green's paper ends an entire issue of this journal devoted to issues concerning the ethics of genetic engineering. The issue begins with a paper by Ronald Lindsay who argues at length that we should not worry about genetic engineering or "enhancing" the human genome. Green as his article makes quite clear is not so sure. (9 refs)

Louis M. Guenin
The morality of unenabled embryo use - arguments that work and arguments that don't
Mayo Clinic Proceedings

Vol. 79 # 6 (Jun 2004) pp. 801-808

Guenin, a molecular geneticist, weighs in to the debate about the use of human embryos in both research and therapy. He looks at six of the arguments that he thinks do not work to support the use of embryos for these purposes. He says that while he sup-

ports such research per se, he believes that all six of the arguments are unsound. He then outlines arguments that he believes are sound, and ends with some thoughts about cloning in particular. He also comments about the risk of abuses.

An "unenabled" embryo is one that will never enter a uterus, a term he used in an earlier paper, "Morals and primordials" in *Science* (2001) Vol 292, Pp 1659-1660.

(Note: The writing style of this author makes the complex arguments about this subject very readable.) (13 refs)

Catherine McG Heilferty
Spiritual development and the dying child: the paediatric nurse practitioner's role
J of Paediatric Health Care

Vol. 18 # 6 (Nov/Dec 2004) pp. 271-275

To effectively promote the spiritual development of a child with life-threatening illness, strategies must be developed with an awareness of the child's development level. Heilferty directs this comment toward paediatric nurse practitioners. However, her overview of the religious development of children and adolescents will also be of interest to chaplains. Like the nurse, the chaplain should be able to demonstrate to families a willingness to understand, accept and nurture a child's desire for connectedness with self, family, community and Creator.

Heilferty includes several boxes of specific information. In the first, she includes McEvoy's BELIEF mnemonic with sample questions that might be asked in conducting a spiritual assessment. (See McEvoy in *J of Paediatric Health Care* Vol. 14 (2000) for the spiritual history model.) In the second box there are web sites and books that Heilferty suggests are good resources for families who have a dying child. In the 3rd box, she includes lists of websites and books she considers helpful resources for paediatric nurse practitioners. (8 refs)

Edmund G. Howe
Some new paradigms for ethics consultants
J of Clinical Ethics

Vol. 15 # 3 (Fall 2004) pp. 211-222

Howe suggests that established paradigms for providing ethical consultations may need to be revised. He takes a case-study from the same issue of *JCE*, and suggests that even though the parents involved in that case were given the best of ethics consultations, the process may still have been flawed. The case concerns a newborn baby who is severely im-

paired, and whose prognosis is grim. The parents have to decide whether or not to continue life-sustaining treatment.

Howe makes several unexpected suggestions concerning the process of an ethics consultation. First: "ethics consultants should try to help parents with the amount of emotional pain they feel." Howe describes how ethics committees can function within such a radical approach. He also describes several other new paradigms for consultants to consider. Second: "It is presupposed here that the preferences and interests of patients' loved ones are exceedingly important, and this is the basis for my suggestion that consultants go to new lengths to protect them." Third: "I suggest that consultants can use a new paradigm with patients who are competent: consultants can ask patients to consider how their loved ones may respond to the choice they are considering."

Howe acknowledges that at first his suggestions may seem radically different from what is now considered good practice. He argues that these new paradigms actually respect patients more than do the current norms. Each implements what most patients want, and have always wanted: the best that is possible for their loved ones.

Howe then suggests a new consideration to be asked patients who are competent. "Consultants can ask patients to consider how their loved ones may respond to the choices they are considering; ask patients if they want to consider their loved one's preferences and interests when they write an advance directive, and, if patients say they do want to consider their loved one's preferences, consultants can ask to what degree loved ones' preferences should be considered." Behind this direct asking, Howe is concerned about several matters, which if overlooked can be detrimental to an ethical consideration process. First is the need for health care providers to watch that they do not unwittingly influence the decision-maker(s). Second is the need for the team to present a united and consistent message. Third is the importance of recognizing that some people are extremely fast, intuitive decision-makers who will need a little time to find rational support (in their own minds) for the decision that quickly came out of their mouth and out of their own depths. Howe's concern is that an ethics committee may decide that the result of such fast decision-making may seem irrational, when in truth it is not.

Karen A. Kehl

Recognition and support of anticipatory mourning

J of Hospice & Palliative Nursing

Vol. 7 # 4 (Jul/Aug 2005) pp. 206-211

Anticipatory mourning (AM) is a concept surrounded by much controversy and very little research. The controversy includes exactly how to define the concept. It is not the same as post-death grief, though it shares many of the same characteristics. There is no clear evidence that anticipatory mourning increases or decreases distress after death. Kehl reviews the ideas of a number of writers as to what exactly this kind of mourning is - Lindemann, Futterman, and Rando. She describes AM, including some of the effects of cultural factors. She also reviews what is known about the later effects of AM. Her concluding section has specific suggestions about providing supportive interventions. Written for nurses, her proposals have value for chaplains. She includes 10 specific guidelines provided by Corr and Corr (Clinical Dimensions of Anticipatory Mourning (Ed: T.A. Rando - 2000) p. 223-252.) (39 refs)

Dale H. Lea, Janet Williams, Patricia Donahue

Ethical issues in genetic testing

J of Midwifery & Women's Health

Vol. 50 # 3 (May/Jun 2005) pp. 234-240

The authors, all nurse-educators, prepared this article to help those working as mid-wives, or in women's health generally to be aware of the clinical dilemmas which are related to genetic testing, and how best to use genetic information. Ethical theories, principles, and decision-making models are reviewed.

They urge readers to be prepared to act as advocates for informed choice, for shared decision-making, and the right to self-determination. They see the advocacy role continuing to expand as knowledge of genetics is increasingly applied in prenatal care. Much of this will take place during the assessment process, when a clinician identifies the likelihood that the woman, her child(ren), or her family members have or may develop a disease or condition in which genetic factors play a major contributing part. One of their cases: "Mrs T has given birth to a baby boy, Ryan, at a community hospital. Mr and Mrs T are both Caucasians. During the first 24 hours, the nurse explains that newborn screening tests done in their state include sickle cell screening. Mr T tells the nurse that he is not worried

about the sickle cell screening because it is primarily a disease in African-Americans. The newborn screening results show that Ryan is a carrier for sickle cell disease. Ryan's paediatrician calls the parents to tell them the results. The parents are both shocked because "... we know that we don't have African-American relatives." At a follow-up visit, Mrs T expresses concern to the nurse-midwife, saying, "I don't know how this can be. What will we tell our family?"

(p. 235) (28 refs)

Robert L. Miller
An appointment with God: AIDS, place and spirituality

J of Sex Research

Vol. 42 # 1 (Feb 2005) pp. 35-45

Studies have shown that gay men are not universally welcomed in the Christian church. Miller himself has previously reported that the same is true for African-American gay men.

In this article he describes how Larry, an African American gay man living with AIDS used his spiritual, religious and cultural strengths to manage his "dislocation" from the church of his upbringing. Learning that his doctor had given up on him in October and predicted his imminent death, "dead by Christmas", Larry decided to mobilize his resources to save himself, by insisting on an appointment with God. He does this by relocating the church in to his hospital room. It is the dislocation/relocation process embedded in this story that is the central subject of this paper.

It is a powerful story of a man's refusal to let God give up on him, despite messages from parts of his life suggesting that he is unworthy of God's response.

In an appendix there is a complete transcript of Larry's appointment with God, as he told it the following morning. (57 refs)

Tomasz R. Okon
Spiritual, religious, and existential aspects of palliative care

J of Palliative Medicine

Vol. 8 # 2 (- 2005) pp. 392-414

This is a review article written for doctors who work in the field of palliative medicine. As such, it will be of interest to chaplains who work either in palliative care or with the terminally ill. It is a very comprehensive review article.

Okon starts by building a careful conceptual foundation. What do certain terms mean: spiritual, religious, existential? He even includes a taxonomy of the concept of spirituality. He then proceeds to describe what is known about some epidemiological issues: what are the religious/spiritual (R/S) attitudes in the general US population; what are the expressed R/S attitudes in ill persons; what are the reported R/S attitudes and beliefs of doctors; what are the reported existential/spiritual needs of patients and families; what do we know about patient preferences regarding the evaluation of spiritual needs; what are the associations between "religiosity" or "spirituality" and health outcomes; what is the association between psychological well-being and affective outcomes; and so on.

He then describes what has been reported about assessment methods to identify patient's spiritual needs. A useful table presenting 8 instruments for investigating beliefs is followed by a summary of the work by Hill and Pargament in which they have created constructs concerning R/S and how people use them to cope when they are ill. In one major section, Okon includes the exploratory questions used by medical doctors, psychologists and nurses to explore with patients how they use their beliefs when they are unwell.

In the same detailed manner, he then examines the characteristics of spiritual needs, and the options for using the information gained about such needs.

This is Okon's conclusion: "Life-threatening illness opens immense challenges in the lives of patients and their families. When facing death, our patients turn to the most fundamental values and practices; they trust intuitions that allow them to transform tragedy into possibilities for growth and peace. No single predetermined scheme of communication can be sufficient to learn the truth of pain despair or transformation. Nevertheless, we remain professionally and morally obliged to recognize, address and study transcendent concerns as they are bound to remain ours and our patients' companions in the times of health and illness." (p. 409)

Okon has done his homework. The names of chaplains can be found at least 16 times in the references; he knows the work of Cabot and Dicks, as well as The HealthCare Chaplaincy in New York. (173 refs) Reprints can be requested from okon.tomasz@marshfieldclinic.org

John E. Paver

**The warrior Jesus confronts the vulnerable Jesus
Ministry, Society and Theology**

Vol. 18 #1 (- 2004) pp. 76-94

Paver's paper is about the task of theological reflection. It is a subject about which he has written in the past. On this occasion, he is truly writing "though the agony and passion of (his) own life. His "authentic self" - always the starting point for his reflections, includes having had two primary cancers - prostate cancer and bowel cancer. These reflections are the result of being diagnosed with the second primary cancer.

In preparation he discusses two issues which concern the general task of theological reflection: the integration of "selves," - who exactly are we as we engage in theological reflection, and the tension between distance and closeness. He then spells out the central propositions of his theology. They are his biblical theology of ministry, what he sees as professional foundations for a theology of ministry. (34 refs)

Christina M. Puchalski

Introduction

**Walking Together: Physicians, chaplains and
clergy caring for the sick - monograph**

Vol. - # - (Summer 2004) pp. 1-2

This is the introduction to a monograph titled Walking Together: Physicians, Chaplains, and Clergy Caring for the Sick edited by Christina Puchalski and published by the George Washington Institute for Spirituality and Health. The publication is the result of a 1999 conference "Clergy and Physician Partnerships in End-of-Life Care." Puchalski is a medical doctor.

In her introduction she provides an overview of the changes that have taken place in recent decades in the way people die in the U.S., and the problems which have arisen as a result. She also reports research which has identified what people say would be effective care for them if they were dying.

Increasingly doctors are being educated to take seriously the spirituality/religious faith of their patients. The monograph is intended to help clergy/chaplains respond when doctors seek their assistance. (16 refs)

Mark Repenshek, John Paul Slosar

**Medically assisted nutrition and hydration: a
contribution to the dialogue**

Hastings Center Report

Vol. 34 # 6 (Nov/Dec 2004) pp. 13-16

In March 2004, Pope John Paul II addressed an International Congress on "Life sustaining treatments and the vegetative state: scientific advances and ethical dilemmas." Reports of the address have sparked much discussion and debate. (Note: Contact the writer for a full English copy of his address. 5 pages.)

The authors begin with what they believe is "the most fundamental tenet of the Roman Catholic moral tradition... that life is a precious gift from God" and "the basis for a duty to protect and preserve our lives." They show how this thread can be found running through the contemporary teaching of the Catholic church.

Next they turn to the origins of certain principles in Dominican thinking in the early 1500s. The ideas of Spanish Dominican Francisco de Vitoria (1486-1546) were expanded on by Domingo Banez, and John de Lugo. It was they who introduced the distinction between "ordinary" and extra-ordinary", words which are now synonymous in ethics discussions with the more commonly used "proportionate" and "disproportionate." The authors look closely at the five criteria which separate the two concepts.

Having done so, they are now ready to examine the comments of Pope John Paul II. Their main thesis is that his remarks were intended to address two extreme views which have developed in medical ethics concerning nutrition and hydration for persons in a persistent vegetative state (PVS), and that he has taken a middle course on the issue. They suggest that a correct reading of the Pope's remarks should be to see them as supporting a presumption in favour of providing nutrition and hydration to patients, as long as this is of sufficient benefit to outweigh the burdens to the patient. "The address holds quite simply that medically assisted nutrition and hydration for PVS cannot always and everywhere be considered either proportionate or disproportionate; instead, its status depends on the circumstances of individual cases." The authors believe that such a position is consistent with earlier teachings of the Roman Catholic church. (Note: Debate on this subject continues within the Roman Catholic community.) (25 refs)