

THE ORERE SOURCE

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Dan G. Blazer

Religious beliefs, practices and mental health outcomes: what is the research question?

American J of Geriatric Psychiatry

Vol. 15 # 4 (Apr 2007) pp. 269-272

Studies looking at the relationship between religion and health often trigger a strong visceral reaction in persons who are either in pastoral care, or in medicine. The response can be either positive or negative. The strength of those reactions suggest to Blazer that there are more emotionally charged questions lurking in the background. He examines such reactions in this editorial because, he believes, we should be clear about why people are trying to understand whether there are linkages or associations that can be made between religion and health, and why we should even be interested. He names two persons who are on opposite sides of the divide in this religion/health debate. Larry Dossey (Healing Words: The Power of Prayer and the Practice of Medicine) asserts that religious practices are as vital to healing as medications or surgery. Richard Sloan (The Unholy Alliance of Religion and Medicine) asserts that there are no curative powers in practices such as prayer, and that "the contamination of medical practice with unproven 'spiritual' approaches seriously undermines the effective as well as the ethical practice of medicine."

Blazer takes a position that avoids both sides of the controversy. He argues that we should carefully look at research about religion and health, absorb what the researcher(s) are trying to do in a study, critique it, and finally accept or reject the findings based on how well they have addressed the specific questions they are asking of the data - nothing more and nothing less. He suggests that this means we should put aside the question whether or not we can study religion and health empirically. Rather he urges us to "accept the research questions for what

they are: questions about self-reported religious beliefs/practices.....".

Blazer's editorial was occasioned by three studies in the same issue of AJGP concerning religion and depression: Braam et al "Prayer and depressive symptoms in a period of secularization: patterns among older adults in the Netherlands." Koenig "Religion and depression in older medical inpatients". Herbert et al: "Religious beliefs and practices are associated with better mental health in family caregivers of dementia patients: findings from the REACH study. They can all be found in Vol 15 # 4 (Apr 2007) of the American J of Geriatric Psychiatry. (18 refs)

James A. Blumenthal, Michael A. Babyak, Gail Ironson, Carl Thoresen, Lynda Powell, Susan Czajkowski, Matthew Burg, Francis J. Keefe, Patrick Steffen, Diane Catellier, for the ENRICHD Investigators

Spirituality, religion and clinical outcomes in patients recovering from an acute myocardial infarction

Psychosomatic Medicine

Vol. 69 # 6 (Jul/Aug 2007) pp. 501-508

After more than 850 articles on religion and mental health, and 350 on religion and physical health, there are still some researchers who dismiss findings which suggest that there is a link or association, mainly because has been a lack of care in the conduct of many of the studies as well as a lack of rigor in many of them. There is a further significant problem. Most studies concerning religion (measured by means of attendance at worship) and health have been done with healthy persons. This study is different. It was designed to examine three key aspects of religion - spiritual experiences, prayer, and church attendance - on objective outcomes in a sample of patients with coronary heart disease. It was done within a larger

study of persons recovering from coronary heart disease, a study called ENRICHED.

The results showed little evidence to support the belief that religion and spirituality can improve physical health outcomes in this group of people.

Patients who attended church regularly tended to have lower depression and more social support compared with patients who never went to communal worship. Higher spirituality scores were associated with less depression.

Patients with high spirituality scores or who engaged in regular prayer had the same likelihood of dying or suffering a recurrent non-fatal heart attack as persons who indicated they were not high in spirituality, or who seldom or never prayed. (48 refs)

Francis Buxton

Spiritual distress and integrity in palliative and non-palliative patients

British J of Nursing

Vol. 16 # 15 (9 Aug/12 Sept 2007) pp. 920-924

The report of a hospital chaplain's research study concerning 22 patients in a Midlands (England) acute hospital. They allowed their stories to be recorded concerning experiences of spiritual distress, their hopes for spiritual integrity, and the means that they found helpful in moving from distress to integrity. The participants were from either a palliative care setting, or were receiving one of a variety of therapies in a non-palliative setting.

There was little difference, overall, between the responses of those in either group. The most frequently expressed spiritual integrities were the hope to help others, and the use of the illness as an opportunity for personal growth and acceptance. Support from hospital staff was seen as most important in assisting change from distress to integrity.

Chaplain Buxton has recently retired.

Laurence T. Cotter

Continuing the spiritual transformation of the hospice movement

American J of Hospice & Palliative Medicine

Vol. 29 # 4 (Aug/Sept 2007) pp. 257-258

Cotter draws a parallel between the transformation that occurred in what Karen Armstrong (in her book *A History of God*) has called the "Axial Age" of over 2000 years ago, and the transformation that the hospice movement has initiated in Western medicine. "The hospice movement might be looked

at as a min-axial age in the history of Western medicine.

This hospice chaplain, however, warns that while the hospice movement has been about transforming "the harmful practices of medicine-driven technology and profit" those in hospice care should not impose impossible expectations on themselves. "...it is not possible to make living and dying trouble-free."

He concludes: "For the Axial Age sages, wise detachment, and engaged loving compassion were the two spiritual legs on which humanity can walk on the way toward union with God. On these two legs we are able to stand up to our suffering as human beings and we are able to lift up our neighbor so that together we may be able to help each other confront and transcend our suffering." (p. 258) (1 ref)

H.T. Davies, T. Wiseman

Introducing "ERIC", a living research ethics database

J of Medical Ethics

Vol. 29 # 2 (Apr 2003) pp. 117

This brief report describes an on-line database that has been created in England to be a resource for ethics committees, especially research ethics committees. The authors describe the kind of information in the database, and what makes it more than "just another web site." <http://www.ericonline.co.uk> and not to be confused with a U.S. educational site with nearly the same URL. (0 refs)

Turner de Sales

As the worm turns - hope as meaning construction in the wake of grief and loss

Advances in Nursing Science

Vol. 30 # 3 (Jul/Sept 2007) pp. E50-E60

In 2002, de Sales carried out a research project which was designed to help her understand how young people hope. She studied 10 young people to find out the meanings they ascribed to their experiences of hope. She published the results (See The Orere Source Issue 85), but apparently felt that she was missing something. So she went back to her original data and has found additional insights that she now presents in this paper.

She believes that there never will be just one satisfactory definition of hope. She thinks that instead of a cognitive approach, nurses (and chaplains) should be placing greater emphasis on identifying, and using "actualizing hope" care practices. She argues that there should be "greater emphasis placed on purposefully using implicit as well as explicit

hope-facilitating strategies" with those in our care. (p. E52)

Her analysis of three cases from her earlier study, plus her description of the work of The Hope Foundation at the University of Alberta (p. E51-E52) provide specific examples of ways in which people can be assisted to find hope. The Foundation has even developed a hope-focused counseling process which they have continued to refine since its inception in 1992. (38 refs)

Eckhard Frick, C. Reidner, M.J. Fegg, S. Hauf, G.D. Borasio

A clinical interview assessing cancer patient's spiritual needs and preferences

European J of Cancer Care

Vol. 15 # 3 (Jul 2006) pp. 238-243

This paper reports the work of a group of doctors in Germany who want to develop a way of assessing the spiritual needs of cancer patients. This is the report of the first step, the development and use of a short (15-30 minute) interview to assess spiritual needs and preferences of patients. (n=30) The doctors used a semi-structured interview known by the acronym SPIR.

S = Would you describe yourself - in the broadest sense of the term - as a believing/spiritual/religious person?

P = What is the place of spirituality in your life? How important is it in the context of your illness?

I = Are you integrated in a spiritual community?

R = What role would you like to assign to your doctor, nurse or therapist in the domain of spirituality?

After the interview both the interviewer and the patient was asked to rate the patient's perceived helpfulness or distress in response to the interview using a 10-cm Visual Analog Scale (VAS, from 'not at all' to 'extremely'). Patients were asked to rate the importance of their spiritual beliefs. Interviewers, independantly rated their perception of the importance of spirituality to the person they had interviewed. There was a high degree of correlation in the ratings by the patient and the interviewer.

Finally, each person was asked if they wished to talk further with someone about these matters. Eighteen wished to continue with the interviewer, 4 with another person, and 9 not at all. (slight statistical error here)

Reading the paper, one gets the sense that the authors are walking cautiously in unfamiliar territory. Additionally, the research was done in a country

where the organized church is not strong, where most people "believe" but do not "belong." Yet they report that this short assessment was "well received by both patients and physicians." (50 refs)

Nicole Hochhausen, Elizabeth M. Altmaier, Richard McQuellon, Stella M. Davies, Esperanza Papadopolous, Shelly Carter, Jean Henslee-Downey
Social support, optimism, and self-efficacy predict physical and emotional well-being after bone marrow transplantation

***** J of Psychosocial Oncology**

Vol. 25 # 1 (- 2007) pp. 87-101

With bone marrow transplantation (BMT) becoming increasingly common, it has become important to learn whether or not there are factors, especially psychosocial factors which will affect the patient's quality of life after surgery; and if there are, perhaps something can be done in anticipation of the surgery to ensure the best quality of life possible.

Health-related quality-of-life (HRQL) refers to the extent to which physical, emotional, and social well-being is directly affected by a medical condition or its treatment, including such things as symptoms, interpersonal relations, and emotional health.

Social support (defined as a person's perception of the availability of support in their social context), optimism (defined as a person's tendency to expect positive outcomes in potentially negative situations) and self-efficacy (defined as a person's self-evaluation of their confidence that they can perform tasks relating to having an illness and undergoing treatment e.g. seeking information) - these three psycho-social variables have all been found to be able to predict better HRQL in cancer patients.

In this study, the authors wanted to understand whether pre-BMT surgery levels of social support, optimism, and self-efficacy could predict post-BMT levels one year after surgery.

The answer was clearly yes, the implication being that if ways can be found to address questions of social support, optimism and self-efficacy beforehand, patients will more fully benefit from their surgery, both physically and emotionally. (Comment: For chaplains, the challenge is to identify pastoral interventions that will address these areas of patient's lives, and to learn how to most effectively intervene.) (26 refs)

Kathie Kobler, Rana Limbo, Karen Kavanaugh
Meaningful moments - the use of ritual in perinatal and pediatric death

MCN American J of Maternity and Child Nursing

Vol. 32 # 5 (Sept/Oct 2007) pp. 288-295

Rituals provide meaning and can encourage the healing processes which people seek and need following times of painful transition. However, despite the prevalence of perinatal losses (through stillbirth, miscarriage or newborn death) and pediatric deaths, little has been written by nurses about the use of rituals at such times. Even chaplains, some of whom spend a great deal of their time providing pastoral care around these events have written only a little about their use of ritual in these painful times. O'Reilly is a notable exception. Her paper was published, though in an educational journal: *Religious Education* Vol. 85 # 4 (1990) p. 536-547.

While this article was written for nurses, the focus on aspects of intention, participation, and meaning-making will make it useful readings for chaplains. Initiating the discussion about ritual, and the timing of the ritual itself are critical matters discussed. The authors' writing reflects familiarity and sensitivity to the issues which arise. The paper could usefully be given to nurses who seem to have limited appreciation for the potential of rituals in their unit. The paper does not imply that such rituals are the exclusive domain of either nursing or chaplaincy.

(Comment: A chaplain looking for a research project might consider exploring the outcomes of such rituals, both in the short- and in the long-term. (47 refs))

Harold G. Koenig

Religion and depression in older medical patients

American J of Geriatric Psychiatry

Vol. 15 # 4 (Apr 2007) pp. 282-291

This paper outlines the largest study to date which examines the associations between religious involvement and depression in hospitalized older medical patients. Koenig wanted to better understand the religious characteristics of persons in this group with either a major or minor depression, to compare the religious characteristics of these depressed patients with those of non-depressed patients, and to examine the religious characteristics in relation to the type and severity of their depression.

Koenig used data from a study done between 1999 and 2003 which had been gathered to examine the

impact of patient characteristics on the course of depression in patients hospitalized for congestive heart failure, or chronic pulmonary disease. For this study, he separated patients into three groups - persons with major depression (n=411); with minor depression (n=585); and those with no depression (n=428). Koenig was able to be much more careful about "religious characteristics". Studies such as this are often criticized because they use one question to assess "religion. (It is usually a question about church/synagogue attendance.) This study asked about religious denomination (6 categories), religious/spiritual categories, religious attendance, other group religious activity (say, prayer meeting etc), private reading of Bible or religious literature, electronic church (watching TV services), and intrinsic religiosity (using the 10-item Hoge Intrinsic Religiosity Scale. This is a tried and tested scale, first published in 1972.).

An examination of the results shows that: patients involved in religious group activities were significantly less depressed, and that held true when various demographic, psychiatric, and physical health factors which might have influenced this finding were taken out of the equation. When the issue of social support was also taken out of the mix, it was shown to be affecting the depression findings, but only slightly.

Patients with higher private religious activity scores also had lower depression-severity scores.

Finally, an inverse relationship between intrinsic religiosity and severity of depression was found. Persons who were more intrinsically religious were usually less severely depressed.

There was no relationship found between any religious characteristics and type of depressive disorder.

To summarize: this study adds to the growing number of studies in both healthy and medically ill persons that show an inverse relationship between religion and depression. Because of the nature of the study, causality cannot be established. Koenig notes, however, that the findings might be explained in several ways. The findings support the belief that religious involvement may protect older persons from depression, and if they become depressed, it may help to lessen the severity of the symptoms by a number of ways. e.g. by providing persons (depressed and non-depressed alike) with hope, meaning and purpose, and social support.

It is of interest that in this study it was found that private religious activities (prayer and religious reading) had the strongest inverse relationship with depression. This would be consistent with religion

being a personal coping behavior; though there are other explanations, as Koenig outlines.

(Comment: The hospital chaplain who can identify depression in a patient has accomplished the first task, a crucial one in their pastoral care of that patient. The second task is knowing how to most effectively encourage that person in their religious life, a subject not the focus of this paper.) (34 refs)

Mary K. Moore

Chaplains increase efficiency

Healing Spirit

Vol. 2 # 2 (Fall 2007) pp. 4-7

Moore describes the growing influence of technology on spiritual care. She focuses on the work of a small number of chaplains - Robert Pfennig, Jon Overvold, Diane Jorengson, Art Lucas - who in different settings across the U.S. have worked with their information technology (IT) department to create technology which will assist chaplains to perform their ministries more effectively. What this means, specifically, is described in the article. (0 refs)

Mary K. Moore

The emergence of spiritual care department

Web sites

Healing Spirit

Vol. 2 # 2 (Fall 2007) pp. 9-11

Gives examples of ways in which pastoral care departments are augmenting their institutional ministry by means of Web sites which they use to communicate with staff, and post resources for institutional staff use. Examples are given from three different institutions. (0 refs)

Christine Newman, Christopher Newell

Embracing cancer: a conversation of theology, health and ethics

***** J of Religion, Disability & Health**

Vol. 11 # 1 (- 2007) pp. 65-74

This is a Socratic dialogue by e-mail between two friends - one with a disability and living in Australia; the other, a nurse living with cancer in New Zealand. The article starts with the woman, Christine, who is three years past a diagnosis of ovarian cancer. She tells her friend, an Episcopal priest that a person had told her when she received her diagnosis that she should "rebuke" the cancer. Instead, she writes, she has chosen to embrace it. She describes at length what this means.

The priest reflects back to her that in her thinking and responses she is throwing down the gauntlet to the biomedical model of cancer, and especially to the ways that the church has uncritically accepted that model. His theology has been influenced by the late Bill Williams, a Lutheran pastor whose book Naked Before God: the Return of a Broken Disciple has been a liberating book for many persons of faith struggling to make sense of their suffering. (10 refs)

Ann M. Osborne, Paul Derrickson

Identifying spiritual needs in patients presenting with chest pain when catheterization reveals no clinical etiologies

Chaplaincy Today

Vol. 23 # 2 (Autumn/Winter 2007) pp. 10-14

A small percentage of patients, after experiencing chest pains which suggest they are having a heart attack, are found by means of cardiac catheterization to have no clinical signs of heart disease or of having had a heart attack. This leaves these people distressed, and they tend to return to their doctors multiple times for more testing.

Osborne and Derrickson, chaplains at Penn State Medical Center in Hershey, Pa have found in the medical literature reports of unusual heart activity which seems to mimic a heart attack. Broken heart syndrome is one of the three research papers they refer to as background for their study.

In reflecting on the reports of absent physical findings, and having read the literature, the authors hypothesized that these patients might be carrying some spiritual/psychosocial distress, and/or stressful family system dynamics which were presenting themselves with no physical cardiac indicators.

After designing an intervention and gaining the necessary consents, a chaplain interviewed a series of 25 patients who had received normal test reports, after having experienced chest pain. Each interview included eight open-ended questions, which had been developed by the Hershey Medical Center Research Team. The questions encouraged exploration of the level of spirituality and/or psychosocial distress in the person's life, or within their immediate family system. The interviews took place right after the catheterization, and lasted between 20 to 60 minutes.

The questions allowed patients to express their feelings concerning six spiritual need categories which were first suggested by Deal and Gross in their Scale of Basic Pastoral Care published in 1999. The authors assessed patients' responses in relation to the six categories of spiritual need.

Eight women and 17 men were interviewed. All expressed strong feelings about one or more of the spiritual concerns.

In their results section, the authors list 10 major themes which emerged from the spiritual concerns. They also draw attention to the questions that triggered the greatest response from respondents. They were fear (versus peace); meaningless (versus hope and grief); and loss (versus reinvestment/reintegration).

The authors and their cath lab colleagues believe they have made an important discovery. Anecdotal reports also indicate a benefit to patient morale as a result of their interview. The lab staff seem to agree. It is now protocol that if a patient shows no clinical signs at catheterization, a pastoral care consult is automatically and immediately scheduled. (5 refs)

Crystal L. Park

Religiousness/spirituality and health: a meaning systems approach

J of Behavioral Medicine

Vol. 30 # 4 (Aug 2007) pp. 319-328

It is clear from what is now a great deal of research data that there are links or associations between health, on the one hand, and spirituality/religion on the other. What is still largely unknown is exactly how the various aspects of spirituality and religion affect health and health outcomes. Park suggests that by using a "meaning systems framework", some space could be made within the health-religion/spirituality relationship, thus making it easier to postulate and investigate possible pathways.

She explains what a meaning system is before turning to the question of mechanisms. She understands meaning systems to consist of cognitive, motivational, and affective components, reflected in global beliefs, global goals, and a sense of meaning and purpose. To state it in another way: "Meaning systems comprise the lenses through which individuals interpret, evaluate, and respond to their experiences and encounters." (p.320)

The section on mechanisms is essentially a review of a number of fields of study in which health and R/S have been associated: a sense of meaning in life; social support; body sanctification; health locus of control; gratitude/hope/optimism/ compassion; health behaviors; and, positive/negative affect/stress. In every case, the mechanisms are as yet essentially lacking. Despite this, she concludes

with suggestions for future research, because in spite of there currently being little data, in time, she believes, we will understand why and how. (95 refs)

Mary R. Robinson, Mary M. Thiel, Meghan M. Backus, Elaine C. Meyer

Matters of spirituality at the end of life in the paediatric intensive care unit

Pediatrics

Vol. 118 # 3 (Sept 2006) pp. e719-e729

This is the of a helpful study which examines perspectives of end-of-life care from 56 parents who had had children die in the paediatric ICU's of the three major hospitals - Children's Hospital in Boston, Massachusetts General Hospital, and Tuft's New England Hospital. Parental responses to open ended questions asked in anonymous questionnaires were examined and responses separated according to themes describing the nature and role of parental spirituality at the end of their child's life. The deceased children ranged from new born to 18 years, and the parents completed questionnaires 12 to 45 months after their child's death. Five open-ended questions were asked:

1. What was most helpful to you in getting through that time at the end of your child's life?
2. What was the least helpful to you in getting through the time at the end of your child's life?
3. How can the hospital staff improve their communication with parents at this difficult time?
4. What advice do you have for hospital staff members in helping parents during this difficult time?
5. What advice do you have for other parents who facing a similar situation?

Note that the questions do not ask about religion or spirituality (R/S) explicitly, so the fact that these topics came up so frequently in the analysis suggests that R/S matters were of considerable importance to this group of parents. Four explicit R/S themes were identified from the responses; Prayer Faith. Access to and care from chaplains and clergy. Belief in a transcendent quality to the parent-child relationship that endures beyond death.

Implicit spiritual themes identified were: Wisdom. Values. Hope. Trust. and Love. Examples of responses to the questions are included to illustrate each of the themes.

There are a number of valuable insights to be gained from the response. First, that it really does take time for a parent to make meaning concerning their child's death, and that a premature attempt at making meaning by someone - even a chaplain - can be distressing to a parent. Another insight: parents take very seri-

ously identifying and doing is right for their child and their family in these situations. Finally: the value of the chaplain and community clergy working together was emphasized by a number of parents.

Among their conclusions, the authors of this study write as follows: "Our data lend additional support to studies that have documented the immediacy and the abundance of parental spiritual needs in the PICU. The American Academy of Paediatrics, and the Institute of Medicine, in their groundbreaking book *When Children Die*, emphasize the clinical and ethical imperatives of incorporating spiritual needs assessment and care at the end of life. The Joint Commission on the Accreditation of Healthcare Organizations mandates that a patient's spiritual needs be both assessed and accommodated." (p. 727)

(*Comment:* This article will be of interest to paediatric chaplains; the first two authors are chaplains. It is also a model paper for other chaplains to emulate as they work toward publication of research of their own.) (64 refs)

Bill Serdahely

**Questions to a hospice chaplain
Chaplaincy Today**

Vol. 23 # 2 (Autumn/Winter 2007) pp. 32-35

Serdahely is a hospice chaplain affiliated with a community hospital. He begins his paper by noting that he is often asked, both by patients and/or loved ones, to explain three phenomena: predeath visions, predeath dreams, and the length of time the dying process takes. So he has organized his paper to answer three questions: 1. What is the difference between a predeath vision and a hallucination? 2. Do non-responsive/comatose people dream, and if so, what are the implications? 3. Why is the dying process often so long and so unpredictable both for alert as well as nonresponsive/comatose patients?

He uses examples from his ministry to explore answers to these questions. (7 refs)

Bruce W. Smith, Alex Zautra

The role of purpose in life in recovery from knee surgery

Int J of Behavioral Medicine

Vol. 11 # 4 (Dec 2004) pp. 197-202

Victor Frankl wrote about his experiences as a Jewish holocaust victim, including his observation that when a person had no reason for living they tended to die quite quickly thereafter. His observation has

been widely quoted over the past half-century, in books and articles, but almost nothing has been done to clinically verify his observation.

Now Smith and Zautra have examined the role of a sense of purpose in life (PIL) in recovery from knee replacement surgery in 64 surgery patients. Each had been diagnosed with severe osteoarthritis of the knee. Before their surgery, data was gathered and analyzed and health changes predicted for 6 months after the surgery. When considered on its own, PIL at the 6-month point was related to: less anxiety, less depression, less negative affect, less functional ability, less stiffness, and more positive affect.

From the authors' perspective, the issue of how to provide an intervention is the next issue to be addressed. (24 refs)

Marilyn Smith-Stoner

**End-of-life preferences for atheists
J of Palliative Medicine**

Vol. 10 # 4 (Aug 2007) pp. 923-928

Pastoral care for atheists is not a subject that has been written about by chaplains. (There was one presentation at the 2004 U.S. Association of Professional Chaplains conference, the nearest exception.) Perhaps this article will encourage some to address this situation, especially as regulatory standards in the U.S. require an individualized plan of care for each patient and their family, which includes this group of the population. Little is known about the end-of-life (EOL) preferences of atheists, and the aim of this study was to find out.

The aims of this pilot study were two-fold: 1. to explore the EOL preferences for atheists; and, 2. to apply a 3-fold model of spiritual care (intrapersonal, interpersonal, and natural connectedness) to assess the appropriateness of potential interventions for this group. Eighty-eight persons completed either an on-line or a paper survey.

The findings will provide concrete guidance for chaplains who see their ministry as including this group of people. One finding: for some atheists, use of the term "spirituality" is acceptable and appropriate, while for others it is not. (25 refs)

John Swinton

Forgetting who we are: theological reflections on personhood, faith and dementia

***** J of Religion, Disability & Health**

Vol. 11 # 1 (- 2007) pp. 37-63

Swinton, now a professor of theology, and former nurse and chaplain, believes that society today repre-

sents personhood and dementia in ways that fundamentally misunderstand what it means to the human and to live humanly. He asserts that persons should not be defined by what they do, but by what they are, or even further, by whose they are.

In his paper, he develops a practical theological critique of contemporary understandings of personhood as they relate to the experience of dementia, and strongly argues for a revised understanding, one which is centered in God's commitment to human beings, a commitment not defined by doing, but by being with and for the other. He argues for the fullness of the personhood of all persons with dementia, in all circumstances, and in so doing, opens the possibility of creating new forms of caring practices which will move us beyond the culturally constructed assumptions of dementia. To do this, he draws on some of the insights of Dietrich Bonhoeffer. (50 refs)

Mang Tiak, Cindy Vanover

**Touchstones: tangible spiritual nourishment
Chaplaincy Today**

Vol. 23 # 2 (Autumn/Winter 2007) pp. 36-37

The importance of tangible items such as beads, shawls, rosaries etc is well known across different religious traditions as a mean of providing comfort and meaning. This note from The Methodist Hospital, Houston describes the search of the spiritual care staff there for something tangible they could leave with patients. They looked for something that was not religion-specific.

They finally settled on "touchstones", "smooth rocks with words etched into them: serenity, peace, strength, grace and patience" are a few of them. The first author admits she was somewhat skeptical about the new practice. Then she describes the occasion that dramatically realigned her thinking. (0 refs)

Larry VandeCreek, Daniel H. Grosseohme, Judith R. Ragsdale, Christine L. McHenry, Celia Thurston

Attention to spiritual/religious concerns in pediatric practice: what clinical situations? What educational preparation?

Chaplaincy Today

Vol. 23 # 2 (Autumn/Winter 2007) pp. 3-9

This paper reports research done in three academic midwestern pediatric hospitals by 4 chaplains, and a pediatrician. The pediatricians were surveyed by mail (n=494 responses, 67%) to 1. identify the clinical

situations in which they considered that the spirituality/religion (S/R) of patients/families played an important role within their practice; 2. learn what education they had received in medical school and during their residency to prepare them to respond to R/S concerns; and, 3. discover their interest in continuing education concerning the role of S/R in their clinical practice.

The paper begins with a review of the literature concerning these 3 topics (they have located 23); they describe their research methods, and the results.

The results indicate that these pediatricians believe R/S concerns are important at the end of life, in medical crises, and when medical management is affected by specific religious beliefs. There is also a valuable section detailing specific topics they think would be of educational benefit to them. (27 refs)

Amy B. Wachholtz, Michelle J. Pearce, Harold Koenig

Exploring the relationship between spirituality, coping and pain

J of Behavioral Medicine

Vol. 30 # 4 (Aug 2007) pp. 311-318

Persistent pain is a complex and multidimensional experience, and when we try to understand it, we have to dip into the fields of biology, psychology, social and spiritual factors. It has been proposed that, because spirituality/religion can increase and decrease pain, it should formally be included in the bio-psycho-social model of pain, which would become a bio-psycho-social-spiritual model.

It has also been found that persons with chronic pain use religious and spiritual forms of coping, such as prayer, and seek spiritual/religious (R/S) support to manage their pain.

In this article, the authors examine the relationship of the experience of pain and R/S with a view to understanding not only why some people rely on their R/S to cope with their pain, but also how R/S may impact the experience of pain and help or hinder the coping process. They also note that people who cope using negative forms of R/S coping are more likely to experience greater levels of pain.

As a review article the authors provide a clear overview of largely unknown territory. They provide encouragement for chaplains to consider how best to bring R/S resources to bear for the benefit of their patients. (56 refs)

Steve Worsley, Pam Duchene
Extending an ethics program with information technology

Health Progress

Vol. 88 # 6 (Nov/Dec 2007) pp. 74-76

In this article, the authors describe how in their hospital, they are using computer-based learning to educate the entire staff concerning ethical issues. With hospital staff increasingly comfortable encountering their mandatory continuing education via computerized learning, (say on safety, changes in policy, infection control to name some examples) they have found that it is not difficult to provide continuing education for staff on issues for which they, the chaplains have responsibility. Ethical issues is where they have begun, and their efforts have been well received. (4 refs)

Amos Yong

Disability, the human condition and the spirit of eschatology long run: toward a pneumatological theology of disability

***** J of Religion, Disability & Health**

Vol. 11 # 1 (- 2007) pp. 5-25

In searching for an alternative theology of disability that incorporates, but is not limited to the biomedical and socio-constructivist models, Nancy Eiesland's proposal of Jesus Christ as "the disabled God" is an attempt to redefine disability in anthropological, ecclesiological, and theological terms. Yong suggests that this approach unfortunately may be less than helpful in addressing the eschatological hope that motivates many persons with disability. He proposes a new methodological model of the Spirit as a "community-enabling God", an

approach that is able to appropriate insights from previous approaches, even as it seeks to complement Eiesland's proposal, and further develop a trinitarian and eschatological theology of disability. (39 refs)

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The chaplain as an authentic and ethical presence
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In their chaplaincy training in the U.S., participants are commonly encouraged to be "fully present" to all people, whoever they may be and whatever their religious or spiritual background. The authors of this article challenge whether this is always possible. Is it beneficial to the chaplain, or to the individual being served? When a chaplain recites words to which they do not ascribe, are they spiritually harmed? Their focal question: Just because chaplains could do something, does it mean they should?

They define and contrast the concepts of religion and that of spirituality. They describe the role of the professional chaplain, pointing out that there are essentially two types of chaplains: multi-faith - those who have a responsibility to minister to people in profess a religious faith other than their own; and mono-faith chaplains - those who minister to persons who happen share their religious faith. Two of the authors of this paper are multi-faith and occasionally mono-faith chaplains. The third is a mono-faith who is occasionally a multi-faith chaplain. They discuss the goals of the professional, multi-faith chaplain before turning to the crucial issues that have to do with authenticity and the ethics of being a multi-faith chaplain. (12 refs)