

Spirituality & Health: A Select Bibliography Of Medline-Indexed Articles Published In 2001

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The following is a selection of 147 Medline-indexed journal articles pertaining to spirituality & health published during 2001. The sample here indicates the great variety of articles appearing in the literature, but note that since Medline is itself a selective index of journals, an even broader range of articles regarding spirituality & health may be found through other health science indices/data bases (e.g., CINAHL/Nursing or PsycINFO).

- Abraham, J. [Pain and Palliative Care Program, Dana Farber Cancer Institute, Brigham and Women's Hospital, Boston; jabrahm@partners.org]. **"Pain management for dying patients. How to assess needs and provide pharmacologic relief."** *Postgraduate Medicine* 110, no. 2 (Aug 2001): 99-100, 108-9, 113-4.
Though the author's focus is on pharmacologic interventions, she also notes the potential need for referral to a pastoral counselor in cases of spiritual distress (p. 114). She offers a practical guide for assessment of spiritual distress, including "indicators that a patient may be spiritually troubled" and "questions to ask the patient" (p. 113).
- Abbott, K. H., Sago, J. G., Breen, C. M., Abernethy, A. P. and Tulskey, JA. [Program on the Medical Encounter and Palliative Care, Durham VA Medical Center, NC]. **"Families looking back: one year after discussion of withdrawal or withholding of life-sustaining support."** *Critical Care Medicine* 29, no. 1 (Jan 2001): 197-201.
[From the abstract:] ...SETTING: Six intensive care units in a tertiary care academic medical center. PARTICIPANTS: Forty-eight family members, one per case, of patients previously hospitalized in the ICU who had been considered for withdrawal or withholding of life-sustaining treatment. ...MEASUREMENTS AND MAIN RESULTS: Two raters coded transcripts of audiotaped interviews with family members about their experiences in the ICU and the decision-making process for withdrawing or withholding life-sustaining treatment. ...Forty-six percent of respondents perceived conflict during their family member's ICU stay; the vast majority of conflicts were between themselves and the medical staff and involved communication or perceived unprofessional behavior (such as disregarding the primary caregiver in treatment discussions). ...Forty-eight percent of family members reported the reassuring presence of clergy, and 27% commented on the need for improved physical space to have family discussion and conferences with physicians. Forty-eight percent of family members singled out their attending physician as the preferred source of information and reassurance. ...CONCLUSIONS: Many families perceived conflict during end-of-life treatment discussions in the ICU. Conflicts centered on communication and behavior of staff. Families identified pastoral care and prior discussion of treatment preferences as sources of psychosocial support during these discussions. Families sought comfort in the identification and contact of a "doctor-in-charge." ICU policies such as family conference rooms and lenient visitation accommodate families during end-of-life decision-making.
- Ameling, A. and Povilonis, M. [Yale University School of Nursing, 100 Church Street South, P. O. Box 9740, New Haven, CT 06536-0740]. **"Spirituality, meaning, mental health, and nursing."** *Journal of Psychosocial Nursing & Mental Health Services* 39, no. 4 (Apr 2001): 14-20. [Review, 17 refs.]
[Abstract:] 1. Spirituality, defined as meaning making, is a primary motivation in life. 2. The medical literature increasingly demonstrates an important positive relationship between spirituality and health. 3. Nurses often feel uncomfortable or unprepared to discuss spiritual issues with patients. 4. Through a few simple questions, nurses can easily make spiritual assessment a routine part of taking a patient's psychosocial history.
- Anandarajah, G. and Hight, E. [Brown University School of Medicine, Providence, RI]. **"Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment."** *American Family Physician* 63, no. 1 (Jan 1, 2001): 81-9. [Review, 44 refs.]
[Abstract:] The relationship between spirituality and medicine has been the focus of considerable interest in recent years. Studies suggest that many patients believe spirituality plays an important role in their lives, that there is a positive correlation between a patient's spirituality or religious commitment and health outcomes, and that patients would like physicians to consider these factors in their medical care. A spiritual assessment as part of a medical encounter is a practical first step in incorporating consideration of a patient's spirituality into medical practice. The HOPE questions provide a formal tool that may be used in this process. The HOPE concepts for discussion are as follows: H—sources of hope, strength, comfort, meaning, peace, love and connection; O—the role of organized religion for the patient; P—personal spirituality and practices; E—effects on medical care and end-of-life decisions.
- Anandarajah, G., Long, R. and Smith, M. [Memorial Hospital of Rhode Island, Brown University School of Medicine, Pawtucket, RI 02860]. **"Integrating spirituality into the family medicine residency curriculum."** *Academic Medicine* 76, no. 5 (May 2001): 519-20.
The authors describe the goals and implementation of the first year of a five-year initiative at the Brown University School of Medicine to integrate "a spirituality and medicine curriculum seamlessly into the existing curriculum" (p. 519). Evaluation has been by qualitative and

quantitative methods. The authors report, in sum: "The initial feedback has been extremely positive and the program has been described as relevant, balanced, and practical" (p. 519).

Association of Professional Chaplains, Association for Clinical Pastoral Education, Canadian Association for Pastoral Practice and Education, National Association of Catholic Chaplains, and National Association of Jewish Chaplains. "**A white paper. Professional chaplaincy: its role and importance in healthcare.**" *Journal of Pastoral Care* 55, no. 1 (Spring 2001): 81-97.

[From the abstract:] This paper describes the role and significance of spiritual care and is the first joint statement on this subject prepared by the five largest healthcare chaplaincy organizations in North America representing over 10,000 members. As a consensus paper, it presents the perspectives of these bodies on the spiritual care they provide for the benefit of individuals, healthcare organizations and communities. Throughout this paper, the word spirituality is inclusive of religion; spiritual care includes pastoral care. Spiritual caregivers in healthcare institutions are often known as chaplains....

Astrow, A. B., Puchalski, C. M. and Sulmasy, D. P. [Saint Vincent's Comprehensive Cancer Center, Saint Vincent's Hospital and Medical Center, 153 West 11th Street, New York, NY 10011]. "**Religion, spirituality, and health care: social, ethical, and practical considerations.**" *American Journal of Medicine* 110, no. 4 (Mar 2001): 283-7.

[Abstract:] The public has shown increasing interest in the interplay of religion, spirituality, and health, but many physicians are either openly skeptical or unsure how best to respond. Religion and medicine were once closely linked, but spiritual concerns have come to be seen as obstacles to scientific progress or, at best, sentimental attachments of little real value in the battle with disease. As a result, many patients and their families have been cut off from a vast storehouse of wisdom, and many physicians complain of being isolated and overburdened with intractable human dilemmas. Although it is crucial that spirituality and religious faith not be reduced to therapeutic nostrums, an emerging literature has demonstrated a salutary impact on patient well-being. Further, if spirituality is seen as the search for transcendent meaning, then all human beings, secular or religious, grapple with spiritual questions. Serious illness can therefore be viewed as both a biologic fact and a spiritual challenge for all patients. Physicians need to learn to be open to discussing spiritual concerns with their patients; to addressing these issues in a respectful, careful and professional way; and to knowing how and when to refer patients to other members of the health care team for spiritual support. Perhaps most important, if to care for a person one must first learn to be a person, physicians may wish to cultivate and deepen their own spiritual lives.

Atallah, S. F., El-Dosoky, A. R., Coker, E. M., Nabil, K. M. and El-Islam, M. F. [Behman Hospital, Helwan, Cairo, Egypt; behman@link.net]. "**A 22-year retrospective analysis of the changing frequency and patterns of religious symptoms among inpatients with psychotic illness in Egypt.**" *Social Psychiatry & Psychiatric Epidemiology* 36, no. 8 (Aug 2001): 407-15.

[Abstract:] BACKGROUND: The aim of the present study was to assess the changes in frequency and pattern of religious symptomatology in a sample of psychiatric inpatients in Egypt suffering from some form of psychotic illness over the time span from 1975 to 1996. METHOD: A sample of 5275 files of psychotic inpatients at Behman psychiatric hospital in Cairo, Egypt, admitted between 1975 and 1996, were scrutinized for the presence or absence of "religious" symptoms. All the files with religious symptoms from this sample (n=632) and an additional 281 comparison files were analyzed. RESULTS: Significant fluctuations in the frequency of religious symptoms over the period of the study were noted. The frequency of religious symptoms peaked in the mid-1970s to early 1980s, and again in the early and mid-1990s, relative to other time periods. Further analyses of changes in the frequency of specific religious themes or symptoms revealed that religious behaviors (i. e., increased reading of religious texts, preaching, and other types of overt religious expression), in particular, showed significant and consistent patterns of change. CONCLUSIONS: These findings were interpreted in light of the fluctuating emphasis on religion and religious affiliation in everyday life in Egypt during the period of the study. While the overall frequency of religious delusional themes in Egypt is sensitive to societal changes across time, the specific content of these delusions remains stable. On the other hand, the relative salience of behavioral modes of pathological religious expression is highly influenced by changing patterns of religious emphasis in Egyptian society.

Avants, S. K., Warburton, L. A. and Margolin, A. [Yale University School of Medicine, Department of Psychiatry, New Haven, CT; kelly.avants@yale.edu]. "**Spiritual and religious support in recovery from addiction among HIV-positive injection drug users.**" *Journal of Psychoactive Drugs* 33, no. 1 (Jan-Mar 2001): 39-45.

[Abstract:] The current study examined the association between support and comfort derived from religion or spirituality and abstinence from illicit drugs in a sample of 43 HIV-positive injection drug users entering a methadone maintenance program. Patients with high ratings of perceived spiritual or religious support were abstinent from illicit drugs significantly longer during the first six months of methadone maintenance than were patients with lower ratings. Controlling for the influence of pretreatment variables (addiction and psychiatric severity, CD4 count, social support, and optimism), and during-treatment variables (methadone dose and attendance at counseling sessions), hierarchical regression analysis showed that strength of religious and spiritual support was a significant independent predictor of abstinence. These findings suggest that spirituality may be an important dimension of patient experience to assess in future addiction treatment outcome research.

Aviles, J. M., Whelan, E., Hernke, D. A., Williams, B. A., Kenny, K. E., O'Fallon, W. M. and Kopecky, S. L. "**Intercessory prayer and cardiovascular disease progression in a coronary care unit population: a randomized controlled trial.**" *Mayo Clinic Proceedings* 76, no. 12 (December 2001): 1192-98.

[Abstract:] OBJECTIVE: To determine the effect of intercessory prayer, a widely practiced complementary therapy, on cardiovascular disease progression after hospital discharge. PATIENTS AND METHODS: In this randomized controlled trial conducted between 1997 and 1999, a total of 799 coronary care unit patients were randomized at hospital discharge to the intercessory prayer group or to the control group. Intercessory prayer, i.e., prayer by 1 or more persons on behalf of another, was administered at least once a week for 26 weeks by 5 intercessors per patient. The primary end point after 26 weeks was any of the following: death, cardiac arrest, rehospitalization for cardiovascular disease, coronary revascularization, or an emergency department visit for cardiovascular disease. Patients were divided into a high-risk group based on the presence of any of 5 risk factors (age \geq 70 years, diabetes mellitus, prior myocardial infarction, cerebrovascular disease, or peripheral vascular disease) or a low-risk group (absence of risk factors) for subsequent primary events.

RESULTS: At 26 weeks, a primary end point had occurred in 25.6% of the intercessory prayer group and 29.3% of the control group (odds ratio [OR], 0.83 [95% confidence interval (CI), 0.60-1.14]; P=.25). Among high-risk patients, 31.0% in the prayer group vs. 33.3% in the control group (OR, 0.90 [95% CI, 0.60-1.34]; P=.60) experienced a primary end point. Among low-risk patients, a primary end point occurred in 17.0% in the prayer group vs. 24.1% in the control group (OR, 0.65 [95% CI, 0.20-1.36]; P=.12). CONCLUSIONS: As delivered in this study, intercessory prayer had no significant effect on medical outcomes after hospitalization in a coronary care unit.

Baider, L., Holland, J. C., Russak, S. M. and De-Nour, A. K. [Sharett Institute of Oncology, Hadassah University Hospital, Jerusalem, Israel; baider@cc.huji.ac.il]. “**The system of belief inventory (SBI-15): a validation study in Israel.**” *Psycho-Oncology* 10, no. 6 (Nov-Dec 2001): 534-40.

[Abstract:] This study focused on the validation of measures assessing religiosity by means of three self-report instruments: the System of Belief Inventory (SBI-15R), the Religious Orientation Inventory (ROI), and the Index of Core Spiritual Experiences (INSPIRIT). These instruments were developed and validated previously in the United States. The study measured the extent to which the self-reports maintain their validity when administered in a different country with its own distinct language, culture and religion (e.g., Israel). It was found that all three self-reports have very good external validity and high convergent reliability, with the SBI demonstrating extremely high internal reliability.

Baldacchino, D. and Draper, P. [Institute of Health Care, University of Malta, Malta, Sicily; cbal1@ihc.um.edu.mt]. “**Spiritual coping strategies: a review of the nursing research literature.**” *Journal of Advanced Nursing* 34, no. 6 (Jun 2001): 833-41. [Review, 91 refs.]

[Abstract:] AIMS OF THE PAPER: This paper reviews some of the limited nursing research-based literature, orientated towards the use of spiritual coping strategies in illness. This review aims at identifying those spiritual coping strategies used by the believers and nonbelievers followed by implications for holistic nursing care. LITERATURE SEARCH: The CINAHL and MEDLINE CD Rom databases were searched, identifying literature published from 1975 onwards which amounted to 187 articles. The majority of the literature traced were found anecdotal with only few studies investigating directly spiritual coping strategies. Following scrutiny of the available articles, only five research studies explored directly the spiritual coping strategies used in various illness, four of which were conducted in USA and one in UK. Because of the small scale research studies, generalization of the findings of this review is limited to the samples used. THEORETICAL BACKGROUND: Research suggests that spiritual coping strategies, involving relationship with self, others, Ultimate other/God or nature were found to help individuals to cope with their ailments. This may be because of finding meaning, purpose and hope, which may nurture individuals in their suffering. Spirituality is often referred by literature as being synonymous with religiosity. Thus the use of spiritual coping strategies is restricted to individuals who hold religious beliefs. However, the definition of spirituality indicates that this concept is broader than religiosity. The theories on stress-coping (Folkman & Lazarus 1984) and the numinous experience (Otto 1950) outline the rationale for the use of these strategies which are applicable to both the believers and nonbelievers. IMPLICATIONS: This review suggests that the onset of illness may render the individual, being a believer or nonbeliever, to realize the lack of control over his/her life. However the use of spiritual coping strategies may enhance self-empowerment, leading to finding meaning and purpose in illness. This implies that holistic care incorporates facilitation of various spiritual coping strategies to safeguard the wholeness and integrity of the patients.

Balducci, L. and Meyer, R. [Senior Adult Oncology Program, H. Lee Moffitt Cancer Center, Tampa, FL 33612]. “**Spirituality and medicine: a proposal.**” *Cancer Control* 8, no. 4 (Jul-Aug 2001): 368-76. [Review, 54 refs.]

This overview of spirituality & medicine proposes an emphatic recognition of human spirituality in the interaction with patients and in their care planning. The author reviews various studies on spirituality & health but focuses on a conceptualization of spirituality as “the connective tissue that allows coordinated and meaningful activities in human beings,” which may inform a revision of the current model of medical practice.

Baldwin, K. A., Humbles, P. L., Armmmer, F. A. and Cramer, M. [University of Illinois at Chicago, College of Nursing, Peoria Regional Program, Peoria, IL 61656-1649]. “**Perceived health needs of urban African American church congregants.**” *Public Health Nursing* 18, no. 5 (Sep-Oct 2001): 295-303.

[Abstract:] Theory-based assessment of congregant expectations and needs should be conducted prior to beginning a parish nurse program. However, no such assessments are found in the literature. Using Andersen's Health Access Model as a framework, investigators conducted interviews with 117 randomly selected congregants in five urban African American churches to describe their perceived needs and expectations. Causing most concern were the following: (a) symptoms of illness—high blood pressure (50.4%), dental problems (43.6%), and back pain (41%); and (b) health habits/risks—weight (75%), exercise (63%), and diet (63%). Younger adults were significantly more concerned about all aspects of their health than their older counterparts. Women were significantly more likely to express concern about health habits and health risks than males. No significant relationship was found between perceived need and access to care. Although terming health care services “adequate,” congregants expressed many unmet health needs. This seemingly contradictory finding may illuminate a concrete role for the parish nurse, i.e., addressing personal health care concerns not alleviated by the current “adequate” health care delivery system. This study's significance lies not only in providing programming guidance, but also in theoretical insights into the role of the parish nurse.

Barg, F. K. and Gullatte, M. M. [University of Pennsylvania School of Nursing, 420 Guardian Dr, Philadelphia, PA 19104]. “**Cancer support groups: meeting the needs of African Americans with cancer.**” *Seminars in Oncology Nursing* 17, no. 3 (Aug 2001): 171-8. [Review, 35 refs.]

[Abstract:] OBJECTIVES: To describe culturally appropriate ways that cancer support groups can meet the needs of African Americans with cancer. DATA SOURCES: Research articles and clinical experience. CONCLUSIONS: Support groups are an important vehicle through which people cope with the emotional and physical impact of their cancer. Most support group participants are middle-class, white women. Faith-based cancer support groups can address the needs of many African Americans with cancer by offering support and education within the context of a spiritually based life-style. IMPLICATIONS FOR NURSING PRACTICE: Coping strategies may vary

among cultural groups. In order to be supportive, cancer support groups must be congruent with the values and beliefs of the group's members.

- Benight, C. C., Flores, J. and Tashiro, T. [University of Colorado at Colorado Springs, CO; benight@mail.uccs.edu]. **"Bereavement coping self-efficacy in cancer widows."** *Death Studies* 25, no. 2 (Mar 2001): 97-125.
[Abstract:] This study applied social cognitive theory to help explain the differential outcomes observed in conjugal bereavement. Specifically, a measure of bereavement coping self-efficacy was created and relationships tested with psychological, spiritual, and physical health outcomes. One hundred and one women whose husbands had died from cancer within the last year served as participants. Mean age of this relatively well-educated, predominately Caucasian sample was 54 years old. Median time since death was between 6 months and a year. Results supported the hypotheses that bereavement coping self-efficacy was a significant predictor of emotional distress, psychological well-being, spiritual well-being, and physical health perceptions after controlling for several other important factors. Theoretical and clinical ramifications of these findings are discussed.
- Berger, J. A. [Oncology Services, Barnes-Jewish Hospital, Washington University Medical Center, St. Louis, MO; jab0539@bjc.org]. **"Living The Discipline on a stem cell transplant unit: spiritual care outcomes among bone marrow transplant survivors."** *Journal of Health Care Chaplaincy* 11, no. 1 (2001): 83-93.
[Abstract:] An oncology chaplain details, using The Discipline for Pastoral Care Giving, common themes in the spiritual journeys of stem cell/bone marrow transplantation survivors, and helpful chaplain interventions.
- Bernardi, L., Sleight, P., Bandinelli, G., Cencetti, S., Fattorini, L., Wdowczyk-Szulc, J. and Lagi, A. [Dipartimento di Medicina Interna, University of Pavia, 27100 Pavia, Italy]. **"Effect of rosary prayer and yoga mantras on autonomic cardiovascular rhythms: comparative study."** *BMJ* 323, no. 7327 (Dec 22-29, 2001): 1446-9.
[Abstract:] OBJECTIVE: To test whether rhythmic formulas such as the rosary and yoga mantras can synchronise and reinforce inherent cardiovascular rhythms and modify baroreflex sensitivity. DESIGN: Comparison of effects of recitation of the Ave Maria (in Latin) or of a mantra, during spontaneous and metronome controlled breathing, on breathing rate and on spontaneous oscillations in RR interval, and on blood pressure and cerebral circulation. SETTING: Florence and Pavia, Italy. PARTICIPANTS: 23 healthy adults. MAIN OUTCOME MEASURES: Breathing rate, regularity of breathing, baroreflex sensitivity, frequency of cardiovascular oscillations. RESULTS: Both prayer and mantra caused striking, powerful, and synchronous increases in existing cardiovascular rhythms when recited six times a minute. Baroreflex sensitivity also increased significantly, from 9.5 (SD 4.6) to 11.5 (4.9) ms/mm Hg, P<0.05. CONCLUSION: Rhythm formulas that involve breathing at six breaths per minute induce favorable psychological and possibly physiological effects.
- Black, H., K. [Philadelphia Geriatric Center]. **"Jake's story: a middle-aged, working-class man's physical and spiritual journey toward death."** *Qualitative Health Research* 11, no. 3 (May 2001): 293-307.
[Abstract:] In this article, the author explores a middle-aged, working-class man's, Jake's, reaction to his life-threatening illnesses and to his impending death. The experiences of illness and dying demand the "thick description" of narrative. Just as the medical model of illness breaks down the person into symptoms and parts, the relational model of illness and death in narrative "puts him back together again" by embedding him in a personal and social history. This article finds that the experience of illness and dying are rooted in the tacit ethos of an individual's family and society. The cultural paradigms of gender and class, religious tradition, and the reaction of others to the dying person shape the individual's response to his approaching death.
- Blank, K., Robison, J., Doherty, E., Prigerson, H., Duffy, J. and Schwartz, H. I. [Braceland Center for Mental Health and Aging, Institute of Living, Hartford CT 06106]. **"Life-sustaining treatment and assisted death choices in depressed older patients."** *Journal of the American Geriatrics Society* 49, no. 2 (Feb 2001): 153-61.
This study of 158 inpatients over age 60 found, among other things, that religious coping was significantly correlated with patients' lower interest in physician assisted suicide (PAS) when they were presented with two hypothetical end-of-life scenarios. (The main finding of the study was [from the abstract:] depressed subjects and even subjects with subtle, passive suicidal ideation were markedly more interested in PAS and euthanasia than non-depressed subjects in hypothetical situations. Depressed subjects were also particularly vulnerable to rejecting treatments if financial consequences might have resulted.)
- Block, S. D. [Department of Adult Psychosocial Oncology, Dana-Farber Cancer Institute and Brigham and Women's Hospital, Harvard Medical School, 44 Binney St., Boston, MA 02115; sblock@partners.org]. **"Psychological considerations, growth, and transcendence at the end of life: the art of the possible."** *JAMA* 285, no. 22 (June 13, 2001): 2898-2905.
The author uses a patient case to illustrate psychosocial concerns of seriously ill patients. She emphasizes the possibility for personal growth at the end of life and considers spiritual issues, though the patient in the exemplary case is not explicitly spiritual. She considers psychosocial and spiritual assessment and offers sample screening questions (p. 2899). She also notes the "total pain" sometimes experienced by patients with unresolved psychological and spiritual issues, depression, and anxiety... (p. 2902).
- Blondheim, D. S., Blondheim, O. and Blondheim, S. H. [Department of Cardiology, Sieff Government Hospital, Safed, Israel; blond@netvision.net.il]. **"The dietary composition of pre-fast meals and its effect on 24 hour food and water fasting."** *Israel Medical Association Journal: IMAJ* 3, no. 9 (Sep 2001): 657-62.
[Abstract:] BACKGROUND: Fasting is required by the Jewish and Islamic religions, and may sometimes be necessary for non-religious reasons as well. Very little empiric data are available on the effect of 24 hours of food and water deprivation. OBJECTIVES: To compare the effects of the dietary composition of different pre-fast meals on subjective discomfort and various other parameters of a 24 hour food and water fast. METHODS: Thirteen volunteers of both genders participated in a non-randomized crossover study. Each consumed three different equicaloric pre-fast meals in which the main source of calories was protein (49% of calories), carbohydrate (86%), or fat (69%). Weight, heart rate, blood pressure, blood and urine were tested before and after 24 hours of fasting, and the subjective evaluations of the discomfort during the three fasts were compared. RESULTS: After the protein-rich meal greater discomfort and more side effects were reported. Weight and blood pressure decreased at the end of the fasts that followed each of the three meals; heart rate increased after the high fat and carbohydrate meals but not after the protein meal. The main laboratory findings were a 40% increase in blood urea nitrogen

and higher urine osmolarity after the protein-rich meal than after the other meals. **CONCLUSION:** A protein-poor pre-fast meal is likely to be followed by easier fasting.

Bolletino, R. C. **“A model of spirituality for psychotherapy and other fields of mind-body medicine.”** *Advances in Mind-Body Medicine* 17, no. 2 (Spring 2001): 90-101, 104-7.

[Abstract:] The spiritual revolution that has permeated our culture challenges psychotherapists and other health practitioners to address the spiritual concerns of their clients and themselves. This challenge is particularly critical in view of the confused, meaningless, and faulty so-called “spiritual” ideas that affect some clients in ways that are toxic to their psychological (and possibly physical) health. However, given the nonspiritual tradition of professional psychology and medicine as a whole, practitioners as a group have no clear and cogent concept or standards with which to acknowledge and address these concerns. The aim of this article is to formulate a concept of spirituality that allows practitioners to include spirituality in their work in a clear, sound, and meaningful way.

Brolinson, P. G., Price, J. H., Ditmyer, M. and Reis, D. [Sports Care & Welltrack, Toledo Hospital, OH 43606]. **“Nurses’ perceptions of complementary and alternative medical therapies.”** *Journal of Community Health* 26, no. 3 (Jun 2001): 175-89.

[Abstract:] The purpose of this study was to identify the perceptions of nurses toward the effectiveness and safety, as well as their recommendations for and personal use of complementary and alternative medical therapies. A random sample of 1000 nurses throughout the United States were surveyed using a three-wave mailing. About half of the respondents perceived there was conclusive evidence or preponderance of evidence that five therapies were effective: biofeedback, chiropractic, meditation/relaxation, multi-vitamins, and massage therapy. The same amount of nurses also perceived five therapies as definitely safe: hypnotherapy, chiropractic, acupressure, acupuncture, and healing touch. However, the nurses were most likely to recommend (regularly or periodically) four therapies: multivitamins, massage, meditation/relaxation, and pastoral/spiritual counseling. The vast majority (79%) of nurses perceived their professional preparation in this area to be fair or poor.

Buijs, R. and Olson, J. [Centre for Health Promotion Studies, University of Alberta, Edmonton, Alberta]. **“Parish nurses influencing determinants of health.”** *Journal of Community Health Nursing* 18, no. 1 (Spring 2001): 13-23. [Review, 42 refs.]

[Abstract:] How are the concepts health, health promotion, faith community, and health determinants connected? How can a nurse draw on the unique features of a faith community to promote health? In this article, we explore the relations among these concepts and consider the answers to these questions. Parish nurses provide a concrete example of the interactions among these concepts. They are often hired by faith communities to intentionally promote health within and beyond the faith community. Increasingly, faith communities are being used as settings for health promotion interventions. We describe examples of how a parish nurse can influence two determinants of health: social support and healthy child development.

Burhansstipanov, L. and Hollow, W. [Native American Cancer Research, Native American Center of Excellence, School of Medicine, University of Washington, Seattle, WA]. **“Native American cultural aspects of oncology nursing care.”** *Seminars in Oncology Nursing* 17, no. 3 (Aug 2001): 206-19. [Review, 36 refs.]

[Abstract:] **OBJECTIVE:** To explain challenges Native American cancer patients experience throughout the continuum of cancer care. **DATA SOURCE:** Preliminary findings from the Native American Cancer Survivors Support Network, summaries from focus groups with Native American cancer survivors, and literature review. **CONCLUSIONS:** Cultural and family issues are diverse and affect cancer care situation in many different ways. **IMPLICATIONS FOR NURSING PRACTICE:** The oncology nurse needs to understand and respect the diversity among Native American cancer patients and to help the patient and provider find ways to allow for the inclusion of family members, spirituality, and traditional Indian medicine within the Western medical treatment model.

Buryska, J. F. [Mayo Foundation Hospitals, Rochester MN]. **“Assessing the ethical weight of cultural, religious and spiritual claims in the clinical context.”** *Journal of Medical Ethics* 27, no. 2 (Apr 2001): 118-22.

[Abstract:] The aim of this paper is to expand upon the conclusions reached by Orr and Genesen in their 1997 article (published in this journal), regarding requests for ‘inappropriate’ treatment based on religious beliefs. Assuming, with Orr and Genesen, that claims made in the name of religion are not absolute, I will propose some principles for determining when claims based on religious beliefs or cultural sensibilities “trump” other considerations and when they do not.

Campbell, D. E. and Fleischman, A. R. [Division of Neonatology, Children's Hospital at Montefiore, Albert Einstein College of Medicine, Bronx, NY 10461]. **“Limits of viability: dilemmas, decisions, and decision makers.”** *American Journal of Perinatology* 18, no. 3 (May 2001): 117-28. [Review, 64 refs.]

The article considers generally the question of medical decisions for infants on the cusp of viability and how [from the abstract:] parents and families bring personal, ideological, cultural, and religious beliefs into their relationship with health-care professionals that have the potential to conflict with professional perceptions of good medical care and the interests of the patient. ...A reasonable, and reasoned, approach for these vulnerable infants requires collaborative decision making incorporating professional recommendations, with an openness, trust and willingness to work with parents to ascertain the best interests of an individual infant. Understanding of and respect for the differing views of the moral obligations of perinatal specialists and families can aid neonatal professionals in resolving interdisciplinary and physician-family conflicts as well as facilitating resolution of neonatal ethical dilemmas.

Casarett, D., Kutner, J. S., Abraham, J. and the End-of-Life Care Consensus Panel [University of Pennsylvania, Institute on Aging, 3615 Chestnut Street, Philadelphia, PA 19104]. **“Life after death: a practical approach to grief and bereavement.”** *Annals of Internal Medicine* 134, no. 3 (Feb 6, 2001): 208-15.

The authors note (*passim*) the potential use of patients' clergy in managing patients' grieving. [Abstract:] This consensus paper describes the essential skills that clinicians need to help persons who are experiencing grief after the death of a loved one. Four aspects of the grieving process are reviewed: anticipatory grief, acute grief, normal grief reactions, and complicated grief. Techniques for assessment and recommendations about interventions and indications for referral are provided for each aspect.

- Chang, S. O. [College of Nursing, Korea University, Seoul, Korea; sungok@mail.korea.ac.kr]. **“The conceptual structure of physical touch in caring.”** *Journal of Advanced Nursing* 33, no. 6 (Mar 2001): 820-7.
 [From the abstract:] DESIGN/METHOD: The Hybrid Model of concept development was applied to develop a conceptual structure of physical touch in caring, which included a field study carried out in Seoul, South Korea using in-depth interviews with 39 adult subjects consisting of health-care professionals, in-patients, and healthy persons. RESULTS/FINDINGS: The concept of physical touch in caring emerged as a complex phenomenon having meanings on several different dimensions which were encompassed several attributes and the conceptual structure of physical touch in caring centered around five aspects of goals for physical touch: promoting physical comfort, promoting emotional comfort, promoting mind-body comfort, performing social role, and sharing spirituality. CONCLUSIONS: Physical touch in caring as a concept having the dimensions of physical, emotional, social, and spiritual significance needs to be treated in a holistic way and it is possible to enrich the meanings and methods of physical touch in nursing so that its application may have effects that have positive impacts on patients' well-being and comfort.
- Chibnall, J. T. and Brooks, C. A. [Department of Psychiatry, Saint Louis University School of Medicine, MO 63104]. **“Religion in the clinic: the role of physician beliefs.”** *Southern Medical Journal* 94, no. 4 (Apr 2001): 374-9.
 [Abstract:] BACKGROUND: Although studies have identified physician beliefs that may cause them to avoid spiritual topics in the clinic (e.g., lack of time), it is unknown to what extent these beliefs predict behavior. The purpose of the present study was to identify physician beliefs about religion and medicine that predict attention to religious issues in the clinic. METHODS: The study was cross-sectional and correlational. Seventy-eight physicians completed a self-report survey of religious behavior in the clinic and beliefs about religion and medicine. RESULTS: Most physicians do not initiate religious discussions with patients, though a majority accept a link between religion and health. Physician personal discomfort with addressing religious topics was the sole multivariate predictor of clinical religious behavior. Time, role definition, health relevance of religion, and physician religiousness were not significant predictors. CONCLUSIONS: Avoidance of religion in the clinic may be primarily belief-based. Future research is needed to examine the role of medical education in creating and/or maintaining these beliefs.
- Chibnall, J. T., Jeral, J. M. and Cerullo, M. A. [Department of Psychiatry, Saint Louis University, School of Medicine, 1221 S Grand Blvd, St Louis, MO 63104; chibnajt@slu.edu]. **“Experiments on distant intercessory prayer: God, science, and the lesson of Massah.”** *Archives of Internal Medicine* 161, no. 21 (Nov 26, 2001): 2529-36.
 [Abstract:] Experimental studies on the health effects of distant intercession (prayer) ignore important facets of construct validity, philosophy of science, and theology while focusing on issues like randomization and double-blinding. These tendencies reflect a desire on the part of researchers to remove nature as a causal factor when intercession seems efficacious. We argue that close attention to construct validity of cause-and-effect variables invalidates distant intercessory prayer as a scientific construct. Further, the application of statistical techniques to metaphysical causal phenomena is critiqued. We conclude that research on the effects of religion and spirituality on health should avoid attempting to validate God through scientific methods.
- Chiu, L. [School of Nursing, University of British Columbia, T201-2211 Wesbrook Mall, Vancouver, BC V6T 2B5, Canada; chiu@nursing.ubc.ca]. **“Spiritual resources of Chinese immigrants with breast cancer in the USA.”** *International Journal of Nursing Studies* 38, no. 2 (Apr 2001): 175-84.
 [Abstract:] A synthesis of ethnographic and phenomenological research approaches was used to investigate spiritual resource as the lived experience of Chinese immigrants with breast cancer in the US. The assumptions for the phenomena in this study were based upon Tu's cultural China and Confucian spirituality, as well as van Manen's phenomenological perspectives and Kleinman's ethnographic works. Fifteen Chinese immigrants with breast cancer in the US were recruited. The results reveal six cultural themes including family closeness, traditional Chinese values, religion, alternative therapy, art, prose and literature and Chinese support groups.
- Choe, M. A., Padilla, G. V., Chae, Y. R. and Kim, S. [College of Nursing, Seoul National University, South Korea]. **“The meaning of health-related quality of life in a Korean sample.”** *International Journal of Nursing Studies* 38, no. 5 (Oct 2001): 557-66.
 [Abstract:] This study describes the impact of diabetes and the meaning of health-related quality of life (HRQOL) for 22 male and female patients in Korea. Open-ended interviews yielded six HRQOL themes: health, overall well-being, harmonious relationships and family responsibilities, a rewarding life, spiritual life, and material support. The physical impact of diabetes included decreased energy, limitations, and physical suffering; while its psychological/spiritual impact extended to general stress, helplessness, fear, depression, anger, and relationship with God. Like Americans, Koreans valued health, psychological well-being and interpersonal support. In addition, the Koreans valued smooth, harmonious interpersonal relationships, overall well-being pertaining to living a comfortable and honorable life.
- Cohen, S. R., Boston, P., Mount, B. M. and Porterfield, P. [Division of Palliative Care, Department of Oncology, McGill University, Department of Medicine, McGill University Health Centre, Canada; robin.cohen@mcgill.ca]. **“Changes in quality of life following admission to palliative care units.”** *Palliative Medicine* 15, no. 5 (Sep 2001): 363-71.
 This study of 88 patients, using the The McGill Quality of Life Questionnaire (MQOL) and interviews, found [from the abstract:] significant improvements...in the MQOL total score and subscale scores reflecting physical, psychological and existential well-being. In the interviews, patients indicated that they had experienced changes in physical, emotional and interpersonal status, in spiritual outlook, and in their preparation for death. They also described the impact of the palliative care unit environment. This is the first study to demonstrate that hospice/palliative care can improve existential well-being in addition to psychological and physical symptoms.
- Cooper, L. A., Brown, C., Vu, H. T., Ford, D. E. and Powe, N. R. [Department of Medicine, The Johns Hopkins University School of Medicine, Baltimore, MD; lcooper@mail.jhmi.edu]. **“How important is intrinsic spirituality in depression care? A comparison of white and African-American primary care patients.”** *Journal of General Internal Medicine* 16, no. 9 (Sep 2001): 634-8.
 [Abstract:] We used a cross-sectional survey to compare the views of African-American and white adult primary care patients (N = 76) regarding the importance of various aspects of depression care. Patients were asked to rate the importance of 126 aspects of depression care

(derived from attitudinal domains identified in focus groups) on a 5-point Likert scale. The 30 most important items came from 9 domains: 1) health professionals' interpersonal skills, 2) primary care provider recognition of depression, 3) treatment effectiveness, 4) treatment problems, 5) patient understanding about treatment, 6) intrinsic spirituality, 7) financial access, 8) life experiences, and 9) social support. African-American and white patients rated most aspects of depression care as similarly important, except that the odds of rating spirituality as extremely important for depression care were 3 times higher for African Americans than the odds for whites.

Cooper-Effa, M., Blount, W., Kaslow, N., Rothenberg, R. and Eckman, J. **“Role of spirituality in patients with sickle cell disease.”** *Journal of the American Board of Family Practice* 14, no. 2 (Mar-Apr 2001): 116-22.

[Abstract:] BACKGROUND: Patients with sickle cell disease cope with their disease in various ways, such as psychological counseling, hypnosis, medication, and prayer. Spirituality is a coping mechanism in a variety of diseases. This study evaluates the role of spirituality in patients coping with the pain of sickle cell disease. METHODS: Seventy-one patients from the Georgia Sickle Cell Clinic completed a questionnaire addressing their ability to cope with the pain of sickle cell disease and their degree of spirituality. A descriptive cross-sectional design was used. Correlation and multiple regression analyses were calculated for the relation between coping with the pain of sickle cell disease and spirituality. RESULTS: The questionnaire provided several scales with high internal consistency for measuring spiritual well-being and its two components, existential well-being and religious well-being, that show a correlation between high levels of spirituality and life control. The study population exhibited high levels of spirituality and religiosity, but the influence of these feelings on coping with sickle cell disease was variable. Spiritual well-being was correlated with life-control but not with perceived pain severity. CONCLUSIONS: Existential well-being was associated with general coping ability. Spiritual well-being is important for some patients who must cope with the pain of sickle cell disease.

Costello, J. [School of Nursing, Midwifery and Health Visiting, University of Manchester, Manchester, UK; john.costello@man.ac.uk]. **“Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards.”** *Journal of Advanced Nursing* 35, no. 1 (Jul 2001): 59-68.

This ethnographic study of 74 patients, 29 nurses and 8 physicians in three elderly care wards found, among other things, that [from the abstract:] nurses reported psychosocial aspects including spiritual and emotional care to be important, although there was little evidence of them being orientated towards this in practice.

Daar, A. S. and al Khitamy, A. B. [College of Medicine, Sultan Qaboos University, Oman; asdoc@omantel.net.om]. **“Bioethics for clinicians, 21: Islamic bioethics.”** *Canadian Medical Association Journal* 164, no. 1 (Jan 9, 2001): 60-3. [Review, 31 refs.]

[Abstract:] Islamic bioethics derives from a combination of principles, duties and rights, and, to a certain extent, a call to virtue. In Islam, bioethical decision-making is carried out within a framework of values derived from revelation and tradition. It is intimately linked to the broad ethical teachings of the Qur'an and the tradition of the Prophet Muhammed, and thus to the interpretation of Islamic law. In this way, Islam has the flexibility to respond to new biomedical technologies. Islamic bioethics emphasizes prevention and teaches that the patient must be treated with respect and compassion and that the physical, mental and spiritual dimensions of the illness experience be taken into account. ...Islam shares many foundational values with Judaism and Christianity....

DiLorenzo, P., Johnson, R. and Bussey, M. [Children's Services, American Humane Association, Englewood, CO]. **“The role of spirituality in the recovery process.”** *Child Welfare* 80, no. 2 (Mar-Apr 2001): 257-73.

[Abstract:] Though innovative approaches to working with substance-abusing parents of maltreated children have emerged within the last few years, child welfare agencies continue to be challenged by the chronic nature of addictive diseases. This article discusses the often ignored element of spirituality as a critical component of recovery for parents. It also highlights how the regulation of spirituality by parents has a significant influence on their ability to responsibly care for their children.

Dunn, G. P. **“Patient assessment in palliative care: how to see the 'big picture' and what to do when 'there is no more we can do.’”** *Journal of the American College of Surgeons* 193, no. 5 (November 2001): 565-73.

With the perspective of a surgeon particularly in mind, the author offers a very practical plan for patient assessment based upon the “Nine Dimensions of Whole Patient Assessment for Palliative Care,” from the American Medical Association’s Education for Physicians on End-of-Life Care (EPEC) curriculum. He considers, as part of this, spiritual assessment (pp. 570-1). He suggests the use of Christina Puchalski’s FICA spiritual assessment tool and offers a table of “Screening Questions During the Spiritual Assessment” (p. 571). The author notes that an entire assessment for palliative care may take about 20-30 minutes and that “this is not only time well spent from a practical point of view (about the time it takes to wait for some frozen section reports), but it establishes a basis of mutual trust that is therapeutic in itself....” (p. 566).

Dunne, T. **“Spiritual care at the end of life.”** *Hastings Center Report* 31, no. 2 (Mar-Apr 2001): 22-6.

The author asserts: “Dying patients have more than medical needs. In fact, what they feel most sharply, whether or not they are religious, are spiritual needs” (p. 22). He addresses, “What is ‘The Spiritual?’” and surveys briefly the spiritual issues of dying, along with a practical sense of care giving. He interprets and translates universally the Christian virtues of faith, hope, and charity as a “starting point” for such spiritual care.

Eakin, E. G. and Strycker, L. A. [AMC Cancer Research Center, Denver, CO; e.eakin@qut.edu.au]. **“Awareness and barriers to use of cancer support and information resources by HMO patients with breast, prostate, or colon cancer: patient and provider perspectives.”** *Psycho-Oncology* 10, no. 2 (Mar-Apr 2001): 103-13.

[From the abstract:] This study assessed patient awareness and use—as well as obstacles to use—of HMO- and community-based psychosocial support services designed for cancer patients. Participants were a randomly selected group of patients from a large Northwest HMO, with breast (N=145), prostate (N=151), or colon cancer (N=72), and their oncology and urology providers (N=29). ...The most commonly reported patient barriers to using such services were already having adequate support, lack of awareness of the service, and lack of provider referral. Results of regression analyses suggest that education, physician referral, social support, and spirituality may be

important influences on use of cancer support services. This study takes a first step toward understanding patient use of existing cancer support services and suggests ways to increase participation in these services.

Easley, M. K. and Elliott, S. [Pain Research Group, The University of Texas M. D. Anderson Cancer Center, Houston, TX 77030; mkohutek@mdanderson.org]. “**Managing pain at the end of life.**” *Nursing Clinics of North America* 36, no. 4 (Dec 2001): 779-94, vii-viii. [Review, 36 refs.]

[Abstract:] There are many threats to a calm and peaceful passing, but none more distressing than unrelenting pain. Pain exists not only in the physical realm, but also in the psychological, social and spiritual senses. Discussion of barriers and responsibilities are important to assure that pain is appropriately treated. Effective pain treatment relies on communication among patients, families, and care providers. Nurses are a central force in this communication and must act as leaders and advocates in planning care and relieving pain in dying patients.

Fallot, R. D. [Loyola College, Maryland]. “**The place of spirituality and religion in mental health services.**” *New Directions for Mental Health Services* 91 (Fall 2001): 79-88.

[Abstract:] Mental health professionals have raised concerns about the role of spirituality and religion in services for people with severe mental disorders, but this [article] offers compelling reasons for increased attention to spiritual issues in service delivery.

Frederich, M. E. [Center for Palliative Studies, San Diego Hospice, San Diego, CA 92103; mfrederich@sdhospice.org]. “**Nonpain symptom management.**” *Primary Care: Clinics in Office Practice* 28, no. 2 (Jun 2001): 299-316. [Review, 56 refs.]

[Abstract:] Excellent symptom management is paramount in palliative care. Without it, the individual patient will be unable to focus appropriately on other issues of concern, including those of a psychosocial, emotional, or spiritual nature. This article reviews current pharmacologic and nonpharmacologic interventions for symptoms commonly encountered in palliative care. These symptoms are organized into gastrointestinal, respiratory and neuropsychiatric categories.

Fry, P. S. [Graduate Program in Psychology, Trinity Western University, Langley, British Columbia; Fry@Twu.ca]. “**The unique contribution of key existential factors to the prediction of psychological well-being of older adults following spousal loss.**” *Gerontologist* 41, no. 1 (Feb 2001): 69-81.

[Abstract:] PURPOSE: This study examined the unique contribution of key existential factors to the prediction of psychological well-being of older adults following spousal loss. DESIGN AND METHOD: A number of measures to assess psychological well-being, socio-demographic standing, social resources, and religious and spiritual resources were administered to a volunteer sample of widows and widowers to test the hypothesis that existential factors such as personal meaning, religiosity, and spirituality are more potent predictors of psychological well-being than are previously hypothesized variables of socio-demographic, social support, and physical factors. RESULTS: A hierarchical regression analysis of the data supported the hypothesis that existential factors are major contributors to psychological well-being of older adults following spousal loss. Findings showed that widowers, compared to widows, scored lower on the measure of psychological well-being. IMPLICATIONS: Implications of the findings are discussed for practitioners working with bereaved spouses; suggestions for further research concerning bereavement and psychological well-being are made.

Gatrad, A. R. and Sheikh, A. [Manor Hospital, Walsall NHS Trust, Moat Road, Walsall WS2 2PS, UK; drgatrad@hotmail.com]. “**Medical ethics and Islam: principles and practice.**” *Archives of Disease in Childhood* 84, no. 1 (Jan 2001): 72-75.

[Abstract:] A minimum level of cultural awareness is a necessary prerequisite for the delivery of care that is culturally sensitive. In this paper we simplify and highlight certain key teachings in Islamic medical ethics and explore their applications. We hope that the insights gained will aid clinicians to better understand their Muslim patients and deliver care that pays due respect to their beliefs.

Getz, G. E., Fleck, D. E. and Strakowski, S. M. [Bipolar and Psychotic Disorders Research Program, Department of Psychiatry, University of Cincinnati College of Medicine, Cincinnati, OH 45267-0559; getzg@email.uc.edu]. “**Frequency and severity of religious delusions in Christian patients with psychosis.**” *Psychiatry Research* 103, no. 1 (Aug 5, 2001): 87-91.

[Abstract:] The influence of religious activity on the severity of religious delusions is unclear. This study examined whether Catholic and Protestant patients experienced more religious delusions than non-religiously affiliated patients. We also explored whether the severity of religious delusions, according to the Religious Delusions item on the Scale for the Assessment of Positive Symptoms (SAPS), was associated with the amount of religious activity. The Protestants experienced more religious delusions than Catholics and those without religious affiliation. Although when the groups were combined, patients who were more religiously active experienced more severe religious delusions (n=133), there was no difference in the severity of religious delusions across the non-religious, Catholic and Protestant groups. Religious affiliation may influence the frequency of religious delusions, particularly in Protestant individuals, but religious affiliation appears to be independent of religious delusion severity.

Gillick, M. R. [Hebrew Rehabilitation Center for Aged, Boston, MA]. “**Artificial nutrition and hydration in the patient with advanced dementia: is withholding treatment compatible with traditional Judaism?**” *Journal of Medical Ethics* 27, no. 1 (Feb 2001): 12-5.

[Abstract:] Several religious traditions are widely believed to advocate the use of life-sustaining treatment in all circumstances. Hence, many believe that these faiths would require the use of a feeding tube in patients with advanced dementia who have lost interest in or the capacity to swallow food. This article explores whether one such tradition—halachic Judaism—in fact demands the use of artificial nutrition and hydration in this setting. Traditional (halachic) arguments have been advanced holding that treatment can be withheld in persons who are dying, in individuals whose condition causes great suffering, or in the event that the treatment would produce suffering. Individuals with advanced dementia can be considered to be dying, often suffer as a result of their dementia, and are likely to suffer from the use of a feeding tube. Given these observations and the absence of a compelling case for distinguishing between tube feeding and other forms of medical treatment, traditional Judaism appears compatible with withholding artificial nutrition for individuals with advanced dementia.

- Goldsand, G., Rosenberg, Z. R. and Gordon, M. [Joint Centre for Bioethics and Centre for the Study of Religion, University of Toronto, Ontario]. **“Bioethics for clinicians, 22: Jewish bioethics.”** *Canadian Medical Association Journal* 164, no. 2 (Jan 23, 2001): 219-22.
 [Abstract:] Jewish bioethics in the contemporary era emerges from the traditional practice of applying principles of Jewish law (Halacha) to ethical dilemmas. The Bible (written law) and the Talmud (oral law) are the foundational texts on which such deliberations are based. Interpretation of passages in these texts attempts to identify the duties of physicians, patients and families faced with difficult health care decisions. Although Jewish law is an integral consideration of religiously observant Jews, secularized Jewish patients often welcome the wisdom of their tradition when considering treatment options. Jewish bioethics exemplifies how an ethical system based on duties may differ from the secular rights-based model prevalent in North American society.
- Graber, D. R. and Johnson, J. A. [Medical University of South Carolina, Charleston; graberd@muscd.edu]. **“Spirituality and healthcare organizations.”** *Journal of Healthcare Management* 46, no. 1 (Jan-Feb 2001): 39-50. Discussion pp. 50-2.
 [Abstract:] In recent years, the place of spirituality in organizations has become increasingly discussed and advocated. On a personal level, this may involve achieving personal fulfillment or spiritual growth in the workplace. In the broader sense, spirituality is considered by many to be essential in an organization's interactions with employees, customers, and the community. This article describes a possible role for greater spirituality in healthcare organizations, whose cultures in recent decades have largely excluded spirituality or religiousness. This is the consequence of an analytical, scientific perspective on human health; a reductionist paradigm in biomedical research; and the inevitable bureaucratization occurring in large healthcare organizations. However, in recent decades, numerous scientific articles supporting a connection between faith or religiousness and positive health outcomes have been published. Because individuals seek meaning when experiencing severe illnesses, and humans universally respond to compassion and caring, spirituality among healthcare workers and managers appears highly appropriate. The article describes organizational barriers to the greater inclusion of spirituality in healthcare and presents several approaches to developing a more caring organization. These include eliciting extensive input from all staff and clinicians in identifying core or common values, ethics, and a philosophy of caring. Programs should ensure that the views of nonreligious staff and patients are respected and that clear guidelines are established for the extent and nature of affective or spiritual support for patients.
- Graham-Pole, J. [J. Hillis Miller Health Science Center, University of Florida, Gainesville, FL; grahajn@pediatrics.ufl.edu]. **“Physician, heal thyself’: how teaching holistic medicine differs from teaching CAM.”** *Academic Medicine* 76, no. 6 (Jun 2001): 662-4.
 [Abstract:] The term complementary and alternative medicine (CAM) has been adopted to describe a system of health care not generally recognized as part of mainstream medical practice. It is often conflated with an older term, holistic medicine, which can briefly be defined as the art and science of healing the whole person—body, mind, and spirit—in relation to that person's community and environment. Coursework in CAM is now offered in at least two thirds of U.S. medical schools. There is also a growing number of courses in the medical humanities and in spirituality and health. However, courses explicitly designed to introduce students to the principles and practices of holistic medicine are unusual. The author describes the fundamental differences between CAM and holistic medicine, highlighting holistic medicine's emphasis on the promotion of healthy lifestyles for practitioners and patients alike. He argues that offering physicians-to-be more coursework in holistic medicine could lay the groundwork for future physicians' adopting and modeling healthy lifestyles.
- Greasley, P., Chiu, L. F. and Gartland, M. [Wakefield and Pontefract Community Health NHS Trust, Fieldhead, Wakefield, UK]. **“The concept of spiritual care in mental health nursing.”** *Journal of Advanced Nursing* 33, no. 5 (Mar 2001): 629-37.
 [Abstract:] AIM: In this paper we aim to clarify the issue of spiritual care in the context of mental health nursing. BACKGROUND: The concept of spirituality in nursing has received a great deal of attention in recent years. However, despite many articles addressed to the issue, spiritual care remains poorly understood amongst nursing professionals and, as a result, spiritual needs are often neglected within the context of health care. METHODS: A series of focus groups was conducted to obtain the views of service users, carers and mental health nursing professionals about the concept of spirituality and the provision of spiritual care in mental health nursing. RESULTS: According to the views expressed in our focus groups, spiritual care relates to the acknowledgement of a person's sense of meaning and purpose to life which may, or may not, be expressed through formal religious beliefs and practices. The concept of spiritual care was also associated with the quality of interpersonal care in terms of the expression of love and compassion towards patients. Concerns were expressed that the ethos of mental health nursing and the atmosphere of care provision were becoming less personal, with increasing emphasis on the 'mechanics of nursing'. CONCLUSIONS: The perceived failure of service providers to attend adequately to this component of care may be symptomatic of a medical culture in which the more readily observable and measurable elements in care practice have assumed a prominence over the more subjective, deeply personal components. In order for staff to acknowledge these issues it is argued that a more holistic approach to care should be adopted, which would entail multidisciplinary education in spiritual care.
- Grossoehme, D. H. [Children's Hospital Medical Center of Akron, 1 Perkins Square, Akron, OH 44308]. **“Self-reported value of spiritual issues among adolescent psychiatric inpatients.”** *Journal of Pastoral Care* 55, no. 2 (Summer 2001): 139-45.
 [Abstract:] Reports on a survey of a prospective, uncontrolled sample of adolescent psychiatric inpatients on the importance of spiritual issues to them. Results indicated that the vast majority of adolescents in this sample indicated that spiritual beliefs are considered important. Notes that a majority reported that mental health professionals rarely asked them about their beliefs in the spiritual areas. Observes that nearly all the patients reported having a chaplain-led spiritual group that they perceived as a helpful part of the therapeutic milieu.
- Halperin, E. C. [Department of Radiation Oncology, Duke University Medical Center, Durham, NC 27710; halperin@radonc.duke.edu]. **“Should academic medical centers conduct clinical trials of the efficacy of intercessory prayer?”** *Academic Medicine* 76, no. 8 (Aug 2001): 791-7. [Review, 51 refs.]
 [Abstract:] Intercessory prayers for health or healing are requests to an object of worship for the preservation or restoration of health. There has been a recent proliferation of clinical trials that compare the health outcome of a group of prayed-for patients with that of controls, to test the efficacy of intercessory prayer. In this essay, the author defines the concept of intercessory prayer, contrasts it with other forms of

prayer, and reviews the literature concerning clinical trials of its efficacy. The arguments put forward in favor of conducting such trials and those against are described and the reader is invited to consider their relative merits. The author concludes by discussing the potential power of faith in healing, reviewing the philosophical basis and pitfalls of clinical trials of intercessory prayer, and urging readers to weigh the arguments for and against such trials in academic medicine.

Hammell, K. W. **“Intrinsicity: reconsidering spirituality, meaning(s) and mandates.”** *Canadian Journal of Occupational Therapy—Revue Canadienne d’Ergotherapie* 68, no. 3 (Jun 2001): 186-94.

[Abstract:] Canadian occupational therapists have placed spirituality as the central core of their theoretical model, depicting inner and outer selves that contradict simultaneous declarations concerning the integration of mind/body/spirit. Even the word spirituality has discrepant meanings and failure to articulate one chosen meaning leads to ambiguity. This paper argues that occupational therapists must agree upon a single definition of spirituality that is congruent with our professional mandate and philosophical perspective; and that prevention of misunderstandings between and amongst clients and other health care professionals demands recourse to our own terminology. It is proposed that intrinsicity be employed to articulate the personal philosophy of meaning with which we interpret our lives. Influenced by environmental context and in homeostatic relationship with the body and mind, intrinsicity constitutes the essence of the self and informs occupational choices based upon personal values and priorities. Acknowledgement of intrinsicity respects the uniqueness of individuals’ meanings.

Hays, J. C., Meador, K. G., Branch, P. S. and George, L. K. [Department of Psychiatry and School of Nursing, Center for the Study of Aging and Human Development, Durham, NC 27710; jch@geri.duke.edu]. **“The Spiritual History Scale in four dimensions (SHS-4): validity and reliability.”** *Gerontologist* 41, no. 2 (Apr 2001): 239-49.

[Abstract:] The goals of this study were to develop a valid, reliable measure of lifetime religious and spiritual experience and to assess its value in explaining late-life health. Procedures included semi-structured interviews with Duke Aging Center volunteers (n = 30), followed by structured interviews of a stratified, random sample of subjects (n = 157) from the Established Populations for Epidemiologic Studies of the Elderly at Duke University. Principal components analysis suggested four factors with favorable psychometrics. Health-impaired subjects reported a history of seeking/receiving divine aid (God Helped). At every level of impairment, Lifetime Religious Social Support and current religious attendance were positively correlated. Regardless of current attendance, subjects who reported higher Lifetime Religious Social Support received more instrumental social support. Healthy behaviors were associated with both God Helped and Lifetime Religious Social Support. Cost of Religiousness predicted depressive symptoms and impaired social support. Family History of Religiousness was unrelated to late-life health. Evaluation of the Spiritual History Scale in Four Dimensions (SHS-4) across geographical settings, cultural subgroups, age cohorts, and clinical samples is warranted.

Hebert, R. S., Jenckes, M. W., Ford, D. E., O’Connor, D. R. and Cooper, L. A. **“Patient perspectives on spirituality and the patient-physician relationship.”** *Journal of General Internal Medicine* 16, no. 10 (October 2001): 685-92.

[Abstract:] OBJECTIVE: To identify the preferences and concerns of seriously ill patients about discussing religious and spiritual beliefs with physicians. DESIGN: Three focus group discussions with patients who had experienced a recent life-threatening illness. Discussions were audiotaped, transcribed verbatim, and reviewed independently by two investigators to identify discrete comments for grouping into domains. A third investigator adjudicated differences in opinion. Comments were then independently reviewed for relevance and consistency by a health services researcher and a pastoral counselor. SETTING: Academic medical center. PARTICIPANTS: Referred sample of 22 patients hospitalized with a recent life-threatening illness. MEASUREMENTS AND MAIN RESULTS: Almost all of the 562 comments could be grouped into one of five broad domains: 1) religiosity/spirituality, 2) prayer, 3) patient-physician relationship, 4) religious/spiritual conversations, and 5) recommendations to physicians. God, prayer, and spiritual beliefs were often mentioned as sources of comfort, support, and healing. All participants stressed the importance of physician empathy. Willingness to participate in spiritual discussions with doctors was closely tied to the patient-physician relationship. Although divided on the proper context, patients agreed that physicians must have strong interpersonal skills for discussions to be fruitful. Physician-initiated conversation without a strong patient-physician relationship was viewed as inappropriate and as implying a poor prognosis. CONCLUSION: Religion and spirituality are a source of comfort for many patients. Although not necessarily expecting physicians to discuss spirituality, patients want physicians to ask about coping and support mechanisms. This exploratory study suggests that if patients then disclose the importance of spiritual beliefs in their lives, they would like physicians to respect these values.

Hedayat, K. M. and Pirzadeh, R. [Department of Pediatrics, William Beaumont Hospital, Royal Oak, MI; khedayat@stanford.edu]. **“Issues in Islamic biomedical ethics: a primer for the pediatrician.”** *Pediatrics* 108, no. 4 (Oct 2001): 965-71.

[Abstract:] The United States is becoming increasingly pluralistic. Pediatricians must become familiar with the factors that affect the emotional, physical, and spiritual health of their patients that are outside the kin of the traditionally dominant value system. Although many articles have addressed the cultural and ethnic factors, very few have considered the impact of religion. Islam, as the largest and fastest-growing religion in the world, has adherent throughout the world, including the United States, with 50% of US Muslims being indigenous converts. Islam presents a complete moral, ethical, and medical framework that, while it sometimes concurs, at times diverges or even conflicts with the US secular ethical framework. This article introduces the pediatrician to the Islamic principles of ethics within the field of pediatric care and child-rearing. It demonstrates how these principles may impact outpatient and inpatient care. Special attention is also given to adolescent and end-of-life issues.

Heeren, O., Menon, A. S., Raskin, A. and Ruskin, P. [Mental Health Clinical Center, Department of Veterans Affairs, Maryland Health Care System, 116A 10 N. Greene St., Baltimore, MD 21201]. **“Religion and end of life treatment preferences among geriatric patients.”** *International Journal of Geriatric Psychiatry* 16, no. 2 (Feb 2001): 203-8.

[Abstract:] The purpose of this study was to determine if religious preference and religiosity influenced choosing end of life treatments in medically ill geriatric patients. The sample consisted of 374 males 60 years of age or older, hospitalized on the acute medical service at the Baltimore Veterans Affairs Medical Center. Choices for end of life treatment preferences were CPR, medical ventilation, tube feeding and IV fluids within six different illness scenarios. Patients indicated how often they attended religious services, how much strength and comfort they got from religion and how religious they would describe themselves. Analyses of variance were performed using as the dependent variables the summation scores across the six scenarios of a willingness to undergo each of the four life saving procedures. The

religious preference, race and religiosity scores served as the independent variables. Only tube feeding showed a significant ($p < 0.05$) relationship, with Catholics less willing to undergo this procedure than other Christians. The same trend was found for the other life saving procedures, but was not statistically significant.

Heintz, L. M. and Baruss, I. [King's College, University of Western Ontario, Canada]. **"Spirituality in late adulthood."** *Psychological Reports* 88, no. 3, pt 1 (Jun 2001): 651-4.

[Abstract:] MacDonald's Expressions of Spirituality Inventory was used to examine spirituality in late adulthood using a sample of 30 people (22 women, 8 men) whose mean age was 72.6 yr. While average scores are higher on scales measuring spiritual and religious beliefs and practices for the sample than for a standardization group of undergraduate students with a mean age of 21.0 yr., means are lower on scales measuring paranormal beliefs. Low scores on death anxiety are correlated only with Existential Well-being and age. And, while some religious behaviors such as frequent religious practice, prayer, and church attendance are correlated with some of the dimensions of spirituality, many of the scores on the Expressions of Spirituality Inventory scales are independent of self-reported religious behaviors.

Hermann, C. P. [School of Nursing, University of Louisville, KY; cpher01@gwise.louisville.edu]. **"Spiritual needs of dying patients: a qualitative study."** *Oncology Nursing Forum* 28, no. 1 (Jan-Feb 2001): 67-72.

[Abstract:] PURPOSE/OBJECTIVES: To identify dying patients' definitions of spirituality and their spiritual needs. DESIGN: Descriptive, qualitative. SETTING: Participants' places of residence. SAMPLE: 19 hospice patients (10 females and 9 males), mean age 72, with a range of length of time as a hospice patient of 2 weeks to 12 months. METHODS: Semistructured interviews were conducted. Interview transcripts and field notes were analyzed to reduce data into codes and themes. Data were coded by extracting verbatim phrases used to describe spirituality and spiritual needs. Themes emerged from the data as commonalities among the codes developed. MAIN RESEARCH VARIABLES: Meaning of "spiritual" and perceived spiritual needs. FINDINGS: Participants initially defined spiritual as relating to God or religion; however, as interviews progressed, it was apparent that their spirituality was a part of their total existence. Twenty-nine unique spiritual needs were identified and grouped into six themes: need for religion, need for companionship, need for involvement and control, need to finish business, need to experience nature, and need for positive outlook. CONCLUSIONS: Participants perceived spirituality as a broad concept that may or may not involve religion. Spiritual needs were likewise broad in scope and were linked closely to purpose and meaning in life. IMPLICATIONS FOR NURSING PRACTICE: Spiritual care of dying patients is within the scope of nursing practice. Spiritual needs are quite varied and encompass more than religion. If nurses are to enhance the quality of life of dying patients, spiritual needs must be addressed.

Hodge, D. R. [George Warren Brown School of Social Work, Washington University, St Louis, MO 63130-4899]. **"Spiritual assessment: a review of major qualitative methods and a new framework for assessing spirituality."** *Social Work* 46, no. 3 (July 2001): 203-14. [Review, 77 refs.]

[Abstract:] This article introduces a new qualitative spiritual assessment instrument. It reviews existing qualitative assessment tools and presents a new multidimensional spiritual assessment framework. The instrument consists of two components: a spiritual history in which consumers relate their spiritual life story in a manner analogous to a family history and an interpretive framework to assist practitioners in eliciting and synthesizing the full potentiality of strengths extant in clients' spiritual lives. Common spiritual strengths the framework is designed to evoke are discussed, and a number of interventions based on prevalent spiritual strengths are suggested.

Hogan, N. S., Greenfield, D. B. and Schmidt, L. A. [University of Miami, Coral Gables, FL; Nhogan@miami.edu]. **"Development and validation of the Hogan Grief Reaction Checklist."** *Death Studies* 25, no. 1 (Jan-Feb 2001): 1-32.

[Abstract:] The purpose of this article is to provide data on a recently developed instrument to measure the multidimensional nature of the bereavement process. In contrast to widely used grief instruments that have been developed using rational methods of instrument construction, the Hogan Grief Reaction Checklist (HGRC) was developed empirically from data collected from bereaved adults who had experienced the death of a loved one. Factor analysis of the HGRC revealed 6 factors in the normal trajectory of the grieving process: Despair, Panic Behavior, Blame and Anger, Detachment, Disorganization, and Personal Growth. Additional data are provided that support reliability and validity of the HGRC as well as its ability to discriminate variability in the grieving process as a function of cause of death and time lapsed since death. Empirical support is also provided for Personal Growth as an integral component of the bereavement process. The article concludes by considering the substantive as well as psychometric findings of this research for such issues as traumatic grief, anticipatory grief, change in the bereaved person's self-schema, and spiritual and existential growth.

Hufford, D. J. **"On immortality and asking the 'hard' questions."** *Alternative Therapies in Health & Medicine* 7, no. 5 (Sep-Oct 2001): 22.

The author writes in support of the "steadfast insistence on reasonable reflection concerning spiritual issues and science" as exemplified in Larry Dossey's article, "Immortality" [*Alternative Therapies in Health & Medicine* 6, no. 3 (May 2000): 12-17, 108-15]. He describes Dossey's approach as "a reasoned approach, that is systematically skeptical in the best sense, privileging no dogma and insisting on reasons for all claims...."

Hull, S. K., DiLalla, L. F. and Dorsey, J. K. [Southern Illinois University School of Medicine, Lindegren Hall Room, Carbondale, IL 62901-6503; shull@siumed.edu]. **"Student attitudes toward wellness, empathy, and spirituality in the curriculum."** *Academic Medicine* 76, no. 5 (May 2001): 520.

The authors report on an initiative at the Southern Illinois University School of Medicine to institute a series of reflective readings and small group sessions for medical students that focused on student self-care and sensitivity to patients' culture, values, spirituality, and end-of-life wishes. Students subsequently completed a Wellness, Empathy, and Spirituality in Health Care (WESIHC) questionnaire for evaluation.

Hyder, A. A. and Nadeem, S. [Department of International Health, Johns Hopkins University, 615 North Wolfe Street, Suite E-8132, Baltimore, MD 21205; ahyder@jhsph.edu]. **"Health ethics in Pakistan: a literature review of its present state."** *Journal of Health, Population & Nutrition* 19, no. 1 (Mar 2001): 6-11. Comment on pp. 4-5. [Review, 25 refs.]

[Abstract:] National literature on ethics provides an insight into the nature and development of a dialogue on health issues within a population. This study investigated the health ethics discourse in Pakistan. The purpose was to critically reflect on the nature and level of such discussions with the aim of stimulating an interest in the ethical implications of health and medicine in developing countries. The study evaluated the literature on biomedical and health ethics published in Pakistan during 1988-1999. Overall, there is a dearth of published discourse on healthcare ethics in Pakistan. Values that are considered to stem from religious teachings predominate in discussions relating to medical ethics. A lack of effective policy and legislation concerning the ethical practice of medicine is reported to have negative effects on the profession. Research ethics has not been captured in the published papers in Pakistan. Consideration of ethical issues in health is at an early stage in the country and may reflect the situation in a large part of the developing world.

Idler, E. L., Kasl, S. V. and Hays, J. C. [Institute for Health, Health Care Policy, and Aging Research, Rutgers University, New Brunswick, NJ; idler@rci.rutgers.edu]. "**Patterns of religious practice and belief in the last year of life.**" *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 56, no. 6 (Nov 2001): S326-34.

[Abstract:] OBJECTIVES: Although it is frequently assumed that issues of religious faith become more salient at the end of life, there is little or no population-based empirical evidence testing this assumption. METHODS: Using data from the New Haven site of the Established Populations for Epidemiologic Studies of the Elderly (N = 2,812), the authors examined self-reports of attendance at services, self-ratings of religiousness, and strength and comfort felt from religion for respondents who did and did not die within 12 months following an interview. Religiousness was assessed at baseline (1982) and in follow-up interviews in 1985, 1988, and 1994. Cross-sectional comparisons of levels of religiousness were made among persons in their last 6 months of life, persons in their last 12 months of life, and persons who survived 12 months, and longitudinal comparisons were made with religiousness at the previous wave. RESULTS: After adjusting for age, sex, education, marital status, religious affiliation, and a set of health status measures, the authors found that although attendance at religious services declined among the near-deceased, this group showed either stability or a small increase in feelings of religiousness and strength/comfort received from religion. Overall levels of attendance and religious feelings were high for this religiously diverse sample. DISCUSSION: Community studies of respondents in their last year of life are rare. In this sample, religious involvement appears to continue throughout the last months of life.

Jernigan, J. C., Trauth, J. M., Neal-Ferguson, D. and Cartier-Ulrich, C. [Department of Health Services Administration, Graduate School of Public Health, University of Pittsburgh, PA]. "**Factors that influence cancer screening in older African American men and women: focus group findings.**" *Family & Community Health* 24, no. 3 (Oct 2001): 27-33.

This study, consisting of 7 focus groups involving 45 African American men and women found, among other things, that "most focus group participants mentioned religion as a positive factor that facilitated cancer screening" (p. 30). Also, "women were more likely to view faith and prayer as coping strategies that reduced fear and anxiety associated with receiving screening tests" (p. 30).

Joishy, S. K. [Oncology/Hematology, Dept. of Oncology/Hematology, Medcenter One, Bismarck, ND]. "**Palliative medical oncology.**" *Surgical Oncology Clinics of North America* 10, no. 1 (Jan 2001): 203-20. [Review; 53 refs.]

[Abstract:] Most advanced cancer patients remain incurable. They are carrying the tumor burden and the burden of symptoms as a result of physical, emotional, and spiritual distress. Modern medical oncology, sophisticated as it may appear in its endeavors to cure cancers, has historically failed to consider pain and symptom control as part of cancer care. Because of this, palliative medicine has emerged as the champion of pain and symptom control in advanced cancer patients. The reasons for medical oncology not embracing palliative care are analyzed and a model for palliative medical oncology is proposed.

Kadiri, A., Al-Nakhi, A., El-Ghazali, S., Jabbar, A., Al Arouj, M., Akram, J., Wyatt, J., Assem, A. and Ristic, S. [Service d'Endocrinologie, Chu Ibn Sina Rabat, Morocco]. "**Treatment of type 1 diabetes with insulin lispro during Ramadan.**" *Diabetes & Metabolism* 27, no. 4, pt 1 (Sep 2001): 482-6.

The article reports research on a method of treating patients with type 1 diabetes who wish to fast during the Islamic holy month of Ramadan.

Kagawa-Singer, M. and Blackhall, L. J. [Community Health Sciences, University of California, Los Angeles School of Public Health and Asian American Studies, Los Angeles, CA]. "**Negotiating cross-cultural issues at the end of life: 'You got to go where he lives.'**" *JAMA* 286, no. 23 (Dec 19, 2001): 2993-3001.

[Abstract:] Culture fundamentally shapes how individuals make meaning out of illness, suffering, and dying. With increasing diversity in the United States, encounters between patients and physicians of different backgrounds are becoming more common. Thus the risk for cross-cultural misunderstandings surrounding care at the end of life is also increasing. Studies have shown cultural differences in attitudes toward truth telling, life-prolonging technology, and decision-making styles at the end of life. Using 2 case studies of patients, one of an African American couple in the southern United States and the other of a Chinese-American family in Hawaii, we outline some of the major issues involved in cross-cultural care and indicate how the patient, family, and clinician can navigate among differing cultural beliefs, values, and practices. Skilled use of cross-cultural understanding and communication techniques increases the likelihood that both the process and outcomes of care are satisfactory for all involved. [The authors particularly address religious issues and offer tables of assessment and techniques for negotiating cross-cultural issues.]

Kane, J. R. and Primomo, M. [Department of Pediatrics, Division of Hematology Oncology Immunology, Palliative Medicine Fellowship Program, University of Texas Health Science Center]. "**Alleviating the suffering of seriously ill children.**" *American Journal of Hospice & Palliative Care* 18, no. 3 (May-Jun 2001): 161-9. [Review; 44 refs.]

[From the abstract:] ...Medical interventions based solely on the diagnosis and treatment of disease limit the medical care of the severely ill child. Such an approach is particularly detrimental when caring for the terminally ill. Successful care of children with chronic, life-threatening, or terminal illnesses requires a comprehensive assessment of their physical, psychological, and spiritual needs as well as a process of collaboration between members of the multiple disciplines involved in the care of the patient and the family unit as a whole... This article expands on a previous paper published in the *American Journal of Hospice & Palliative Care* [Kane JR, Barber RG, Jordan M, et al.: "Supportive/palliative care of children suffering from life-threatening and terminal illness," vol. 17, no. 3 (May/June 2000): 165-72].

- Kane, R. A. [Division of Health Services Research and Policy, School of Public Health, University of Minnesota; kanex002@tc.umn.edu]. **“Long-term care and a good quality of life: bringing them closer together.”** *Gerontologist* 41, no. 3 (Jun 2001): 293-304. [Review, 80 refs.]
 [Abstract:] Long-term care policies and programs in the United States suffer from a major flaw: they are balanced toward a model of nursing home care that, regardless of its technical quality, tends to be associated with a poor quality of life for consumers. This article proposes quality-of-life domains—namely, security, comfort, meaningful activity, relationships, enjoyment, dignity, autonomy, privacy, individuality, spiritual well-being, and functional competence. It argues that these kinds of quality-of-life outcomes are minimized in current quality assessment and given credence only after health and safety outcomes are considered. Five trends are reviewed that might lead to a more consumer-centered emphasis on quality of life: the disability rights movement, the emphasis on consumer direction, the growth of assisted living, increasing attention to physical environments, and efforts to bring about culture change in nursing homes. Building on these trends, the article concludes with strategies to move beyond current stalemates and polarized arguments toward forms of long-term care that are more compatible with a good quality of life.
- Kelley-Moore, J. A. and Ferraro, K. F. [Department of Sociology and Gerontology Program, Purdue University, West Lafayette, IN 47907-1365; kelleyj@sri.soc.purdue.edu]. **“Functional limitations and religious service attendance in later life: barrier and/or benefit mechanism?”** *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 56, no. 6 (Nov 2001): S365-73.
 [Abstract:] OBJECTIVES: Why do some studies report a negative relationship between religious service attendance and functional limitations? Two possible mechanisms, the health benefit mechanism and the functional barrier mechanism, were systematically examined. METHODS: With 2 waves of a national probability sample of adults aged 60 years and older, this research used structural equation models to estimate the influence of these 2 mechanisms. RESULTS: Results indicated that functional limitations were associated with less frequent religious service attendance at the same wave, largely because of the barrier mechanism; no support was found for the benefit mechanism. Neither mechanism was significant over time. DISCUSSION: Findings suggest that there is a temporal and salient decline in social activities such as religious service attendance when lower body functional limitations are highest. However, long-term engagement in religious service attendance is not predicted by baseline functional limitations, indicating that there are not long-term declines in attendance because of higher levels of functional limitations.
- Keung, Y. K. and McQuellon, R. [Department of Internal Medicine, Wake Forest University Comprehensive Cancer Center, Winston-Salem, NC 27157; ykeung@wfubmc.edu]. **“When medical meets spiritual.”** *North Carolina Medical Journal* 62, no. 4 (Jul-Aug 2001): 192-4. Discussion on p. 195. [Review, 11 refs.]
 The authors cover the topic broadly, considering the possible relation of spirituality to health outcomes, the limits of studies, the increase in papers on spirituality and prayer, the role of spirituality in medical curricula, and the perspective of spirituality on the finite human condition.
- King, M., Speck, P. and Thomas, A. [Department of Psychiatry and Behavioural Sciences, Royal Free and University College Medical School, London.]. **“The royal free interview for spiritual and religious beliefs: development and validation of a self-report version.”** *Psychological Medicine* 31, no. 6 (Aug 2001): 1015-23.
 [Abstract:] BACKGROUND: Spiritual beliefs are rarely considered in psychological or medical publications. We recently published the psychometric properties of an interview designed to measure religious and spiritual belief. In this study, we aimed to develop this instrument further as a self-report questionnaire and to make it more comprehensive by including measurement of spiritual experiences in addition to faith or intellectual assent. METHODS: Based on extensive discussion with colleagues, advice from users of the interview and comments from respondents, a self-report format was designed. We then evaluated the final format of the questionnaire in terms of (1) patterns of response and demographic predictors of beliefs; (2) test-retest reliability and internal consistency; (3) criterion and internal validity; and (4) the nature of spiritual experiences and their relationship to beliefs and strength of beliefs. RESULTS: Two hundred and ninety-seven people took part in the validity and reliability tests of the questionnaire. Criterion validity, predictive validity, internal consistency and test-retest reliability were acceptably high. The instrument consistently differentiated between people with high and low spiritual beliefs. CONCLUSIONS: This instrument is brief and simple to complete. We would recommend that measures of religious and/or spiritual belief like this be more widely applied in health services research as they evaluate aspects of people's lives that go somewhat further than health status or quality of life.
- Kirkpatrick, H., Landeen, J., Woodside, H. and Byrne, C. [Schizophrenia Psychosocial Rehabilitation Program, Hamilton Psychiatric Hospital, Ontario]. **“How people with schizophrenia build their hope.”** *Journal of Psychosocial Nursing & Mental Health Services* 39, no. 1 (Jan 2001): 46-53.
 [Abstract:] 1. Both clinicians and consumers identified the importance of maintaining relationships and experiencing success as helpful in building and nurturing hope for consumers. 2. To provide holistic care, clinicians need to discuss spirituality and meaning with clients. 3. Because being hopeful is an active process, clinicians need to talk to clients about hope, openly, realistically, and strategically.
- Koenig, H. G. **“Religion, spirituality, and medicine: how are they related and what does it mean?”** *Mayo Clinic Proceedings* 76, no. 12 (December 2001): 1189-91.
 This editorial by a well-established leader in the study of spirituality and health serves as a companion piece for two articles in the December 2001 issue of the *Mayo Clinic Proceedings*: a research article by Aviles, J. M, et al., “Intercessory Prayer and Cardiovascular Disease Progression in a Coronary Care Unit Population: A Randomized Controlled Trial” (pp. 1192-98) and a review article by Mueller, P. S., et al., “Religious Involvement, Spirituality, and Medicine: Implications for Clinical Practice” (pp. 1225-35). [See the particular citations for these articles in this bibliography.]
- Koenig, H. G. **“Spiritual assessment in medical practice.”** *American Family Physician* 63, no. 1 (Jan 1, 2001): 30, 33.
 This long-time leader in research about spirituality and medicine encourages physicians to take a “spiritual history” (p. 30) of patients and recommends the HOPE questionnaire by Anandarajah and Hight. [See, also in this bibliography: Anandarajah, G. and Hight, E.

“Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment.” *American Family Physician* 63, no. 1 (Jan 1, 2001): 81-9.]

Koopman, C., Angell, K., Turner-Cobb, J. M., Kreshka, M. A., Donnelly, P., McCoy, R., Turkseven, A., Graddy, K., Giese-Davis, J. and Spiegel, D. [Department of Psychiatry & Behavioral Sciences, Stanford University, CA 94305-5718]. **“Distress, coping, and social support among rural women recently diagnosed with primary breast cancer.”** *Breast Journal* 7, no. 1 (Jan-Feb 2001): 25-33.

This study of 100 participants found, among other things, that [from the abstract:] women varied considerably in which kind of social group provided them with the most support, with as many reporting that they found the greatest support in spiritual/church groups or within their family units as with breast or general cancer groups....

Krizek, T. J. [Department of Surgery, The Ethics Center, The University of South Florida, Tampa, FL]. **“Spiritual dimensions of surgical palliative care.”** *Surgical Oncology Clinics of North America* 10, no. 1 (Jan 2001): 39-55. [Review; 12 refs.]

[Abstract:] Death is the most complex of religious issues and suicide is the most complex of philosophic issues. Our century has seen a massive technological expansion in our ability to prolong life, and unfortunately, to kill with unparalleled efficiency. Society has demanded that physicians explore with them whether death by suicide is a logical extension of palliative care. For surgeons, these profoundly spiritual concerns are, in many ways, beyond our education and training and may not be compatible with the current practice of surgery.

Lackey, N. R., Gates, M. F. and Brown, G. [School of Nursing, University of Missouri, Kansas City, MO; lackeyn@umkc.edu]. **“African American women's experiences with the initial discovery, diagnosis, and treatment of breast cancer.”** *Oncology Nursing Forum* 28, no. 3 (Apr 2001): 519-27.

In this qualitative study of 13 African American women (aged 30-66) from two oncology clinics in the mid-South, spirituality emerged as a major theme, especially in terms of reliance on God. Spirituality seemed to help these women through their experience of illness and treatment. Other major themes were “experience trajectory” and “femininity.”

Larimore, W. L. [Hertiage Family Physicians, Kissimmee, FL; wlarimore@pol.net]. **“Providing basic spiritual care for patients: should it be the exclusive domain of pastoral professionals?”** *American Family Physician* 63, no. 1 (Jan 2001): 36, 38-40. [Review, 25 refs.]

In this Medicine and Society section of the journal, the author suggests that spiritual issues should not be left only to pastoral professionals, but he acknowledges that physicians must have appropriate training in this area. He notes the HOPE questionnaire by Anandarajah and Hight. [See, also in this bibliography: Anandarajah, G. and Hight, E. “Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment.” *American Family Physician* 63, no. 1 (Jan 1, 2001): 81-9.]

Lawrence, R. M. and Duggal, A. [Neurodegeneration Research Group, c/o Division of Geriatric Medicine, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE, UK; rlawrenc@sghms.ac.uk]. **“Spirituality in psychiatric education and training.”** *Journal of the Royal Society of Medicine* 94, no. 6 (Jun 2001): 303-5. [Review; 41 refs.]

The author proposes the integration of patients' spiritual matters and religiosity into clinical psychiatric assessment, and that this is pertinent for understanding patients' contexts, inasmuch as “the spiritual dimension is intrinsic to any culture” (p. 304). The author also considers what he terms “the 'religiosity gap' between doctors and patients” (p. 303).

Leibovici, L. [Department of Medicine, Beilinson Campus, Rabin Medical Center, Petah-Tiqva 49100, Israel; leibovic@post.tau.ac.il]. **“Effects of remote, retroactive intercessory prayer on outcomes in patients with bloodstream infection: randomised controlled trial.”** *BMJ* 323, no. 7327 (Dec 22-29, 2001): 1450-1.

[Abstract:] OBJECTIVE: To determine whether remote, retroactive intercessory prayer, said for a group of patients with a bloodstream infection, has an effect on outcomes. DESIGN: Double blind, parallel group, randomised controlled trial of a retroactive intervention. SETTING: University hospital. SUBJECTS: All 3393 adult patients whose bloodstream infection was detected at the hospital in 1990-6. INTERVENTION: In July 2000 patients were randomized to a control group and an intervention group. A remote, retroactive intercessory prayer was said for the well being and full recovery of the intervention group. MAIN OUTCOME MEASURES: Mortality in hospital, length of stay in hospital, and duration of fever. RESULTS: Mortality was 28.1% (475/1691) in the intervention group and 30.2% (514/1702) in the control group (P for difference=0.4). Length of stay in hospital and duration of fever were significantly shorter in the intervention group than in the control group (P=0.01 and P=0.04, respectively). CONCLUSION: Remote, retroactive intercessory prayer said for a group is associated with a shorter stay in hospital and shorter duration of fever in patients with a bloodstream infection and should be considered for use in clinical practice.

Levin, J. and Steele, L. **“On the epidemiology of 'mysterious' phenomena.”** *Alternative Therapies in Health & Medicine* 7, no. 1 (Jan 2001): 64-6.

[Abstract:] In the field of epidemiology, research topics are favored or dismissed depending on whether respective variables under investigation are believed to exist according to current scientific theories. Unconventional independent variables or exposures, such as religiousness and spirituality, and controversial dependent variables or outcomes, such as chronic fatigue syndrome, may be considered unacceptable topics for researchers because they do not fit comfortably into the consensus clinical perspectives of mainstream medical scientists or physicians. Disapproval of research in these and other taboo areas is generally masked by claims that such studies are “pseudoscientific,” despite hundreds or thousands of peer-reviewed publications on these topics. In reality, seemingly “mysterious” variables are equally as amenable to epidemiologic research as any other exposure or disease. Similarly, alternative therapies are able to be investigated using existing methods, despite claims to the contrary. Such research is vital for scientific understanding to be expanded into new areas of inquiry.

Lissoni, P., Cangemi, P., Pirato, D., Roselli, M. G., Rovelli, F., Brivio, F., Malugani, F., Maestroni, G. J., Conti, A., Laudon, M., Malysheva, O. and Giani, L. [Divisione di Radioterapia Oncologica, San Gerardo Hospital, 20052 Monza (Milan), Italy]. **“A**

review on cancer—psychospiritual status interactions.” *Neuroendocrinology Letters* 22, no. 3 (Jun 2001): 175-80. [Review, 19 refs.]

[Abstract:] With the advances in the knowledge of neuroimmunomodulation, a new era of investigations about the chemical basis of the state of mind has been initiated. Both emotions and states of spiritual consciousness may influence immune functions and cancer growth. Stress, anxiety and depressive states are associated with immunosuppression and enhanced frequency of tumors. On the other hand, the states of sexual pleasure and spiritual joy enhance the immune efficacy, by counteracting tumor onset and dissemination. The biochemistry of pleasure and immunostimulation is mainly mediated by pineal indoles and cannabinergic substances, whereas that of stress, anxiety and depression is associated with enhanced production of adrenal steroids, opioids and catecholamines. The sexual repression would allow a progressive immunosuppression through a profound damage in the biochemistry of pleasure. Therefore, a better definition of psychospiritual status-associated neuroimmunochimistry could allow us to improve the immune dysfunction by acting on the same neuroendocrine secretions which are involved in mediating the psychic influence on the immunity, including that against cancer.

Lowe, J. and Struthers, R. [Florida International University, School of Nursing, North Miami Campus, AC II 230, 3000 NE 151st Street, North Miami, FL 33181; lowej@flu.edu]. “**A conceptual framework of nursing in Native American culture.**” *Journal of Nursing Scholarship* 33, no. 3 (Third Quarter 2001): 279-83.

[From the abstract:] PURPOSE: To depict the phenomenon of nursing in the Native American culture. DESIGN: At the 1997 annual Native American Nursing Summit held on the Flathead Reservation in Montana, 203 Native American nurses, nursing students, and others who provide health care to Native American people attended and participated in focus groups that provided the data for this qualitative study. The participants represented many tribes from across the United States. Follow-up in 1998 included a similar group of 192 participants. METHODS: Native American nurses facilitated focus groups. The facilitators provided direction for the focus groups and supervised the data collection. Native American nurses with advanced degrees in nursing performed the data analysis utilizing theme, taxonomic, and componential analysis methods. FINDINGS: Seven dimensions were identified in the data: (a) caring, (b) traditions, (c) respect, (d) connection, (e) holism, (f) trust, and (g) spirituality. Each dimension is essential to the practice of nursing in Native American culture. Together they provide the basis for a systematic approach to Native American nursing practice, education, research, and administration....

Lyon, M. E., Townsend-Akpan, C. and Thompson, A. [The Burgess Clinic and Section of Adolescent and Young Adult Medicine, Children's National Medical Center, Washington, DC 20010-2970; mlyon@cnmc.org]. “**Spirituality and end-of-life care for an adolescent with AIDS.**” *AIDS Patient Care & Studies* 15, no. 11 (Nov 2001): 555-60.

[Abstract:] AIDS is a life-threatening illness and, as is the case with all life-threatening illnesses, the spiritual beliefs of patients may influence their well being at the end of life. Patients' spiritual beliefs can offer comfort or be a source of distress. Health care professionals face ethical dilemmas, as they work with patients whose religious or spiritual idioms are incongruent with their own beliefs and traditions. The discussion in this case focuses on increasing health care professionals' sensitivity to the diverse spiritual needs of their patients. Guidelines are provided for assessment and interventions, as appropriate.

Maltby, J. and Day, L. [School of Social Science and Law, Sheffield Hallam University, Collegiate Crescent Campus, Sheffield, S10 2BP, United Kingdom]. “**The relationship between spirituality and Eysenck's personality dimensions: a replication among English adults.**” *Journal of Genetic Psychology* 162, no. 1 (Mar 2001): 119-22.

This study of 179 adults from South Yorkshire sought to understand the place of spiritual and religious beliefs within Eysenck's conceptual model of personality, with its three dimensions of psychoticism, neuroticism, and extraversion. The findings suggest that “a distinction between religiosity and spirituality when considering which of Eysenck's personality dimensions underpins these beliefs—that is, psychoticism underpins religiosity and extroversion underpins spirituality” (p. 121).

Matthews, W. J., Conti, J. M. and Sireci, S. G. [School Psychology Program, School of Education, University of Massachusetts, Amherst, MA 01003; shamrock@educ.umass.edu]. “**The effects of intercessory prayer, positive visualization, and expectancy on the well-being of kidney dialysis patients.**” *Alternative Therapies in Health & Medicine* 7, no. 5 (Sep-Oct 2001): 42-52.

[Abstract:] CONTEXT: Little replicable empirical evidence on the effectiveness of prayer is available. OBJECTIVE: To explore the effect of intercessory prayer, positive visualization, and outcome expectancy on a wide range of medical and psychological measures in critically ill patients. DESIGN: 2 x 3 (expectancy x treatment) factorial study. PARTICIPANTS: 95 adult male and female volunteer hemodialysis subjects with end-stage renal disease from an outpatient clinic in Miami, Fla. INTERVENTION: Participants were randomly assigned to 1 of the 6 treatment conditions. MAIN OUTCOME MEASURES: A total of 20 dependent measures (10 medically based and 10 psychological) were used to assess the subjects' overall well-being. Analysis of covariance was used to control for pre-treatment differences between groups. RESULTS: Subjects who expected to receive intercessory prayer reported feeling significantly better than did those who expected to receive positive visualization ($F_{1,93} = 5.42; P < .02$). No other statistically significant main effects or interactions were found for either expectancy, intercessory prayer, or positive visualization on the remaining dependent measures. Analysis of effect sizes on all dependent measures failed to indicate even a small magnitude of effect for intercessory prayer as contrasted with expectancy on the medical or psychological variables. CONCLUSIONS: The effects of intercessory prayer and transpersonal positive visualization cannot be distinguished from the effect of expectancy. Therefore, those 2 interventions do not appear to be effective treatments.

McCormick, D. P., Holder, B., Wetsel, M. A. and Cawthon, T. W. [Infectious Disease Clinic, Greenville Hospital System, Greenville, SC]. “**Spirituality and HIV disease: an integrated perspective.**” *Journal of the Association of Nurses in AIDS Care* 12, no. 3 (May-Jun 2001): 58-65. [Review, 25 refs.] Comment on pp. 14-6.

[Abstract:] Spirituality is an important resource that individuals use to cope with a chronic illness such as HIV disease. Spirituality has both a religious and an existential component that share the concepts of meaning in life, hope, self-transcendence, and rituals. An integrated perspective utilizing these shared concepts is proposed to assist HIV-positive individuals in coping with the challenges of their disease. Nursing interventions include promoting hope, teaching, sharing information, and creating a sense of empowerment in people with HIV to

address spiritual issues. The article concludes with a case study that emphasizes application of the integrated perspective of spirituality with an HIV-positive person.

McDonnell, F. J., Sloan, J. W. and Hamann, S. R. [Palliative Care Service, Department of Anesthesiology, University of Kentucky College of Medicine, Rose Street, Lexington, KY 40536; kcase2@pop.uky.edu]. “**Advances in cancer pain management.**” *Current Pain & Headache Reports* 5, no. 3 (Jun 2001): 265-71. [Review, 70 refs.]

[From the abstract:] Control of malignant pain and related symptoms is paramount to clinical success in caring for cancer patients. To achieve the best quality of life for patients and families, oncologists and palliative care clinicians must work together to understand problems related to psychologic, social, and spiritual pain. [Note: the article focuses primarily on pharmacologic interventions in light of the World Health Organization's “analgesic ladder.”]

Messikomer, C. M., Fox, R. R. and Swazey, J. P. [Acadia Institute, Exton, PA 19341; carlamessikomer@email.msn.com]. “**The presence and influence of religion in American bioethics.**” *Perspectives in Biology & Medicine* 44, no. 4 (Fall 2001): 485-508.

[Abstract:] From the inception of the relatively short history of American bioethics in the mid-to-late 1960s, the place of religion in this field has been complex and controversial. It has also been a subject of more than casual interest and concern to bioethicists, and to an array of medical and non-medical groups in U.S. society for whom the activities and issues in which bioethics is engaged have ongoing import. The questions and the tensions linked to the status and influence of religion in the sphere of bioethics have ramifications that extend beyond bioethics and biomedicine into matters involving the relationship of religion to the institutional structure of American society--most particularly its political, legal foundations, and realm of public affairs--and to its cultural attributes and tradition. It is within this larger perspective that we will consider the association between American bioethics and religion. Our analysis includes two case studies: (1) how, in the early years of bioethics, a pioneering organization in the field dealt with the “redefinition of death” in its discussions and in a major medical journal publication; and (2) the way in which the most recently appointed federal bioethics commission, the National Bioethics Advisory Commission, involved religion in its work on cloning and stem cell research.

Meyer, C. R. “**Making sense of pain.**” *Minnesota Medicine* 84, no. 7 (Jul 2001): 13-7.

This article by the journal's editor-in-chief considers pain broadly in terms of human experience and *suffering*. He offers an historical overview of perspectives on pain and notes also the meaning of pain from theological (principally Christian) perspectives.

Morris, E. L. [Franklin Cardiac Rehab. Program, Southwestern Community College, Franklin, NC; edmorris2000@yahoo.com]. “**The relationship of spirituality to coronary heart disease.**” *Alternative Therapies in Health & Medicine* 7, no. 5 (Sep-Oct 2001): 96-8.

[Abstract:] Several studies suggest that religious involvement or spiritual well-being may affect health outcomes. This study was designed to investigate whether the scores from a questionnaire measuring spiritual well-being correlated with progression or regression of coronary heart disease as measured with computerized cardiac catheterization data. Participants in Dr. Dean Ornish's Lifestyle Heart Trial were given the “Spiritual Orientation Inventory.” A significant difference was found in the spirituality scores between a control group and a research group that practiced daily meditation. The spirituality scores were significantly correlated with the degree of progression or regression of coronary artery obstruction over a 4-year time period. The lowest scores of spiritual well-being had the most progression of coronary obstruction and the highest scores had the most regression. This study suggests that the degree of spiritual well-being may be an important factor in the development of coronary artery disease.

Mueller, P. S., Plevak, D. J. and Rummans, T. A. “**Religious involvement, spirituality, and medicine: implications for clinical practice.**” *Mayo Clinic Proceedings* 76, no. 12 (December 2001): 1225-35. [Review, 146 refs.]

[Abstract:] Surveys suggest that most patients have a spiritual life and regard their spiritual health and physical health as equally important. Furthermore, people may have greater spiritual needs during illness. We reviewed published studies, meta-analyses, systematic reviews, and subject reviews that examined the association between religious involvement and spirituality and physical health, mental health, health-related quality of life, and other health outcomes. We also reviewed articles that provided suggestions on how clinicians might assess and support the spiritual needs of patients. Most studies have shown that religious involvement and spirituality are associated with better health outcomes, including greater longevity, coping skills, and health-related quality of life (even during terminal illness) and less anxiety, depression, and suicide. Several studies have shown that addressing the spiritual needs of the patient may enhance recovery from illness. Discerning, acknowledging, and supporting the spiritual needs of patients can be done in a straightforward and non-controversial manner. Furthermore, many sources of spiritual care (e. g., chaplains) are available to clinicians to address the spiritual needs of patients.

Narayanasamy, A. and Owens, J. [Faculty of Medicine and Health Sciences, School of Nursing, Queens Medical Centre, University of Nottingham, Nottingham, UK; aru.narayamasamy@nottingham.ac.uk]. “**A critical incident study of nurses' responses to the spiritual needs of their patients.**” *Journal of Advanced Nursing* 33, no. 4 (Feb 2001): 446-55.

[Abstract:] AIMS OF STUDY: The aims of the study were to carry out a critical incident study to: (1) Describe what nurses consider to be spiritual needs; (2) Explore how nurses respond to the spiritual needs of their patients; (3) Typify nurses' involvement in spiritual dimensions of care; (4) Describe the effect of nurses' intervention related to spiritual care. BACKGROUND: In the caring professions a focus on individuals as bio-psychological-spiritual beings is gaining recognition and this notion is based on the premise that there should be a balance of mind, body and spirit for the maintenance of health in a person (Stoll 1979). Emerging research highlights the importance of spiritual care in nursing and suggests that there is scope for improving this dimension of care in order to improve the quality of life for many patients. However, there is very little evidence about how nurses respond to the spiritual needs of their patients. Therefore the purpose of this study was to map by critical incident techniques how nurses construct and respond to patients' spiritual needs in a variety of clinical settings. METHODS: Critical incidents were obtained from 115 nurses. The data from these incidents were subjected to content analysis and categories were developed and described. The emerging categories were subjected to peer reviews to ensure reliability and validity of findings. FINDINGS: The findings suggest that there is confusion over the notion of spirituality and the nurse's role related to spiritual care. A variety of approaches to spiritual care emerged in this study from the critical incidents derived from nurse respondents. These were categorized as ‘personal’, ‘procedural’, ‘culturalist’ or ‘evangelical’. There was an overwhelming consensus that patients' faith

and trust in nurses produces a positive effect on patients and families, and nurses themselves derived satisfaction from the experience of giving spiritual care. In this respect, spiritual care interventions promote a sense of well-being in nurses as well as being a valuable part of total patient care. CONCLUSION: The study concluded that there is scope for developing an ideal model of spiritual care using the critical incident data from this study.

Nerenz, D. R. [Health Care Studies, Institute for Managed Care, Michigan State University, East Lansing, MI 48824]. “**Capacities and limitations of information systems as data sources on quality of care at the end of life.**” *Journal of Pain & Symptom Management* 22, no. 3 (Sept 2001): 773-83.

[From the abstract:] This paper describes how various data sources can be used to obtain the key data elements required for quality of care measures, as well as the challenges to linking data elements across sites and levels of care. There are some important quality domains (e.g., interpersonal and spiritual aspects of care) that are very difficult to assess using readily available data; primary data collection through interview and survey methods will be required to assess quality in these areas.

O'Connor, C. I. [Spiritual Care Services, St. Elizabeth's Medical Center, 736 Cambridge Street, Boston, MA 02135]. “**Characteristics of spirituality, assessment, and prayer in holistic nursing.**” *Nursing Clinics of North America* 36, no. 1 (Mar 2001): 33-46. [Review; 47 refs.]

[Abstract:] There is a rediscovery and interest in spirituality at the outset of the third millennium. The challenge will be to harness the spiritual energy naturally available so that patients may be healed and not necessarily cured. Engaging in a patient's own healing process, nurturing a spirituality of life, learning the tools of spiritual assessment, developing ways of praying, being attentive to developing caring relationships so as to be an “Anam Cara” or soul friend, and networking with other spiritual care professionals are useful resources for the holistic nurse.

O'Connor, T. S., Koning, F., Meakes, E., McLarnon-Sinclair, K., Davis, K. and Loy, V. [Waterloo Lutheran Seminary, Waterloo, Ontario, Canada N2L 3C5]. “**Quantity and rigor of qualitative research in four pastoral counseling journals.**” *Journal of Pastoral Care* 55, 3 (Fall 2001): 271-80.

[Abstract:] Examines the quantity (N = 26) and rigor of qualitative research in *The Journal of Pastoral Care*, *Pastoral Sciences*, *Journal of Religion and Health*, and *Pastoral Psychology* for 1993-1997. Defines qualitative research using the work of Douglas Sprenkle and Sidney Moon. Uses the eleven criteria developed by Nicholas Mays and Catherine Pope in *British Medical Journal* for judging rigor. Finds low quantity and mixed quality and discusses implications.

Orchard, H. and Clark, D. [Lincoln Theological Institute, Sheffield University]. “**Spiritual care. Soul survivors.**” *Health Service Journal* 111, no. 5769 (Aug 23, 2001): 28-9.

The authors note that there seems to be increasing acknowledgment in (British) health care of the importance meeting spiritual needs, especially for elders. They report a survey of nursing and residential homes in the Trent region that indicated managers interpreted spiritual care very broadly, and spiritual care was influenced by favorite television programs.

Palmer, C. [Barnes-Jewish Hospital Spiritual Care Services, One Barnes-Jewish Hospital Plaza, St. Louis, MO 63110; clp1840@bjcmail.org]. “**A disciplined approach to spiritual care giving for adults living with cystic fibrosis.**” *Journal of Health Care Chaplaincy* 11, no. 1 (2001): 95-102.

[Abstract:] Adults living with cystic fibrosis are less likely than other pulmonary patients to describe themselves as religious, to attend worship services regularly, to use god language, to describe their spiritual life, and in general, to give any obvious, outward indications of their spiritual strength, concerns, and depth. And yet, they have consistently demonstrated in chaplain-patient encounters an awareness of the function and importance of their spirituality in relation to life choices, coping with illness, facing mortality, and expressing life meaning, beliefs, and values. A disciplined approach by chaplains is a key component to engaging these patients so that each person's unique spiritual story unfolds. Results from *The Disciplina* demonstrate how adults with cystic fibrosis are different in their expression and approach to spirituality from other pulmonary patients.

Panicola, M. R. “**Catholic Teaching on Prolonging Life: Setting the Record Straight.**” *The Hastings Center Report* 31, no. 6 (Nov-Dec 2001): 14-25.

This is an expansion of the author's article, “Withdrawing nutrition and hydration. The Catholic tradition offers guidance for the treatment of patients in a persistent vegetative state,” (noted directly below).

Panicola, M. R. [SSM Health Care, St. Louis, MO]. “**Withdrawing nutrition and hydration. The Catholic tradition offers guidance for the treatment of patients in a persistent vegetative state.**” *Health Progress* 82, no. 6 (Nov-Dec 2001): 28-33.

The author, the ethicist for SSM Health Care, addresses the subject in the wake of two recent cases that brought much debate within Catholic circles. He argues that the provision of nutrition and hydration to patients in PVS is not morally obligatory within the Catholic tradition. His argument emphasizes the concept of *beneficial* treatment. An expansion of this article is published by the author as, “Catholic Teaching on Prolonging Life: Setting the Record Straight,” (noted directly above).

Pargament, K. I., Koenig, H. G., Tarakeshwar, N. and Hahn, J. [Department of Psychology, Bowling Green State University, Bowling Green, OH 43403; kpargam@bgsu.edu]. “**Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study.**” *Archives of Internal Medicine* 161, no. 15 (Aug 13-27, 2001): 1881-5.

[Abstract:] BACKGROUND: Although church attendance has been associated with a reduced risk of mortality, no study has examined the impact of religious struggle with an illness on mortality. OBJECTIVE: To investigate longitudinally the relationship between religious struggle with an illness and mortality. METHODS: A longitudinal cohort study from 1996 to 1997 was conducted to assess positive religious coping and religious struggle, and demographic, physical health, and mental health measures at baseline as control variables. Mortality during the 2-year period was the main outcome measure. Participants were 596 patients aged 55 years or older on the medical inpatient services of Duke University Medical Center or the Durham Veterans Affairs Medical Center, Durham, NC. RESULTS: After controlling for the demographic, physical health, and mental health variables, higher religious struggle scores at baseline were predictive of

greater risk of mortality (risk ratio [RR] for death, 1.06; 95% confidence interval [CI], 1.01-1.11; $\chi^2(2) = 5.89$; $P = .02$). Two spiritual discontent items and 1 demonic reappraisal item from the religious coping measure were predictive of increased risk for mortality: "Wondered whether God had abandoned me" (RR for death, 1.28; 95% CI, 1.07-1.50; $\chi^2(2) = 5.22$; $P = .02$), "Questioned God's love for me" (RR for death, 1.22; 95% CI, 1.02-1.43; $\chi^2(2) = 3.69$; $P = .05$), and "Decided the devil made this happen" (RR for death, 1.19; 95% CI, 1.05-1.33; $\chi^2(2) = 5.84$; $P = .02$). CONCLUSIONS: Certain forms of religiousness may increase the risk of death. Elderly ill men and women who experience a religious struggle with their illness appear to be at increased risk of death, even after controlling for baseline health, mental health status, and demographic factors.

Parker, M. W., Fuller, G. F., Koenig, H. G., Vaitkus, M. A., Bellis, J. M., Barko, W. F., Eitzen, J. and Call, V. R. [School of Social Work, University of Alabama, Little Hall, Box 870314, Tuscaloosa, AL 35487-0314]. **"Soldier and family wellness across the life course: a developmental model of successful aging, spirituality, and health promotion. Part I."** *Military Medicine* 166, no. 6 (Jun 2001): 485-9.

[Abstract:] The primary purposes of this article are to (1) highlight current challenges facing health promotion advocates within the military and civilian culture; (2) present the strengths and weaknesses of the current Army approach to health promotion and preventive medicine; and (3) present several unifying themes that contribute to enhanced progress within the field of health promotion. A conceptual model that links common goals across the fields of successful aging, health promotion, spirituality and health, and life course is advocated to maximize efficacious interventions and to transform the current Army approach to health promotion. A companion article will describe an integrative model of health promotion and wellness that responds to the challenges and incorporates the unifying themes described in this article.

Patton, G. L. [St. Mary's Hospital, Huntington, WV]. **"Spirituality assessment in health care. In examining a patient's 'objects of devotion,' the clinician may find clues to an unhealthy lifestyle."** *Health Progress* 82, no. 5 (Sep-Oct 2001): 15-8.

This article, in the official journal of the Catholic Health Association of the United States, considers the evaluation of patients' "objects of devotion" as part of a spiritual assessment for health care. The author provides "guidelines for distinguishing a healthy object of devotion from one that is not" (p. 16). A case example is offered. The author supports a holistic approach to health care.

Penson, R. T., Yusuf, R. Z., Chabner, B. A., Lafrancesca, J. P., McElhinny, M., Axelrad, A. S. and Lynch, T. J. Jr. [Department of Medicine, Division of Hematology/Oncology, Massachusetts General Hospital, 100 Blossom Street, Boston, MA 02114-2617; rpenon@partners.org]. **"Losing God."** *Oncologist* 6, no. 3 (2001): 286-97.

The article presents patient case illustrative of the principles of the Schwartz Center at Massachusetts General Hospital. [Abstract:] Shortly before his death in 1995, Kenneth B. Schwartz, a cancer patient at Massachusetts General Hospital (MGH), founded the Kenneth B. Schwartz Center. The Schwartz Center is a non-profit organization dedicated to supporting and advancing compassionate health care delivery, which provides hope to the patient, support to caregivers, and sustenance to the healing process. The center sponsors the Schwartz Center Rounds, a monthly multidisciplinary forum where caregivers reflect on important psychosocial issues faced by patients, their families, and their caregivers, and gain insight and support from fellow staff members. Nebulous language, distrust, and dogma confound spiritual aspects of cancer care. However, existential well being is an important determinant of quality of life: finding meaning and purpose make suffering more tolerable. The case presented is of a patient who experienced "losing God" as a Hodgkin's disease survivor with metastatic prostate cancer and severe coronary artery disease. His caregivers were able to provide the sense of community in which he could re-establish his faith. Health care providers do not have to be religious in order to help patients to deal with a spiritual crisis. The clinical skills of compassion need to be deployed to diagnose and respond to spiritual suffering. Acknowledging and addressing anger or guilt, common sources of suffering, are essential to adjustment. Simply being there for the patient and being open to their hurt can help resolve their spiritual crisis, a responsibility that is shared by the whole health care team.

Pierce, L. L. [School of Nursing, Medical College of Ohio, Toledo]. **"Caring and expressions of spirituality by urban caregivers of people with stroke in African American families."** *Qualitative Health Research* 11, no. 3 (May 2001): 339-52.

[Abstract:] Expressions of spirituality by urban caregivers in African American families are the focus of the study discussed in this article. Data presented here were collected as part of a larger study that examined these caregivers' experience and meaning of caring as they influenced their capacity to care for people with stroke within their family systems. This study was executed within and supported the framework of systemic organization by Friedemann, according to which families as open systems strive for well-being. Spirituality, a component of well-being, is based on values concerning commitment, love, and affection. Eight themes concerning spirituality for all caregivers emerged from the data. Through spirituality, the caregivers felt well-being and were connected and comforted in difficult times related to caring.

Pullman, D. and James-Abra, B. [Faculty of Medicine, Memorial University of Newfoundland, St. John's, Newfoundland, Canada A1B 3V6]. **"Care for the caregiver: effective pastoral support for nursing home staff."** *Journal of Pastoral Care* 55, no. 1 (Spring 2001): 35-45.

[Abstract:] Notes that the contexts in which caregivers work shape the kinds of relationships they develop with those under their care. Suggests that it is possible to map these contextual features on a continuum with detached professionalism and involved familialism representing the extremes. Claims that nursing home staff are more akin to family members in their relationships with residents than are other professional caregivers who work in acute care settings. Sketches possible implications as to how recognizing and responding to these relational dynamics may influence specific modes of care.

Puri, B. K., Lekh, S. K., Nijran, K. S., Bagary, M. S. and Richardson, A. J. [MRI Unit, MRC Clinical Sciences Centre, Imperial College School of Medicine, Hammersmith Hospital, Du Cane Road, W12 0HS, London, UK; basant.puri@csc.mrc.ac.uk]. **"SPECT neuroimaging in schizophrenia with religious delusions."** *International Journal of Psychophysiology* 40, no. 2 (Mar 2001): 143-8.

[Abstract:] Functional neuroimaging techniques such as single-positron emission computed tomography (SPECT) and positron emission tomography (PET) offer considerable scope for investigating disturbances of brain activity in psychiatric disorders. However, the heterogeneous nature of disorders such as schizophrenia limits the value of studies that group patients under this global label. Some have addressed this problem by considering schizophrenia at a syndromal level, but so far, few have focussed at the level of individual symptoms. We describe the first neuroimaging study of the specific symptom of religious delusions in schizophrenia. 99mTc HMPAO high-resolution SPECT neuroimaging showed an association of religious delusions with left temporal overactivation and reduced occipital uptake, particularly on the left.

Qaisi, V. G. [American Pharmacy Service Corporation Pharmacy Relief Service, Frankfort, KY]. **“Increasing awareness of health care concerns during Ramadan.”** *Journal of the American Pharmaceutical Association* 41, no. 4 (Jul-Aug): 511.

This brief article considers some practical implications of fasting for Muslims during Ramadan, especially in terms of medication dosing. He notes specific concerns for patients with diabetes, respiratory disorders, arthritis pain, osteoporosis, and conditions requiring anticholinergic medications.

Quill, T. E., Arnold, R. M. and Platt, F. [University of Rochester Medical Center, 601 Elmwood Avenue, Box 601, Rochester, NY 14642]. **“I wish things were different': Expressing wishes in response to loss, futility, and unrealistic hopes.”** *Annals of Internal Medicine* 135, no. 7 (October 2, 2001): 551-5.

The article addresses very practically how physicians may speak with patients in emotion-laden situations when the physician must convey the limits of medicine and still respond personally to the patient. Among the suggestions about how to help the patient search for hope is that of “exploring spiritual or religious issues” (p. 553).

Ray, J. B. [Clinical Pharmacist, Pain/Palliative Care, Department of Pharmacy and Drug Information Services, Hamot Medical Center, Erie, PA 16550]. **“Pharmacologic management of pain: the surgeon's responsibility.”** *Surgical Oncology Clinics of North America* 10, no. 1 (Jan 2001): 71-87. [Review, 68 refs.]

[Abstract:] Historically, surgeons have had to witness their patients' pain probably longer than any specialty within medicine. Pain relief in palliative care forms the cornerstone of a comprehensive pattern of care that encompasses the physical, psychologic, social, and spiritual aspects of suffering. In a society that lives by mottoes, such as “no pain, no gain,” and “just say no to drugs,” pervasive subconscious barriers to effective pain relief exist. In being responsible for effective pain management to the patient, the surgeon must first set aside his or her own beliefs and attitudes regarding pain and its control and be open to change.

Robbins, R. A., Simmons, Z., Bremer, B. A., Walsh, S. M. and Fischer, S. **“Quality of life in ALS is maintained as physical function declines.”** *Neurology* 56, no. 4 (Feb 27, 2001): 442-4.

[Abstract:] OBJECTIVES: To study patients with ALS to determine how physical function, quality of life (QOL), and spirituality or religiousness change over time, and what relationship these changes have to one another. METHODS: Sixty patients with ALS were studied prospectively. They were assessed at baseline, 3 months, and 6 months, using questionnaires designed to measure general quality of life (McGill Quality of Life questionnaire), religiosity (Idler Index of Religiosity), ALS-specific health-related quality of life (SIP/ALS-19), and ALS-specific function (ALS functional rating scale). RESULTS: A two-way repeated measures multivariate analysis of variance revealed that both the passage of time and the specific QOL scales used were factors in predicting patient quality of life.... Despite a progressive decline in physical function as measured by the ALS-specific function score, the general QOL and religiosity scores changed little. In contrast, the ALS-specific health-related QOL score declined in parallel with the ALS-specific function score. CONCLUSIONS: QOL in patients with ALS appears to be independent of physical function, which agrees with a previous cross-sectional study. The ALS-specific health-related QOL score is primarily a measure of physical function. QOL instruments that assess spiritual, religious, and psychological factors produce different results than those obtained using measures of physical function alone.

Rosner, F. [Mount Sinai Services, Queens Hospital Center, 82-68 164th St, Jamaica, NY 11432; rosnef01@hotmail.com]. **“Religion and medicine.”** *Archives of Internal Medicine* 161, no. 15 (Aug 13-17, 2001): 1811-2.

This brief commentary gives an overview of the current dialogue on spirituality and health and encourages attention to patient spirituality while noting that specific links between spirituality and health are tenuous according to the present body of research. The author addresses the use of religion by patients as a “complementary therapy,” and he decries intercessory prayer studies as “miss[ing] the whole point of the purpose of prayer” (p. 1811).

Rossmann, M. L. **“Should a doctor ask about a patient's spiritual beliefs?”** *Advances in Mind-Body Medicine* 17, no. 2 (Spring 2001): 101-3.

This article is an excerpt from the author's book, *Guided Imagery for Self-Healing* (2000), offering a brief overview of how a patient's spiritual orientation may interplay with health care and health, positively and negatively. .

Rousseau, P. **“Existential suffering and palliative sedation: a brief commentary with a proposal for clinical guidelines.”** *American Journal of Hospice & Palliative Care* 18, no. 3 (May-Jun 2001): 151-3. [Review; 15 refs.]

The author briefly reviews the clinical context and ethical arguments for palliative sedation, especially in light of the spiritual and psychosocial concerns of “refractory existential suffering” (*passim*). He concludes: “Although PS is more readily accepted as a palliative strategy in physical suffering, existential anguish can be equally debilitating and may warrant aggressive palliation. Consequently, in cases where existential suffering is unabated, PSD offers an acceptable alternative to intractable existential distress” (p. 153).

Sadler, G. R., Sethee, J., Tuzzio, L., Sieben, M., Ko, C. M. and Christ, H. N. [University of California at San Diego Cancer Center, La Jolla 92093-0658]. **“Cancer education for clergy and lay church leaders.”** *Journal of Cancer Education* 16, no. 3 (Autumn 2001): 146-9.

[Abstract:] BACKGROUND: Reaching diverse population subgroups with information about cancer prevention/early detection, pain management, and clinical trials has historically been a significant public health challenge. A partnership between clergy and cancer educators might help reduce this challenge. METHODS: Participating churches were randomized into two programs for delivering cancer education after their church leaders completed a baseline survey about their knowledge, attitudes, and roles related to the cancer ministry.

RESULTS: Clergy reported opportunities to use their acquired cancer knowledge, a high receptivity to their information, comfort discussing cancer care and clinical trials, and a strong recommendation that the educational program/partnership continue to be offered.

Salmon, D. [McGill University Health Centre, Palliative Care Service, Royal Victoria Hospital, Montreal, Quebec, Canada]. **"Music therapy as psychospiritual process in palliative care."** *Journal of Palliative Care* 17, no. 3 (Autumn 2001): 142-6.

[Abstract:] This paper proposes a theoretical framework for understanding how music therapy elicits and supports depth experiences in palliative care. The author explores music therapy as a containing or sacred space in which ventures into the realm of psychospiritual awareness may safely occur. The ultimate goal is to facilitate the process of connecting to that which is psychologically and spiritually significant for the patient, thereby transforming experiences of suffering into those of meaning.

Salyer, J., Sneed, G. and Corley, M. C. [Department of Adult Health Nursing, Virginia Commonwealth University, Richmond, VA 23298]. **"Lifestyle and health status in long-term cardiac transplant recipients."** *Heart & Lung* 30, no. 6 (Nov-Dec 2001): 445-57.

[From the abstract:] OBJECTIVE: The purpose of this pilot study was to describe the lifestyle and health status of long-term cardiac transplant recipients. DESIGN AND SETTING: The study was a descriptive correlational design at a health sciences center. MEASURES: We measured lifestyle, using the Health-Promoting Lifestyle Profile-II, and indicators of health status (e.g., number of medications, infections, and rejections; systolic and diastolic blood pressure; lipid profile; and percent ideal body weight) in 47 patients after an annual evaluation or follow-up visit after patients received cardiac transplantation. RESULTS: Patients were primarily male, white, 56.5 years old and 75.6 months after transplant. Spiritual growth was the most frequently reported lifestyle characteristic (mean, 27.4; SD, 4.9). The least frequently reported lifestyle characteristic was engagement in physical activity (mean, 18.4; SD, 5.7). Factorial between-subjects analysis of variance demonstrated that women had a higher high-density lipoprotein level ($P = .0001$) and reported healthier dietary habits ($P = .02$) and greater spiritual growth ($P = .006$) than men....

Schuster, M. A., Stein, B. D., Jaycox, L., Collins, R. L., Marshall, G. N., Elliott, M. N., Zhou, A. J., Kanouse, D. E., Morrison, J. L. and Berry, S. H. [RAND, Santa Monica, Calif 90407-2138; schuster@rand.org]. **"A national survey of stress reactions after the September 11, 2001, terrorist attacks."** *New England Journal of Medicine* 345, no. 20 (Nov 15, 2001): 1507-12. Comment on p. 1490.

[Abstract:] BACKGROUND: People who are not present at a traumatic event may also experience stress reactions. We assessed the immediate mental health effects of the terrorist attacks on September 11, 2001. METHODS: Using random-digit dialing three to five days after September 11, we interviewed a nationally representative sample of 569 U.S. adults about their reactions to the terrorist attacks and their perceptions of their children's reactions. RESULTS: Forty-four percent of the adults reported one or more substantial stress symptoms; 91 percent had one or more symptoms to at least some degree. Respondents throughout the country reported stress syndromes. They coped by talking with others (98 percent), turning to religion (90 percent), participating in group activities (60 percent), and making donations (36 percent). Eighty-five percent of parents reported that they or other adults in the household had talked to their children about the attacks for an hour or more; 34 percent restricted their children's television viewing. Thirty-five percent of children had one or more stress symptoms, and 47 percent were worried about their own safety or the safety of loved ones. CONCLUSIONS: After the September 11 terrorist attacks, Americans across the country, including children, had substantial symptoms of stress. Even clinicians who practice in regions that are far from the recent attacks should be prepared to assist people with trauma-related symptoms of stress.

Sherman, A. C., Simonton, S., Adams, D. C., Latif, U., Plante, T. G., Burns, S. K. and Poling, T. [Behavioral Medicine, University of Arkansas for Medical Sciences, Little Rock, AR 72205; ShermanAllenC@uams.edu]. **"Measuring religious faith in cancer patients: reliability and construct validity of the Santa Clara Strength of Religious Faith questionnaire."** *Psycho-Oncology* 10, no. 5 (Sep-Oct 2001): 436-43.

[Abstract:] Growing attention has focused on associations between religious involvement and health outcomes for cancer patients. Unfortunately, research has been hampered by lack of measures suitable for use in oncology settings. This study examined the performance of one recently developed measure, the Santa Clara Strength of Religious Faith Questionnaire (SCSORF). Initial investigations with cancer patients in a bone marrow transplant program and with non-oncology patients yielded promising results. This study provided additional information about temporal stability and convergent validity. The measure was evaluated in two well-defined samples: (1) 95 breast cancer patients, and (2) 53 healthy young adults. Most of the cancer patients had recent diagnoses and localized or regional disease. In each sample, the instrument demonstrated high test-retest reliability (r 's=0.82-0.93) and internal consistency (r 's=0.95-0.97). It displayed strong correlations with measures of intrinsic religiosity (r 's=0.67-0.82, $p < 0.0001$), and moderate correlations with organizational religiosity (r 's=0.61-0.69, $p < 0.0001$), non-organizational religiosity (r 's=0.52-0.55, $p < 0.0001$), comfort from religion ($r = 0.58$, $p < 0.0001$), and ratings of self as religious ($r = 0.58$, $p < 0.0001$). Among cancer patients, scores were significantly associated with optimism ($r = 0.30$, $p < 0.01$), but not with openness of family communication about cancer or perceived social support. These data build on previous findings with cancer patients, and suggest that the SCSORF may be a useful measure of religious faith in oncology settings.

Sherman, D. W. and Ouellette, S. C. [New York University, School of Education, Division of Nursing]. **"Patients tell of their images, expectations, and experiences with physicians and nurses on an AIDS-designated unit."** *Journal of the Association of Nurses in AIDS Care* 12, no. 3 (May-Jun 2001): 84-94.

Among the findings was [from the abstract]: Although patients appreciate recognition of their spiritual needs, they attempt to avoid discussions about religion.

Steffen, P. R., Hinderliter, A. L., Blumenthal, J. A. and Sherwood, A. [Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC 27710]. **"Religious coping, ethnicity, and ambulatory blood pressure."** *Psychosomatic Medicine* 63, no. 4 (Jul-Aug 2001): 523-30.

[Abstract:] OBJECTIVE: To investigate the relationship between religious coping, ethnicity, and ambulatory blood pressure (ABP) measured during daily life. METHODS: A 24-hour ABP was obtained from 155 men and women (78 African American and 77 white) on a typical workday. ABP was averaged over awake and sleep periods, and clinic BP was also assessed. Psychosocial measures of coping style,

negative affect, social support, stress, and health behaviors were completed before ABP measurement. RESULTS: Multiple regression analyses, controlling for demographic variables, revealed a significant religious coping by ethnicity interaction for ABP ($p < .01$) and clinic BP ($p < .05$). Religious coping was not related to BP among whites. Among African Americans, however, higher levels of religious coping were associated with lower awake ($p < .05$) and sleep ($p < .01$) ABP. Social support satisfaction also was related to lower awake ABP among African Americans, but it did not mediate the relationship between religious coping and ABP. CONCLUSIONS: The results of this study extend previous findings by showing that, among African Americans, religious coping and BP are related during daily activities as well as in the clinic. Lower 24-hour BP load may be a pathway through which religiosity and cardiovascular health are related.

Storey, P. [St Luke's Episcopal Hospital Palliative Care Service, Houston, TX]. "**Spiritual care at the end of life.**" *Texas Medicine* 97, no. 8 (Aug 2001): 56-9. [Review, 11 refs.]

[Abstract:] An essential part of end-of-life medical care, spiritual care allows physicians to recognize problems like meaninglessness, anguish, and hopelessness, for which effective interventions are available. This form of care can be a deeply rewarding area of medical practice.

Stranahan, S. [Division of Nursing Education, Indiana Wesleyan University]. "**Spiritual perception, attitudes about spiritual care, and spiritual care practices among nurse practitioners.**" *Western Journal of Nursing Research* 23, no. 1 (Feb 2001): 90-104.

[Abstract:] The purpose of the non-experimental study was to examine the relationships among spiritual perception, attitudes about spiritual care, and spiritual care practices in nurse practitioners. Attitudes about providing spiritual care and spiritual care practices have been studied among nurse generalists, but little research has been conducted on nurses in advanced practice. All nurse practitioners registered by the state of Indiana were sent Reed's Spiritual Perspective Scale (SPS) and a modified version of the Nurses' Spiritual Care Perspectives Scale developed by Taylor, Highfield, and Amenta. Pearson correlation techniques were used to test for significant relationships. Statistically positive relationships were between perception of personal spirituality and 9 of the 12 spiritual care practices. Eight of the 13 items describing attitude toward providing spiritual care were statistically significant with the SPS. Implications of the findings are discussed.

Strang, S. and Strang, P. [Department of Oncology, Sahlgrenska University Hospital, 413 45 Gothenburg, Sweden; susan_strang@hotmail.com]. "**Spiritual thoughts, coping and 'sense of coherence' in brain tumor patients and their spouses.**" *Palliative Medicine* 15, no. 2 (Mar 2001): 127-34.

[Abstract:] When a person is diagnosed with a life-threatening disease, existential questions are easily triggered. The aims of this study were to explore to what extent brain tumor patients and their next of kin were able to cope, understand and create meaning in their situation, to explore whether spirituality could be supportive and to analyze whether these concepts are related to Antonovsky's concept of sense of coherence. Using a purposive sampling technique, 20 patients and 16 of their next of kin took part in tape-recorded interviews. A content and context analysis was performed using a hermeneutic approach. We found that comprehensibility was to a large extent constructed by the patient's own thoughts and theories, despite an insecure situation. Manageability was achieved by active information-seeking strategies, by social support and by coping, including positive reinterpretation of the situation. Meaningfulness was central for quality of life and was created by close relations and faith, as well as by work. A crucial factor was whether the person had a "fighting spirit" that motivated him or her to go on. As only three patients were believers, trust in God had generally been replaced by a belief and confidence in oneself, in science, in positive thinking and by closeness to nature. Sense of coherence as a concept can explain how exposed persons handle their situation. In its construction, sense of coherence integrates essential parts of the stress/coping model (comprehensibility, manageability) and of spirituality (meaning).

Stuck, J., Faine, J. and Boldt, A. [Indiana University Department of Medical and Molecular Genetics, IU Genetic Counseling Program, Indianapolis, IN]. "**The perceptions of Lutheran pastors toward prenatal genetic counseling and pastoral care.**" *Journal of Genetic Counseling* 10, no. 3 (Jun 2001): 251-63.

[Abstract:] The purpose of this study is to explore a theological perspective toward genetic counseling. A survey was sent to 207 ministers within the Evangelical Lutheran Church of America (ELCA), to determine their perspectives toward four different scenarios in a prenatal genetic counseling setting. The four different scenarios included situations involving Huntington disease, Down syndrome, trisomy 18, and anencephaly. Nearly all ELCA Lutheran pastors perceived genetic counseling as beneficial and useful and wanted to be involved in the decision-making process for whether or not to terminate pregnancy. Their views toward termination of pregnancy varied depending on the severity of the genetic abnormality. Severity in this study was based upon life compatibility. As the severity of the genetic abnormality increased, the percentage of Lutheran pastors who viewed termination as an option increased from 23% (Down syndrome) to 62% (anencephaly). A better understanding of how spiritual leaders view genetic counseling would provide an insight into how genetics and religious beliefs together play a significant role in shaping the decisions of those faced with abnormal pregnancies.

Sulmasy, D. P. [The John J Conley Department of Ethics, St Vincent's, Manhattan, 153 W 11th St, New York, NY 10011; daniel_sulmasy@nymc.edu]. "**Addressing the religious and spiritual needs of dying patients.**" *Western Journal of Medicine* 175, no. 4 (Oct 2001): 251-4.

The author presents briefly a patient case and in light of that addresses quite pragmatically spiritual assessment and the role of the physician in regard to patients' spirituality. He proposes four domains for spiritual assessment: religiosity, spiritual coping, spiritual well-being, and spiritual need.

Swinney, J., Anson-Wonkka, C., Maki, E. and Corneau, J. [School of Nursing, University of Massachusetts, Amherst, MA 01003-0420; jswinney@nursing.umass.edu]. "**Community assessment: a church community and the parish nurse.**" *Public Health Nursing* 18, no. 1 (Jan-Feb 2001): 40-4.

[Abstract:] In central Massachusetts a large urban parish asked the University of Massachusetts, Amherst School of Nursing to conduct a community assessment for the church and newly employed parish nurse. The aims of the assessment were: to determine the health status of parishioners, identify their perceived health needs and perceived barriers in meeting those needs, and to assist the church and parish nurse in developing a health program for their faith community. Findings of the assessment are based on questionnaire and focus group data.

Four hundred and twenty-one questionnaires were completed, and six focus groups were held to validate the data. Results showed most parishioners felt they were in good health (93%), believed faith and spiritual beliefs were important in maintaining health and well-being (91%), and thought that the church should play a role in helping parishioners meet their health needs (70%). In addition, focus group discussions revealed a need for respite care for primary caretakers of the ill and elderly, and health education programs for their teen and elderly populations. In conclusion, parishioners were positive and articulated support of the parish nurse and activities designed to address the physical, emotional, and spiritual needs of their community.

Taylor, E. J. [School of Nursing, Loma Linda University, Loma Linda, CA]. **“Spirituality, culture, and cancer care.”** *Seminars in Oncology Nursing* 17, no. 3 (Aug 2001): 197-205. [Review, 40 refs.]

[Abstract:] OBJECTIVES: To explore the inter-relatedness of culture and spirituality in the context of cancer caregiving and to provide suggestions for improving clinical practice. DATA SOURCES: Research reports and theoretical and clinical papers from nursing and medicine. CONCLUSION: Understanding spiritual-cultural influences that affect responses to cancer are essential if a nurse is to provide effective care. Research has documented spiritual-cultural aspects of cancer prevention and screening, living and coping with cancer, and dying with cancer. This research suggests that African American and Hispanic cancer patients are more religious, recognize more spiritual needs, and benefit more from religious coping strategies, than do white Americans. IMPLICATIONS FOR NURSING PRACTICE: Strategies proposed for increasing a nurse's effectiveness while caring for clients with diverse spiritual-cultural beliefs and behaviors include: increasing awareness of personal spiritual-cultural values and beliefs, gaining knowledge about diverse religious traditions, and negotiation with clients when values and beliefs that compromise care conflict.

Tucakovic, M., Bascom, R. and Bascom, P. B. [Pulmonary, Allergy and Critical Care Medicine, Department of Medicine, Penn State College of Medicine, The Milton S. Hershey Medical Center, Hershey, PA]. **“Pulmonary medicine and palliative care.”** *Best Practice & Research in Clinical Obstetrics & Gynecology* 15, no. 2 (Apr 2001): 291-304. [Review, 65 refs.]

The article addresses how gynecological malignancies affect the respiratory system and the role of palliative care in overall treatment plans. Among the non-pharmacological therapies noted, especially for dyspnea, is “attention to spiritual suffering.” Cases are used to illustrate quality of life (QOL) issues.

Tuck, I., McCain, N. L. and Elswick, R. K. Jr. [School of Nursing, Virginia Commonwealth University, Richmond, VA; ituck@hsc.vcu.edu]. **“Spirituality and psychosocial factors in persons living with HIV.”** *Journal of Advanced Nursing* 33, no. 6 (Mar. 2001): 776-83.

[Abstract:] AIM OF THE STUDY: This pilot study was designed to examine the relationships among spirituality and psychosocial factors in a sample of 52 adult males living with human immunodeficiency virus (HIV) disease and to determine the most reliable spirituality measure for a proposed longitudinal study. BACKGROUND: HIV disease is among the most devastating of illnesses, having multiple and profound effects upon all aspects of the biopsychosocial and spiritual being. Although research has suggested relationships among various psychosocial and spiritual factors, symptomatology and physical health, much more research is needed to document their potential influences on immune function, as well as health status, disease progression, and quality of life among persons with HIV disease. METHODS: This descriptive correlational study explored the relationships of spirituality and psychosocial measures. Spirituality was measured in terms of spiritual perspective, well-being and health using three tools: the Spiritual Perspective Scale, the Spiritual Well-Being Scale, and the Spiritual Health Inventory. Five psychosocial instruments were used to measure aspects of stress and coping: the Mishel Uncertainty in Illness Scale, Dealing with Illness Scale, Social Provisions Scale, Impact of Events Scale, and Functional Assessment of HIV Infection Scale. The sample was recruited as part of an ongoing funded study. The procedures from the larger study were well-defined and followed in this pilot study. Correlational analyses were done to determine the relationship between spirituality and the psychosocial measures. FINDINGS: The findings indicate that spirituality as measured by the existential well-being (EWB) subscale of the Spiritual Well-Being Scale was positively related to quality of life, social support, effective coping strategies and negatively related to perceived stress, uncertainty, psychological distress and emotional-focused coping. The other spirituality measures had less significant or non-significant relationships with the psychological measures. CONCLUSIONS: The study findings support the inclusion of spirituality as a variable for consideration when examining the psychosocial factors and the quality of life of persons living with HIV disease. The spiritual measure that best captures these relationships is the EWB subscale of the Spiritual Well-Being Scale.

Tuck, I., Wallace, D. and Pullen, L. [School of Nursing, Virginia Commonwealth University, Richmond, VA]. **“Spirituality and spiritual care provided by parish nurses.”** *Western Journal of Nursing Research* 23, no. 5 (Aug 2001): 441-53. Discussion on pp. 454-62.

[Abstract:] The high level of religious participation in the United States provides a venue for parish nursing, a holistic nursing specialty that emphasizes the relationship between spirituality and health. This descriptive study measured two aspects of spirituality (spiritual perspective and spiritual well-being) in a national sample of parish nurses and described variables related to their practice. Furthermore, it qualitatively examined the provision of spiritual care to clients in this parish nurse sample. Parish nurses scored high in spiritual perspective and spiritual well-being and reported an emphasis on health promotion and education in their activities. Three views of spiritual interventions (ideal, general, and specific) were reported. Types of spiritual interventions typically fell into one of four categories: religious, interactional, relational, and professional.

Weaver, A. J., Flannelly, L. T., Flannelly, K. J., VandeCreek, L., Koenig, H. G. and Handzo, G. [HealthCare Chaplaincy, New York, NY 10022]. **“A 10-year review of research on chaplains and community-based clergy in 3 primary oncology nursing journals: 1990-1999.”** *Cancer Nursing* 24, no. 5 (Oct 2001): 335-40.

[Abstract:] A manual examination of 3 primary oncology nursing journals was conducted to identify quantitative studies about chaplains and community-based clergy that were published between 1990 and 1999. This systematic review identified 7 studies involving chaplains and/or clergy dealing with a range of issues. Although the rate at which such studies were published in the oncology nursing literature was relatively low (1 in 123 studies), this rate far exceeds the rate found in a similar review of psychology journals (1 in 600 studies). The nature of the 7 studies and the issues they addressed are discussed and the authors make recommendations for future collaborative efforts.

- Webb, T. E. [Webb & Associates Chaplaincy Consulting, 4660B Los Alamos Way, Oceanside, CA 92057-7834; prayerboss@earthlink.net]. **“Assessing a crisis of faith and making a pastoral crisis intervention.”** *International Journal of Emergency Mental Health* 3, no. 3 (Summer 2001): 181-6.
- This article follows two others published in this journal the previous year (2000) by the journal's executive editor, G. S. Everly, Jr. dealing with the basic definition and role of the pastoral crisis intervention. The present author writes systematically but seemingly mostly from his personal experience rather than from research or a broad consensus. Though his perspective is presented in a generalized/universalized manner, it clearly comes from a particular Christian source and follows a particular cognitive-therapy approach—and thus the author's generalizations may be problematic in application with a diverse population. The journal is a recent product of the independent International Critical Incident Stress Foundation, Inc. [The abstract of the article is as follows:] Evaluating the spiritual impact of a critical incident upon an individual is a vital aspect of restoring an individual to functioning in their relationships and work responsibilities. Being able to recognize and respond to spiritual symptoms of critical incident stress will allow crisis interventionists to address crisis recovery issues that are often central to an individual's identity and purpose for living. Spiritual symptoms of traumatic stress issue from the defining identity of an individual. With an understanding of the nature of a crisis of faith, crisis interventionists can employ critical incident stress management skills to support a person in spiritual as well as psychological trauma.
- Weiner, E. L., Swain, G. R., Wolf, B. and Gottlieb, M. [Behavioral Medicine Education, McLaren Family Practice Residency Program G-3245 Beecher Rd., Flint, MI 48532]. **“A qualitative study of physicians' own wellness-promotion practices.”** *Western Journal of Medicine* 174, no. 1 (Jan 2001): 19-23.
- [From the abstract:] DESIGN, SETTING, AND PARTICIPANTS: 304 members of a primary care practice-based research group responded by mail to a survey on physician well-being. From the original survey, 130 subjects responded to an open-ended survey item regarding their own wellness-promotion practices. METHODS: Qualitative content analysis was used to identify the common themes in the physicians' responses to the open-ended question. A validated 18-item instrument, the Scales of Psychological Well-Being (SPWB), was used for measurement. MAIN OUTCOME MEASURES: Similarities and differences between the various wellness-promotion practices that respondents reported using and associations between the use of these practices and SPWB scores. RESULTS: The 5 primary wellness-promotion practices that evolved from thematic analysis of the survey responses included “relationships,” “religion or spirituality,” “self-care,” “work,” and “approaches to life.” The use of the last type of practice was significantly associated with increased psychological well-being (SPWB) scores compared with the use of any of the other wellness-promotion practice categories ($P < 0.01$), and there was a trend toward increased well-being among users of any category of wellness-promotion practices. Comments by our respondents provide specific descriptions of how physicians attend to their emotional, spiritual, and psychological well-being.
- Wenger, N. S. and Rosenfeld, K. [Department of Medicine, Division of General Internal Medicine and Health Services Research, University of California, Los Angeles, 911 Broxton Plaza, Los Angeles, CA 90095-1736; nwenger@mednet.ucla.edu]. **“Quality indicators for end-of-life care in vulnerable elders.”** *Annals of Internal Medicine* 135, no. 8, pt. 2 (Oct 16, 2001): 677-85.
- Among the 14 quality indicators addressed is Attention to Spiritual Care [for the dying patient]: “If a vulnerable elder who was conscious during the last 3 days of life died an expected death, then the medical record should contain documentation about spirituality or how the patient was dealing with death or religious feelings because spiritual issues play a prominent role at the end of life and can be addressed by a variety of interventions” (p. 682). Attention to spiritual issues is noted as “an important component of a good death” (p. 683).
- Westlake, C. and Dracup, K. [University of California, Los Angeles, CA]. **“Role of spirituality in adjustment of patients with advanced heart failure.”** *Progress in Cardiovascular Nursing* 16, no. 3 (Summer 2001): 119-25.
- [Abstract:] Heart failure is a chronic and progressive disease often characterized by severe symptoms, frequent hospitalization, and poor prognosis. It may threaten the individual's sense of self and lead to questions related to spirituality. The purpose of this qualitative, phenomenologic study was to describe the role of spirituality in the adjustment of patients to advanced heart failure. Purposive sampling of all patients who presented to two university-affiliated, outpatient heart failure clinics was used. Eighty-seven patients were interviewed using a semistructured questionnaire. Data were subjected to content analysis and thematic coding. Patients described a three-step process where spirituality contributed to their adjustment to advanced heart failure: development of regret regarding past behaviors and lifestyles; the search for meaning within the present experience of heart failure; and the search for hope for the future and reclaiming of optimism. Assessment and interventions that include a spiritual dimension can facilitate the adjustment of patients to advanced heart failure.
- Williams, C. D., Lewis-Jack, O., Johnson, K. and Adams-Campbell, L. [Division of Epidemiology and Biostatistics, Howard University Cancer Center, Washington, DC 20060]. **“Environmental influences, employment status, and religious activity predict current cigarette smoking in the elderly.”** *Addictive Behaviors* 26, no. 2 (Mar-Apr 2001): 297-301.
- Among the findings of this study of a predominantly African American sample of older adults in the Washington, DC area was [from the abstract:] Subjects who reported less frequent participation in organized religious activities were also more likely to smoke (odds ratio = 2.04, 95% CI = 1.17-50.38).
- Wilson, S. M. and Miles M. S. [School of Nursing, North Carolina Agricultural and Technical State University, Greensboro]. **“Spirituality in African-American mothers coping with a seriously ill infant.”** *Journal of the Society of Pediatric Nurses* 6, no. 3 (Jul-Sep 2001): 116-22.
- [Abstract:] ISSUES AND PURPOSE: To describe how African-American mothers' spirituality helped them cope during the time of their infants' hospitalization for a serious illness. DESIGN AND METHODS: Fourteen mothers whose infants were seriously ill in the early months of life were interviewed for this retrospective, descriptive study. RESULTS: The core theme related to prayer. Four mothers reported a strengthened faith, while two mothers continued to have difficulty relating to God or attending church. PRACTICE IMPLICATIONS: These findings support the importance of understanding and respecting the spiritual needs and expressions of spirituality in African-American mothers who are coping with a serious illness in one of their children.

- Wrede-Seaman, L. D. [Yakima Physicians Pain and Palliative Medicine Consultants, Yakima, WA]. “**Treatment options to manage pain at the end of life.**” *American Journal of Hospice & Palliative Care* 18, no. 2 (Mar-Apr 2001): 89-101.
[From the abstract:] Experts believe that the time preceding death can be comfortable if people die without pain, with dignity, and in their own way. Given current analgesic options, psychological and spiritual interventions, and an effective health care delivery system, all these goals are achievable. Pain management is one of the most important aspects of end-of-life care....
- Yawar, A. [John Radcliffe Hospital, Oxford OX3 9DU, UK; athar.yawar@doctors.org.uk]. “**Spirituality in medicine: what is to be done?**” *Journal of the Royal Society of Medicine* 94, no. 10 (Oct 2001): 529-33. [Review, 44 refs.]
The author offers a brief overview of current thinking on the relationship between patients’ spirituality and medical practice, with special attention to the varying perspectives of “different medical traditions.”
- Zeckhausen, W. “**Spirituality and your practice.**” *Family Practice Management* 8, no. 5 (May 2001): 60.
This brief article from a pastoral counselor who has led physician support groups comments on the role of spirituality not just for patients but for physicians, especially as it may affect physician “burnout.”

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