

## THE ORERE SOURCE

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The Rev. W. Noel Brown is a recently retired hospital chaplain and former ACPE supervisor. He is the Convenor of the Standards Committee of ACPE and the Convenor of the Research Committee of the Association of Professional Chaplains. He is also the Editor of The Orere Source, a bi-monthly publication of his abstracts from the pastoral care and healthcare literature. There are over 16,000 abstracts in the database.

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

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### **Association of Professional Chaplains**

#### **Healing Spirit**

**Vol. 1 # 1 (Feb 2006) 35 pp**

This is a new publication of the Association of Professional Chaplains, under the editorship of Mary K. Moore. It appears to have a dual purpose. Using a highly professional style and glossy look, it appears to be a publication that will represent chaplains and chaplaincy to healthcare professionals, for example, administrators and persons who might wish to be supportive of the pastoral care movement. Second, it includes several articles about chaplaincy which will be of interest to chaplains: pastoral care in the Baylor Healthcare System in Atlanta, the key role of the chaplain in supporting staff etc

Not mentioned is its intended frequency of publication, nor how non-members might obtain a copy, but check the website: [www.professionalchaplains.org](http://www.professionalchaplains.org)

### **Richard Beck**

#### **God as secure base: attachment to God and theological exploration**

##### **J of Psychology and Theology**

**Vol. 34 # 2 (Summer 2006) p.125-132**

Most of us met one in the course of our theological training or in our formation process as a chaplain: a person who was unwilling or unable to explore theology, especially their own. This is a major problem both for those involved in theological training and in the work of pastoral formation. Fortunately, it is possible to obtain a better understanding of the roots of this problem because of studies that have been done concerning "attachment", a concept from John Bowlby and subsequently expanded upon by Ainsworth. Beck provides a succinct but clear explanation of what is meant by "the attachment bond," and what it means to consider God to be a "secure base." He also describes the nature of "theological exploration" in this kind of research.

The paper reports his study which was designed to explore whether persons who had a "secure" at-

tachment to God would be more willing to "explore" their "theological world." The participants were undergraduate students (n=117).

He found that those who saw (or perhaps better experienced) God as a "secure base" were able more fully to engage in theological exploration and were more tolerant of Christian faiths different from their own. These same persons also reported more peace and less distress during their spiritual journeys.

To his colleagues, Beck suggests that the attachment paradigm has useful implications in several areas of psychology. For chaplains, an understanding of this model may help us better understand the struggles some of our patients seem to have, especially when we can make the distinction between those who say they place their trust/faith in God (that is, they say they have a secure attachment) as opposed to those who speak the same way, but who in fact have what Beck (and Ainsworth) would call an avoidant attachment. (25 refs)

### **Herbert Benson, Jeffrey A. Dusek, Jane B. Sherwood, Peter Lam, Charles F. Bethea, William**

#### **Study of the therapeutic effects of intercessory prayer (STEP) in cardiac bypass patients: a multi-center randomized trial of uncertainty and certainty of receiving intercessory prayer**

##### **American Heart J**

**Vol. 151 # 4 (Apr 2006) pp. 934-942**

This is the 6th (and most expensive study to date) to report that intercessory prayer had no measurable effect on the wellbeing of the patients prayed for. It was a study of intercessory prayer, the results of which suggest that praying for the health of patients at a distance is not effective in reducing complications after heart surgery.

Patients in 6 hospitals were randomly assigned into one of three groups. 604 patients were the focus of intercessory prayer, after they had been informed that they may or may not be prayed for. 597 were not prayed for, after they had been informed that

they may or may not be prayed for; and 601 were prayed for after being informed that they would be prayed for. Praying began for each person the night before they underwent a coronary artery bypass graft (CABG) surgery, and then for the following 13 days. The outcome watched for was the presence of complications.

The intercessors were from three Christian groups - 2 Roman Catholic, and one Protestant. Each day a fax was sent to the intercessors with the first name and the first initial of the last name and an anonymous site code. The praying had to begin before midnight each day, and the pray-ers agreed to simply add to their usual prayers: "for a successful surgery with a quick, healthy recovery and no complications".

In the 2 groups which were uncertain if they were being prayed for, complications occurred in 52% of those who were prayed for, versus 51% of those who were not. Complications occurred in 59% of those who were prayed for versus only 51% of those who were not. Complications occurred in 59% of those who had been certain of being the focus of prayers versus just 52% of those who were not certain whether they were prayed for or not.

The paper is a model of clarity with the methods, definitions, results etc laid out in great detail. Included in the 16 authors there are three hospital chaplains. (27 refs)

**Paul Browde**

**Discretion often the better part of valor  
American Medical News - Ethics Forum  
(2 Aug 2004) 6 pages**

In this era of exploding knowledge and information, and with amazingly easy access into the lives of so many persons, we are often faced with dilemmas regarding the disclosure of information. It is an issue that parish clergy and institutional chaplains must deal with every day in their ministry. Browde writes about the issue from a medical perspective but his insights may also help those in pastoral ministry.

The focus question is: What should physicians (clergy/chaplains) do when they discover family secrets? In trying to answer the question, he takes a post-modern approach. i.e. he does not try to apply universal rules to everyone. Rather he focuses on people in their unique situations. About any situation he asks six questions, always keeping in the background "first, do no harm". Where is the secret located? What are the contents of the secret? What are the meanings of the secret? What would be the

consequences of opening the secret? What biases and beliefs does he himself carry that would influence a decision regarding telling? If one decides to tell, how does one proceed?

Browde gives brief vignettes to illustrate the importance of each of the questions. (6 refs)

**P. Burnard**

**Sisyphus happy: the experience of depression  
J of Psychiatric and Mental Health Nursing  
Vol. 13 # 2 (Apr 2006) pp. 242-246**

What is it like to be seriously depressed? "I suspect that many psychologists, psychiatrists and theologians say too much about that which it is impossible to speak." (p.243)

This is among the observations about depression written by a man who describes his own symptoms and personal ideas about this common condition, which also happens to be his own. He raises questions about the legitimacy of psychiatric and psychological theorizing about depression, and draws upon a number of existential thinkers to support what he is describing. He claims that depression is not particularly a "learning experience," and, far less, a form of personal growth.

Burnard is a professor of nursing, and vice-dean of a school of nursing in Wales. (14 refs)

**Lindsay Carey, Mark Cobb, David Equeall  
The utility of WHO pastoral intervention codings  
at the Sheffield Teaching Hospitals  
Ministry, Society & Theology  
Vol. 19 # 2 (2005) p.89-107**

Carey is the National Research Officer for the Australian Health and Welfare Chaplains Association. Between April 2004 and March 2005 he went to the Sheffield Teaching Hospitals in South Yorkshire where he introduced the chaplaincy staff of the five units comprising the Sheffield group to a method of recording the pastoral work of chaplains.

The methodology is based on the World Health organization (WHO) Pastoral Intervention Codings which were subsequently modified in Australia and released in that country in July 2002. They are now used in a number of the larger pastoral care departments in that country for the collection and assessment of chaplains' work. This permits the assessment of chaplaincy competence, which in turn assists in planning for training and development.

Carey et al describe the movement in collecting data from the former "contact type" of the Sheffield System to the WHO (Aust modified) pastoral interven-

tion codings. They also describe some of the lessons they learned about the transition process. One lesson: "It would seem that Chaplains do not need to work harder in terms of their pastoral care but that chaplains need to work smarter by accurately recording the work they already undertake." (p.100) In an Appendix the WHO ICD (ICD-10 3<sup>rd</sup> ed) Pastoral Care Interventions (Aust July 2002) are printed in full. (18 refs)

**Eric Cohen**

**Conservative bioethics and the search for wisdom  
Hastings Center Report**

**Vol. 36 # 1 (Jan/Feb 2006) p.44-56**

There is a new view of bioethical thinking at work in the U.S. It has been labeled "conservative" bioethics, a label not repudiated by those who are within its aegis. (See also the summary by Macklin below.)

The previous article in this issue of Hastings is a strong and sustained criticism of the group's thought, including that of Cohen. Here Cohen describes the values central to conservative bioethicists. He says their approach is informed by a rich view of human personhood, has a decent respect for the well-considered views of persons across the political spectrum, and that they hold to a philosophy of the state that is carefully calibrated to ensure that "imperfect people" can live together in community. He maintains that the deepest disagreements between conservatives and liberals are rooted in different ways of understanding the moral ideal of equality. In his essay he proceeds to explore the moral anthropology and the governing philosophy that inform the work of this group of thinkers. His approach is to make the sharpest conservative-liberal divisions seem more like disagreements between friends. (44 refs) (Comment: It would be important to read both Cohen and Macklin to gain an understanding of what this fight is all about.)

**D. Paul Dalzell**

**Ten solid facts**

**Ministry, Society and Theology**

**Vol. 19 # 2 (2005) p.108-128**

Writing for the editorial board of MS&T, Dalzell reproduces a list of "solid facts" which came originally from the World Health Organization (WHO). All of them concern the relationships between shortened life-span and poor health on the one hand, and social conditions on the other. Dalzell takes each "fact" and comments on what it means and the re-

search behind it. A full outline of the WHO research can be downloaded at:  
<http://www.who.dk/document/e81384.pdf>

Early in 2005, MS&T readers were informed of this document, and invited to write a response to it in light of their own ministry. Four responses are printed in this issue. The first is from an educational consultant and former UNICEF senior education advisor; the second is from an Anglican priest who is Canon of St John's Cathedral, Gahini in Rwanda; the third is a member of the Salvation Army, now their Communications Director with special responsibility for the ethics and social work of that church; and the fourth is an Anglican parish priest in Alexandra, Victoria.

(Comment: The document is an excellent starting-place for chaplains concerned about issues of health, social conditions, and social justice.) (1 ref)

**Barbara M. Dossey**

**Revisiting Nightingale – a response to Grypma,  
and commentary on mysticism**

**J of Christian Nursing**

**Vol. 23 # 3 (Summer 2006) p.27-31**

In this article, the debate in the nursing profession continues concerning the place of Florence Nightingale within that profession. Dossey is responding to an earlier article by Grypma, a nurse history specialist. What she wrote can be read at: [www.ncf-jcn.org/jcn/archive/05su/sg21.pdf](http://www.ncf-jcn.org/jcn/archive/05su/sg21.pdf)

Dossey who has written one book, and co-authored a second on Nightingale defends her understanding of this major figure in healthcare (and not just for nurses). She describes her as a "practical mystic," and discusses at length the distinction between spirituality and spiritualism. Dossey disagrees with Grypma's position that Nightingale was a practitioner of spiritualism, arguing that she was a mystic in the footsteps of Meister Eckhart and Hildegard of Bingen.

(Comment: This argument is not an academic one. The place of Nightingale within the nursing profession is being hotly debated both in the UK and in the US. Nightingale's supporters see her role as a necessary corrective to a technological and secular practice of nursing now being taught in some nursing schools. As a coda: Nightingale is now included in the US Episcopal Church's Liturgical Calendar of Lesser Feasts and Fasts. Her name appears in the Book of Common Prayer – 2004.

**J Irene Harris, Sean W Schoneman, Stephanie R. Carrera**

**Preferred prayer styles and anxiety control  
J of Religion and Health**

**Vol. 44 # 4 (Winter 2005) pp. 403-412**

Research concerning prayer is still relatively undeveloped. Basic questions such as: how do we define “prayer”? what “results” or “outcomes” should be looked for? how exactly should we go about “measuring” prayer? - these and other issues are still being discussed. And this all presupposes that prayer is an appropriate matter for research anyway, a question still being hotly debated.

In *The Orere Source*, we assume that research concerning prayer is a legitimate subject for research and discussion, if for no other reason than to keep readers abreast of what others are thinking. (In the interests of full disclosure, we believe that prayer as an activity should be studied, so that it can be better understood.)

This paper concerns the relationship between the ways people pray and the levels of anxiety that accompany their praying. Development of a new instrument, the Prayer Functions Scale (PFS) by Bade and Cook enabled the authors to better measure individual’s prayer styles, which were then correlated with anxiety levels. For clarification, the PFS instrument identified four styles of praying, and we list here two questions linked to each style: A. Seeking Acceptance style of praying: “Ask God to direct my life and actions in ways that God wants.” “Prays that the difficulty will lead me to a closer relationship with God.” B. Provides calm and focus: “Pray that I might be able to deal with obstacles.” “Allows me to reflect on the issues.” C. Deferring/Avoiding: “Pray for God to change the situation.” “Pray for things to get better.” D. Providing Assistance: “Ask God to help me face difficult situations.” “Put things in God’s hands when I can’t handle them alone.” The subjects were 85 students in introductory psychology classes in the southwest U.S.

The paper is up the usual high standard of this journal with a clearly stated rationale for the project, a review of the existing literature (and the currently confusing picture about the effects of prayer in those who pray), following by method and results.

Those results suggest that persons whose prayer style is characteristically to actively seek assistance from God – as opposed to seeking assistance to defer or avoid situations that could cause anxiety – seemed to have better control of their anxiety and lower levels of trait anxiety.

The findings suggest that persons whose prayers were more deferring/avoiding in nature, may not have been coping with their stressors with maximal effectiveness. (35 refs)

**Barry Hoffmaster**

**What does vulnerability mean?**

**Hastings Center Report**

**Vol. 36 # 2 (Mar/Apr 2006) p.38-45**

Human vulnerability is defined by Hoffmaster to mean lack of control or power. He believes that vulnerability is important to morality. “Vulnerability does not mean much to morality because, in part, it is missing from moral philosophy, yet it is our very vulnerability that creates the need for morality.” He argues that only by keeping in mind our shared vulnerability will we recognize our bonds to other human beings and affirm our shared humanity.

As Hoffmaster sees it, vulnerability is antithetical to our current emphasis on individualism and rationality. To be vulnerable requires that we pay attention to our physical body and to our feelings. To amplify his case, he describes the life struggles of his parents, and their inter-relationships now that they are both aging and unwell. (17 refs)

**Stephen D. King, Debra Jarvis, Adrienne Schlosser-Hall**

**A model for outpatient care**

**J of Pastoral Care & Counseling**

**Vol. 60 # 1-2 (Spring/Summer 2006) p.95-107**

A major part of the medical care formerly provided within the hospital setting has been moved to outpatient settings. Chaplains have not exactly followed. These authors have, and they describe how it started and how they have made pastoral care in an outpatient oncology setting really work. (And before you get too excited: it really began after a clergyman underwent a bone marrow transplant, and returned a year later, first as a volunteer chaplain, who was then subsequently hired as the first chaplain and director of pastoral care.)

This is a detailed paper describing what these chaplains do, why, when and how. They refer to a number of specific initiatives they have begun to amplify their care: Finding Soul – a time-limited, small group experience for staff to talk about their work. Existential Expedition – a time-limited, small group experience for staff to talk about their own experiences and values regarding vocation, spirituality, death and dying. The After Book – a notebook for logging deaths. The Labyrinth Program – a program

that addresses needs to de-stress and the need for spiritual nurturance. They describe their chapel, which is named a sanctuary. They detail for the reasons why that name was chosen. There are three websites illustrating where their places of ministry are located: [www.seattlecca.org](http://www.seattlecca.org) [www.uwmedicine.org](http://www.uwmedicine.org) [www.seattlechildrens.org](http://www.seattlechildrens.org)

**Karin T. Kirchoff, Prashanth R. Anumandla, Kristine T. Froth, Shea N. Lues, Stephanie H. Gilbertson-White**

**Documentation of withdrawal of life support in adult patients in the intensive care unit**

**American J of Critical Care**

**Vol. 13 # 4 (Jul 2004) pp.328-334**

This study was done by a group of nurses to find out how well the staff of an intensive care unit document the end-of-life care they give to patients, especially at the very end. The blunt answer – documentation is not done very well at all.

They reviewed 50 charts. In all 50, initiation of the decision to discontinue aggressive care was documented. However, 1/3 made no mention of the presence or absence of advance directives. In 2/3, there was documentation of nurse involvement but only 1 in 10 mentioned doctor participation in discussion of withdrawal. Less than a half (44%) of the charts recorded interactions between families and a chaplain. The family of one patient was documented as having declined the services of the chaplain. (36 refs)

Comment: The paper raises the question: do chaplains, as a matter of course, record their involvement around the time of a patient's death? If not, why not? The mantra in healthcare circles is that if something is not charted, it did not happen.

**Ruth Macklin**

**The new conservatives in bioethics: why are they and what do they seek?**

**Hastings Center Report**

**Vol. 36 # 1 (Jan/Feb 2006) p.34-43**

On some subjects, ethical discussions in the US have recently turned ugly. Macklin looks at what she believes is happening. She claims that a new political movement has arisen in bioethics, self-consciously distinguished from the rest of the field and characterized by a new way of writing and arguing. Unfortunately, the new method is mean-spirited, mystical, and emotional. It claims insight into ultimate truth yet disavows reason.“ (p. 34)

She names the people she considers are the members of this new movement, the “new conservatives,” describes what she believes they are doing and how. Yuval Levin. Eric Cohen. Leon Kass. Richard John Neuhaus. She characterizes their writings by their use of poetic and metaphoric language; that appeals to emotions, sentiment and intuition; that engages in “mean-spirited rhetoric;” a group that engages in “projects.”

Her last criticism is that the new conservatives appear to have no interest in matters of justice. (61 refs)

**Mark R. McMinn, R. Allen Lish, Pamela D. Trice, Alicia M. Root, Nicole Gilbert, Adlene Yap**

**Care for pastors: learning from clergy and their spouses**

**Pastoral Psychology**

**Vol. 53 # 6 (Jul 2005) p.563-581**

This paper is based on five different studies which report how pastors and their spouses care and cope for themselves. The studies were quite varied, and all of the authors of this article were not necessarily involved in conducting the five studies they have based their paper on. The studies were focused as follows: 1. Coping with sexual attraction. 2. Exemplar pastors (those who had exceptional ways of coping with stress. 3. Senior pastors. 4. Staying healthy. 5. Interviews with (25) male pastors and their wives.

The conclusions they reach are that pastors appear to rely heavily on intra-personal activities for their self-care – devotional life, hobbies, exercise, taking time off from work. “It is striking to see how rarely clergy turn to relationships outside their families for support.” (p. 578) Several clergy spouses in the 5<sup>th</sup> study mentioned the importance of female friends, but “most were atypical forms of friendship that do not lead to deep trusting relationships.” (p. 578) (35 refs)

**Rumm H. Morag, Sylvie DeSouza, Peter A. Steen, Ashraf Salem, Mark Harris, Oyvind Ohnstad,**

**Performing procedures on the newly deceased for teaching purposes. What if we were to ask?**

**Archives of Internal Medicine**

**Vol. 165 # 1 (10 Jan 2005) pp. 92-96**

Practicing medical procedures on the body of a newly deceased person has been a controversial topic. It has been done because here is no health risk

to the patient. However, few institutions have policies about the matter (Does yours?) and as recently as 2002, the Council on Ethical and Judicial Affairs of the A.M.A. "encouraged" supervising doctors to get the consent of the next of kin for post-mortem procedures.

The authors of this paper conducted the same study in Brooklyn NY and in Oslo Norway. They asked adults whether they would give permission for their own body, or the body of a relative to be used, in the event of their death, for physician training.

Willingness was directly related to the age of the deceased and inversely related to the perceived invasiveness of the procedure, in both countries. The respondents in Brooklyn were much less willing to give permission than were those in Oslo. In Brooklyn, almost half would be angered even to be asked for permission, whereas in Oslo less than 10% would be angered.

(Comment: Does your institution ask, or do they still operate a "don't ask, don't tell policy"?) (21 refs)

**Timothy F. Murphy**

**Would my story get a kidney?**

**Hastings Center Report**

**Vol. 36 # 2 (Mar/Apr 2006) p.49**

A perspective on the growing phenomenon of people appealing directly to the public for organs and tissue for use in transplantation; solicitations via the internet, "directed donations" to members of groups. Murphy thinks we should "cringe a little bit" when we begin to consider such possibilities but acknowledges that we don't have enough donors available by traditional means.

**Christina M. Puchalski, Sylvia McSkimming**

**Creating healing environments**

**Health Progress**

**Vol. 87 # 3 (May/June 2006) p.30-35**

There is a crisis within healthcare in the US as a result of many forces that pressure individual professionals as they do their work. Studies report that many feel they are functioning more impersonally and less compassionately than they did when they began their work. In response, many of these people seek to engage their spirituality to help them find meaning and strength as they do their work.

This paper describes an initiative designed to test ways of restoring heart and humanity and so compassion, into health care again, by reintegrating an awareness of spirituality and spiritual care into the role of each care provider. The authors' starting

point: "Care providers who learn more about the spiritual lives of their patients find they are able to provide more personalized care while, at the same time, nurturing their own spiritual awareness and growth." (p. 30) They have developed a program which is called: "Hospital-Based Spirituality Initiative: Creating Healing Environments." The program has been piloted at five faith-based, and two secular hospitals. This paper describes the goals of the initiative, the sites, the teams and the process of the retreat method used. There are diagrams portraying: a healing environment (from three perspectives) accompanied by explanations of each perspective, and a brief review of the FICA Tool developed by Puchalski for doing spiritual assessments.

The authors evaluate what has been accomplished through the program, they give some narrative results, and include lessons and recommendations.

**Roy Sanders**

**A comprehensive approach to pastoral care  
Chaplaincy Today**

**Vol. 22 # 1 (Spring/Summer 2006) pp. 3-12**

Sanders has developed and here describes a model for assessing the theological, religious and spiritual resources of patients. The assessment is intended to be the basis for good continuity of care across the membership of a chaplaincy team.

The assessment tool he has developed is theory-based building on the work of Erik Erickson, James Fowler and Carol Nash. The assessment approach is done within a conversational style of interacting with patients, which is intended to invite the patient's "narrative story" which can "reveal the crisis between religion taught and religion experienced. It reveals where the patient's coping strategies work and where they do not work." (p.4)

The spiritual assessment system has four sections which are connected to one or more phases in a pastoral conversation: a. religious demographic and spiritual practices data; b. interpersonal relationships with family/society, church/spiritual community, and Deity/Loving Higher Power; c. intrapersonal relationship or view of self; d. interventions offered to the patient in the course of the conversation.

An additional feature of this approach is the concept of pastoral care units (PCU's). Sanders uses this concept to enable his staff to gather data which he can then use to demonstrate the work and the worth of his chaplains, allowing him (and them) to be accountable to the administration of his facility.

Sanders concludes his paper by describing the benefits of the approach he has developed: "The pastoral conversation approach promotes a non-interrogative approach to patient-directed care. The assessment articulates the level of care given and provides a tool for providing continuity. The PCU facilitates budgetary management, articulates levels of staff competency, and acts as a peg in the test for assessment validity. The assessment fits the clinical model of charting interventions and patient responses within the patient's health information record. Managing this model in order to assure the institution that consistent quality of care is provided at a predictable cost per unit of care is not difficult." (p. 6)  
The article includes all of the categories used in this approach, with detailed definitions. (5 refs)

**Jeff Sandoz**

**Neuro-spirituality: a theoretical, philosophical, and physiological examination of the conversion experience in Alcoholics Anonymous**  
**American J of Pastoral Counseling**  
**Vol. 8 # 2 (2005) p.55-71**

There have been significant number of articles published in the last 3-4 years in a variety of professional publications all dealing with the links between the physical brain and religious experiences, along with a significant number of articles claiming that evening thinking about such "relationships" is a snare and a delusion. Sandoz is aware of the controversy and points out that those who read his article will fall into one of three groups: 1. Those who hold that any physiological changes taking place when a person has a religious experience is only a neurological event. 2. Those who hold that the neural change is the result of one's contact with the Divine. 3. Those who hold no position.

His thesis is that as human beings, we are neurologically "wired" in such a way as to evoke experiences which, for some, may be evidence for contact with the Divine. He offers a theoretical understanding of what we call "spiritual experiences" from several different perspectives, all of them located within the processes of recovery – what he calls "spiritual return" from alcoholism.

(Comment: Sandoz did not construct his paradigm solely for intellectual reasons. He has done so in order to better understand the trajectory of spiritual experiences when one is undergoing a radical life change.)

**Sally A. Schwab**

**Bridge or barrier**  
**Chaplaincy Today**

**Vol. 22 # 1 (Spring/Summer 2006) p.14, 16-17**

Schwab, a chaplain in a mid-western US medical center is intimately involved in the process of organ procurement in her hospital. In talking about her work, she has met with surprise and concern from others – nurses and doctors - in health care who are unfamiliar with such involvement.

In her paper, she describes the potential roles of the chaplain: as a bridge between family and organ procurement team, or if lacking in knowledge, about the process and dynamics of becoming a barrier. She clearly believes that the chaplain should be a bridge-builder, and outlines what this can involve. (0 refs)

**Dane R. Sommer**

**Set free**  
**Chaplaincy Today**

**Vol. 22 # 1 (Spring/Summer 2006) p.15,17-18**

In this brief paper, Sommer throws down a challenge to chaplains, especially those who work with the families of dying patients who are potential organ donors.

As a "traditional chaplain" Somers has heard, and here recounts, some of the concerns family members express when they decide not to allow their dying family member to be an organ donor. "My loved one has already suffered too much." "I don't want my baby cut on no more." A body intact at the resurrection.....

According to Sommer, respect for the autonomy of patients and families has been central in his chaplaincy for the past 20 years. However, he has begun to re-think his position. He writes: "I have begun to explore the possibility that our spirituality – the part of us that deals with the meaning of life and death and connects us with others – and our religious beliefs might move us to a new model of decision-making in healthcare. Rather than always focusing on the autonomy of the individual, perhaps we chaplains might move to a broader model of interaction that includes a greater awareness of what is right and fair for all people. Is there a greater good that can be discussed when someone dies?" (p. 18) (0 refs)

**Dick Tibbits, Greg Ellis, Chris Piramelli, Fred Luskin, Roy Lukman**

**Hypertension reduction through forgiveness training**

**J of Pastoral Care & Counseling**

**Vol. 60 # 1-2 (Spring/Summer 2006) p.27-34**

This study was conducted to see if persons with diagnosed stage-1 hypertension could benefit from a forgiveness training program that would help them achieve measurable reductions in both anger expression and blood pressure. Twenty-five participants were randomly placed in either a wait-list control group or in an intervention group. The first group self-monitored blood pressure, while the intervention group took part in an 8-week forgiveness training program. At the end of the 8 weeks, the wait group became the intervention group.

Those who received the forgiveness training achieved significant reductions in their blood pressure compared to the control group. All participants did not see their blood pressure lowered, but those who entered the program with elevated anger expression scores did see significant reduction in blood pressure.

The study was done and has been written in such a way that it lays a foundation for the eventual standardization of forgiveness training. The authors hope that some day, chaplains and other clinicians can recommend hypertensive patients, who have been screened for elevated anger, to forgiveness training programs for the self-management of high blood pressure. (25 refs)

**Ralph L. Underwood**

**Enlarging hope for wholeness: ministry with persons in pain**

**J of Pastoral Care & Counseling**

**Vol. 60 # 1-2 (Spring/Summer 2006) p. 3-12**

Chronic pain can have a profound impact on a person's faith and theology. Underwood is concerned that with the current emphasis on health and wholeness in the church and in US society as a whole, it is easy to overlook the role that chronic pain plays in forming the soul, or erodes the faith of a believer.

Underwood is concerned that the major theme in pastoral ministry, especially by those in mainline Protestant traditions, has encouraged believers to identify with suffering, to reach out to the poor, and to become more attuned to the social context in which persons suffer and are oppressed. He admits that these messages are consistent with the gospel message, but asks whether on their own, they may short-change the healing dimension of ministry, and so run the risk of not being fully sustaining. He believes that to be the case, that asking people to simply identify with the suffering Jesus is to deny them of another aspect of the Gospel. Underwood asks: "What understanding of God might under gird a more paradoxical ministry of sustaining and healing? I want to suggest that any understanding of God based on the cross is incomplete if it is not balanced with an understanding of God based on the resurrection of Jesus Christ..... we lack a solid basis for the paradoxical ministry of sustaining and healing." He believes that by holding the cross and the resurrection together in one theological vision, "Christian mission can be both one of compassion and one of dynamic restoration." (p. 10) (26 refs)