

THE ORERE SOURCE

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Paul S. Bay, Daniel Beckman, James Trippi, Richard Gunderman, Colin Terry
The effect of pastoral care services on anxiety, depression, hope, religious coping, and religious problem solving styles: a randomized controlled study

J of Religion and Health

Vol. 47 # 1 (Mar 2008) pp. 57-69

Can it be demonstrated, by means of scientific study, that pastoral care by chaplains effect changes in hospitalized persons, changes that move them towards greater health and wholeness? Most chaplains, indeed most health care professionals would agree that what chaplains do in their ministry does have value for patients, but the question just asked is more specific: can the effect of pastoral care be identified and measured in a tangible way? Bay and his colleagues have made an impressive attempt to do so in what it is hoped will be the first of future attempts by chaplains to replicate and build on what this group has done.

So what did they do? They report a study to measure the effect of one chaplain's ministry on coronary artery bypass graft (CABG) patients over a period of time, with testing done pre-surgery, at 1 month and then at 6 months post-surgery in.

In establishing the project, they followed the necessary steps for gathering reliable data: they put patients into 2 groups randomly, with the members of one group receiving pastoral care, the other group's members not (unless their own parish clergy visited). They created a pool of patients (who were then split into the two groups) that would be sufficiently large to produce relatively reliable results. They hypothesized ahead of time what they thought would happen as a result of the pastoral care that would be given and then established ways of looking for the changes. They had someone else (not the chaplain) do the initial qualifying and testing of

the patients so the chaplain's interactions with the patient and family would be only the planned pastoral care. They sought and received the permission of the hospital's Institutional Review Board to do the research.

The authors review what has already been described in the literature concerning some of the links between religion and health They also carefully describe the method of their research, the four questionnaires they used (Hospital Anxiety and Depression Scale - HADS), the Herth Hope Index, the Brief R-COPE which identifies coping styles, and the Religious Problem Solving Scale which Pargament first described in 1988 and which is now a well-tested instrument.

Bay et al describe very carefully just what he, Bay, did in his pre-surgery visit, his visit to the family during the actual surgery, the 3rd visit on surgery day +2 and the 4th visit and the 5th visit. The mean total time of the 5 visits totaled 44 minutes per patient and family.

We are given a description of the data-gathering and the results. In the results we are presented with the comparison scores and analysis for anxiety, depression, hope, positive and negative religious coping styles found in both groups.

A significant difference was found between the two groups in positive religious coping, and a marginally significant difference in negative religious coping. No significant differences were found between the groups regarding anxiety, depression, hope, or the self-directing, deferring or collaborative subscales of the Religious Problem Solving Scale.

The discussion section is an extended one with the authors seeking to understand why some of their anticipated findings did not emerge.

(Comment: This paper is important for two major reasons. First, it is an example of a very useful piece of research that is sophisticated in its design and exe-

cution. The writing of the article is a model for other chaplains to emulate.

Second, and this is what all good research papers do - it gives all of us in chaplaincy the information we need in order to discuss and think about how to advance and strengthen the field of pastoral care.) (30 refs)

David B. Bekelman, Sydney M. Dy, Diane M. Becker, Llan S. Wittstein, Danetta E. Hendricks, Traci E. Yamashita, Sheldon H. Gottlieb

Spiritual well-being and depression in patients with heart failure

J of General Internal Medicine

Vol. 22 # 4 (Apr 2007) pp. 470-477

This paper describes research that began with two facts. First, that patients with chronic heart failure are commonly depressed and have a poor quality of life, are hospitalized more frequently than most, and have a higher mortality rate. Second, that spiritual well-being has been shown to be an important resource in persons with terminal cancer, and has been linked to less depression in this group of people. They wondered, is the same true for patients in heart failure?

They studied 60 persons in two cardiology clinics - one at a community hospital, the other at an academic referral hospital, both in Baltimore. Persons had to be 60 or older; in fact the median was 75 years. They had to be sufficiently in heart failure to meet a certain clinical threshold (NY Heart Association class II-IV heart failure).

Each person was assessed for depression, and their spiritual well-being was assessed using a well-tested tool: the Functional Assessment of Chronic Illness Therapy - Spiritual Well-Being (FACIT-sp) scale. It is a 12-item self-report questionnaire that has been developed and validated with medically ill patients. (Chaplain George Fitchett of Chicago has co-authored a paper using this test.) The scale measures overall spiritual well-being, and includes two sub-scales: meaning/peace, and faith. The faith subscale assesses the relationship between illness and faith and spiritual beliefs. The meaning/peace subscale measures a person's sense of meaning, peace and harmony, and purpose in life.

The overall results showed in this group of patients, greater spiritual well-being, particularly for those who scored high on the meaning/peace sub-scale was found in persons who showed less depression;

a very significant finding in that 30% of patients in heart failure are significantly depressed.

The authors conclude that "enhancement of patient's sense of spiritual well-being might reduce or prevent depression and thus improve quality of life and other outcomes in this population."

Having presented their findings and conclusions, the paper concludes with an extended section which is of significance. Bekelman and his colleagues are aware of the difficulties involved in measuring spiritual well-being; they discuss the issues at some length. But they then raise some questions which have implications for chaplains. First, why was it that greater meaning/peace but not faith was strongly correlated with less depression? (Our question - what are the implications of this for pastoral care?) Second, what are the spiritual interventions that might most effectively strengthen a person's sense of meaning/peace? The authors (only in passing) mention that chaplains "may also be helpful" to this group of patients, but as chaplains, which are our most effective interventions? They mention interventions based on Victor Frankl's work, Dignity therapy and others. Have we, as chaplains, developed and described interventions more useful than these? (45 refs)

Paolo Bruzzone

Religious aspects of organ transplantation Transplantation Proceedings

Vol. 40 # 4 (May 2008) pp. 1064-1067

Presented at an international conference, in his paper Bruzzone has gathered together in one place information about organ transplantation and its acceptability to persons from a wide range of religious traditions. He has looked world-wide in gathering his information.

Some of his findings: No religion formally forbids donation or receipt of organs or is against transplantation from living or deceased donors. Only some orthodox Jews may have religious objections to "opting in."

Transplantation from deceased donors may be discouraged by Native Americans, Roma Gypsies, Confucians, Shintoists, and some orthodox rabbis.

Some south-east Asia Muslim ulemas (scholars) and muftis (jurists) oppose donation from human living and deceased donors because the human body is an "amanat" (trusteeship) from God and must not be desecrated following death. However, they encourage xenotransplantation research.

The facts Bruzzone presents are wide in their scope and the high fact content in this paper prevent easy

summary. "Bonus points." Payment for organs. Acceptability (or not) of xenotransplantation. Directed organ donation. Obligation to be a donor. All are included.

(Comment: A paper for your departmental resource file.) (12 refs)

George A. Burn

A life-context approach for developing end-of-life decisions

Chaplaincy Today

Vol. 24 # 1 (Spring/Summer 2008) pp. 23-25

Hospitals in the U.S. (if they receive any money from the government) are required to ask patients who are being admitted, if they have completed an advance directive document. If they haven't, they must be given the opportunity to do so. It is commonly a chaplain who then becomes involved.

Burn believes that this is not the ideal context within which such decisions should be made, and so over several years he has developed a format which he uses in local congregations and in the community. He is made available through his hospital's speakers bureau. His presentation is titled: "Ethical, psychological and spiritual reflections influencing end-of-life decisions."

Burn describes the format he has developed (three or four small group sessions); and some of the psychological, spiritual and financial issues that are commonly discussed. (1 refs)

Lindsay B. Carey, Christopher J. Newell

Chaplaincy and resuscitation

Resuscitation

Vol. 75 # 1 (Oct 2007) pp. 12-22

In their paper, Carey and Newell summarize the results of a survey of 327 healthcare chaplains in Australia, asking them if they had been, and if so, to what extent they had been involved in withdrawal of life-support from patients. Had they been involved in issues concerning Not for Resuscitation (NFR) and/or Do Not Attempt Resuscitation (DNAR) decisions?

The findings are that 24% of the chaplains had provided some level of pastoral intervention either directly to patients and/or their families; also that 18% of the chaplains had assisted the clinical staff with issues around NFR/DNAR decisions.

They also found that there were significant differences between staff chaplains and volunteer chaplains around NFR/DNAR situations. Volunteers were significantly less involved in these kinds of

situations. (Comment: This fact needs to be highlighted for institutions which believe they can provide pastoral care by using volunteer chaplains!).

The authors also note some implications of their findings regarding chaplaincy training and practice. (41 refs)

Kirsten H. Christensen, de Sales Turner

Spiritual care perspectives of Danish registered nurses

J of Holistic Nursing

Vol. 26 # 1 (Mar 2008) pp. 7-14

This article represents one of the latest research efforts within the nursing profession to better understand the essence of spiritual care. A useful literature review precedes a phenomenological approach (n=6) with registered nurses in Denmark.

Perhaps the central finding from these nurses is that "deep knowledge" of a patient is essential before a registered nurse can engage in spiritual care, with the demands on a nurse's time often making that difficult. More importantly, they point out that because spirituality is understood to be a private matter, that "chaplains are seen as the most appropriate providers of such care." (24 refs)

Steve W. Cole, Louise C. Hawkley, Jesusa M. Arevalo, Caroline Y. Sung, Robert M. Rose John T. Cacioppo

Social regulation of gene expression in human leukocytes

Genome Biology

Vol. 8 # 9 (Sept 2007) pp. 13pp

It has long been known that loneliness is directly linked to increased likelihood of illness and shorter lifespan. This article describes how, at a biological level this happens.

Their findings suggest that people suffering from loneliness turn off genes that fight illness and may be turning on genes that produce unhealthy inflammation. In other words, the psychological stress of loneliness seems to damage the ability of important human cells to fight disease. Or to put it another way, loneliness has an impact on how cells express things, such as proteins and antibodies, particularly the one needed to keep a person healthy.

And what is loneliness? These researchers (note the presence of John Cacioppo whom we have previously met in The Orere Source concerning loneliness) believe that loneliness is a state of mind as much as the number of interactions a person has with others. It is not how many people you know and

meet, it is how many you feel close to, even if they are not physically close by. (66 refs)

James C. Coyne, Michael Stefanek, Steven C. Palmer

Psychotherapy and survival in cancer: the conflict between hope and evidence

Psychological Bulletin

Vol. 133 # 3 (Oct 2007) pp. 367-394

In 1989, a seminal study by Dr. David Spiegel and his colleagues claimed that psychotherapy, specifically group therapy, promotes survival in people who have been diagnosed with cancer. It was a belief that Spiegel had been hoping to demonstrate since his paper with Yalom on the value of support for cancer patients had been published in 1981.

Now in this paper, Coyne and his colleagues give a detailed critique of the literature on the question of support and survival that have appeared since 1989. As they do, they introduce questions about the design of the studies supporting the idea, the interpreting of the results and the reporting of the clinical trials. They conclude that "No randomized clinical trial designed with survival as a primary endpoint and in which psychotherapy was not confounded with medical care has yielded a positive effect." In other words, the case has not been made. The reason they are anxious to find clarity on this issue is because they believe that if psychotherapy does not prolong survival, recognition of this fact removes one basis for blaming persons with cancer for the progression of their disease, even though such negative judgments are unfair to begin with. As these authors remind us, this idea comes too close to a sense that some cancer patients have, that a judgment is being made about them that "brave and good people defeat cancer and that cowardly and undeserving people allow it to kill them." (An example of this is the satiric article recently in the U.S. newspaper *The Onion* which had the headline: "Loved ones recall man's cowardly battle with cancer.")

The authors conclude with the observation that to actually demonstrate that psychotherapy does have an effect on survival after a diagnosis of cancer would require resources that, at this time, "are not justified by the strength of the available evidence." (166 refs)

Hannah Dale, Nigel Hunt

Perceived need for spiritual and religious treatment options in chronically ill individuals

J of Health Psychology

Vol. 13 # 5 (July 2008) pp. 712-718

This paper reports two studies, both of which sought to examine whether or not people who are chronically ill seek spiritual or religious "treatment" - to use the language of the authors. Done in the Nottingham area, the findings show that "Spiritual and religious treatment options are of great interest to many people who suffer from chronic illnesses, who would clearly benefit from the provision of treatments that incorporate spiritual and religious facets." (p. 716)

The popularity scores from a list of possible options show that spiritual guidance, and quiet spaces are especially desired.

(*Comment:* This is a paper which might be given to hospital administrators who are at all reluctant to support pastoral care. The lead author is now a trainee health psychologist for NHS Fife.)

Tracy A. Demmons

Tacit and tactile knowledge of God: toward a theology of revelation for persons with intellectual disabilities

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

Vol. 11 # 4 (- 2007) pp. 5-21

Is the following question any oxymoron? Can persons with intellectual disabilities have knowledge of God? Demmons addresses this question bringing into dialogue the theologian Karl Barth's concept of co-humanity with scientist/philosopher Michael Polanyi's understanding of tacit knowledge. She wants to move the reader's thinking away from Enlightenment-informed theories of knowledge, with a theologically informed conception of knowledge of God.

She suggests that through the use of imagination and the arts may be found a hermeneutic of sorts that allows communication with persons who have intellectual disabilities. The result is a theory of knowledge of God that could really be inclusive for the whole Christian community. (10 refs)

Rachel E. Dew, Stephanie S. Daniel, David B. Goldston, Harold G. Koenig

Religion, spirituality, and depression in adolescent psychiatric patients

J of Nervous and Mental Disease

Vol. 196 # 3 (Mar 2008) pp. 247-251

This paper presents early research designed to better understand the relationship between different aspects of religion/spirituality and depression in adolescents who have sought help for their depression. One hun-

dred and seventeen teenagers aged 12 to 18 completed the Beck Depression Inventory (21-item self-report questionnaire, used for 20 years, well-validated), a substance abuse inventory (2 questions only, created for this study), and the BMMRS (a 40-item questionnaire which asks about various aspects of religion and spirituality. It was created by a working group of the Fetzer Institute in 2003). The authors describe their methods and how they analyzed the results.

They found that in this group, depression was related to feeling abandoned or punished by God; was related to feeling unsupported by one's religious community; and that they lacked being forgiven.

Those adolescents who said they less frequently exercised forgiveness, and felt unforgiven by God were significantly more depressed.

A higher depression score was also related to negative religious support, meaning the degree to which others in their religious community were perceived as critical or demanding.

Depressive symptoms were also found to relate to negative religious coping or religious struggle.

As the authors note, these findings have all been reported by others. They also note that because of the way the study was done, agreement with all or any of the above three (forgiveness-issues, lack of religious support, religious struggle) does not necessarily lead to depression. That will take further work. However, they do claim that, until more research is completed, anyone working with a depressed teenager should be sensitive to their religious and/or spiritual life. (32 refs)

Kevin J. Flannelly, Christopher G. Ellison, Kathleen Galek, Harold G. Koenig
Beliefs about life-after-death, psychiatric symptomatology, and cognitive theories of psychopathology

J of Psychology and Theology

Vol. 36 # 2 (Summer 2008) pp. 94-103

This study reports an examination of the association between beliefs about life-after-death, and mental health. The authors used data from a national web-based survey of US adults involving almost 1900 persons. Beliefs about life-after-death were divided into five pleasant beliefs, which included three widely accepted in the US - union with God, peace and tranquility, and reunion with loved ones; one which is not widely accepted - a paradise of pleasures and delights - and the last - that

life-after-death is a world of eternal reward or punishment. The two unpleasant beliefs were that - life after death is a pale shadowy form of life, hardly life at all; and, second, that persons are reincarnated into another form.

Analyses with each were checked for association with six classes of psychiatric symptoms, and as the authors had postulated, pleasant after-life beliefs were associated with better, and unpleasant beliefs were associated with poorer mental health, after controlling for age, gender, education, income, race, marital support, prayer or church attendance.

This is a unique study. No previous work has examined specific beliefs about life-after-death and psychopathology. There have been studies about belief in life-after-death generally and mental health. This study is different because it looks at specific identified beliefs.

As the authors point out, their study does not clarify whether unpleasant beliefs lead to pathology, or vice-versa, the chicken-and-egg question. There are several additional findings that they also report. (68 refs)

Karen K. Giuliano, Michelle Polanowicz
Interpretation and use of statistics in nursing research

AACN Advanced Critical Care

Vol. 19 # 2 (Apr/Jun 2008) pp. 211-222

This is a straight teaching article. Written for nurses, it will assist any chaplain who is thinking of doing research, or who wishes to read the research results of others with greater understanding.

With a focus on quantitative research, the authors describe common statistical terms, present some common tests, and explain the interpretation of the results.

A.C. Grayling

What is this thing called religion?

New Scientist

Vol. 198 # 2650 (5 Apr 2008) pp. 50-51

A group of 9 European universities, led by the University of Oxford have begun to examine religious belief and behavior. The project is called Explaining Religion (EXREL). It will bring together history, biology, anthropology and psychology to identify both the common and the varying features of "religiosity." They will also test theories about it, of which the current most important is: that religiosity exists because of the way that human cognitive architecture functions.

Grayling is not happy about the project. One of his main objections: "religion" and "religiosity" are so ill-defined. (0 refs)

Daniel H. Grosseohme, Sian Cotton, Anthony Leonard

Spiritual and religious experiences of adolescent psychiatric patients versus healthy peers

J of Pastoral Care & Counseling

Vol. 61 # 3 (Fall 2007) pp. 197-204

This is the report of a study done, first, to determine if the INSPIRIT tool could be used with adolescents; second, to describe the religious/spiritual experiences of two groups of adolescents (psych in-patient and non-patient adolescents) based on the INSPIRIT data; and third, to examine any differences in responses.

The test instrument, INSPIRIT is a 7-item questionnaire which assesses core spiritual experiences with the 7th question offering 12 possible responses. The paper includes the actual questions. This is the first time that data from an INSPIRIT study of adolescents has been published.

There were significant differences in the responses from the two groups. The non-patient adolescents reported a greater frequency of spiritual experiences and a more positive impact of such experiences on their belief in God, than did their inpatient peers. Adolescent inpatients reported higher frequencies of experiencing angels, demons, God or guiding Spirits; feeling unity with the earth and other living things; and with near death or life after death when compared with their healthy peers. Overall, the females reported a higher frequency of spiritual experiences and a higher impact of those experiences on their belief in God than did males. (28 refs)

Christine J. Guth

Legion no more: confessions of a Gerasen (Mark 5:1-20)

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

Vol. 11 # 4 (- 2007) pp. 71-77

In this first-person narrative, Guth tells the story of Mark 5:1-20 from the imagined perspective of the man from whom Jesus cast out the demons.

The manner of the re-telling reflects Guth's wish to allow this biblical story to speak to contemporary experiences of mental illness and trauma. She attempts to incorporate understandings of demon possession and faith that ancient readers might have held, while at the same time respecting the strug-

gles that modern persons of faith experience as they cope with mental illness.

Guth herself has a mental illness, as have four generations of her family, and so she writes as an "accidental expert." (8 refs)

W. George Kernohan, Mary Waldron, Caroline McAfee, Barbara Cochrane, Felicity Hasson

An evidence base for palliative care chaplaincy service in Northern Ireland

Palliative Medicine

Vol. 21 # 6 (Sept 2007) pp. 519-525

This is an unusual paper in that it describes a study which looked at chaplaincy services, but the study was not done by chaplains. The nurse-authors wanted to know whether (a) the formal standards for pastoral care in a palliative care service could be assessed and if they could, (b) were the standards being met? The answers are: (a) yes; and (b) for the most part, yes. Assessments were done using a questionnaire survey and reviewing the data recorded by the chaplain in their pastoral care chart notes.

In the United Kingdom, there are national standards of care in place, both for general and psychiatric hospitals, and also for hospices. In this case, the objective standards are codified in the AHPCC Standards for Hospice and Palliative Care Chaplaincy (2nd edition - 2006).

The 62 persons whose pastoral care was examined highlighted their six main spiritual needs as: to have time to think; to have hope; to deal with unresolved issues; to prepare for death; to express true feelings without being judged; to speak of important relationships. (19 refs)

Kristi L. Kirschner

**Decision making in a case of personality change
Virtual Mentor**

Vol. 10 # 3 (Mar 2008) pp. 138-143

This is an ethics case which involves a middle-aged man, a construction worker who has suffered an accident in which a co-worker's nailing gun slipped, discharging and lodging a nail deep into the man's frontal lobe. As a result his personality changes radically and dramatically. While he makes a good physical recovery, there is still the fact that he has a nail in his brain. Should it be removed? The man's behavior strongly suggests that he is no longer himself: he insults and disparages his wife, he doesn't want to see his children and doesn't even believe they are his. However his wife has his power of attorney for health care, and she thinks the risks of surgery are

too great, but the man wants to have the surgery. What should be done?

On the team it is argued that the man is not himself, that he is a different person, that he's impaired. It is also argued that he is oriented, and capable of abstract reasoning. "Personality changes don't mean you can trample on autonomy."

Kirschner provides an extended comment on the ethics of this and other such cases.

Harold G. Koenig

Concerns about measuring "spirituality" in research

J of Nervous and Mental Disease

Vol. 196 # 5 (May 2008) pp. 349-355

If you have been reading the chaplaincy and health care literature over the past 15 or so years, you will have noticed that the understanding of spirituality has been changing. At first, "spirituality" included various, mostly varying constructs alongside "religion." Today, it is a very large concept that writers are still struggling to define and delimit, but religion sits alongside and sometimes inside the construct. The term spirituality is now applied to the superficially religious person, the religious seeker, the seeker, the seeker of happiness and well-being, and even the completely secular person.

Attempting to measure "spirituality" in the midst of these shifting meanings has become increasingly difficult. Koenig points out that mental health measures and positive character traits (such as optimism, forgiveness, gratitude, meaning-seeking and meaning-making, purpose in life, peacefulness, harmony, and general well-being) are now being included in definitions of spirituality.

Koenig thinks it is time to call a halt. He believes that either spirituality should be defined and measured "in traditional terms as a unique, uncontaminated construct, or it should be eliminated from use in academic research."

Koenig describes his understanding of the changing relationships between religion, spirituality, mental health and physical health using 4 related, but evolving diagrams. He draws on the relevant literature, and provides a challenge to us both at a theoretical and at a practical level. (36 refs)

Jonathan Koffman, Myfanwy Morgan, Polly Edwards, Peter Speck, Irene J. Higginson

"I know he controls cancer": The meanings of religion among Black Caribbean and White British patients with advanced cancer

Social Science & Medicine

Vol. - # - (June 2008) pp. 1-10

It is clear that spirituality and religion affect psychosocial adjustment to cancer. At the same time, little is known about the perceptions of and meanings given by Black and minority ethnic groups within their spirituality and religion when they are living with cancer.

The authors had semi-structured interviews with 26 black Caribbean and 19 white British patients who were living with advanced cancer in the south London area. Within the interviews, almost all of the Caribbean patients volunteered views about God or the place of religion in their life. 13/19 of the white patients did. Spirituality was rarely mentioned. Christianity was the only religion referred to.

An analysis of the contents of the interviews revealed three main themes: first, the ways in which they believed religion and their belief in God helped them to make sense of their cancer. Some, for example, believed that their cancer was due to God. However, this did not make them passive in face of their illness; rather such views "appeared to be embedded in a deliberate and trusting relationship with God who controlled their lives."

Second theme: how they felt their faith, plus the support of their religious communities helped them live with the physical and psychological effects of their cancer.

Third theme: the Caribbean patients described the ways in which their experience of their cancer helped to promote a religious identity. "A better life" refers to a number of this group for whom their cancer and its progress were embraced rather than viewed as a source of burden. They described it as something worthy of spiritual investment.

Each of the themes is illustrated in greater detail which will alert chaplains to the potential perspectives they will meet when they minister to patients from these two groups.

The writers found that patients from both groups derived benefit from their belief in God and their religious faith. (58 refs)

Dorothy A. Lander, John R. Graham-Pole

Love medicine for the dying and their caregivers - the body of evidence

J of Health Psychology

Vol. 13 # 2 (Mar 2008) pp. 201-212

Love medicine appears to be a relatively new concept in both the pastoral care and nursing literature. The authors deliberately draw back from giving us a pre-

cise definition of the concept, saying simply that it "originates in the sacred, shamanic healing art characterizing physical/spiritual touch as an imperative force to bind people and cultures together." (p.202)

"We refrain from defining love medicine further, except to say that, like an intimate relationship, you know it when you experience it; like all art it is better shown than told, so the data for this qualitative study take the form of exemplars." (p. 202) Not examples, but exemplars which are examples that represent the essence of what they are attempting to convey.

The intention behind their research is to show that love medicine should be the central reality for the best possible end-of-life palliative care.

For their study, they have gathered their exemplars using a methodology known as "appreciative inquiry." (AI) It is a research approach that attempts to blend knowledge and empathy. Appreciative Inquiry "steers attention.....toward storying the best of what is, (in order to) to envision what might be." (Watkins and Mohr, in Appreciative Inquiry: Change At the Speed of Imagination. (2001) Jossey-Bass.)

Their agenda in attempting to describe and present their research of love medicine is a radical one. They believe that the "European biomedical model of evidence-based medicine" cannot identify the essence of the best care for persons who are dying. So their paper presents a new concept, and presents a comparatively recent research methodology for illuminating the nature of the concept. In some ways, it makes for frustrating reading because it lacks the familiar evidence of most contemporary research, and yet their exemplars will leave you with glimpses of the essences they seek to have us know about. It is worth the effort. (51 refs)

Mark LaRocca-Pitts, Gary Batchelor, Larry M. Connelly, Robert W. Duvall, Brenda K. Green, Eugene T. Locke, Joan L. Murray, Jeff Thompson, C.H. (Skip) Wisenbaker

A collegial process for developing better practices

Chaplaincy Today

Vol. 24 # 1 (Spring 2008) pp. 3-15

This article is the report of a project undertaken by chaplains from eight hospitals in north Georgia who worked together to identify to, initially at least, identify the "best practices" of each hospital's group of chaplains.

They began with a seminal article by Handzo (in "Best practices in professional pastoral care," Southern Medical J (June 2006) 99 # 6; 663-4.) Handzo had not tried to argue for any particular best practices, but described what he considered were minimum standards of practice for a pastoral care department. He listed 12 practice areas.

These authors took Handzo's twelve, and examined the patterns of pastoral care in each of their own hospitals, and compared their practices.

There were important results arising from the process for these chaplains and it is these results which are at the heart of the article. They quickly realized that best practices would look quite different in different hospitals. Second, they learned a new language for describing and discussing their work, a most important step because they were quickly talking the language that hospital administrators understand. "Much of the pastoral care language we have inherited is theological and congregation based. Translating our pastoral work into the clinical language of outcomes, targeting, protocol- based referrals, screening/assessment processes, cost enhancement, and quality improvement was relatively new for some of us." (p. 8) Third, in examining their current functioning within Handzo's original framework, some of the chaplains found ways to improve their own practices. Finally, the process of working together was apparently itself an empowering process. "We had much more energy and excitement about the work of chaplaincy than had we functioned in isolation." (p. 8)

Two tables accompany the paper, which is well written with useful references. As the authors note, they have identified for themselves "better practices," which makes the title of the article misleading.

(*Comment:* Best practises will only follow if other chaplains follow the lead described here into the kind of process the authors have undertaken, but more rigorously build on the kind of initial steps described in this article.) (20 refs)

Arthur J. Matas, Jeremy Chapman

Should we pay donors to increase the supply of organs for transplantation?

British Medical J

Vol. 336 # 7657 (14 June 2008) pp. 1342-1343

There continues to be a major shortage of human organs for transplantation in most countries, but payment to living donors of organs is illegal in most countries. Matas, a transplant surgeon believes that legalization of such payments is needed in order to shorten the waiting times. At the moment, wait-time

for a body part can be five to ten years. Chapman, in a supplementary piece and who directs a transplant center argues that paying donors will actually reduce the supply of organs.

(Comment: What at first glance may seem like a helpful suggestion by Matas is strongly challenged by Chapman. A useful point-counterpoint paper.) (0 refs)

Susan H. McFadden

Mindfulness, vulnerability, and love: spiritual lessons from frail elders, earnest young pilgrims, and middle aged rockers

J of Aging Studies

Vol. 22 # 2 (Apr 2008) pp. 132-139

There is now a long list of studies from the past quarter-century that have described religion and spirituality in relation to aging. Many of them struggled with the issue how elders' religious beliefs, practices and spiritual beliefs affect their well-being.

In this article, McFadden critiques many of the assumptions that this research was built on. She is especially critical of much of its "individualistic" orientation. Her experiences have taught her that it is more revealing to think in terms of community. Her experiences in religious/spiritual communities have shown her that such communities help everyone to be mindfully present to others, to recognize that we are all vulnerable to the afflictions of aging and the certainty of death, and to love and care for others.

McFadden describes how her marriage to a parish minister (who is now a chaplain) has enabled her to develop relationships with frail elders and young adults. In a well-written piece, she describes how these friends she has made have influenced her thinking, her work, and have shaped her view of her own aging. (33 refs)

Jay M. Milstein

Introducing spirituality in medical care - transition from hopelessness to wholeness

JAMA

Vol. 299 # 20 (28 May 2008) pp. 2440-2441

This article was not written for chaplains, but it may be one that you can pass on to a medical colleague or medical student.

Milstein, a neonatologist values the importance of spiritual interventions, suggesting that healing and curing can "co-exist" within the clinical setting. By creating and using "healing space" he writes that "a

spiritual intervention can serve as an experiential basis to restore a sense of order and meaning for patients and their families, improving their ability to cope and to attain a sense of wholeness." (p. 2440)

He goes on to describe, using secular language what can happen as a result of such spiritual interventions. He then turns to two related issues (which I, WNB, suspect is intended to whet the appetite of the scientist in the doctor): he briefly introduces a theoretical and empirical framework that would support his ideas, and says to his medical colleagues - what I am suggesting can be assessed scientifically. In effect he is saying: let us, as a profession, embrace spiritual interventions as a part of "conventional medical culture....." (15 refs)

Kenneth I. Pargament, Annette Mahoney

Sacred matters: sanctification as a vital topic for the psychology of religion

International J for the Psychology of Religion

Vol. 15 # 3 (- 2005) pp. 179-198

Pargament is an academic psychologist who for over a quarter of a century has been investigating various aspects of the effects of religion and spirituality on coping in different parts of human life. In this article, Pargament and colleague Mahoney issue a challenge to others involved in the psychology of religion to study "sacred matters" more closely.

But what are "sacred matters"? They point out that people can perceive virtually any aspect of their life as "having divine character and significance"; that is, they "sanctify" both the unusual and the usual experiences of living - the discovery of what is sacred. For the authors, sanctification is a "psychospiritual" construct. It is because of its point of reference - sacred matters. It is psychological in two ways: first, it focuses on perception of what is sacred; second, the methods for studying sacred matters are social scientific rather than theological. Sanctification takes place within any religious tradition; there is also nontheistic sanctification.

They describe the processes of how people come to sanctify objects, or to perceive aspects of their lives as having divine character and significance. The result is a process which has a number of implications for human functioning and so there should be further studies of the process. They suggest some specific directions for research. (52 refs)

Katherine M. Piderman, Dean V. Marek, Sarah M Jenkins, Mary E. Johnson, James F. Buryska, Paul S. Mueller

**Patients' expectations of hospital chaplains
Mayo Clinic Proceedings**

Vol. 83 # 1 (Jan 2008) pp. 58-65

This is a study done in the hospitals associated with the Mayo Clinic. Four of the authors are chaplains, who report the results of research which was done to discover (a) what patients' expectations are of chaplains, and (b) what the patients actual experiences had been of the ministry of hospital chaplains. Fifteen hundred persons who had been discharged from hospital within the previous three weeks were mailed questionnaires. Just over 1/3 were returned, and no follow-ups were attempted. The questionnaire had been constructed by the research committee of the Mayo Clinic Department of Chaplaincy Services, in consultation with staff chaplains and the authors. Questions were included about: 1. demographics 2. period and location of hospitalization 3. awareness of the availability of chaplains, and 4. expectations regarding visit initiation, follow-up and frequency of visits.

The paper contains a detailed report of the findings which indicate that: just over half reported they had been visited, 86.4% said the visit was important to them. The main reason for wanting to see a chaplain was "to be reminded for God's care and presence." Other responses highlighted ritual, prayer and pastoral support.

The results have been sufficiently analyzed to show that the results were dependent on gender, age, religious affiliation, and length of hospitalization. (34 refs)

**Karen L. Schneider, Edmond Shenassa
Correlates of suicide ideation in a population-based sample of cancer patients**

***** J of Psychosocial Oncology**

Vol. 26 # 2 (- 2008) pp. 49-62

This study, in contrast to similar, earlier studies looks at suicidal ideation in a population-based sample - a group of cancer patients. (n=980) Data concerning the presence (or not) of suicidal thoughts was gathered from first-degree and step-relatives. The prevalence of suicidal thinking in this group was found to be almost 20% - 1 in 5 adult cancer patients.

Thoughts of suicide were more common in those patients who had the following characteristics: they were previously married; had a history of mental illness; died of lung, respiratory or oral cancer; had one or more chronic diseases and used multiple prescription drugs in the year before their death.

The authors also conclude that thinking of suicide is not solely a reflection of depression. Overall poor physical health influences a person's desire for an early death. (26 refs)

Loralee Sessanna, Deborah Finnell, Mary A. Jezewski

Spirituality in nursing and health-related literature

J of Holistic Nursing

Vol. 25 # 4 (Dec 2007) pp. 252-262

The authors report their analysis of "spirituality" and how this concept is being used in the current nursing and health-related literature. Their methodology involves uncovering what the concept's critical attributes/characteristics are, and they conclude with a proposed definition of spirituality based on their concept-analysis findings.

In their study they examined 90 literature references, including 73 in the nursing and health-related literature. They found two references in the pastoral care literature.

Their conclusion is that there are four main themes within the writings. First, spirituality as religious systems of beliefs and values. i.e. spirituality = religion. Second, spirituality understood as life-meaning, purpose, and connection with others. Third, spirituality as non-religious systems of beliefs and values. Fourth, spirituality as metaphysical or transcendental phenomena.

Based on their analysis, they propose that the most inclusive definition of spirituality consistent with their findings is the one presented by Fowler and Peterson in the Journal of Supervision and Training in Ministry: "Spirituality is the way in which a person understands and lives life in view of his or her ultimate meaning, beliefs and values. It is the unifying and integrating aspect of the person's life and, when lived intentionally, is experienced as a process of growth and maturity. It integrates, unifies and vivifies the whole of a person's narrative or story, embeds his or her core identity, establishes the person's fundamental basis for relationship with others, and with society, includes a sense of the transcendent, and is the interpretative lens through which the person sees the world. It is the basis for community for it is in spirituality that we experience our co-participation in the shared human condition. It may or may not be expressed or experienced in religious categories." ("Spiritual themes in clinical pastoral education." Vol. 18 (1997), 47.) (110 refs)

Kevin S. Seybold

Physiological mechanisms involved in religion/spirituality and health

J of Behavioral Medicine

Vol. 30 # 4 (Aug 2007) pp. 303-309

Within the past quarter century, psychology rediscovered spirituality/religiosity (S/R) as a legitimate focus for enquiry. In large part, this interest was because of the growing understanding in the literature that there was a positive association between S/R and health.

Seybold develops a rationale for why such an association might be expected, and then describes various mechanisms that could mediate the effect of S/R on health. He draws on research coming from neuroscience, psychology, and cognitive science. It should be noted that his possible pathways, while plausible, have yet to be demonstrated.

"It is increasingly being recognized that religiosity and spirituality are embodied, that is to say, a person relates to God, or a "higher being," or the transcendent, using one's body. (Coakley 1997). As such, one should not be surprised that any effect of ritual, meditation, prayer, or potentially any other religious or spiritual practice would express itself through physical mechanisms." (p. 304)

This is one of five papers in a special section on Religion/Spirituality and Behavioral Medicine in this issue of the journal. (59 refs)

Alison Whyte

A serious ethical dilemma

Nursing Standard

Vol. 22 # 30 (2 Apr 2008) pp. 18-19

In November 2007, Emma Gough died in a Shropshire Hospital after she refused a blood transfusion consequent to complications and blood loss following the birth of her twins. Since then, there have been voices raised suggesting that the law which allows Jehovah's Witnesses to refuse blood transfusions should be changed. Whyte's article points out that under the Mental Capacity Act (2005), advance decision by a mentally competent person over age 16 must be respected provided it is written, signed and witnessed. But, there must be a separate written statement, also signed and witnessed, making it clear that the decision is to stand even if the patient's life is at risk. The act states that a person is not to be treated as lacking in capacity just because to others their decision seems "unwise," "irrational," or "eccentric." (0 refs)

Alison S. Witte, Dirk M. van der Wal, H. Chrissie Steyn

Mystical experience in the context of health care

J of Holistic Nursing

Vol. 26 # 2 (Jun 2008) pp. 84-92

Patients have mystical experiences in relation to their health care, either while hospitalized, or before or after. This paper gives examples of people's stories about their experiences, as told to a nurse. Twelve of the 48 persons she approached in a rural Appalachian community were interviewed. 25% had experienced a mystical experience. It is a limitation of the study; too small a sample.

Witte conducted the interviews in order to be able to better understand and describe mystical phenomena. She also wanted to find out how nurses could support the sharing of such experiences; it is an important matter for nursing in that there is a nursing diagnosis: Readiness for enhanced spiritual well-being. (from NANDA International - the North American Nursing Diagnosis Association International). She describes clearly her project methodology.

Her working definition of mystical experience was: "a subjective experience of transcendent phenomena that are apprehended directly in human consciousness and that are not mediated by normal cognitive or sensory perceptual faculties."

Based on her review of what she had been told, she concludes that a mystical experience is a process, with several steps including: initiation, occurrence, maturation, and integration. She describes and illustrates each of these.

She includes a concept map of mystical experience, which unfortunately is not adequately supported by the data she has included in her study, even though with additional data it may be proven to be accurate. (32 refs)

F. Susan Zengerle

The controversy over pastoral care of parents after a stillbirth

J of Pastoral Care & Counseling

Vol. 61 # 3 (Fall 2007) pp. 243-246

There have been a number of articles in the recent literature suggesting that it is not necessarily best to encourage parents to hold their stillborn child after birth. Zingerle provides a nice review of the literature dealing with this topic, which has seen a swing from the historic "don't show the baby" all the way to "the baby must be held".

Zingerle rightly concludes that "As yet there is no objective evidence supporting either benefit or harm

related to various rituals offered to parents after childbirth." She urges chaplains to be aware of the studies she has described.

(Comment: A research question waiting to be addressed.) (22 refs)