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Attribution: The creator of these pastoral abstracts is the Rev. W. Noel Brown, a retired Presbyterian minister, and hospital chaplain-supervisor. He was formerly chairman of the Standards Committee of A.C.P.E. and is a board-certified chaplain of the Association of Professional Chaplains.

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Christi Bamford, Kristin H. Lagattuta

A new look at children's understanding of mind and emotion: the case of prayer

Developmental Psychology

Vol. 46 # 1 (- 2010) pp. 78-92

Studies have shown that between the ages of 4 and 8 years, children consistently show a growing understanding about the relationship between mind and emotion; including the reverse side, that one's emotional state can influence how one thinks. Other research has shown that strategies for coping with negative or uncontrollable events does not develop for children until they are aged about 7 or 8, when they understand about how people can use their minds to alleviate negative emotions, by, for instance, changing the focus or the content of their thoughts.

In adults, one method that is widely used to handle negative emotions, one that has a clear mental component, is prayer. However, until this paper, there had been little attention given to young children's knowledge about the relationship between prayer ("nonsecular activity" is the authors' term) and emotions. This study examines the development of children's understanding about the relationship between mind and emotion in the context of prayer; and beliefs about prayer as both a cause and an effect of a person's emotional state. The age-related differences in the responses provide a deeper understanding of the ways that children begin to pray, and how.

The methods used are carefully described, with illustrations of the printed materials that were used in the conversations with children and adults. (76 refs)

Tami Borneman, Betty Ferrell, Christina M. Puchalski

Evaluation of the FICA Tool for spiritual assessment

J of Pain and Symptom Management

Vol. 40 # 2 (Aug 2010) pp. 163-173

When the National Consensus Project for Quality Palliative Care was setting its standards in 2002 (published in 2006), spiritual care was one of the eight essential elements of care, as described in Domain 5 of the NCP Guidelines: "Spiritual, Religious and Existential Concerns." However, the desire to provide thorough and effective spiritual care, while completely laudable in itself, if it employs a check-list approach will at the same time, in all probability, lose the very subjectivity and specific human elements that are at the very heart of spirituality. If spirituality is rationalized and reduced to make it manageable, it loses those ingredients that make it significant.

In 1996, Christina Puchalski and three primary care physicians devised the FICA Spiritual History Tool as a way for physicians to integrate open-ended questions about religion and spirituality in the standard medical history. It has been slightly modified since then, and is now used by some chaplains to obtain an understanding of the presence of Faith, belief or meaning in a person's life; the Importance of spirituality for a person's life and the influence that beliefs and values have on the person's health care decisions; the person's spiritual/religious Community; the interventions to Address the person's spiritual needs.

The aim of this study was to evaluate the usability of FICA. Seventy-six patients with solid tumors provided feedback about the instrument, which is

itself printed in full in the article. Responses to FICA were placed alongside the responses patients made to a second assessment tool, the Functional Assessment of Cancer Therapy QOL tool. This latter has been developed by second-author Ferrell in the City of Hope medical center (1995).

The findings are that FICA does enable the spiritual life of a person to be addressed in a helpful way, and lend support to the belief that spiritual care is an important part of patient care. Responses to the questions reveal the depth and breadth of spirituality, and provided many opportunities for addressing patients' search for faith, meaning, hope and relationships at the end of life. (44 refs)

Herbert Bronstein

Heart transplants: Three views - the power over life and death

Chest

Vol. 136 # 5 Supplement (1 Nov 2009) pp. 346-348

In a commemorative supplement to mark 75 years of its publication, Chest includes what its editors still consider three classic essays dealing with the philosophical and theological questions raised by heart transplants. They were first published in the October 1968 issue of the journal. The first of the three is this article by a rabbi, and while written from an unabashedly Jewish perspective it states very clearly the basic questions that need to be considered by any persons of religious faith who is involved in some manner with heart transplantation. He refers to "historic moral and religious questions", which he spells out. And while the answers to the questions he lifts up - both theological and practical - have been refined over the past 40 years, his words are words of encouragement to push forward into the ever-new uncertainties that transplant surgery raises today. "..... we cannot go back. We are barred as by angels with revolving swords of flame from the paradise of previous innocence." (0 refs)

James D. Campbell, Dong Phil Yoon, Brick Johnstone

Determining relationships between physical health and spiritual experience, religious practices and congregational support in a heterogeneous medical sample

J of Religion and Health

Vol. 49 # 1 (Jan 2010) pp. 3-17

Efforts to understand the relationships between physical health on the one hand, and religious

practices/spirituality on the other continue to increase in sophistication. In 1999, the Fetzer Institute and the National Institute on Aging Workgroup created the Multidimensional Measure of Religiousness and Spirituality (MMRS) and its short-form, the Brief-MMRS, and subscales were developed to measure distinct aspects of spiritual experience and religious practices. They were chosen because they held promise for determining the casual mechanisms that relate religious, spiritual and health variables. Additional work has subsequently been done to see if using B-MMRS can lead to reliable results. One of Johnstone's studies which is about to be published, has found that the B-MMRS can be better understood if it is used to measure three rather than two domains of religious/spiritual experience including: (a) the emotional experiences associated with feelings of connectedness with a high power/the universe (termed by these authors spiritual experience) (b) culturally-based activities such as prayer, meditation, reading religious texts, attending services (termed religious practices), and (c) the support provided by others in one's religious/spiritual community (termed congregational support). By conceptualizing B-MMRS in this way they suggested it might be possible to determine the specific mechanisms by which "religious" and "spiritual" variables impact health, i.e. through emotional experiences, cultural behaviors, and/or social support. It was with this model in mind that they conducted the research and gathered the findings reported in the paper. They studied a convenience sample of 168 patients from an academic health center and a private group practice, deliberately choosing patients from a number of different patient groups.

Frankly, the results in this study are limited in that they were cross-sectional in nature, so the causal mechanisms that exist between religion and health cannot be determined. The results are also not completely generalizable in that the people studied were primarily Christian.

The results showed that persons with chronic medical conditions do not automatically turn to religious or spiritual resources after the onset of their condition. That physical health is positively related to frequency of attendance at religious services, though this may be related to better health leading to increased ability to attend religious/spiritual gatherings.

Finally, spiritual belief in a loving, higher power, and a positive worldview are associated with better health, which is consistent with psychoneuro-immunological (PNI) models of health. They suggest: "This encouragement/practice of spiritual interventions may be promoted by religious leaders, hospital chaplains, and/or health professionals, although questions still exist about the best manner in which (they) can address these religious/spiritual matters in their practices. (Johnstone has addressed this matter in an unpublished paper.) (56 refs)

Donald Capps

A spiritual person

J of Religion and Health

e-Pub Aug 2010

An essay about spirituality, written in Capp's inimitable accessible style. He begins with the answer that William James gave when he was asked to describe a spiritual person. His answer instead was to name one - Phillip Brookes.

Capps turns to Brookes to explore spirituality through a human subject, describing his life, his sermons, and most importantly, "his ideals and the active imagination."

Capps is of the view that "there is no spirituality in general but only individual manifestations of it." (15 refs)

Bonnie E. Carlson and Heather Larkin

Meditation as a coping intervention for treatment of addiction

***** J of Religion & Spirituality in Social Work - Social Thought**

Vol. 28 # 4 (Oct/Dec 2009) pp. 379-392

Addiction is a complex problem which usually intrudes into every aspect of an addict's life; its treatment calls for a holistic response. Stress can contribute to addiction, and stress also results from its consequences.

Within a stress and coping framework, these authors describe meditation as a coping intervention for persons who are in treatment for substance abuse. They see it as a form of emotion-focused coping.

They describe the research to date concerning this kind of intervention with this population, with particular attention to its limitations. This section is effectively a brief historic overview of the development in the use of meditation in substance abusers. They then describe a mindfulness meditation group intervention model. (50 refs)

Kevin J. Flannelly, Kathleen Galek, Christopher G. Ellison, Harold G. Koenig

Beliefs about God, psychiatric symptoms, and evolutionary psychiatry

J of Religion and Health

Vol. 49 # 2 (Jun 2010) pp. 246-261

The premise on which this study was based is quite straightforward: if psychiatric symptoms can be caused by the belief that the world is a dangerous place, they should be ameliorated by beliefs that provide a sense of security, such as belief in a close and loving God.

The authors discuss the general relationship between beliefs and psychiatric disorders before introducing a concept that they first developed and described in 2007. Out of current understandings of the brain's processes, they have constructed what they call the evolutionary threat assessment systems of the brain. (ETAS) They describe how ETAS "change the thresholds or sensitivity" for interpreting life situations that might pose a risk of harm." This way of thinking is in contrast to the commonly accepted model. It proposes that people have increased psychological distress after a disaster because of an increased sense of vulnerability, or perceived threat of potential harm. In contrast, the ETAS make assessments about the dangerousness of people and situations, and these assessments underlie many psychiatric symptoms. The threat assessments are influenced by beliefs that influence the ETAS toward viewing the world as being more or less threatening. Consequently, "some religious beliefs may moderate the intensity of psychiatric symptoms arising from everyday fears and emotions." (p.248)

The study reported in this paper attempted to directly compare different beliefs about God that ETAS Theory predicts will "differentially affect psychiatric symptoms through brain mechanisms involved in threat assessment." (p. 249) The study was somewhat handicapped by the fact that they chose to use data collected in the 2004 National Study (U.S.) of Religion and Health. Three sets of beliefs about God were compared to determine their degree of association with six groupings of psychiatric symptoms: general anxiety, social anxiety, depression, paranoid ideation, obsessive-compulsive disorder, and somatization. The three sets of religious beliefs were: 1. belief in a Close and Loving God. 2. belief in an Approving and Forgiving God. 3. belief in God as Creator and

Judge. These were now examined to see how they were related in the 1 629 persons in the study.

This paper should be carefully read for the discriminating results the authors have found. Some of those results, in broad terms are these: Belief in a Close and Loving God appeared to moderate most psychiatric symptoms. Also, belief in an Approving and Forgiving God had a significant association with social anxiety. And as the authors also state: "...certain beliefs about God may have an ameliorating influence on psychiatric symptomatology to the degree that they provide a sense of security." (p. 256)

(Comment: As the authors rightly note, they have interpreted their findings as evidence for the influence of beliefs on psychiatric symptoms, but it is possible that psychopathology influences one's beliefs about God." (94 refs)

Jane S. Grassley, Tommie P. Helms
Tales of resistance and other emancipatory functions of storytelling
J of Advanced Nursing
Vol. 65 # 11 (Nov 2009) pp. 2447-2453

This paper does not mention pastoral care in its background nor in its findings, which is a shame. Written for nurses by two nurses, they describe the importance of storytelling, and the liberating effects of doing so.

They focus on the subject of breastfeeding because of its significant place in the lives of women.

In their background and introduction they describe the theory behind their work. "Listening to their (women's) stories can be an emancipatory intervention..." "By asking women in their care to tell their stories, nurses can enter into women's experiences and help make sense of them." (p. 2448) However, while pastoral care's understanding of the power of story-telling has grown more out of the field of psychotherapy, these writers base their understandings from the fields of social change and social justice. They start with Paulo Freire and continue through the work of others such as Williams, Barnes, and Abrums.

(Comment: A paper which may provide some readers with a fresh way of conceptualizing their listening ministry." (22 refs)

Melissa M. Kelley
The grace of teaching mistakes
***** J of Spirituality in Mental Health**
Vol. 11 # 4 (Oct/Dec 2009 pp. 282-289

Kelley makes the case for her belief that making a mistake while teaching may be "an occasion for grace" both for the teacher and for students. They can benefit teaching and learning in four different ways: by helping the teacher identify something needing more research; by humanizing the teacher in the eyes of students; by helping the teacher find liberation from unreasonable expectations; and, helping the teacher "move toward helpful and creative humility in teaching."

Kelley, who teaches pastoral care and counseling, describes her "most powerful teaching mistake." (8 refs)

Ian M. Kenway
Blessing or curse? Autism and the rise of the Internet
***** J of Religion, Disability and Health**
Vol. 13 # 2 (Apr/Jun 2009) pp. 94-103

This article looks with a deep sense of appreciation at people with an autistic syndrome. In the past, such persons were often considered simply "handicapped." But a closer examination of persons with this syndrome, aided by discoveries that have been made since they began using the Internet has led persons like Kenway to be fuller perception of their gifts. Using the Internet, these persons can by-pass verbal cues and avoid the physical hindrances inherent in having to share emotions. The results of this use of the Internet has been a broader appreciation of the nature of autism and the gifts of persons so described. The result has been for many of them, an empowering and a deeper sense of self-worth. For "neurotypicals," (NT's) a label given to "normals" by auties themselves, the way has been cleared for a whole new appreciation of who they are, their humanity and their spirituality.

As Kenway sees it, auties must overcome the temptation to devalue their bodies as they make use of virtual communication. And NT's "need to articulate with greater vigor and conviction that people living with autism are not alone in their need to rediscover the essential goodness of the body." (p. 94)

This essay appears in an entire issue of this Journal devoted to questions of religion and autism. It is the 2nd part, (see also the previous issue), of a collection of articles all edited by John Swinton and Christine Trevett. There are five essays in this 2nd part. This issue concludes with a 9-page annotated listing of resources concerning faith and autism. (13 refs)

**Majlinda Lako, Alan Trounson, Susan Daher
Law, ethics, religion and clinical translation in
the 21st century - a conversation with Stephen
Bellamy**

Stem Cells

Vol. 28 # - (2010) pp. 177-180

Bellamy is an Anglican priest, vicar of St Nicholas' Church in Durham. His doctorate focused on helping people make ethical decisions about human genetic intervention. In the introduction he is described as standing in the evangelical tradition of the Church of England.

The article is a summary of a wide-ranging conversation in which Bellamy speaks of his values as a Christian as they relate to issues such as in-vitro fertilization, the implantation of embryos, the moral status of pre- and implanted embryos, embryos produced by cell nuclear transfer, the formation of cytoplasmic hybrids (mixing human material and animal gametes), and the so-called war between religion and science. "I would like to end the phoney "war between science and faith," he says. He also indicates that he strongly believes there is a deficit in medical ethics in the U.K.

**Jennifer W. Mack, Susan D. Block, Matthew Nilsson, Alexi Wright, Elizabeth Trice, Robert Friedlander, Elizabeth Paulk, Holly G. Prigerson
Measuring therapeutic alliance between oncologists and patients with advanced cancer -
The Human Connection Scale**

Cancer

Vol. 115 # 14 (15 Jul 2009) pp. 3302-3311

Terminally ill patients are exquisitely sensitive to their relationship and the human connection they have with their primary physician. This paper describes the development and validation process of a measure of the alliance between patients with advanced cancer, and physicians, in order to evaluate the therapeutic alliance's effect on end-of-life experiences and care. They have named the measure The Human Connection Scale (THC). It is a 16-item questionnaire, it has been tested and found reliable (n=217 patients).

The authors plan to use the scale to assess different aspects of end-of-life care. (48 refs)

Debora MacKenzie

Living in denial: why sensible people reject the truth

New Scientist

Vol. 206 # 2760 (15 May 2010) pp. 38-43

Have you read about the latest medical scandal? The swine flu pandemic was a hoax. Scientists, governments and the World Health Organization worked together to create a conspiracy so that vaccine companies could create profits during the global recession.....

Of course, there are also the facts that the flu fulfilled every criteria for a pandemic; that thousands of people did die; and that the pandemic did not lead to huge profits for the vaccine producers. What also happened was that a group of obscure European politicians - members of the Parliamentary Assembly of the Council of Europe; see their Document 12110 dated 18 Dec 2009 - created this conspiracy theory, and it is now spreading in the Western world, even in educated circles.

With this example of what she calls "denialism", MacKenzie starts her account of this latest incarnation of a movement whereby people reject a set of facts or body of knowledge in favor of "make believe." Other recent examples she points to are: AIDS, the effects of tobacco, the Holocaust, evolution, 9/11 and climate change.

MacKenzie defines what she means by deniers, and how they differ from sceptics; the underlying psychology supporting denier thinking; the links between deniers of different issues; and the careful manipulation of deniers by large corporations and political parties with have vested interests. For example Big Tobacco concerning the effects of tobacco smoke.

There are two accompanying stories. Michael Shermer describes how to differentiate between a sceptic and a denier. Jim Giles follows the life-history of one claim about global warming that was made in November 2006, based on a statement that had never been spoken. As Giles observes, "In the battle for hearts and minds, a plausible falsehood too often trumps the truth." Finally, Marlin McKee, an epidemiologist, offers specific suggestions concerning how one can be an effective denier.

(Comment: In this era, when there are battles taking place between competing ideologies in different parts of our society, this article shines a light on some of the methods being used to change people's minds on significant issues within Western society, its cultural, social and religious beliefs, significant issues in which clergy and chaplains happen to have an important stake. (4 books)

Yadollah A. Momtaz, Rahiman Ibrahim, Tengku Aizin Hamid, Nurizan Yahaya

Mediating effects of social and personal religiosity on the psychological well being of widowed elderly people

Omega (Westport)

Vol. 61 # 2 (Mar 2010) pp. 145-162

The death of a spouse is one of life's most stressful events. The authors of this study wanted to learn whether or not the effects of personal or social religiosity mediates the psychological impact of a partner's death. The subjects of the study were 1367 widowed elderly Muslims in Malaysia.

A thorough study, three different instruments were used to test psychological, and physical health, plus Gorsuch and McKenzie's Internal External Religiosity Scale (1989). Their literature review reflects a world-wide awareness of their topic.

The overall finding was that the personal comfort of Muslim religiosity can decrease the negative effects of widowhood on the psychological well being of elderly widowed Muslims. Social religiosity was not found to have a significant effect. (57 refs)

Patricia E. Murphy, George Fitchett

Introducing chaplains to research: "This could help me"

***** J of Health Care Chaplaincy**

Vol. 16 # 3-4 (Jul/Dec 2010) pp. 79-94

Why are a large percentage of chaplains afraid of research? The findings reported in this article shed some important light on that important question.

For almost a decade, Fitchett, who is on the staff of Rush University Medical Center in Chicago has been working to encourage chaplains to benefit from research. He would like to see the profession of chaplaincy become an evidence-based profession. In this paper he is joined by his colleague, Pat Murphy in identifying and examining the barriers to making chaplains "research literate."

In 2002, Fitchett conducted a workshop for chaplains in Australia which gave him the opportunity to identify chaplains' attitudes towards research and the barriers to their becoming involved in research activities. He published the findings, with two Australian colleagues, the following year in a now-discontinued journal, Ministry Society & Theology.

Now Fitchett and Murphy have built on those initial findings as a result of conducting five subsequent workshops in the U.S. between 2004 and 2006. In this article they present data from 94 chaplains who

attended one of their workshops. They describe it's goals and objectives, the process of gathering and analyzing the reactions and feelings of the participants, the results and their analysis of them.

Their discussion will encourage chaplains to take advantage of the benefits of research, to become better "consumers" of research results. There are a large percentage of chaplains who are fearful of research (for a variety of reasons) and avoid its findings. There are widely-held misconceptions about what research involves. With many chaplains functioning in the medical world where the dominant research model is quantitative in nature, this is hardly surprising, even if misleading.

The insights in this paper will be of value to those seeking to effect change in chaplaincy practices. (22 refs)

James C. Peterson, Kelvin F. Mutter

Some pains are worth their price: discerning the cause of pain to guide its alleviation

***** J of Spirituality in Mental Health**

Vol. 12 # 3 (Jul/Sept 2010) pp. 182-194

This essay invites the reader to understand pain as a multidimensional domain which may require differentiated responses beyond the often immediate impulse to alleviate or block it. They propose a typology of pain that encourages consideration of the components in each case in order to discern the most useful alleviation. That typology invites reflection on how the pain experience relates to the domains of a person's being, the onset and duration of the pain experience, and the processes of meaning-making.

They illustrate working within their typology by means of a case study. (46 refs)

Ann C. Recine, Joan S. Werner, Louis Recine

Health promotion through forgiveness intervention

J of Holistic Nursing

Vol. 27 # 2 (Jun 2009) pp. 115-123

Over the past ten years, the nursing profession in the U.S. has worked at expanding its commitment to patients who are in need of forgiveness. This paper is by a nurse practitioner in private practice who has specialized in helping her patients find forgiveness, often for health-related matters. In her paper, she offers evidence-based forgiveness interventions that she believes will be useful to nurses in both medical and community settings.

She starts by making the case for being able to help people find forgiveness, defines forgiveness and some of the recent research on forgiveness interventions, describes the theoretical framework underlying her approaches, and then describes four approaches for forgiveness interventions. She describes: 1. giving the patient persuasive information. 2. helping a patient vicariously experience forgiveness. 3. helping the patient with awareness of and coping with own physiological responses; and 4. helping the patient experience "enactive attainment."

(*Comment:* A well-trained chaplain may be able to add to their pastoral skills by taking some of the material in this paper and with it build on to their own theological base.) (40 refs)

Larry VandeCreek, Kenneth Mottram

**The religious life during suicide bereavement
Death Studies**

Vol. 33 # 8 (Sept 2009) pp. 741-761

Are there changes that take place in the religious life of a woman who has experienced the death of a partner by suicide, and if so, what are they? That is the central question of this exploratory study which examines the stories of 10 woman, exploring three dimensions of their religious life during their bereavement: 1. the function of the woman's personal religion; 2. the function of the religious support of their family and friends; and 3. the function of established religious communities.

The authors identify 10 themes in the stories: the afterdeath destiny of the loved one, a more spiritual perspective, the impact of religious beliefs, support from family and friends, the survivors' contribution to emotionally distant relationships, long-term and in- depth spiritual support, religious support from members of religious community, the ministry of clergy, the funeral service, and returning to public worship services.

The authors found that religion did play an important part in the bereavement process. They also make three suggestions for future research.

Rob Whitley

Atheism and mental health

Harvard Revue of Psychiatry

Vol. 18 # 3 (Jun 2010) pp. 190-194

The relationship between religion/religiosity and mental health has long been discussed in the various literatures - pastoral, psychiatric etc. However, while it is not a "religion", atheism is also a worldview

that is often consciously adopted by adherents; they firmly believe in the truth of atheism, commonly referred to as "positive-atheism."

In his essay, Whitley asserts that atheism, especially positive atheism should be treated as a variable in the study of mental health, in a way that parallels studies of religion and mental health. Specifically, he posits that (1) atheism needs to be accurately measured as an individual-level variable, with the aim of relating this variable to psychiatric outcomes; (2) that there needs to be greater systematic study of the influence of atheism in psychiatry as an institution; and (3) that the relation of atheism to mental health needs to be explored by examining atheistic theory and its practical implication, especially as it relates to the human condition, suffering, and the concepts of personality theory.

Urs Winter-Pfändler, Christoph Morgenthaler
**Are surveys of quality improvement of
healthcare chaplaincy emotionally distressing for
patients? A pilot survey**

***** J of Health Care Chaplaincy**

Vol. 16 # 3/4 (Jul/Dec 2010) pp. 140-148

This paper reports the results of a Swiss survey which sought to clarify whether asking patients to participate in surveys which focused on the services of chaplains was emotionally distressing, and if so how much? The lead author is a chaplain. Thirty-seven persons, of whom 8 were actually in the hospital were asked to complete a fairly extended questionnaire designed to discover if "research on quality improvement in healthcare chaplaincy is emotionally distressing for patients in the Swiss context." (p. 143)

The results clearly show that having to complete such questionnaires appeared not to be stressful to the vast majority (over 90%) of participants. (35 refs)

William Yang, Ton Staps, Ellen Hijmans

**Existential crisis and the awareness of dying: the
role of meaning and spirituality**

Omega (Westport)

Vol. 61 # 1 (Jan 2010) pp. 53-69

For over thirty years, the first two authors worked in the field of psychosocial oncology but in different hospitals before meeting in a counseling center specializing in counseling with cancer patients and their relatives. When they compared notes about their experiences in their hospitals and now in the counseling center, they found there was a clear

difference in the requests that patient made for support. In the hospitals, patient requests had been about problems relating to the physical impact of their illness, its treatment, and the immediate consequences e.g. managing their feelings of fear, decisions concerning treatment.

But in the counseling center, with their medical treatment ended, their requests for help concerned the emotional process of the loss of meaning and the struggle to (hopefully) recover it. This paper describes their counseling work responding to what patients described as moments of great emotional distress in which they "totally lost all anchorage." "My world collapsed." "I looked into a black hole." The authors call this loss of anchorage "existential distress" and its implications motivated their study

of "existential crisis" and the ways patients deal with it.

In their research they used Grounded Theory methodology, which they describe in sufficient detail for the naïve reader to understand; their data gathering process with 15 persons by interview and 68 by questionnaire; their use of sensitizing concepts.

They note seven characteristics of the existential crisis: awareness of finitude, dissolving of the future, loss of meaning, fear-anxiety-panic-despair, loneliness, powerlessness, identity crisis. They further analyze the processes that they found occurring within the existential crisis.

They have a number of suggestions for those who care for this group of patients. (30 refs)