

## THE ORERE SOURCE

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**Aida L. Al-Aqeel**

**Ethical guidelines in genetics and genomics – an Islamic perspective**

**Saudi Medical J**

**Vol. 26 # 12 (Dec 2005) pp. 1862-1870**

This is an important resource paper which unfortunately may not be readily obtainable. A copy is worth pursuing.

In her paper, Al-Aqeel, a paediatrician in Riyadh, provides detailed information about various Islamic teachings concerning a wide variety of medical issues which Islamic patients now face because of advances in the fields of genetics and genomics, including cloning and stem cell research; cord blood transplantation; somatic gene therapy; contraception and sterilization, adoption, donation of sperm, ovum or pre-embryo; or motherhood surrogacy, pre-implantation diagnosis; and, pre-natal diagnosis. Al-Aqeel's descriptions note the variations between interpretations which may be found concerning the same issue in different parts of the Islamic world. She points out that there are seven major schools of jurisprudence which can pass edicts within Islam, making nuances inevitable.

For example, concerning the issue of abortion. A fatwah (issued 10-17 Feb 1990 in Makkah-Al-Mukarama, by a majority vote) allows for the option of an abortion, but only if a committee of specialized, competent physicians has decided that the foetus is grossly malformed, and that its life would be a calamity for both the family and itself. The malformation must be "untreatable, unmanageable and very serious, and the abortion may only be carried out prior to the 120th day of conception (computed from the date of fertilization, not the last menstrual cycle." Other interpretations have been more strict.

Concerning a second issue – the start of human life - she writes: "Human life begins at the time of en-

soulment, which is stated in the Sayings of the prophet Mohammed, to be the 120th day from the moment of conception, which is equivalent to 134 days from the last menstrual period used by the obstetricians. Prior to the moment, the embryo has sanctity, but not reaching that of a full human being."

To request a copy of the article, the author may be reached at: [alaeel1@hotmail.com](mailto:alaeel1@hotmail.com) (50 refs)

**Maysaa S. Bazna, Tarek A. Hatab**

**Disability in the Qur' an: the Islamic alternative to defining, viewing, and relating to disability**

**\*\*\* J of Religion, Disability and Health**

**Vol. 9 # 1 (- 2005) pp. 5-27**

A word study of the Qur' an which looks at all of the phrases it contains relating to disability. Based on their study, the authors make two helpful observations: 1. That people with disabilities are at times to be excused from some of the faith responsibilities that would otherwise be incumbent on them, though they are still expected and encouraged to respond to the best of their ability. 2. There is a clear religious mandate for others in Muslim society to respond to anyone who is "disadvantaged" by any kind of disabling conditions.

The question of responsibility for disability in the Qur' an is not about who is to blame for the disability, but is rather about the responses of persons with disabilities, and the responses of other persons around them. (30 refs)

**Suzanne Bosisto**

**The therapeutic relationship between spirituality and mental health**

**Ministry, Society and Theology**

**Vol. 19 # 1 (- 2005) pp. 27-46**

Bosisto describes the dramatic change which has taken place in recent years, with mental health pro-

professionals now increasingly seeking to include religious beliefs and spirituality in their assessment, treatment and psychosocial rehabilitation of persons who are mentally ill. She describes the background of, and the changes and the benefits which spirituality contributes to people's mental health. She concludes with a description of current mental health policy in Australia, which clearly locates religion and spiritual care within the Standards of care for the mentally ill.

Bosisto provides a substantial bibliography, which is incomplete in many details and not up to the usual standards for this publication. (32 refs)

**M.A. Branthwaite**

**Taking the final step: changing the law on euthanasia and physician assisted suicide**

**British Medical J**

**Vol. 331 # - (24 Sept 2005) pp. 681-3**

This is the first of 4 articles in this issue of BMJ which focuses on the right to die. The reason they are published at this time is because the House of Lords in London will begin debating this issue in October 2005.

Branthwaite, an ICU physician and anaesthesiologist makes the case for such a law change. The legislation proposes that: a competent adult who has lived in Great Britain for at least one year, and is suffering unbearably as a result of a terminal illness may receive assistance to die at his/her considered and persistent request. The bill would incorporate various qualifiers and safeguards to protect the interests of patients and clinicians. She tells us what is proposed in the legislation. She also notes that public opinion has moved in favour of such a law: 69% (1976) to 82% (2004). Some professional opinion has apparently also moved in favour of dropping their opposition. e.g. the B.M.A. has moved from opposed to neutral. Finally, she points out that the fears of the nay-sayers have not come to pass in places like the Netherlands, or in Oregon. (18 refs)

**Lisa Burkhart**

**A click away: documenting spiritual care**

**J of Christian Nursing**

**Vol. 22 # 1 (Winter 2005) pp. 6-12**

The nursing profession in the U.S. is vigorously addressing the question how best to document the spiritual care being given by nurses. They are creating an impressive track-record.

There are three groups of classifications which have been developed: NANDA, NIC and NOC. The

North American Nursing Diagnosis Association (NANDA) list has diagnoses which are defined as "a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes." The diagnoses can be divided into three classes: actual-, risk-, or wellness-focused. The actual diagnoses on this list which will be of particular interest to chaplains are: spiritual distress, hopelessness, decisional conflict, and dysfunctional grieving. Risk diagnoses are issues that may develop in vulnerable persons, families or communities. Examples are: risk for spiritual distress, and risk for loneliness. Wellness diagnoses are used when patients are uncompromised but wish to enhance their level of health. e.g. readiness for enhanced spiritual well-being. In 2003, three new diagnoses were accepted into the NANDA list: impaired religiosity, risk for impaired religiosity, and readiness for enhance religiosity.

NIC refers to the Nursing Interventions Classification. This is a list of terms which describe the interventions nurses make. There are 484 interventions listed in the current version of NIC. Examples of NIC interventions include: Bibliotherapy, Decision-making Support, Dying Care, Grief Work Facilitation, Presence etc. The article gives 17 examples.

NOC is the Nursing Outcomes Classification. This is a list of nursing-sensitive patient outcomes measured on a 5-point scale. Examples of spiritual concepts in NOC, include: Spiritual Health, Grief Resolution, Hope, Acceptance, Health Status, and Comfortable Death.

Burkhart's article is a clear and helpful source of information for chaplains who are working to develop computerized charting systems in order to record their ministry, something that all chaplains will eventually use as a matter of course. A significant value of the article lies in the fact that it approaches key issues affecting all chaplains from a sympathetic but different direction. (16 refs)

**Robert A. Burt**

**The end of autonomy**

**Hastings Center Report (Supplement)**

**Vol. 35 # 6 (Nov/Dec 2005) pp. S9-S13**

Burt argues that efforts to encourage patient autonomy through the use of advance directives (AD), and through encouragement of persons to talk about their wishes for future health-care and end-of-life care simply have not worked. He asserts that we need to find a new approach because it is clear that

many people do not wish to talk about the reality that they will face or are facing.

He offers three proposals to address this situation. They are in his own words: "1. No one should be socially authorized to engage in conduct that directly, purposefully and unambiguously inflicts death, whether on another person or on himself. 2. Decisions that indirectly lead to death should be acted upon only after a consensus is reached among many people. No single individual should be socially authorized to exercise exclusive control over decisions that might lead to death, whether that individual is the dying person, the attending physician, or a family member acting as a health care proxy. 3. As much as possible, end of life care should not depend on explicit decisions made at the bedside of a specific dying person but rather should be implicitly dictated by system-wide decisions about available resources, personnel, and institutional settings – that is, by setting up default pathways that implicitly guide and even control caretaking decisions in individual cases."

He then provides his rationale for these suggestions and discusses them. (2 refs)

**Lindsay B. Carey, Christine Meese**

**Do pastoral care and spirituality services make a positive difference? Results from a quality assurance evaluation undertaken at the Royal Women's Hospital in Melbourne**  
**Ministry, Society and Theology**

Vol. 19 # 1 (- 2005) pp. 114-128

As part of its strategic planning and quality assurance, the Pastoral Care and Spirituality Services (PCSS) of Royal Women's commissioned a survey to gauge hospital staff awareness of, satisfaction with, and value of the PCSS team. They also wanted to learn whether the staff believed that the PCSS made a positive difference to the well-being of both staff and patients.

Carey and Meese present their method, the results and their recommendations. Nurses, doctors, management and allied health staff all participated in the study.

The findings are detailed and thorough, typical for Carey's research. Some findings:

93% of the respondents value the pastoral support of the PCSS.

66% said it was important to have a pastoral care worker available at all times.

96% said that PCSS made a positive difference to the well-being of patients. (8 refs)

**Jason Cusick**

**The clown: toward a metaphor for chaplaincy in the post-modern hospital**  
**Chaplaincy Today**

Vol. 21 # 2 (Autumn/Winter 2005) pp. 12-18

Cusick draws the reader's attention to Heije Faber's metaphor of "the clown" as a possible way for chaplains to think afresh about their identity and role in the modern hospital – just as Faber did when he published his book *Pastoral Care in the Modern Hospital* in the 1960s. (Interesting footnote: Cusick cites the book as being published in the US in 1971. It had been previously been published in 1964 in the U.K.) He finds Faber's approach to understanding the chaplain's role to be consistent with post-modern thinking, and so to hold promise for us these 30+ years later.

Cusick begins by pointing out that clergy in health care settings live and work within three tensions: (a) between being professional and non-professional; (b) as an included other; and, (c) as the artistic technician.

As Cusick notes, Faber wanted to emphasize that the minister's role in the hospital cannot be defined in static terms, hence his use of the three identity tensions. But Cusick adds a fourth which is, knowing how to apply what we know (on the basis of our training and experience), yet refusing to allow knowledge to be an end in itself.

Cusick concludes by describing how he personally has experienced these tensions in his life, both as a Christian and as a chaplain.

He closes with words that sum up his own sense of who he is as chaplain in a post-modern world. They are the words of R.E.M.'s hit song: "It's the end of the world as we know it... (and I feel fine)." (45 refs)

**Karen S. Dunn, Ann L. Horgas**

**Religious and non-religious coping in older adults experiencing chronic pain**  
**Pain Management Nursing**

Vol. 5 # 1 (Mar 2004) pp. 19-28

Chronic pain is a significant problem for many older adults. When poorly managed or under-treated, it can take a considerable toll on a person's life.

Dunn and Horgas report their findings from a study (n=200) done in the midwest of the U.S. to better understand how older persons cope with pain. They describe older persons' pain experience; report the

frequency and types of religious and non-religious coping skills used by this group; and look at the differences in use of religious versus non-religious coping across gender and race.

Of those who use religious coping strategies, the most commonly used was a collaborative one, with deferring strategies next, and self-directive strategies last of the three. The most frequently reported collaborative strategy was "When I worry about pain, I work together with God to make sense of it."

Some of the findings in this study are not consistent with earlier findings of others.

**Catherine Exley**

**Review article: the sociology of dying, death and bereavement**

**Sociology of Health & Illness**

**Vol. 26 # 1 (- 2004) pp. 110-122**

Exley outlines the work that sociologists have done studying death, dying and bereavement in the last fifty years. She has selected six books to introduce the reader to the breadth and depth of the field. Initially, the amount of work done was fairly modest. According to Exley it is only in the past 10-15 years that the amount of research done has increased significantly.

She devotes one section of her paper to "the neglect of spiritual care," pointing out that sociologists have generally steered clear of the topic. However, she does comment positively ("a fascinating read") on Cobb's *The Dying Soul: Spiritual Care at the End of Life*. (Buckingham: Open University Press. 2001) He is an Anglican minister. (37 refs)

**Terry L. Gall, Claire Charbonneau, Neil H. Clarke, Karen Grant, Anjali Joseph, Lisa Shouldice**

**Understanding the nature and role of spirituality in relation to coping and health: a conceptual framework**

**Canadian Psychology**

**Vol. 46 # 2 (May 2005) pp. 88-104**

Most of what has been written to date about religion, spirituality, coping and health has been descriptive in nature. It is only since the turn of the century that the more difficult task of trying to understand the complex associations, pathways (i.e. meditation) and possible models relating religion to coping and health have been proposed, based on some carefully designed studies.

Gall et al have chosen to take a model by Lazarus and Folkman, and build on it to try and explain the

nature and role of spirituality in relation to coping and health. It is a transactional model of stress and coping. They write: "We are proposing to use the transactional model of stress and coping in its most recent form as a framework from which to approach, organize and understand the diverse literature on spirituality, coping and health. Specifically, the basic tenets (e.g. dynamic process) and structural components (e.g. coping behaviour) of the transactional model are used as a "scaffold" for the integration of the growing empirical research on spirituality. The goal of this paper is to provide a conceptual framework of spirituality and coping that illuminates key spiritual constructs that can have a role in coping as well as provide a schema of how these constructs might function in the process of coping with stress. It is acknowledged that our approach presents a rational-theoretical framework that requires empirical validation." (p. 89-90) They proceed to describe what is known about the individual components of spiritual coping.

Having presented their model, it is then critiqued by four hospital chaplains - one each with a Muslim, Jewish, Christian and Hindi background. Each chaplain responds positively to the constructs of the model, describing from their own religious perspective how they see the model relating to their pastoral care of patients. (150 refs)

**Richard M. Glass**

**Is grief a disease? Sometimes**

**JAMA**

**Vol. 293 # 21 (1 Jun 2005) pp. 2658-2660**

Making complete sense of the grief process is an unfinished task for all who respond to persons who have sustained a loss. The problems lie mainly in the area of abnormal or complicated grief, and how to help people who are experiencing this form of grief. Glass provides a brief and clear description of the history of conceptualizing the nature of grief and the process of grieving (Freud and Engel) before turning turnin to the present problem how to diagnose complicated grief, and how to treat it. He refers to an article by Shear et al in the same issue of JAMA (p. 2601-2608) In it, Shear and colleagues report a new approach which they describe. However, questions still remain: how best to treat complicated grief? How to respond to the "separation trauma" syndrome that seems to lie within this kind of grief? Shear's comprehensive grief treatment approach using a 16-session format did produce a 51% response rate, which is the best result reported in the

literature, (to date for treating such patients. Unfortunately, this still leaves half of the sufferers no better off than they were before. (17 refs)

**David Glenister**

**Less than human**

**Ministry, Society and Theology**

**Vol. 19 # 1 (- 2005) pp. 65-75**

With considerable reluctance, Glenister decides to take a job at a day-care centre for persons with disabilities.

In his article he describes his reactions to the people he has worked among. As a framework for his writing, he takes Joseph Fletcher's 15 propositions regarding what Fletcher believed to be "the profile of a man" (See *Humanhood: Essays in Biomedical Ethics*. 1979 Prometheus Books) and gives us a dialogue between Fletcher and the disabled persons in the centre.

Near the end of his essay, he has already described some of the persons who come to the centre, and he then writes: "time would fail me to tell of Kim and of George, and of Diane, and of John and of Clare also, and Sam, and of the other non-profits (in the world's view): who through faith learned to assist themselves to do the simplest things, such as drink from a cup, learned to be able to make others aware of their choices; through seemingly insurmountable obstacles, learned how to bridge the distance between me and the other, were stoned (by uncomprehending eyes), were sawn asunder (by surgeon's knives), were slain with the sword (of blind words), they wandered about in sheepskins but mostly goat-skins, being destitute, afflicted, tormented (of whom the word was not worthy)." (2 refs)

**Scott D. Halpern**

**Towards evidence based bioethics**

**British Medical J**

**Vol. 331 # - (15 Oct 2005) pp. 901-903**

Evidence-based medical practice has greatly changed the way doctors practice their profession. Halpern even gives two examples from the cardiovascular field to make this point.

Now, he asserts, it is time for the same to happen in the field of medical bioethics. He begins to make his case by presenting an ethical debate that has been settled with the help of evidence. Many ethicists have argued that paying research subjects represents an "undue" inducement, that a person would not fully assess the risk that they might be taking in agreeing to participate in a research study, if they

were paid. Halpern presents two research studies which have found that there is no evidence to support this concern. Halpern also cites research work of Beauchamp and Childress which has challenged given ethical theory as well.

He doesn't want to dismiss theory completely, just to encourage any empirical work that can be done to document the extent to which ethical concerns are true or not, and to identify the ways in which those concerns might be addressed and alleviated. (23 refs)

**Tobin Hart**

**Kids' spirituality: when imaginary friends are angels**

**Science & Theology News**

**Vol. - # - (1 May 2004) pp. 3 pp**

Hart is a psychologist, a university professor of psychology. Imagine his surprise when he was putting his 7-year-old daughter to bed one night, and she told him about her angel. Neither Hart nor his wife had ever spoken to her of angels, or meditation, yet it was clear that the little girl was able to access some kind of altered state, and the translating between the "angel" and her father. "Most significant about the whole scene was the quality of her responses; they had a kind of deep wisdom to them, offering crystal clarity and remarkable depth that I had not heard from my daughter before, and only rarely seen in the wisest adults I know."

Over the past six years since that fateful night, Hart has interviewed hundreds of children and adults about their spiritual experiences, looked at the writings of historical spiritual figures, and explored how various spiritual and psychological traditions have understood the spirituality of children.

Hart has published a book: *The Secret Spiritual World of Children* (2003: Inner Ocean) whose main theme is that young persons are capable of having genuine spiritual moments, and great awareness of their significance, and that such moments can shape the course of their lives.

**Stanley Hauerwas**

**The church and the mentally handicapped: a continuing challenge to the imagination**

**\*\*\* J of Religion, Disability and Health**

**Vol. 8 # 3/4 (- 2004) pp. 53-62**

In this 1994 article, reprinted here in an issue devoted entirely to his work, Hauerwas examines the experiences of children with developmental disabilities and of their parents.

His focus question is: What are children for? He makes the case that the "problems" that these children encounter are not inherent in their condition, but are rather created by the kind of society that live in, and the assumptions about the purpose of children within such a society. Hauerwas sees our society as tending to treat children as commodities, to be picked and chosen according to one's personal desire. He believes that we should think of children as "signs of hope in a dark world," that children, all children, should be seen as gifts to the community.

**Gerald L. Jones**  
**The art of written prayer**  
**Chaplaincy Today**

**Vol. 21 # 2 (Autumn/Winter 2005) pp. 19-21**

Jones describes how, as chaplain, he and a patient will write a prayer together, imaging that God is right there with them and in the prayer it is God who is being addressed. They find the words the patient would wish to say given their situation. The chaplain returns later with the words of the prayer in print, and gives it to the patient.

Jones notes the value of this intervention: as a way of validating a patient's feelings; in order to gain a sense of the person's self-worth; in order to make connection with the Divine; and, as a final blessing. He includes four of the prayers, but mostly describes the impact this intervention has for people, which according to his report is considerable. (0 refs)

**Michael King, Louise Jones, Kelly Barnes, Joseph Low, Carl Walker, Susie Wilkinson, Christina Mason, Juliette Sutherland, Adrian Tookman.**

**Measuring spiritual belief: development and standardization of a Beliefs and Values Scale**  
**Psychological Medicine**

**Vol. 36 # 3 (March 2006) pp. 417-425**

Michael King is a professor of psychology in London England who for a decade has been working to devise a way of measuring spirituality. In this report he has the help of a completely new team. The reason they want to better understand spirituality is because higher levels of religious involvement have been modestly associated with better health. They wanted to create a standardized measure of spirituality to then be able to better study the spirituality/health link.

To develop their Scale this is what they did. They started by interviewing 39 people to see if an analy-

sis of the interviews would lead to their being able to identify the core components of spirituality. They then took that material from the interviews and based upon it they created a 47-item questionnaire that they evaluated with the help of a further 372 people in both non-medical and medical settings. This led to a 24-item questionnaire they tested on 284 people, which then allowed them to create their final 20-item questionnaire. Their testing of this final instrument satisfied them that the questionnaire was reliable, and could measure spirituality - what they call beliefs and values - across a broad religious AND non-religious population. The result: a measure of spiritual belief that is not limited to religious thought that they hope to use for research. A copy of their final questionnaire is included.

Comment: Of equal interest to their description of how they developed the Scale is following the process the team used to try and unravel the threads that together make up what we call "spirituality." They were working in England, and so, of additional interest is comparing their work to what is being done in the U.S.

**Kathleen L. Meert, Celia S. Thurston, Sherylyn H. Briller**

**The spiritual needs of parents at the time of their child's death in the paediatric intensive care unit and during bereavement: a qualitative study**  
**Paediatric Critical Care Medicine**

**Vol. 6 # 4 (Jul 2005) pp. 420-427**

This paper reports the results of a study done in the U.S. to gain a deeper understanding of the spiritual needs of parents at the time of their child's death in an ICU. Thirty-three parents of 26 children who had died in such a setting were interviewed face-to-face two years after the death.

The main spiritual need described by these parents was the need to be able to maintain a connection with their child. At the time of death, this was done simply by physical presence. After the death, connection was maintained in any of a wide variety of ways: memories, mementos, memorials and altruistic acts such as organ donation, volunteer work, charitable fund raising, support group development, and adoption. As they note, parents' spiritual needs often present themselves in non-religious language and behaviours.

Spiritual needs as death was approaching included: the need for truth, (including truth in communication, truth in knowledge, and truth in being), compassion, prayer, ritual, gratitude, meaning and

purpose, trust, anger and blame, and dignity. Each of these terms is defined in specific behavioural terms.

This is the conclusion of the authors: "Bereaved parents have intense spiritual needs. Health care providers can help support parents' spiritual needs through words and actions that demonstrate a caring presence, impart truth, and foster trust; by providing opportunity to stay connected with the child at the time of death; and by creating memories that will bring comfort in the future."

The second author is the chaplain at the hospital where the study was done. (36 refs)

**Bernard G. Prusak**

**Rethinking "liberal eugenics" - reflections and questions on Habermas on bioethics**

**The Hastings Center Report**

**Vol. 35 # 6 (Nov/Dec 2005) pp. 31-42**

In our futures lie eugenics and selection, the prospect of prenatal genetic engineering, or enhancement, according to Prusak. Understandably there are very serious ethical questions relating to such developments. Should children be genetically enhanced, and if so, under what conditions? Some have suggested that children could be genetically improved as long as the changes allow them to choose from a wide variety of ways to then live their lives.

The German philosopher Jurgen Habermas has come out against such an argument, arguing that even positive and restrained genetics enhancements would be counter to the notion of autonomy, not because the choices might be at odds with what a child might want - but because they would undermine the conditions of autonomy. In other words, argues Habermas, a person could not really regard their life as their own if the person lived in a body that someone else had, but without asking their opinion, "enhanced" them. Habermas lays out his ideas in his book *The Future of Human Nature* (2003 Polity Press) (63 refs)

**G.B. Rahm, B. Renck, K.C. Ringsberg**

**"Disgust, disgust beyond description" - shame cues to detect shame in disguise, in interviews with women who were sexually abused during childhood**

**J of Psychiatric and Mental health Nursing**

**Vol. 13 # 1 (Feb 2006) pp. 100-109**

Shame is a constant companion of women who have been sexually abused. It affects the development of a woman and her relationships, and it is emotionally painful.

The first aim of this study was to discover if and how women exposed to sexual abuse in their childhood verbally expressed unacknowledged overt and covert shame when they talked about their physical and mental health, relationships and circumstances relating to the sexual abuse. A second aim was, if shame was present, to describe the quality of the shame expressed by the woman. Ten women who were attending a self-help group for abused women were interviewed about their current physical and mental health, their relationships with present and original family members, their childhood and the circumstances under which the sexual abuse occurred. The language of the interviews was then analyzed.

The findings clearly show that the effect of shame is still present in these women, and that the shame was negatively affecting their lives. The most common "code" words for shame were found to be: "alienated," "inadequate" and "hurt." The paper includes more detail about the language of the women and a great many examples of the words/sentences they spoke.

For the hospital chaplain, the article sensitizes us to those code words which we might otherwise hear and not recognize them for what they may be saying. (26 refs)

**A. Elizabeth Rippentrop, Elizabeth M. Altmaier, Joseph J. Chen, Ernest M. Found, Valerie J. Kefala**

**The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population**

**Pain**

**Vol. 116 # 3 (Aug 2005) pp. 311-321**

The report of a study of 122 patients suffering from chronic musculoskeletal pain. The authors sought to better understand the relationships between religion/spirituality (R/S), and physical health, and mental health. R/S was held to be a multidimensional factor, and it was measured using a new instrument - the Brief Multidimensional Measure of R/S.

The authors knew from other research that pain experienced by patients with religious and spiritual beliefs seems to be different from that experienced by the general population. e.g. pain patients often feel less desire to reduce pain in the world, and feel more abandoned by God.

It was hypothesized that R/S would be significantly related to better physical health. Au contraire, increased private religious activities (prayer and medi-

tation) were associated with poorer physical health. Their suggested explanation for this unexpected result? It may be that the patients who are doing the worst physically feel the greatest need to rely on their faith for comfort, so they engage more frequently in religious activities. (Remember though, causal relationships cannot be inferred here.) The authors suggest that their findings may be best understood using the stressor response model (of Ellison and Levin (1998). In this model, stressors (e.g. chronic pain) prompts individuals to increase the frequency of their religious behaviours.

Concerning the R/S - mental health relationship; a lower ability to forgive and negative religious coping (e.g. anger towards God) seem to contribute to poorer mental health and higher pain intensity.

A final hypothesis was that higher levels of R/S would be related to less pain, and less life interference due to pain. This hypothesis was not supported. The authors don't have a good explanation for this.

This is only the start of the needed examination of an important and complicated subject. The study is limited in that the assessments only looked at one point in time. A longitudinal study is needed. (46 refs)

**T.J. Ryan**

**Psychology of pain and wound healing**

**www.worldwiderounds.com**

**Vol. - # - (Sept 2004) pp. 6 pp**

People have been interested in the impact of mental activity on pain and wound healing for many years. In this article, Ryan, a professor at a wound healing institute in England describes in simple terms how wounds and pain are linked, but then includes some realms of relevance to chaplains.

After a passing note on stigmata, he goes on to say: "Further methods (of pain control) include exercises that control mental activity, for example. Other more spiritual approaches such as hymn singing and Gregorian or Buddhist chanting may also be appropriate for some individuals." "... the answers for the palliation of pain do not lie simply in the lower levels of the nervous system, but also in the "spirit. An individual's perception of pain is not separate to the perception of everything else and some of the most intense suppression or enhancement of pain is to be found linked to religious belief."

The article may be downloaded free at: <http://www.worldwidewounds.com> On their front page, type into the search box: TJ Ryan. (11 refs)

**Amy Saldinger, Albert C. Cain**

**Deromanticizing anticipated death: denial, disbelief and disconnection in bereaved spouses**

**\*\*\* J of Psychosocial Oncology**

**Vol. 22 # 3 (- 2004) pp. 69-92**

Cain and his co-author have done another excellent job in describing and discussing what takes place in a marital relationship where one of the pair has a terminal illness. Their article is based on interviews with 30 bereaved spouses with whom they explored the extent to which they were able, during the illness, to make cognitive, emotional, practical and interpersonal changes in light of the impending death.

In the paper we are presented with the strains caused by a terminal illness, the interruption of spousal intimacy, separation anxiety, the undermining of the sense of the world as a safe place, the helplessness of having to watch a loved one die.

In contrast to some of the literature which describes the advantages of having time to adjust during a period of anticipatory grieving, Cain and Saldinger found that this period can bring stressors that often preclude the undertaking of anticipatory task.

Their primary conclusion: "Our findings underscore the desirability of primary intervention during the illness - a time when families are most in need of help and least likely to seek or receive it. Interventions should be available as early as the time of initial diagnosis and continue throughout the illness. Waiting until the prognosis is terminal could prove to be too little, too late. The findings also highlight the importance of attending to the nuances of individual coping styles and to the pre-existing nature of the spousal relationship in a given couple, rather than maintaining a one-size fits-all approach." (p. 90) (25 refs)

**Robert Sapolsky**

**Sick of poverty**

**Scientific American**

**Vol. 293 # 6 (Dec 2005) pp. 93-99**

This is a paper concerning social justice. Sapolsky reports new studies which suggest that the stress of being poor has "a staggeringly harmful influence on health." Researchers have known for a long time that people with a low socioeconomic status (SES) have dramatically higher disease risks and shorter life spans than persons in wealthier parts of society. The conventional explanation has been that the poor have more limited access to health care, and engage in more injurious lifestyle behaviours, say smoking.

New research shows that these explanations cannot account for the huge differences in health outcomes. The new studies that Sapolsky describes indicate that the psychosocial stresses associated with poverty may increase the risks for many illnesses. e.g. the chronic stress induced by living in a poor, violent neighbourhood can increase a person's susceptibility to cardiovascular diseases, depression, and diabetes.

He also reports other studies which show a correlation between income inequality and poor health in the U.S. Some researchers believe that the poor feel poorer, and this in itself causes greater stress, especially in communities with wide gaps between highest and lowest incomes.

The figures are disturbing. "It is not a subtle statistical phenomenon. When you compare the highest versus the lowest rungs of the socioeconomic ladder, the risk of some diseases varies 10-fold."

Comment: For those of us exposed to television, the following comment by Sapolsky bears considering: "The surest way to feel poor is to be endlessly aware of the haves when you are a have-not." Sapolsky includes a simplest test (1 question) that will allow you to identify whether or not you are poor, and so at risk. (4 refs)

#### **Steven Spidell**

##### **A survey of beliefs and practices in professional chaplaincy**

##### **Chaplaincy Today**

**Vol. 21 # 1 (Spring/Summer 2005) pp. 23-29**

This article joins the small but growing number of research studies conducted by chaplains which add to our knowledge of the profession. In this study, we gain some important insights about what chaplains do and what they believe.

Spidell conducted an Internet survey of the approximately 1,800 board-certified members of the Association of Professional Chaplains in the U.S. One hundred fifty-nine chaplains responded. Spidell wanted to find out: 1. How do chaplains' beliefs relate to their actual practices? 2. How frequently do chaplains in health care use specific forms of ministry? 3. What, if any, forms of linkage are there between the training a chaplain received in clinical pastoral education (C.P.E.) and what they actually do?

Spidell provides four pages of results. Perhaps the most striking are these: Almost 97% of respondents said they believed that prayer has a direct influence on the physical condition of the patient, but only

38% said they usually or often pray for physical cure. Almost 88% said they believed in miracles but only 53% rarely or never pray for one. Over 99% believe that pastoral care has an influence on a person's physical condition, but very few bring that care to bear on a person's condition except by listening and prayer.

In the first accompanying table, Spidell gives his survey questions and the results. In the second table, he lists the frequency of practices performed by chaplains - there are a total of 53. He also reports the linkage to CPE training. At the bottom end of frequency, there are only a very few chaplains using crystals, employing Qi Gong practices or performing exorcisms. (0 refs)

#### **Laura Spinney**

##### **Last rights**

##### **New Scientist**

**Vol. 186 # 2496 (23 Apr 2005) pp. 46-49**

Euthanasia and end-of-life issues are looked at from a global perspective by a writer in England. Spinney gives a global picture of the slowly developing acceptance of the belief that persons should be allowed to be assisted medically to die. Switzerland has the longest history of allowing assisted suicide, though not euthanasia. A 1942 Swiss law allows that it is only illegal to help someone commit suicide "with a selfish motive", which is widely taken to mean that disinterested helpers are safe from the law. Spinney also has a long section on pain control.

The last attempt to legalize assisted dying in the UK was in 1994. A new bill (The Assisted Dying for the Terminally Ill Bill) being sponsored by Lord Joffe has been referred to a House of Lords Select Committee which in July 2004 called for evidence on the Bill. It is not certain if it will become law. The British Medical Association is opposed, though the Royal College of General Practitioners has moved from opposed to neutral.

#### **Karen E. Steinhauser, Corrine I Voils, Elizabeth C. Clipp, Hayden B. Bosworth, Nicholas A.**

##### **"Are you at peace?" - one item to probe spiritual concerns at the end of life**

##### **Archives of Internal Medicine**

**Vol. 166 # 1 (9 Jan 2006) pp. 101-105**

Earlier research by this team has picked up the fact that the phrases "come to peace" or "being at peace" showed that for many people this phrase was related to the religious notion "being at peace with God." They wondered if the use of the phrase "at peace"

might be a useful one in enquiring about a person's spiritual well-being, being readily answerable by either a religious or a spiritual person, and not offensive to persons who were neither. The authors provide good information about their research process, the demographics, and their method of analysis.

They found that asking patients about the extent to which they are at peace offered a gateway to assessing spiritual concerns. The specific language a person used in response to the question: "Are you at peace?" was found to reveal their frame of reference, dimensions of distress, and acceptable terminology for talking with the person. Although the study focussed on persons near the end-of-life, they wonder if it might also be useful at other points in people's lives. (34 refs)

**Larry VandeCreek**

**Spiritual assessment: six questions and an annotated bibliography of published interview and questionnaire formats**

**Chaplaincy Today**

**Vol. 21 # 1 (Spring/Summer 2005) pp. 11-22**

VandeCreek has long been one of the major figures in chaplaincy research in the U.S. Now retired, he continues to teach and consult, making important contributions to the practice of chaplains. This article is another excellent example.

As he notes, spiritual assessment has been a topic of growing importance in health care. However, the pastoral literature has not critically examined the key issues associated with the task of spiritual assessment, nor do chaplains seem familiar with the wide variety of assessment formats that have been created.

His agenda then is to identify and discuss six concerns that are central to spiritual assessment, and then to provide an annotated bibliography of some of the published formats. His questions: 1. Why bother with spiritual assessment? 2. Can assessments be insulting to spirituality? 3. What is a spiritual assessment? 4. Are the formats in the literature - and in the attached bibliography - really assessments? 5. Who should conduct spirituality screenings and assessments? 6. What formats should chaplains use?

There are 29 formats in the bibliography.

This is VandeCreek's closing paragraph: "if spiritual screening and assessment results are to be entered into official medical records, communicated to fellow health care team members, and utilized in the pastoral care of patients, then chaplains need to de-

velop practices that stand up to the scrutiny of scientific colleagues. Although this task is fraught with theological and professional challenges, professional chaplaincy likely will not gain the respect it deserves in health care until it does so." (9 refs)

**Walter Wink**

**Why turn the other cheek?**

**Spirituality & Health**

**Vol. 7 # 5 (Sept/Oct 2004) pp. 60-63**

Wink suggests that the major ethical task of our age is finding out how to overcome evil without being evil ourselves, and creating ever newer forms of evil.

He turns to three sayings of Jesus that have become embedded in the culture of the Western world: 1. If anyone strikes you on the right cheek, turn the other also. 2. If a creditor takes you to court and sues you for your outer garment, give him your undergarment as well. 3. If one of the occupation troops forces you to carry his pack one mile, carry it two.

He discusses each saying in turn, providing a context and explanation. In doing so he describes a new response to evil, one that may seem contrary to logic. However, he believes that each of the sayings in the three passages suggest "a path of non-violence that can end our penchant for violence." (p. 61)

He gives several large and small examples where individuals and groups have non-violently confronted "evil" in the modern era. One comes from a hospital. He recounts how at a hospital in Saskatchewan, doctors were bullying nurses in front of colleagues, visitors, and patients. The nurses took the problem to administration and together they devised a plan. The next time a doctor dissed a nurse publicly, the hospital sent out a "pink alert. Nurses who were free converged on the spot and surrounded the doctor, holding hands. The first time it was tried, the doctor tried to break out of the circle, but he found himself unable to do so. It became like the children's game Red Rover. The doctor began running at what looked like the weakest nurse, only to find the entire circle give way, like a giant amoeba. Finally, he conceded defeat and apologized. It was not necessary to repeat the exercise." (p. 63)

Wink is a professor of biblical interpretation at Auburn Theological Seminary in New York.

**Susan K. Wintz, George F. Handzo**  
**Pastoral care staffing and productivity: more than ratios**

**Chaplaincy Today**  
**Vol. 21 # 1 (Spring/Summer 2005) pp. 3-10**

A perennial concern of chaplains is the fact that they are (usually) expected to provide pastoral care to more and sicker patients, and there is an increasing amount of work for fewer chaplains. In the past, in an attempt to construct a rationale that might sway the thinking of "hard-hearted" administrators, ratios have been found to justify increasing staffing levels. Wintz and Handzo, two experienced American chaplains look at this issue again, but with a level of sophistication not seen in previous writings on this subject.

They start with an overview of the history of ratios in US chaplaincy, then identify what they consider are the major factors that impact staffing and productivity. Finally, and most significantly, they describe a process that any chaplain could use to identify and then present the needs of their department. They even provide a 2-page template which a chaplain can follow in order to survey their departmental staffing levels and productivity.

Their final suggestion: that chaplains "consider carefully how to present their plans to management, taking into account their particular organizational culture and the particular process by which decisions are made. This is so important that chaplains who don't know how to go about it need to seek help or coaching before attempting to do so." (p.8) (12 refs)

**Christine Zaza, Scott M. Zellick, Loretta M. Hiller**

**Coping with cancer: what do patients do?**

**\*\*\* J of Psychosocial Oncology**

**Vol. 23 # 1 (- 2005) pp. 55-73**

In this Canadian study (n=292), the authors looked at cancer patients' experiences in using a number of different strategies to help them cope with their cancer. They were looking at five issues: 1. the extent to which cancer patients use coping strategies; 2. the reasons for them not using coping strategies; 3. participants' interest in trying strategies if they were suggested; 4. the perceived effectiveness of the coping strategies; and, 5. if the strategies were being recommended to participants. To answer their questions, they interviewed a sampling of cancer patients who were being cared for in an outpatient cancer treatment centre.

Among other things they found:

60% said they did something to help themselves cope.

57% reported using solitary activities (e.g. hobbies)  
33% used task-oriented coping activities (e.g. taking their medications, changing diet)

23% used social activities (e.g. volunteering)

The three most commonly used activities were: prayer (engaged in by 64%), music (43%), and religious support (27%) - and this in a country that is far less religiously active than the U.S. (34 refs)