

Spirituality & Health: A Select Bibliography Of Medline-Indexed Articles Published In 2002

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The following is a selection of 173 Medline-indexed journal articles pertaining to spirituality & health published during 2002. 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).

- Abrahm, J. L. and Hansen-Flaschen, J. [Pain and Palliative Care Program, Dana-Farber Cancer Institute and the Brigham and Women's Hospital, Harvard Medical School, Boston, MA]. "**Hospice care for patients with advanced lung disease.**" *Chest* 121, no. 1 (Jan 2002): 220-9. Comment on pp. 11-12.
Among the authors' points, [from the abstract:] hospice offers expert palliation of physical, psychological, social, and spiritual distress, as well as practical support for home care needs, hospitalization for short-term control of symptoms, and inpatient respite care for relief of home caregivers. ...This article reviews hospice care in the United States with particular attention to eligibility criteria and services available for patients who are dying of an advanced lung disease. Specific recommendations are offered for referring respiratory disease patients to hospice programs.
- Abramowitz, J. S., Huppert, J. D., Cohen, A. B., Tolin, D. F. and Cahill, S. P. [Mayo Clinic, Dept. of Psychiatry and Psychology, Rochester, MN 55905; abramowitz.jonathan@mayo.edu]. "**Religious obsessions and compulsions in a non-clinical sample: the Penn Inventory of Scrupulosity (PIOS).**" *Behaviour Research & Therapy* 40, no. 7 (Jul 2002): 825-38.
[Abstract:] The present investigation reports on the development and psychometric evaluation of the Penn Inventory of Scrupulosity (PIOS), a 19-item self-report scale measuring religious obsessive-compulsive symptoms. Factor analysis yielded a two factor solution with the first subscale measuring fears about having committed sin, and the second measuring fears concerning punishment from God. Using a sample of college students, the PIOS was shown to be internally consistent and possess good convergent and discriminant validity. Highly devout participants evidenced higher scores on both PIOS subscales, but devout Jews evidenced fewer fears of sin and punishment from God compared to devout Protestants or Catholics. The PIOS has utility both as a research and clinical tool.
- Aftanas, L. I. and Golocheikine, S. A. [Psychophysiology Laboratory, State-Research Institute of Physiology, Siberian Branch, Russian Academy of Medical Sciences, Timakova str. 4, 630117, Novosibirsk, Russia; aftanas@iph.ma.nsc.ru]. "**Non-linear dynamic complexity of the human EEG during meditation.**" *Neuroscience Letters* 330, no. 2 (Sep 20, 2002): 143-6.
[Abstract:] We used non-linear analysis to investigate the dynamical properties underlying the EEG in the model of Sahaja Yoga meditation. Non-linear dimensional complexity (DCx) estimates, indicating complexity of neuronal computations, were analyzed in 20 experienced meditators during rest and meditation using 62-channel EEG. When compared to rest, the meditation was accompanied by a focused decrease of DCx estimates over midline frontal and central regions. By contrast, additionally computed linear measures exhibited the opposite direction of changes: power in the theta-1 (4-6 Hz), theta-2 (6-8 Hz) and alpha-1 (8-10 Hz) frequency bands was increased over these regions. The DCx estimates negatively correlated with theta-2 and alpha-1 and positively with beta-3 (22-30 Hz) band power. It is suggested that meditative experience, characterized by less complex dynamics of the EEG, involves 'switching off' irrelevant networks for the maintenance of focused internalized attention and inhibition of inappropriate information. Overall, the results point to the idea that dynamically changing inner experience during meditation is better indexed by a combination of non-linear and linear EEG variables.
- Agrawal, M. and Danis, M. [Department of Clinical Bioethics, National Institutes of Health, Bethesda, Maryland 20892-1156]. "**End-of-life care for terminally ill participants in clinical research.**" *Journal of Palliative Medicine* 5, no. 5 (Oct 2002): 729-37. Comment on pp. 661-5. [Review, 30 refs.]
[From the abstract:] We examine six domains that have been suggested for measuring a good death: physical symptoms; psychological and cognitive symptoms; economic and caregiving needs; social relationships; spiritual beliefs; hopes and expectations. For each of these domains we examine how the goals of clinical research may conflict or coincide with taking care of a patient with a terminal illness. Finally, we offer suggestions to address these tensions....
- Ai, A. L., Peterson, C., Bolling, S. F. and Koenig, H. [University of Washington, Seattle 98105-6299; amyai@u.washington.edu]. "**Private prayer and optimism in middle-aged and older patients awaiting cardiac surgery.**" *Gerontologist* 42, no. 1 (Feb 2002): 70-81.
[Abstract:] PURPOSE: This study investigated the use of private prayer among middle-aged and older patients as a way of coping with cardiac surgery and prayer's relationship to optimism. DESIGN AND METHODS: The measure of prayer included three aspects: (a) belief in the importance of private prayer, (b) faith in the efficacy of prayer on the basis of previous experiences, and (c) intention to use prayer to cope with the distress associated with surgery. The sample was 246 patients awaiting cardiac surgery. The first in-person interview was administered 2 weeks before surgery and optimism was measured the day before surgery by telephone. RESULTS: Private prayer predicted optimism, along with older age, better socioeconomic resources, and healthier affect. Neither measures of general religiosity nor any type

of prayers used by patients were associated with optimism. IMPLICATIONS: Suggestions were made for clinicians to improve spiritual assessment and care, and for researchers to address spiritual coping in clinical situations.

Akhtar, S. G. [King George Hospital, Essex, UK]. "Nursing with dignity. Part 8: Islam." *Nursing Times* 98, no. 16 (Apr 16-22, 2002): 40-2.

[Abstract:] This article describes the main teachings and customs of Islam. It offers some guidelines to enable nurses to provide sensitive and appropriate care to Muslim patients.

al-Shahri, M. Z. [Department of Oncology, Palliative Care, King Faisal Specialist Hospital and Research Center]. "Culturally sensitive caring for Saudi patients." *Journal of Transcultural Nursing* 13, no. 2 (Apr 2002): 133-8.

[From the abstract:] In this article, a Saudi health professional describes some of the pertinent cultural aspects that could help non-Saudi health professionals improve their awareness about Saudi culture. The religion of Islam is the main, though not the only, factor that shapes the Saudi culture. This article, therefore, could also interest those caring for Arab and Muslim patients worldwide.

Ang, D. C., Ibrahim, S. A., Burant, C. J., Siminoff, L. A. and Kwoh, C. K. [Louis Stokes Department of Veterans Affairs Medical Center, Cleveland, OH]. "Ethnic differences in the perception of prayer and consideration of joint arthroplasty." *Medical Care* 40, no. 6 (Jun 2002): 471-6. Comment on pp. 447-50.

[Abstract:] CONTEXT: Ethnic differences in utilization of arthroplasty may reflect differences in health-related attitudes and beliefs. OBJECTIVE: To examine ethnic differences in the perception and use of prayer in the treatment of arthritis and its role in patients' decision making toward surgery. DESIGN: A cross-sectional survey. SETTING: VA Primary Care Clinics. PATIENTS: Patients older than 50 years with chronic moderate-to-severe knee pain, hip pain, or both. MEASURES: The "helpfulness of prayer" in the treatment of arthritis and patients' attitude toward joint arthroplasty. RESULTS: Five hundred ninety-six veterans; 44% black patients, 56% white patients. Groups were comparable with respect to age (65 +/- 9.5 vs. 66 +/- 9), disease severity as assessed by WOMAC (47 +/- 17 vs. 45 +/- 17). Black patients scored higher than white patients on the religiosity scale (77 +/- 17 vs. 70 +/- 21). In multivariate analysis, black patients were more likely than white patients to perceive prayer as helpful in the management of their arthritis (OR, 2.1; 95% CI, 1.19, 3.72). Black patients were also less likely than white patients to consider surgery for severe hip/knee pain (OR, 0.58; 95% CI 0.34, 0.99); this relationship between ethnicity and consideration of surgery is mediated by perceptions of "helpfulness of prayer." The odds ratio for this relationship changes to 0.70 (P = 0.215). CONCLUSION: In this sample, black patients were more likely than white patients to perceive prayer as helpful and to have actually used prayer for their arthritis. Perception of helpfulness of prayer may be an important explanatory variable in the relationship between ethnicity and patients' decision in considering arthroplasty.

Antai-Otong, D. [Veterans Affairs, North Texas Health Care System, Employee Support Program, Ambulatory Care (11C), 4500 South Lancaster Rd., Dallas, TX 75216]. "Culturally sensitive treatment of African Americans with substance-related disorders." *Journal of Psychosocial Nursing & Mental Health Services* 40, no. 7 (Jul 2002): 14-21.

[From the abstract:] Spirituality, religion, families, and communities play key roles for African Americans with substance-related disorders.

Baetz, M., Larson, D. B., Marcoux, G., Jokic, R. and Bowen, R. [Department of Psychiatry, University of Saskatchewan, 103 Hospital Drive, Room 111, Ellis Hall, Saskatoon SK, Canada S7N 0W8]. "Religious psychiatry: the Canadian experience." *Journal of Nervous & Mental Disease* 190, no. 8 (Aug 2002): 557-9.

This survey of the religious beliefs and professional practices of Canadian Christian psychiatrists is complementary to a 1991 survey of American Christian Psychiatrists [Galanter, M., Larson, D. B. and Rubenstone, E. "Christian psychiatry: the impact of evangelical belief on clinical practice." *American Journal of Psychiatry* 148 (1991): 90-5.] and involved 35 of the 42 members of the psychiatry section of the Christian Medical and Dental Society in Canada. Among the findings: 80% make inquiries into their patients' spirituality, and 88% felt that their religiousness made them more compassionate than they would be otherwise. Seventy-five percent said that they were sensitive to issues of harmful religiousness or "spiritual abuse."

Barrows, K. A. and Jacobs, B. P. [Osher Center for Integrative Medicine, University of California-San Francisco, San Francisco, CA; kb1@onebox.com]. "Mind-body medicine. An introduction and review of the literature." *Medical Clinics of North America* 86, no. 1 (Jan 2002): 11-31. [Review, 91 refs.]

This article deals broadly with the concept of mind-body medicine and does not focus on spirituality, but it offers a good overview of the literature and a developing conceptualization that often informs clinical research into spirituality and health.

Beery, T. A., Baas, L. S., Fowler, C. and Allen, G. [University of Cincinnati, College of Nursing-Department of Adult Health, Institute for Nursing Research]. "Spirituality in persons with heart failure." *Journal of Holistic Nursing* 20, no. 1 (Mar 2002): 5-25; quiz 26-30.

[Abstract:] Spiritual expression has been proposed as a dimension of quality of life. Persons with chronic diseases such as AIDS or cancer have described the value of spiritual expression in living with their illnesses. The authors examined the role spirituality plays in the lives of 58 people with heart failure being treated medically or by transplant. Instruments used included the Medical Outcome Survey Short Form 36 and Index of Well-Being measures of quality of life, the Spiritual Well-Being Scale, and the Relative Importance Scale. Combined spirituality scores predicted 24% of the variance in global quality of life. There were no significant gender differences in spiritual well-being or quality of life.

Bell, I. R., Caspi, O., Schwartz, G. E., Grant, K. L., Gaudet, T. W., Rychener, D., Maizes, V. and Weil, A. [Program in Integrative Medicine, The University of Arizona Health Sciences Center, 1501 N. Campbell Ave, Tucson, AZ 85724; ibell@u.arizona.edu]. "Integrative medicine and systemic outcomes research: issues in the emergence of a new model for primary health care." *Archives of Internal Medicine* 162, no. 2 (Jan 28, 2002): 133-40.

[From the abstract:] Clinicians and researchers are increasingly using the term *integrative medicine* to refer to the merging of complementary and alternative medicine (CAM) with conventional biomedicine. However, combination medicine (CAM added to conventional) is not integrative. Integrative medicine represents a higher-order system of systems of care that emphasizes wellness and

healing of the entire person (bio-psycho-socio-spiritual dimensions) as primary goals, drawing on both conventional and CAM approaches in the context of a supportive and effective physician-patient relationship. Using the context of integrative medicine, this article outlines the relevance of complex systems theory as an approach to health outcomes research....

- Benn, C. and Hyder, A. A. [Department for Health Policy and Studies, German Institute for Medical Mission, Tübingen; benn@difaem.de]. **“Equity and resource allocation in health care: dialogue between Islam and Christianity.”** *Medicine, Health Care & Philosophy* 5, no. 2 (2002): 181-9. [Review, 19 refs.]
[From the abstract:] This article gives an overview on the positions of Islam and Christianity on equity and the distribution of resources in health care. It has been written in close collaboration and constant dialogue between the two authors coming from the two religions. Although there is no specific concept for the modern term equity in either of the two religions, several areas of agreement have been identified: All human beings share the same values and status, which constitutes the basis for an equitable distribution of rights and benefits. Special provisions need to be made for the most needy and disadvantaged. The obligation to provide equitable health services extends beyond national and religious boundaries. Several areas require intensified research and further dialogue: the relationship between the individual and the community in terms of rights and responsibilities, how to operationalize the moral duty to decrease global inequalities in health, and the understanding and interpretation of human rights in regard to social services.
- Berry, D. [University of Washington, Seattle, WA; berryd@u.washington.edu]. **“Does religious psychotherapy improve anxiety and depression in religious adults? A review of randomized controlled studies.”** *International Journal of Psychiatric Nursing Research* 8, no. 1 (Oct 2002): 875-90. [Review, 23 refs.]
[From the abstract:] Religious psychotherapy (RPT) is an approach to therapy that attempts to recognize and utilize the religious beliefs of clients in treatment for the purposes of reducing mental health difficulties. The purpose of this paper is to review the current randomized and controlled research (RCT) on the utilization of RPT in adult populations with anxiety and depressive disorders and to make recommendations for practice and future research. A search of the literature yielded four studies. A critical review of the studies yielded the following findings: (1) The findings across studies consistently demonstrate that RPT is as effective as standard treatment; (2) the results in each study were statistically significant and appeared to qualify as being clinically significant; and (3) the studies reviewed, although varying in quality, were true experiments marked by intervention, randomization, and control groups or comparison with standard treatment groups. There is warrant for greater consideration of the religious beliefs of depressed and anxious clients in outpatient settings....
- Bosch, F. and Banos, J. E. [Dept. of Pharmacology, Therapeutics, and Toxicology, School of Medicine, Universitat Autònoma de Barcelona, E-80832 Barcelona, Spain]. **“Religious beliefs of patients and caregivers as a barrier to the pharmacologic control of cancer pain.”** *Clinical Pharmacology & Therapeutics* 72, no. 2 (Aug 2002): 107-11. [Review, 27 refs.]
The authors address generally the idea that some religious beliefs may be problematic to pain management, drawing on a broad base of literature and giving an illustration that focuses on Christian beliefs.
- Boudreaux, E. D., O’Hea, E. and Chasuk, R. [Louisiana State University School of Medicine, Earl K. Long Medical Center, Emergency Medicine Residency Program, 5825 Airline Highway, Baton Rouge, LA 70805; eboudr@iamerica.net]. **“Spiritual role in healing. An alternative way of thinking.”** *Primary Care: Clinics in Office Practice* 29, no. 2 (Jun 2002): 439-54 and viii. [Review, 98 refs.]
[Abstract:] Research shows convincingly that patients with serious medical illnesses commonly use spiritual methods to cope with and manage their illnesses. This reliance on spirituality seems to be associated with a range of positive outcomes in the form of an enhanced sense of well-being, improved feelings of resiliency, and decreased adverse physical symptoms (e.g., pain and fatigue) and psychologic symptoms (e.g., anxiety). The methodologic flaws and limitations of this literature, however, make more research necessary before confident conclusions can be made regarding the objective, biologic benefit. Further efforts should focus on identifying the potential mechanisms through which spirituality enhances both subjective and objective outcomes. Care should be taken to use reliable, valid spirituality assessment measures and more advanced methodologic designs, such as prospective, longitudinal studies, and randomized, controlled trials.
- Breitbart, W. [Psychiatry Service, Department of Psychiatry and Behavioral Sciences, Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, Box 421, New York, NY 10021; breitbaw@mskcc.org]. **“Spirituality and meaning in supportive care: spirituality- and meaning-centered group psychotherapy interventions in advanced cancer.”** *Supportive Care in Cancer* 10, no. 4 (May 2002): 272-80. [Review, 88 refs.]
[Abstract:] Existential and spiritual issues are at the frontier of new clinical and research focus in palliative and supportive care of cancer patients. As concepts of adequate supportive care expand beyond a focus on pain and physical symptom control, existential and spiritual issues such as meaning, hope and spirituality in general have received increased attention from supportive care clinicians and clinical researchers. This paper reviews the topics of spirituality and end-of-life care, defines spirituality, and suggests measures of spirituality that deal with two of its main components: faith/religious beliefs and meaning/spiritual well-being. These two constructs of spirituality are reviewed in terms of their role in supportive care. Finally, a review of existing psychotherapeutic interventions for spiritual suffering are reviewed and a novel meaning-centered group psychotherapy for advanced cancer patients is described.
- Carosella J. [Gambro Healthcare-Hartford, Hartford]. **“Incorporating spirituality into the delivery of dialysis care: one team’s perspective.”** *Advances in Renal Replacement Therapy* 9, no. 2 (Apr 2002): 149-51. [Review, 2 refs.]
[Abstract:] The importance of spirituality and organized religion in coping with chronic kidney disease (CKD) and other medical illnesses has been cited in the literature in recent years. This article describes how one dialysis unit recognized the importance of spiritual resources for patients and incorporated the role of chaplain into its interdisciplinary health care team. The resulting enhancement of team functioning and sensitivity to patients’ spiritual needs is discussed.
- Carter, H. [Dept. of Psychiatry, Duke Univ. Medical Center, Durham, NC 27710]. **“Religion/spirituality in African-American culture: an essential aspect of psychiatric care.”** *Journal of the National Medical Association* 94, no. 5 (May 2002): 371-5.

[From the abstract:] ...Asking about religion/spirituality during a health assessment can help the physician determine whether religious/spiritual factors will influence the patient's medical decisions and compliance. Two psychiatric case histories of African Americans are presented in which religion/spirituality significantly influenced treatment decisions and results. Neither of these patients suffered major debilitating medical comorbidity.

Chase-Ziolek, M. and Iris, M. [Health Ministry Programs, North Park Theological Seminary, 3225 W. Foster Avenue, Chicago, IL 60625-4895; mchase-ziolek@northpark.edu]. **"Nurses' perspectives on the distinctive aspects of providing nursing care in a congregational setting."** *Journal of Community Health Nursing* 19, no. 3 (Fall 2002): 173-86.

[Abstract:] As the number of parish nurses grow, it is important to understand the unique attributes of providing nursing care in a congregation. Through a focus group and interviews, this qualitative research study explored this question with 17 parish nurses participating in a hospital-sponsored, volunteer health ministry program. Content analysis revealed the nurses felt they had the greatest impact through health promotion and prevention, advocacy, health education, and health counseling, including psychosocial support and spiritual care. The nurses appreciated the unique opportunities afforded by the congregational setting including integrating faith and health in nursing practice, the more relaxed environment, the opportunity for long-term relationships, and the level of professional autonomy. Challenges were experienced from the client's autonomy, the impact of religious beliefs, the nurse's worship experience, and time constraints. This study demonstrates that parish nurses can provide a valuable adjunct to the traditional care system as they practically and conceptually integrate faith and health.

Chibnall, J. T., Videen, S. D., Duckro, P. N. and Miller, D. K. [Department of Psychiatry, Saint Louis University School of Medicine, St. Louis, MO 63104; chibnajt@slu.edu]. **"Psychosocial-spiritual correlates of death distress in patients with life-threatening medical conditions."** *Palliative Medicine* 16, no. 4 (Jul 2002): 331-8.

[From the abstract:] The purpose of this study was to identify demographic, disease, health care, and psychosocial-spiritual factors associated with death distress (death-related depression and anxiety). Cross-sectional baseline data from a randomized controlled trial were used. Outpatients (n=70) were recruited from an urban academic medical center and proprietary hospital. ...In a hierarchical multiple regression model, higher death distress was significantly associated with living alone, greater physical symptom severity, more severe depression symptoms, lower spiritual well-being, and less physician communication as perceived by the patient. Death distress as a unique experiential construct was discriminable among younger patients with specific, diagnosable life-threatening conditions, but less so among geriatric frailty patients. The findings suggest that the experience of death distress among patients with life-threatening medical conditions is associated with the psychosocial-spiritual dimensions of the patient's life. Attention to these dimensions may buffer the negative affects of death distress.

Collins, A. [King's College, University of London]. **"Nursing with dignity. Part 1: Judaism."** *Nursing Times* 98, no. 9 (Feb 28-Mar 6, 2002): 34-5.

This first installment of a nine-part series addresses issues of religious diversity in health care very practically, beginning with issues concerning Jewish patients.

Coyle, J. [joanne.coyle1@btopenworld.com]. **"Spirituality and health: towards a framework for exploring the relationship between spirituality and health."** *Journal of Advanced Nursing* 37, no. 6 (Mar 2002): 589-97.

[Abstract:] BACKGROUND: A growing body of evidence has found that spirituality enhances health. However, spirituality is an elusive concept that defies clear definition. This inevitably presents difficulties when comparing the findings of studies. Therefore conceptual clarification is essential if practitioners are to better understand the relationship between spirituality and health. AIMS: The aim of this paper is to develop a conceptual framework, which can be used to explore the relationship between spirituality and health. METHODS: The concept-indicator model was used to analyze spirituality in the literature. The literature was searched for empirical indicators or what are taken as essential attributes of spirituality. Similarities and differences between approaches were identified and these formed the basis of a framework. FINDINGS: The analysis identified three approaches (a trichotomy) to spirituality in the literature. These were termed the transcendent, the value guidance and the structuralist-behaviourist approaches. The paper shows how by clarifying the different conceptualizations of spirituality and the interrelationship between them researchers can also clarify their respective contributions to health. Thus a contribution is made towards making more explicit the ways in which key aspects of spirituality such as transcendence, meaning and purpose, connectedness, hope, and faith, work to produce health benefits in terms of prevention, recovery from illness, or coping with illness. CONCLUSIONS: The framework (or trichotomy) will enable practitioners to understand better the connection between spirituality and health. In particular, it will show that to appreciate the benefits that patients might experience from their value or belief systems, practitioners must actively explore the content of those systems in a respectful way.

Crowther, M. R., Parker, M. W., Achenbaum, W. A., Larimore, W. L. and Koenig, H. G. [Department of Psychology, The University of Alabama, Tuscaloosa, AL 35487-0348; crowther@bama.ua.edu]. **"Rowe and Kahn's model of successful aging revisited: positive spirituality--the forgotten factor."** *Gerontologist* 42, no. 5 (Oct 2002): 613-20. [Review, 57 refs.]

[From the abstract:] PURPOSE: We explain a new concept, positive spirituality, and offer evidence that links positive spirituality with health; describe effective partnerships between health professionals and religious communities; and summarize the information as a basis for strengthening the existing successful aging model proposed by Rowe and Kahn....

Cutcliffe, J. R. and Herth, K. [University of Alberta, Canada]. **"The concept of hope in nursing 1: its origins, background and nature."** *British Journal of Nursing* 11, No. 12 (Jun 27-Jul 10, 2002): 832-40. [Review, 19 refs.]

In this first article of a six-part series, the authors offer a general introduction to the concept of hope--including attention to philosophical backgrounds such as those from Existentialist and Christian traditions—with an eye to the clinical context. (Other articles in the series by these two authors may be found in issues 13, 14, 17, 18 and 21.)

Daaleman, T. P., Frey, B. B., Wallace, D. and Studenski, S. A. [Department of Family Medicine, University of Kansas Medical Center, Kansas City; tim_daaleman@med.unc.edu]. **"Spirituality Index of Well-Being Scale: development and testing of**

- a new measure.” *Journal of Family Practice* 51, no. 11 (Nov 2002): 952. [Abstract (only) appears in the print journal, with a reference to the complete article in the journal's on-line pages.]
 [Abstract:] OBJECTIVE: To evaluate the reliability and validity of the Spirituality Index of Well-Being (SIWB) Scale in a patient population. STUDY DESIGN: Cross-sectional survey. POPULATION: Community-dwelling elderly individuals (n = 277) recruited from primary care clinic sites in the Kansas City metropolitan area. OUTCOMES MEASURED: Internal consistency, concurrent construct validity, discriminant validity, and factor analysis with Varimax rotation. RESULTS: The initial version of the SIWB contained 40 items: 20 from a self-efficacy domain and 20 from a life scheme domain. Factor analysis yielded 6 items loaded most strongly on factor 1 (intrapersonal self-efficacy) and 6 other items loaded strongly on factor 2 (life scheme). The Self-efficacy subscale had an alpha of .83 and the Life Scheme subscale had an alpha of .80; the total 12-item SIWB Scale had an alpha of .87. The SIWB had significant and expected correlations with other quality-of-life measures related to subjective well-being: EuroQol (r = .18), Geriatric Depression Scale (r = -.35), the Physical Functioning Index from the Short Form 36 (r = .28), and the Years of Healthy Life Scale (r = -.35). Religiosity did not correlate significantly with the SIWB (r = .12, P = .056). CONCLUSIONS: The 12-item SIWB Scale is a valid and reliable measure of subjective well-being in an older patient population.
- Darr, K. [Department of Health Services Management and Policy, George Washington University, Washington, DC]. “**Cultural, ethnic, and religious diversity in service delivery.**” *Hospital Topics* 80, no. 1 (Winter 2002): 29-33.
 The authors address generally issues of diversity in the practical delivery of health care services, with examples from various cultural, ethnic, and religious traditions.
- Davies, B., Brenner, P., Orloff, S., Sumner, L. and Worden, W. [Department of Family Health Care Nursing, School of Nursing, University of California, San Francisco, CA]. “**Addressing spirituality in pediatric hospice and palliative care.**” *Journal of Palliative Care* 18, no. 1 (Spring 2002): 59-67. [Review, 55 refs.]
 [Abstract:] Hospice and palliative care principles mandate clinicians to provide "total" care to patients and their families. Such care incorporates not only physical, emotional, and psychosocial care, but spiritual care as well. Even though considerable attention has been directed to spiritual issues for adult patients in hospice and palliative care, spirituality in pediatric palliative care has been virtually neglected. The need for guidelines to assess spirituality in this population was identified as a priority issue by members of a subcommittee of the Children's International Project on Children's Palliative/Hospice Services, created under the auspices of the National Hospice Organization. Committee members, based on their clinical, research, and personal experiences, identified several aspects relevant to spirituality in general, and to spirituality in pediatric palliative care in particular, and developed guidelines for clinicians in pediatric palliative care. The purpose of this paper is to share the results of this committee's work and, in particular, to present their guidelines for addressing spiritual issues in children and families in pediatric hospice and palliative care.
- Deatcher, J. [Seelig Regional Diabetes Education Center, Catskill Regional Medical Center, Harris, NY; JD198@aol.com]. “**Use of prayer in diabetes self-management.**” *Diabetes Educator* 28, no. 3 (May-Jun 2002): 390-4.
 This small study of 9 participants and 9 control group members, all with type-2 diabetes used Rossiter-Thornton's "Prayer Wheel" as an intervention for 3 months. Results suggest possible beneficial effects for the intervention group's A1C values. [NOTE: For more on the "Prayer Wheel," see Rossiter-Thornton, J. F. "Prayer in your practice," also listed in this bibliography.]
- Dell'Orfano, S. [N Neurosurgery, The Children's Hospital of Denver, 1056 East 19th Avenue, Denver, CO 80218; shelley.dellorfano@uchsc.edu]. “**The meaning of spiritual care in a pediatric setting.**” *Journal of Pediatric Nursing* 17, no. 5 (Oct 2002): 380-5.
 This is a report of [from the abstract:] an evidence-based clinical project that evolved from a nurse's recognition of the importance of spiritual care for families of children with serious brain injuries, [and it is presented as an example of] how an evidence-based practice formula can facilitate change and innovation
- Dendaas, N. R. [University of Wisconsin, Milwaukee, WI; ndendaas@uwm.edu]. “**Prognostication in advance cancer: nurses' perceptions of the dying process.**” *Oncology Nursing Forum* 29, no. 3 (Apr 2002): 493-9.
 [From the abstract:] PURPOSE/OBJECTIVES: To determine how experienced nurses describe the dying process of patients with advanced cancer. SAMPLE/SETTING: Fifteen nurses, experienced in the care of patients with advanced cancer, employed by a midsize midwestern hospice or academic inpatient oncology unit. METHODS: Individual interviews using structured and semi-structured questions. Responses were content-analyzed using Krippendorff's techniques. ...FINDINGS: Nurses view the dying process as a weeks-to-months-long, multidimensional process that encompasses physical, psychosocial, and spiritual/existential domains....
- Derose, K. P., Duan, N. and Fox, S. A. [Department of Health Services, UCLA School of Public Health, RAND Health]. “**Women's receptivity to church-based mobile mammography.**” *Journal of Health Care for the Poor & Underserved* 13, no. 2 (May 2002): 199-213.
 [Abstract:] Mobile mammography can increase access to preventive screening and might be effective in church-based settings. Among 1,117 women ages 50 to 80 from 45 Los Angeles County churches, 31.7 percent said they would definitely use a mobile van at church, 21.9 percent would probably use one, 28.7 percent would probably not use one, and 17.6 percent would definitely not use one. The odds of saying yes to mobile mammography were six times higher for Spanish-speaking Latinas than for whites, over two times higher for English-speaking nonwhites than for whites, five times higher for the uninsured than for those with public or private health insurance, and three times higher for women who reported no mammogram in the previous 24 months than for women who reported a mammogram. Partnering with churches to provide mobile mammography offers the potential to increase screening adherence for traditionally underscreened women.
- Desai, P. P., Ng, J. B. and Bryant, S. G. [Patient and Family Support Services, Sibley Heart Center, Children's Healthcare of Atlanta, Atlanta, GA]. “**Care of children and families in the CICU: A focus on their developmental, psychosocial, and spiritual needs.**” *Critical Care Nursing Quarterly* 25, no. 3 (Nov 2002): 88-97. [Review, 24 refs.]

[Abstract:] The staff of Patient and Family Support Services oversees the developmental, psychosocial, and spiritual care of the child in the cardiac intensive care unit. Staff collaborate with medical team members, as well as the patient's family, to promote holistic care. This article describes the roles and responsibilities of the child life specialist, the social worker, and the chaplain and identifies discipline-specific assessment techniques and interventions. The article highlights identified needs of children and their families, offering tools and interventions health care clinicians can use in the cardiac intensive care unit.

Dorff, E. N. [University of Judaism, Los Angeles, CA]. "**Setting moral limits on technology. The Jewish perspective differs in some ways from Catholic and Protestant ones.**" *Health Progress* 83, no. 1 (Jan-Feb 2002): 39-43, 54.

The author addresses the topic of biotechnology from a Jewish moral perspective (with some attention to contrasting with Christian perspectives), including the application to such areas as stem cell research and gene therapy.

Dossey, L. "**How healing happens: exploring the nonlocal gap.**" *Alternative Therapies in Health & Medicine* 8, no. 2 (Mar-Apr 2002): 12-6, 103-10.

This essay by a well-published physician explores the phenomenon of "distant healing," understandings of its possible means of occurrence, and implications for research.

Duldt, B. W. [College of Nursing and Health Science, George Mason University, Fairfax, VA; bduldt@gmu.edu]. "**The spiritual dimension of holistic care.**" *Journal of Nursing Administration* 32, no. 1 (Jan 2002): 20-4.

The author, a nurse who has been a volunteer with a hospital pastoral care department for three years, identifies 27 "services or activities" of hospital pastoral care departments that may be incorporated into the practices of a variety of health care professionals to the purpose of broadening the provision of holistic care.

Dusek, J. A., Sherwood, J. B., Friedman, R., Myers, P., Bethea, C. F., Levitsky, S., Hill, P. C., Jain, M. K., Kopecky, S. L., Mueller, P. S., Lam, P., Benson, H. and Hibberd, P. L. [Mind/Body Medical Institute, Beth Israel Deaconess Medical Center, Caregroup, Department of Medicine, Harvard Medical School, Boston, MA 02215; jdusek@caregroup.harvard.edu]. "**Study of the Therapeutic Effects of Intercessory Prayer (STEP): study design and research methods.**" *American Heart Journal* 143, no. 4 (Apr 2002): 577-84.

[Abstract:] BACKGROUND: The effect of intercessory prayer (IP) on outcome in cardiac cases has been evaluated previously, but results are controversial. The goals of the Study of the Therapeutic Effects of Intercessory Prayer (STEP) are to evaluate the effects of receipt of additional study IP and awareness of receipt of additional study IP on outcomes in patients undergoing coronary artery bypass graft surgery. STEP is not designed to determine whether God exists or whether God does or does not respond to IP. METHODS: STEP is a multicenter, controlled trial of 1802 patients in 6 US hospitals, randomized to 1 of 3 groups. Two groups were informed that they may or may not receive 14 consecutive days of additional IP starting the night before coronary artery bypass graft surgery; Group 1 received IP, Group 2 did not. A third group (Group 3) was informed that they would receive additional IP and did so. Three mainstream religious sites provided daily IP for patients assigned to receive IP. At each hospital, research nurses blinded to patient group assignment reviewed medical records to determine whether complications occurred, on the basis of the Society for Thoracic Surgeons definitions. A blinded nurse auditor from the Coordinating Center reviewed every study patient's data against the medical record before release of study forms. RESULTS: The STEP Data and Safety Monitoring Board reviewed patient safety and outcomes in the first 900 study patients. Patients were enrolled in STEP from January 1998 to November 2000.

Ebright, P. R. and Lyon, B. [School of Nursing, Indiana University, Indianapolis, IN; prebrigh@iupui.edu]. "**Understanding hope and factors that enhance hope in women with breast cancer.**" *Oncology Nursing Forum* 29, no. 3 (Apr 2002): 561-8.

[From the abstract:] Self-esteem and helpfulness of religious beliefs influence women's appraisals regarding the potential for coping; appraisals and antecedent variables relevant for differentiating hope are beliefs about the potential for coping, self-esteem, and social support. IMPLICATIONS FOR NURSING: Care of women with breast cancer during the first year of treatment should include assessment of beliefs regarding the potential for coping. Results suggest that support for interventions related to self-esteem, social support, and helpfulness of religious beliefs increase confidence in coping abilities and hope.

Efficace, F. and Marrone, R. [European Organisation for Research and Treatment of Cancer, Brussels, Belgium; fef@eortc.be]. "**Spiritual issues and quality of life assessment in cancer care.**" *Death Studies* 26, no. 9 (Nov 2002): 743-56.

[Abstract:] Being diagnosed with cancer forces most human beings to face their own death. The comfortable sense of both invulnerability and immortality is shattered, making the patient thoroughly aware that life is finite and limited. Approaching death, cancer patients commonly embark on an inner journey involving a search for meaning as well as a reordering of priorities involving physical, psychological, social, and spiritual needs. Although interest in the role of spirituality, relating to both adjustment to cancer and the overall quality of life of cancer patients, has increased in recent years, most of the commonly used quality of life (QOL) instruments in oncology typically do not include spiritual issues. In this article, it is argued that assessing QOL effectively should involve all aspects of the personality, including mind, body, and spirit as well. This article also reviews recent studies, which have shown that spiritual well-being, although a many-sided and difficult construct to define, is closely related to the QOL of cancer patients. It is also suggested that further research is needed to understand how the new focus on spirituality can contribute to a more comprehensive assessment of patient's QOL in cancer care.

Eliasi, J. R. and Dwyer, J. T. "**Kosher and Halal: religious observances affecting dietary intakes.**" *Journal of the American Dietetic Association* 102, no. 7 (Jul 2002): 911-3.

The authors offer practical explanations of Jewish and Muslim dietary laws.

Ellis, M. R., Campbell, J. D., Detwiler-Breidenbach, A. and Hubbard, D. K. [Cox Health Systems, Family Practice Residency Program, Springfield, MO 65802; mellis@coxnet.org]. "**What do family physicians think about spirituality in clinical practice?**" *Journal of Family Practice* 51, no. 3 (Mar 2002): 249-54.

[Abstract:] OBJECTIVES: To describe the context in which physicians address patients' spiritual concerns, including their attitudes toward this task, cues to discussion, practice patterns, and barriers and facilitators. STUDY DESIGN: This was a qualitative study using semistructured interviews of 13 family physicians. POPULATION: We selected board-certified Missouri family physicians in a nonrandom fashion to represent a range of demographic factors (age, sex, religious background), practice types (academic/community practice; urban/rural), and opinions and practice regarding physicians' roles in addressing patients' spiritual issues. OUTCOMES MEASURED: We coded and evaluated transcribed interviews for themes. RESULTS: Physicians who reported regularly addressing spiritual issues do so because of the primacy of spirituality in their lives and because of the scientific evidence associating spirituality with health. Respondents noted that patients' spiritual questions arise from their unique responses to chronic illness, terminal illness, and life stressors. Physicians reported varying approaches to spiritual assessment; affirmed that spiritual discussions should be approached with sensitivity and integrity; and reported physician, patient, mutual physician-patient, and situational barriers. Facilitators of spiritual discussions included physicians' modeling a life that includes a spiritual focus. CONCLUSIONS: These physicians differ in their comfort and practice of addressing spiritual issues with patients but affirm a role for family physicians in responding to patients' spiritual concerns. Factors that form a context for discussions of spiritual issues with patients include perceived barriers, physicians' role definition, familiarity with factors likely to prompt spiritual questions, and recognition of principles guiding spiritual discussions.

Fiala, W. E., Bjorck, J. P. and Gorsuch, R. [Azusa Pacific University, USA]. **"The Religious Support Scale: construction, validation, and cross-validation."** *American Journal of Community Psychology* 30, no. 6 (Dec 2002): 761-86.

[Abstract:] Cutrona and Russell's social support model was used to develop a religious support measure (C. E. Cutrona & D. W. Russell, 1987), including 3 distinct but related subscales respectively measuring support from God, the congregation, and church leadership. Factor analyses with the main sample's data (249 Protestants) and cross-validation (93 additional Protestants) supported the scales' reliability and validity. All 3 types of religious support were related to lower depression and greater life satisfaction. Moreover, several relationships between the 3 subscales and psychological functioning variables remained significant after controlling for variance because of church attendance and social support. Results suggest that religious attendance does not automatically imply religious support, and that religious support can provide unique resources for religious persons, above and beyond those furnished by social support. Findings are discussed regarding relevance to community psychology.

Finfgeld, D. L. [University of Missouri-Columbia]. **"Feminist spirituality and alcohol treatment."** *Journal of Holistic Nursing* 20, no. 2 (Jun 2002): 113-27; quiz 128-32. [Review, 32 refs.]

[Abstract:] Although there is some evidence that spirituality may play a role in successful resolution of alcohol problems, there are those who assert that traditional androcentric theologies may be detrimental to the healing process among women. Within conventional religious traditions, women have been relegated to positions of diminished status and power and may be subject to expectations of self-abnegation. For these reasons, asserting powerlessness and abdicating control to a male-defined deity may be nontherapeutic. In contrast, feminist spirituality represents a collage of traditions that enable women to identify the divine within and find strength and power through their interpersonal relationships and lived experiences. Together, the foci of feminist spirituality and women's health care provide new perspectives for alcohol treatment. Nurses need to become aware of these viewpoints and ways in which they can be integrated into their practices.

Flannelly, L. T., Flannelly, K. J. and Weaver, A. J. [School of Nursing and Dental Hygiene, University of Hawaii at Manoa, Honolulu, HI; flannel@hawaii.edu]. **"Religious and spiritual variables in three major oncology nursing journals: 1990-1999."** *Oncology Nursing Forum* 29, no. 4 (May 2002): 679-85.

[Abstract:] PURPOSE/OBJECTIVES: To review qualitative and quantitative research studies measuring religious and spiritual variables published in American oncology nursing journals from 1990-1999 and the types of measures used. DATA SOURCES: All research studies published from 1990-1999 in *Oncology Nursing Forum*, *Cancer Nursing*, and the *Journal of Pediatric Oncology Nursing*. DATA SYNTHESIS: A higher percentage of qualitative (27%) than quantitative (14%) oncology nursing studies reported findings on religious and spiritual variables. Religion or spirituality was the major focus of 14% of qualitative studies, and these concepts emerged in qualitative studies even when they were not a study's research focus. Religion or spirituality was the primary independent or dependent variable in 10% of quantitative studies and was a prominent measure in quantitative studies on patients' needs, coping, and quality of life. CONCLUSIONS: Nursing researchers in oncology are more likely to study issues relating to religion and spirituality than researchers in other fields of nursing, and substantially more research on these topics has been reported in oncology nursing than in the research literature on psychology or various fields of medicine. IMPLICATIONS FOR NURSING: Implications include the value of (a) combining qualitative and quantitative methods in a single study, (b) incorporating demographic measures, such as religious denomination, as independent variables in analyses, (c) using separate and multiple measures of religion and spirituality in research, and (d) differentiating between religious and spiritual needs in research and practice.

Friedemann, M. L., Mouch, J. and Racey, T. [School of Nursing, Florida International University, Biscayne Bay Campus, Miami, FL; friedemm@fiu.edu]. **"Nursing the spirit: the framework of systemic organization."** *Journal of Advanced Nursing* 39, no. 4 (Aug 2002): 325-32.

[Abstract:] AIMS. To elucidate the concept of spirituality as an essential and integrated dimension of the functioning of individuals and families through the Framework of Systemic Organization (Friedemann 1995) and to demonstrate with a case example, how a nurse can integrate spirituality in the care of a terminally ill patient. ...IMPLEMENTATION OF THE THEORETICAL FRAMEWORK. Spirituality is defined as connecting to systems such as God, nature or other people, and thus finding meaning through relationships. Key to spiritual care is the establishment of a balance between control and spirituality that is tailored to an individual patient's history, values and needs. A case example is used to show how a nurse intervenes with a patient who faces death. FINDINGS. The example shows that control remains important in a patient's life process until death arrives. Nevertheless, a dying patient benefits from an increasing focus on spirituality to gain self-acceptance, reconciliation with the family and restoration of emotional health. Nurses are instrumental in finding the balance between control and spirituality that a patient desires. CONCLUSION. Nurses who have explored and reconciled their own spiritual beliefs can learn to address their patients' unique needs within the broad context of family and environment. Nursing the spirit by using the Framework of Systemic Organization is a client-directed and intimate process that leads to growth of both patient and nurse.

- Gallagher, E. B., Wadsworth, A. L. and Stratton, T. D. [Department of Behavioral Science, College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086]. **“Religion, spirituality, and mental health.”** *Journal of Nervous & Mental Disease* 190, no. 10 (Oct 2002): 697-704.
This authors addresses broadly the place of spirituality in US health care and identify various “platforms” for discourse on the subject.
- Gardner, A. P. [ILO Photographic Unit, 330 Gray's Inn Road, London WC1X 8EE, UK. a.gardner@ucl.ac.uk]. **“Exposing the body—baring the soul.”** *Journal of Audiovisual Media in Medicine* 25, no. 2 (Jun 2002): 64-8.
[Abstract:] It is often considered important that clothing should not be visible in a good medical photograph. Medical illustrators offer the clinical professionalism to allow most of their patients to feel comfortable being photographed. For some patients, however, consenting to medical photography involves more than a temporary embarrassment. This paper seeks to explore some of the religious and cultural beliefs that the medical photographer may be asking the patient to compromise in the studio.
- Gatrad, A. R. and Sheikh, A. [Manor Hospital, Birmingham University, UK]. **“Palliative care for Muslims and issues before death.”** *International Journal of Palliative Nursing* 8, no. 11 (Nov 2002): 526-31.
[From the abstract:] National and European directives have now enshrined within European law the requirement that healthcare professionals provide their patients with culturally appropriate and sensitive care. Although well intentioned, many health professionals find it difficult to translate these directives into practice. Barriers to providing culturally competent care include racism, institutional discrimination and gaps in our understanding of the interface between culture and health--this latter factor reflecting the lack of training in transcultural health care. In this paper, we concentrate on issues relating to the provision of palliative care near death to Muslims of South Asian origin in the UK, although much of what is said will equally be applicable to Muslims from other parts of the world. This is the first of two articles giving insights into the palliative care of Muslims....
- Gatrad, R. and Sheikh, A. [Manor Hospital, Walsall NHS Trust, UK]. **“Palliative care for Muslims and issues after death.”** *International Journal of Palliative Nursing* 8, no. 12 (Dec 2002): 594-7.
[From the abstract:] ...We focus on death customs and bereavement. We cover issues relating to the immediate handling of the body after death, washing the deceased and reasons for early burial. Muslim views on post-mortems and organ transplantation are explored. In addition to sharing information on practices common among Muslim communities, we also provide practical advice on the day-to-day issues that may arise when caring for a 'recently deceased' Muslim patient and his or her relatives.
- George, L. K. [Department of Sociology, Institute for Care at the End of Life, Duke University, Durham, NC 27708; lkg@geri.duke.edu]. **“Research design in end-of-life research: state of science.”** *Gerontologist* 42, Spec. No. 3 (Oct 2002): 86-98. [Review, 98 refs.]
[From the abstract:] Gaps in the research base include insufficient attention to psychological and spiritual issues, the prevalence of psychiatric disorder and the effectiveness of the treatment of such disorders among dying persons, provider and health system variables, social and cultural diversity, and the effects of comorbidity on trajectories of dying.
- Ghalib, K. and Peralta, L. [University of Maryland School of Medicine, Department of Pediatrics, Division of Adolescent and Young Adult Medicine, 120 Penn Street, Baltimore, MD 21201]. **“AIDS and Islam in America.”** *Journal of the Association for Academic Minority Physicians* 13, no. 2 Apr 2002): 48-52. [NOTE: Erratum appears in *Journal of the Association for Academic Minority Physicians* 13, no. 3 (July 2002): 65.]
[Abstract:] Islam is the fastest growing religion in the United States. African Americans make up the largest part of the Muslim community in America, and they are also the individuals at greatest risk for contracting HIV. With the objective of understanding the impact of religious and cultural beliefs on HIV risk behaviors, this article reviews the literature on HIV and AIDS in Muslim communities in America. While no specific data exists regarding HIV seroprevalence or the risk factors for transmission of HIV in specifically American Muslim communities, the available information is presented describing American Muslims' attitudes and beliefs regarding HIV. Furthermore, in order to help clinicians improve the delivery of HIV preventive services to members of these communities, Islamic doctrine is described in relation to the three main risk factors for acquiring HIV: sexual activity, drug use and perinatal transmission. American Muslims make up a diverse population which have unique needs regarding prevention of HIV and AIDS. These needs must be more fully investigated and understood in order to minimize rates of HIV transmission in these rapidly growing communities.
- Gill, B. K. [Thames Valley University, Stough]. **“Nursing with dignity. Part 6: Sikhism.”** *Nursing Times* 98, no. 14 (Apr 2-8, 2002): 39-41.
[Abstract:] This article describes the main teachings and customs of Sikhism. It offers some guidelines to enable nurses to provide sensitive and appropriate nursing care to Sikh patients.
- Gilmer, M. J. [Vanderbilt Univ. School of Nursing, Nashville, TN; maryjo.gilmer@vanderbilt.edu]. **“Pediatric palliative care: a family-centered model for critical care.”** *Critical Care Nursing Clinics of North America* 14, no. 2 (Jun 2002): 207-14.
[Abstract:] ...Children with life-threatening conditions and their families and communities may benefit from a family-centered model of pediatric palliative care. Benefits from its implementation are not just at the end of life, but throughout the course of therapy. Compassion coupled with a holistic approach incorporating humane and family-centered care is essential in meeting physical, mental, and spiritual needs....
- Gordon, J. S., Blackhall, L., Bastis, M. K. and Thurman, R. A. [Georgetown University Medical School, Washington, DC]. **“Asian spiritual traditions and their usefulness to practitioners and patients facing life and death.”** *Journal of Alternative & Complementary Medicine* 8, no. 5 (Oct 2002): 603-8.
In this report of a panel presentation, a physician, a chaplain, and a professor of Indo-Tibetan studies address issues of end-of-life care with attention to Asian spiritual traditions, illustrating their points with case anecdotes and offering practical guidance to clinicians.

- Graves, D. L., Shue, C. K. and Arnold, L. [University of Missouri-Kansas City, School of Medicine, 64108; GravesD@umkc.edu]. **“The role of spirituality in patient care: incorporating spirituality training into medical school curriculum.”** *Academic Medicine* 77, no. 11 (Nov 2002): 1167.
 [Abstract:] OBJECTIVE: To answer the call for the implementation of spirituality into medical school curriculum.(1) UMKC-School of Medicine has incorporated experiential spirituality instruction into the third year of a six-year combined BA-MD degree program. The multifaceted objective of the program is to (1) expand students' conceptualization of the patient as person to include dimensions of spiritual beliefs and needs, (2) develop an understanding of how patients' spiritual belief systems impact their health, (3) recognize how the student's spiritual beliefs impact his or her practice of medicine, and (4) highlight the value of the chaplain as a member of the health care team. With increased understanding of the role spirituality plays in healing as well as the spiritual services available to patients, students will be able to serve the needs of their patients. DESCRIPTION: To accomplish this objective, students participate in lectures on spirituality, small-group activities focusing on skills such as taking/crafting spiritual histories, and an on-call experience with a hospital chaplain. During the oncall experience, students shadow a chaplain for approximately six hours. The experience includes discussing philosophies of spirituality and medicine with the chaplain, rounding with the chaplain, visiting and praying with patients when requested, comforting family members, and assisting with advance directive discussions and paperwork. After completing the experience, the students are required to write a reflective essay examining the following components: (1) the interaction between the chaplain and other members of the health care team, (2) the utilization of alternative interview and history taking methods, (3) the connection between spirituality and illness as illustrated through patient encounters, and (4) the insights gained from the experience that can be applied to the practice of medicine. DISCUSSION: The writing of one's spiritual history and the on-call experience were integrated into a new portion of the curriculum. The components were initially met with some reticence. In the beginning, students had difficulty distinguishing spirituality from religion and were concerned that the curriculum would take away from their study of "real medicine." To ease concerns regarding the spiritual history, the course director modeled the objectives by sharing her own spiritual journey. Participation in the on-call experience substantially changed students' negative attitudes toward the curriculum. Essays revealed that the on-call experience had greatly impacted their view of the chaplain as well as their practice of medicine. Specifically, students demonstrated an understanding of the role of spirituality in healing, identified key components of the chaplain role in the hospital setting, shared ways in which they would utilize chaplains in the future, and discovered personal struggles. Crafting one's spiritual history, the on-call experience, and essays will continue to be a required part of the third-year curriculum. Modifications include adding the option of constructing one's own advance directive and striving for increased diversity of spiritual perspectives. The data provided in the essays and course evaluations will be utilized in several ways to determine the success of the curriculum and to answer critical research questions in the areas of spirituality and medical education.
- Guillaume, C. and McMillan, K. [Nursing Spiritual Care and Development, Loma Linda University Medical Center, Loma Linda, CA]. **“Spirit lifting.”** *Nursing Management (Springhouse)* 33, no. 6 (Jun 2002): 39-40.
 This description of a staff stress management program uses the language of spirituality very broadly, but the program contains a prayer component.
- Hinshaw, D. B. [Department of Surgery, VA Ann Arbor Healthcare System and University of Michigan, Ann Arbor, MI 48105]. **“The spiritual needs of the dying patient.”** *Journal of the American College of Surgeons* 195, 4 (Oct 2002): 565-8; discussion on pp. 568-9.
 The author offers a brief overview of the spiritual needs of dying patients, their assessment, and examples of means by which such needs may be addressed.
- Hoover, J. [School of Nursing and Midwifery Studies, University of Wales College of Medicine, Heath Park, Cardiff, UK; hooverj11@cf.ac.uk]. **“The personal and professional impact of undertaking an educational module on human caring.”** *Journal of Advanced Nursing* 37, no. 1 (Jan 2002): 79-86.
 [From the abstract:] ...RESEARCH METHODS: A full cohort of 25 part-time students, divided into four groups, participated in audiotaped focus groups before and after undertaking the module. FINDINGS: From a personal perspective, the students experienced increased spiritual awareness characterized by: (1) enhanced connecting relationships with self and others, (2) finding purpose and meaning in life, and (3) clarification of values. Professionally, the module resulted in: (1) an increased knowledge and understanding of caring theory and related concepts, (2) a more holistic approach to care, and (3) enhanced caring practice. CONCLUSIONS: Education may enhance students' capacity to be caring practitioners. Spirituality, in particular, was illuminated for the students as an important means of developing both themselves and their caring practices. They experienced transformative learning, and the focus groups, employed as the research method, served as a useful vehicle in this process. Reflective groups will be used as a teaching method on future modules.
- Husaini, B. A., Sherkat, D. E., Levine, R., Bragg, R., Van, C. A., Emerson, J. S. and Menten, C. M. [Center for Health Research, Tennessee State University, Nashville, TN 37209]. **“The effect of a church-based breast cancer screening education program on mammography rates among African-American women.”** *Journal of the National Medical Association* 94, no. 2 (Feb 2002): 100-6.
 [Abstract:] This study examines the effectiveness of breast cancer screening education programs on mammography rates among African-American women 40 years of age and over. We conducted two types of educational programs in community settings, primarily in African-American churches. Three-month follow-up interviews were used to determine whether women who participated in programming were more likely to get a mammogram if they had not had a mammogram in the last year. Our results demonstrate that the educational programs significantly increased the likelihood of getting a mammogram when compared to a control group that received no educational programming. Further, we found that the programs were effective for motivating breast cancer screening in housing projects as well as in the churches, and that the effectiveness of the programs remained even when we controlled for socioeconomic status, depression, and age.
- Ingersoll-Dayton, B., Krause, N. and Morgan, D. [Berit Ingersoll-Dayton School of Social Work, University of Michigan, Ann Arbor, MI 48109]. **“Religious trajectories and transitions over the life course.”** *International Journal of Aging & Human Development* 55, no. 1 (2002): 51-70.

[Abstract:] This study examined patterns of change and stability in religiosity over the life course. Open-ended interviews with 129 adults aged 65 and older provided a rich source of data for applying a life course perspective to the study of religion. Two theoretical constructs from the life course perspective (i.e., trajectories and transitions) were used as a framework for understanding religion and aging. The interviews were content analyzed to identify: 1) dimensions of religiosity that exhibit change; 2) patterns of religious trajectories; and 3) social forces that promote changes in religiosity. These analyses revealed four distinct patterns: stable, increasing, decreasing, and curvilinear trajectories. Several forces were involved with either increasing religiosity (e.g., child rearing, adverse life experiences) or decreasing religiosity (e.g., disillusionment with church members, adverse life experiences). Directions for future research are discussed.

Ingram, S. S., Seo, P. H., Martell, R. E., Clipp, E. C., Doyle, M. E., Montana, G. S. and Cohen, H. J. [Dept. of Radiation Oncology, Duke Univ. Med. Center, Durham, NC; ingram@radonc.duke.edu]. **“Comprehensive assessment of the elderly cancer patient: the feasibility of self-report methodology.”** *Journal of Clinical Oncology* 20, no. 3 (Feb 1, 2002): 770-5.

[From the abstract:] ...Two hundred sixty-six male outpatient oncology patients at the Durham Veterans Affairs Medical Center were asked to fill out a survey assessing 10 domains (demographics, comorbid conditions, activities of daily living, functional status, pain, financial well being, social support, emotional state, spiritual well-being, and quality of life). ...Members of all age cohorts reported a sense of social support, with younger patients deriving this more from family and friends than older patients, and older patients deriving social support more from membership in religious communities than younger patients....

Ironson, G., Solomon, G. F., Balbin, E. G., O'Cleirigh, C., George, A., Kumar, M., Larson, D. and Woods, T. E. [Department of Psychology and Psychiatry, University of Miami, Coral Gables, FL 33124-2070; gironson@aol.com]. **“The Ironson-Woods Spirituality/Religiosity Index is associated with long survival, health behaviors, less distress, and low cortisol in people with HIV/AIDS.”** *Annals of Behavioral Medicine* 24, no. 1 (Winter 2002): 34-48.

[Abstract:] The purpose of this study was to determine the reliability and validity of an instrument that measures both spirituality and religiosity, to examine the relation between spirituality and religiosity and important health outcomes for people living with HIV and to examine the potential mediators of these relations. One aim was to determine whether subscales of spirituality, religiosity, or both would be independently related to long survival in people living with AIDS. The Ironson-Woods Spirituality/Religiosity (SR) Index is presented with evidence for its reliability and validity. Four factors were identified on the Ironson-Woods SR Index (Sense of Peace, Faith in God, Religious Behavior, and Compassionate View of Others). Each subscale was significantly related to long survival with AIDS. That is, the long-term survivor (LTS) group (n = 79) scored significantly higher on these factors than did the HIV-positive comparison (COMP) group (n = 200). Long survival was also significantly related to both frequency of prayer (positively) and judgmental attitude (negatively). In addition, the Ironson-Woods SR Index yielded strong and significant correlations with less distress, more hope, social support, health behaviors, helping others, and lower cortisol levels. The relation between religious behavior and health outcomes was not due to social support. Further analyses were conducted, which identified urinary cortisol concentrations and altruistic behavior as mediators of the relation between SR and long survival.

Johnson, P. [Department of Breast Medical Oncology, University of Texas, M. D. Anderson Cancer Center, Houston, TX; paugejohnsonnp@hotmail.com]. **“The use of humor and its influences on spirituality and coping in breast cancer survivors.”** *Oncology Nursing Forum* 29, no. 4 (May 2002): 691-5.

[Abstract:] PURPOSE/OBJECTIVES: To describe patients' perspectives concerning the use of humor in their care and recovery. DESIGN: Descriptive. SETTING: Community-based. SAMPLE: Nine women with a diagnosis of breast cancer. METHODS: Open-ended interviews were conducted with participants to identify their use of humor, its influence on spirituality, and their perceptions of how nurses use humor in caring for them during their treatment for breast cancer. MAIN RESEARCH VARIABLE: The use of humor as a coping skill. FINDINGS: The narrative data revealed three major categories, each with five to six themes illuminating humor as a coping factor, the relationship between humor and nursing, and the relationship between humor and spirituality. CONCLUSIONS: Participants identified humor as an important coping factor. They also believed it played a role in their spirituality and their perception of the meaning and purpose of life. Nurses' use of humor is important to foster deeper, more trusting relationships with patients. IMPLICATIONS FOR NURSING: Humor must be recognized as an element of spiritual coping in patients with breast cancer. A need exists for further education for nurses concerning the importance of humor in the care of patients to promote recovery and improve the nurse-patient relationship. Research is needed to explore the use of cultural influences on humor, family perspectives of humor, and the influences of the overall environment.

Jootun, D. [Bell College, School of Health Studies, Hamilton]. **“Nursing with dignity. Part 7: Hinduism.”** *Nursing Times* 98, no. 15 (Apr 9-15, 2002): 38-40.

[Abstract:] This article outlines the main beliefs and customs of Hinduism. It offers some guidelines to enable nurses to provide sensitive and appropriate nursing care to Hindu patients.

Kennedy, J. E., Abbott, R. A. and Rosenberg, B. S. [University of Wisconsin, Stevens Point, WI]. **“Changes in spirituality and well-being in a retreat program for cardiac patients.”** *Alternative Therapies in Health & Medicine* 8, no. 4 (Jul-Aug 2002): 64-6, 68-70, 72-3.

[Abstract:] CONTEXT: Many epidemiological studies indicate that spirituality or religion are positively correlated with health measures, but research is needed on interventions that change spirituality to verify that it actually affects health and to justify suggestions that changes in spiritual practices or beliefs may have health benefits. However, it is not clear that health interventions can influence spirituality or which techniques are effective. OBJECTIVE: To evaluate whether participation in a retreat program for cardiac patients and their partners resulted in changes in spirituality and whether changes in spirituality were related to changes in well-being meaning in life, anger, and confidence in handling problems. DESIGN: Participants filled out questionnaires before and after participating in the retreat. SETTING: Retreats were sponsored by the Health Promotion and Wellness Program, University of Wisconsin-Stevens Point, and were held in a remote training center. PARTICIPANTS: Notices were sent to cardiac rehabilitation programs and directly to heart patients, resulting in the enrollment of 72 first-time participants. INTERVENTION: The 2.5-day educational retreats included discussion and opportunities to experience healthy lifestyle options. Exercise, nutrition, stress management techniques, communication skills that enhance social support,

and spiritual principles of healing were incorporated. Experiential practices included yoga, meditation, visualization, and prayer. RESULTS: Of the participants, 78% reported increased spirituality after the retreat. Changes in spirituality were positively associated with increased well-being meaning in life, confidence in handling problems, and decreased tendency to become angry. CONCLUSIONS: Programs that explore spirituality in a health context can result in increased spirituality that is associated with increased well-being and related measures. Many patients and their families want to integrate the spiritual and health dimensions of their lives. Further work is needed to develop healthcare settings that can support this integration.

Kirchhoff, K. T. [School of Nursing, University of Wisconsin, Madison, WI 53792-2455; ktkirchhoff@facstaff.wisc.edu]. **“Promoting a peaceful death in the ICU.”** *Critical Care Nursing Clinics of North America* 14, no. 2 (Jun 2002): 201-6.

The author addresses the need for interdisciplinary support of patients' physical, psychosocial, and spiritual needs, and the needs of families, amid the circumstance of death in the ICU.

Kloosterhouse V. and Ames, B. D. [Allied Health, Oakland Community College, Waterford, MI]. **“Families' use of religion/spirituality as a psychosocial resource.”** *Holistic Nursing Practice* 16, no. 5 (Oct 2002): 61-76.

[Abstract:] The hospitalization of a child is stressful for a family. Turning to religion/spirituality (R/S) is a potential coping mechanism. Using an integration of Antonovsky's salutogenic model and human ecological theory, this study sought to determine if there is a relationship between the use of R/S as a psychosocial resource and the ability of the family to cope with the stress of child hospitalization. Although findings were inconclusive, a majority of families believed that R/S was important in helping them cope and that their beliefs and practices influenced their choice to use R/S as a resource. Implications for health care providers and administrators are discussed.

Koenig, H. G. [Duke University Medical Center, Geriatric Research, Education and Clinical Center, Veterans Affairs Medical Center, Durham, NC 27710; koenig@geri.duke.edu]. **“A commentary: the role of religion and spirituality at the end of life.”** *Gerontologist* 42, Spec. No. 3 (Oct 2002):20-3.

This overview addresses the role of religion and spirituality for the dying person, the family, and the health care provider, with notes also on the situation of non-religious persons and those without families.

Koenig, H. G. [Psychiatry & Medicine, Duke University Medical Center, Box 3400, Durham, NC 27710; koenig@geri.duke.edu]. **“An 83-year-old woman with chronic illness and strong religious beliefs.”** *JAMA* 288, no. 4 (Jul 24-31, 2002): 487-93.

The author works from a patient case to examine the significance of religious beliefs for the patient and her treatment, especially in terms of the patient's coping with chronic pain. The article is very practical, with the clinician in mind. There are 74 references.

Koopman, B. G. and Blasband, R. A. [Mount Sinai Hospital, New York, NY; mozg7@aol.com]. **“Distant healing revisited: time for a new epistemology.”** *Alternative Therapies in Health & Medicine* 8, no. 1 (Jan-Feb 2002): 100-1. Further comment by the authors on pp, 120, 116-9 (“Two case reports of distant healing: new paradigms at work?”)

[Abstract:] As distant healing becomes a valid object of scientific scrutiny, state-of-the-art statistical techniques point to outcomes clearly outside the realm of chance. Accordingly, a variety of experimental designs have come into play that highlight the many challenges and hazards of trying to objectify conscious intention. Our survey pinpoints some landmark studies geared toward relatively modest, short-term healing through the application of multiple modalities. In view of the transient and modest results of the distant healing reported, we suggest that the full range of its potential and its longitudinal effects have yet to be uncovered. To this end, we believe that broader, nonlinear thought processes would better serve us in fathoming the mysterious leap from mind to living matter.

Kotecki, C. N. [School of Nursing, University of Medicine and Dentistry of Stratford, New Jersey]. **“Developing a health promotion program for faith-based communities.”** *Holistic Nursing Practice* 16, no. 3 (Apr 2002): 61-9.

[Abstract:] The article describes the partnership formed between community outreach programs, a school of nursing, and hospitals to implement Healthy People 2010 goals in urban, faith-based communities. To date this program has provided health promotion programs to 125 people from more than 18 congregations in the context of their faith setting. The program has allowed congregants to develop ministry strategies to meet health care needs within the congregation and community. The article provides overall program goals, specific lesson plans, and evaluation strategies. Outcome measures include an increase in health promotion knowledge, participant satisfaction, and improved health in congregations.

Krause, N. [School of Public Health and Institute of Gerontology, University of Michigan, Ann Arbor, MI; nkrause@umich.edu]. **“Church-based social support and health in old age: exploring variations by race.”** *Journals of Gerontology Series B-Psychological Sciences & Social Sciences* 57, no. 6 (Nov 2002): S332-47.

[Abstract:] OBJECTIVES: A conceptual model is evaluated that explores the relationship between church-based support and health. In the process, an effort is made to see if the relationships in this model differ for older White and African American people. METHODS: Interviews were conducted with a national sample of 748 older White and 752 older Black people. The responses of 1,126 of these study participants are used in the analyses presented herein. Survey measures were administered to assess church-based social ties and health. RESULTS: Empirical support was provided for the following theoretical linkages: Older people who attend church often feel their congregations are more cohesive; older people in highly cohesive congregations receive more spiritual and emotional support from their fellow parishioners; older respondents who receive more church-based support have a more personal relationship with God; older people who feel more closely connected with God are more optimistic; and older people who are more optimistic enjoy better health. Data further reveal that older Black people are more likely than older White people to reap the health-related benefits of religion. DISCUSSION: The findings contribute to research on religion and health by specifying how the salubrious effects of religion may arise.

Kuzu, M. A., Topcu, O., Ucar, K., Ulukent, S., Unal, E., Erverdi, N., Elhan, A. and Demirci, S. [Department of Surgery, University of Ankara, Ankara, Turkey]. **“Effect of sphincter-sacrificing surgery for rectal carcinoma on quality of life in Muslim patients.”** *Diseases of the Colon & Rectum* 45, no. 10 (Oct 2002): 1359-66.

This study of studied 178 Muslim patients who had undergone curative surgery for colorectal carcinoma indicated that a colostomy may impair not only fasting practices but prayer practices in general: colorectal carcinoma patients with permanent colostomies were more

likely to stop their daily prayer practices than similar patients whose surgical treatment did not involve permanent colostomy. [From the abstract:] **CONCLUSION:** Two aspects of religious worship (praying and fasting) were significantly impaired in the Muslim patients who had a stoma as a result of sphincter-sacrificing surgery. To improve quality of life in these patients, religious issues as they relate to the presence of a stoma should be discussed during preoperative counseling, the informed consent process, and counseling with local religious authorities.

Larimore, W. L., Parker, M. and Crowther, M. [Department of Social Work, The University of Alabama, Tuscaloosa, AL 35487-0348]. **“Should clinicians incorporate positive spirituality into their practices? What does the evidence say?”** *Annals of Behavioral Medicine* 24, no. 1 (Winter 2002): 69-73.

[Abstract:] Most of the rhetoric decrying the incorporation of basic and positive spiritual care into clinical practice is not based on reliable evidence. We briefly review the current evidence, which demonstrates that (a) there is frequently a positive association between positive spirituality and mental and physical health and well being, (b) most patients desire to be offered basic spiritual care by their clinicians, (c) most patients censure our professions for ignoring their spiritual needs, (d) most clinicians believe that spiritual interventions would help their patients but have little training in providing basic spiritual assessment or care, (e) professional associations and educational institutions are beginning to provide learners and clinicians information on how to incorporate spirituality and practice, and (j) anecdotal evidence indicates that clinicians having received such training find it immediately helpful and do apply it to their practice. We point out the reasons that much more research is needed, especially outcome-based, clinical research on the effects of these spiritual interventions by clinicians. We conclude that the evidence to date demonstrates trained or experienced clinicians should encourage positive spirituality with their patients and that there is no evidence that such therapy is, in general, harmful. Further, unless or until there is evidence of harm from a clinician's provision of either basic spiritual care or a spiritually sensitive practice, interested clinicians and systems should learn to assess their patients' spiritual health and to provide indicated and desired spiritual intervention. Clinicians and health care systems should not, without compelling data to the contrary, deprive their patients of the spiritual support and comfort on which their hope, health, and well-being may hinge.

Larson, D. B., Larson, S. S. and Koenig, H. G. [International Center for the Integration of Health and Spirituality, Rockville, MD]. **“Mortality and religion/spirituality: a brief review of the research.”** *Annals of Pharmacotherapy* 36, no. 6 (Jun 2002): 1090-8.

This critical review of research is clear and perceptive and provides an excellent overview, indicative of the work of the late Dr. Larson.

Lemmer C. [Mount Marty College, Yankton, SD; clemmer@mtmc.edu]. **“Teaching the spiritual dimension of nursing care: a survey of U.S. baccalaureate nursing programs.”** *Journal of Nursing Education* 41, no. 11 (Nov 2002): 482-90.

[Abstract:] One-hundred-thirty-two randomly selected baccalaureate nursing programs in the United States responded to a survey exploring how the spiritual dimension of nursing care currently is being taught. The majority of programs included the concept of the spiritual dimension in curricula, but few programs had definitions of spirituality or spiritual nursing care. Content addressed most consistently by programs included assessment of spiritual needs, the needs of dying individuals, and the spiritual dimension as a component of holism or culture. There appeared to be a lack of clarity in the understanding of the concept of spirituality, as well as uncertainty about levels of faculty knowledge and comfort with teaching this topic.

Lipe, A. W. [Shenandoah University, Institute for Music-Centered Wellness]. **“Beyond therapy: music, spirituality, and health in human experience: a review of literature.”** *Journal of Music Therapy* 39, no. 3 (Fall 2002): 209-40. [Review, 46 refs.]

[Abstract:] In the current healthcare environment, there is a growing interest in the relationship between spirituality and health. The connections between music and both medicine and religious experience are well-established, but little is known about how the musical and spiritual aspects of human experience work together to influence well-being. A review of the healthcare literature from 1973-2000 identified 52 published reports on the topic of music, spirituality, and health. The majority of the papers were narrative descriptions or case studies, and appear within a variety of clinical contexts. Fifty-two percent of the authors were credentialed music therapists. Examination of the literature indicated that many papers used terms and concepts associated with both spirituality and health interchangeably, which might lend support to the basic interconnectedness of these two aspects of being. The function of music across the literature was explored, and a transformational model of music experience derived from the literature is proposed. Based on the findings of the review, several conclusions about the future role of music in spirituality and health are drawn, and recommendations for further research are offered.

Lo, B., Ruston, D., Kates, L. W., Arnold, R. M., Cohen, C. B., Faber-Langendoen, K., Pantilat, S. Z., Puchalski, C. M., Quill, T. R., Rabow, M. W., Schreiber, S., Sulmasy, D. P., Tulsky, J. A., the Working Group on Religious and Spiritual Issues at the End of Life [bernie@medicine.ucsf.edu]. **“Discussing religious and spiritual issues at the end of life: a practical guide for physicians.”** *JAMA* 287, no. 6 (Feb 13, 2002): 749-54.

[Abstract:] As patients near the end of life, their spiritual and religious concerns may be awakened or intensified. Many physicians, however, feel unskilled and uncomfortable discussing these concerns. This article suggests how physicians might respond when patients or families raise such concerns. First, some patients may explicitly base decisions about life-sustaining interventions on their spiritual or religious beliefs. Physicians need to explore those beliefs to help patients think through their preferences regarding specific interventions. Second, other patients may not bring up spiritual or religious concerns but are troubled by them. Physicians should identify such concerns and listen to them empathetically, without trying to alleviate the patient's spiritual suffering or offering premature reassurance. Third, some patients or families may have religious reasons for insisting on life-sustaining interventions that physicians advise against. The physician should listen and try to understand the patient's viewpoint. Listening respectfully does not require the physician to agree with the patient or misrepresent his or her own views. Patients and families who feel that the physician understands them and cares about them may be more willing to consider the physician's views on prognosis and treatment. By responding to patients' spiritual and religious concerns and needs, physicians may help them find comfort and closure near the end of life.

Longo, D. A. and Peterson, S. M. [Psychosocial Rehabilitation Program, Eastern State Hospital, Williamsburg, VA 23187; dlongo@esh.state.va.us]. **“The role of spirituality in psychosocial rehabilitation.”** *Psychiatric Rehabilitation Journal* 25, no. 4 (Spring 2002): 333-40. [Review, 61 refs.]

[Abstract:] The role of spirituality in mental health and general wellness has begun to receive much needed attention in the psychological literature. Historically, however, mental health researchers and practitioners alike have generally neglected spirituality. There have been at least three significant barriers to the acceptance of spirituality as a clinical tool in mental health treatment. These barriers are identified in the article as (a) the history of mental health treatment; (b) professional stereotypes; and (c) confusion and fears over the meaning of spirituality. Although more empirical evidence is needed to investigate the role of spirituality and how to integrate spiritual beliefs in treatment, the time may have come to incorporate spirituality in the mental health professional's tool kit.

Lottes, C. R., Engstrom, D. and Engstrom, L. F. [Kutztown University of Pennsylvania]. **“A spiritual health community seminar based on religious commitment research.”** *Journal of Holistic Nursing* 20, no. 4 (Dec 2002): 418-24.

[Abstract:] There is a need for spiritual health seminars at the work site and through hospital and other community venues. This article describes how the authors prepared for and conducted seminars in their community. The research demonstrates that religious commitment may play a beneficial role in an individual's health. Once the authors were armed with this research and a fundamentally sound and practical program, they were able to assist individuals in their community in designing and initiating their own individual spiritual health workouts, which may then influence their physical and mental health. In this way, the authors were able to apply holistic principles of spirit, mind, and body.

Lowry, L. W. and Conco, D. [College of Nursing, East Tennessee State University, Johnson City, TN]. **“Exploring the meaning of spirituality with aging adults in Appalachia.”** *Journal of Holistic Nursing* 20, no. 4 (Dec 2002): 388-402.

[Abstract:] This phenomenological study explored the meaning of spirituality in the lives of aging adults in Appalachia. Forty adult volunteers in varying states of health ranging in age from 59 to 94 years participated in focus groups. Through open-ended questions, respondents described their perceptions of spirituality, spirituality, and health, and the role of spirituality in helping them cope. Themes that emerged from the data were a conviction that God exists and acts in the lives of persons, calls them to action, and is a source of connection in times of loss. Spirituality positively affects attitude, particularly as health declines. Respondents expected respectful and empathic health care providers who would meet their physical needs and be concerned about their spiritual needs. Spirituality was of paramount importance in the lives of these elders; thus, health care providers must consciously include spirituality in assessments and interventions. Nursing curricula must prepare students to provide spiritual care.

Lynch, M. and Abraham, J. [Pain & Palliative Care Program, Dana-Farber Cancer Institute, Boston, MA 02115]. **“Ensuring a good death.”** *Cancer Practice* 10, Suppl 1 (May-Jun 2002): S33-8.

This description of an institutional strategy for end-of-life care addresses, among other things, the role and importance of a patient's spirituality.

MacDonald, D. A. and Friedman, H. L. **“Assessment of humanistic, transpersonal and spiritual constructs: state of the science.”** *Journal of Humanistic Psychology* 42, no. 4 (Fall 2002): 102-25.

[Abstract:] This article reports on the current status of psychometric testing as it pertains to the measurement and assessment of constructs relevant to humanistic and transpersonal psychologies. In so doing, information is provided on available instruments and associated empirical research findings exploring the relation of humanistic/transpersonal phenomena/concepts to human functioning. The article concludes with a listing of recommendations for investigators who wish to employ standardized assessment instruments in humanistic and/or transpersonal research.

Maillet, J. O., Potter, R. L. and Heller, L. [School of Health Related Professions, University of Medicine and Dentistry of New Jersey, Newark, NJ]. **“Position of the American Dietetic Association: ethical and legal issues in nutrition, hydration, and feeding.”** *Journal of the American Dietetic Association* 102, no. 5 (May 2002): 716-26.

This general position statement by the American Dietetic Association focuses on legal and ethical issues, but it includes a discussion of cultural and religious positions (p. 719) pertinent to nutrition, hydration, and feeding.

Malinski, V. M. [Hunter-Bellevue School of Nursing, Hunter College, City University of New York, 425 E. 25th Street, Box 945, New York, NY 10010-2590; vmalinsk@hunter.cuny.edu]. **“Developing a nursing perspective on spirituality and healing.”** *Nursing Science Quarterly* 15, no. 4 (Oct 2002): 281-7.

[From the abstract:] The author...presents an overview of selected research and nursing theoretical thinking on spirituality and then offers a beginning exploration of the interrelationships of spirituality and healing. Work in both the totality and simultaneity paradigms is highlighted in the belief, following Nightingale, that spirituality and healing are crucial concepts in both paradigms, although currently defined differently if at all. ...General directions for research using nursing theoretical frameworks and, in some cases, research methods derived from particular theories/models, are suggested.

Mansfield, C. J., Mitchell, J. and King, D. E. [Center for Health Services Research and Development, East Carolina University, Greenville, NC 27858; mansfieldc@mail.ecu.edu]. **“The doctor as God's mechanic? Beliefs in the Southeastern United States.”** *Social Science & Medicine* 54, no. 3 (Feb 2002): 399-409.

[Abstract:] Spiritual practice and beliefs related to healing are described using data from a telephone survey. Questions in the survey address the practice of prayer and spiritual beliefs related to healing. Questions explore belief in miracles, that God acts through religious healers, the importance of God's will in healing, and that God acts through physicians. Questions also ask whether people discuss spiritual concerns with their physician and whether they would want to if seriously ill. We create a composite index to compare religious faith in healing across race, gender, education, income denomination, and health status. Logistic regression predicts types of patients who believe God acts through physicians and those inclined to discuss spiritual concerns when ill. The most important findings are that: 80% of respondents believe God acts through physicians to cure illness, 40% believe God's will is the most important factor in recovery, and spiritual faith in healing is stronger among women, African-Americans, Evangelical Protestants, the poorer, sicker, and less educated. Those who believe that God acts through physicians are more likely to be African-American than White (OR = 1.9) and 55 or older (OR = 3.5). Those who discuss spiritual concerns with a physician are more likely to be female (OR = 1.9) and in poor health (OR = 2.1). Although 69% say they would want to speak to someone about spiritual concerns if seriously ill, only 3% would choose to speak to a

physician. We conclude that religious faith in healing is prevalent and strong in the southern United States and that most people believe that God acts through doctors. Knowledge of the phenomena and variation across the population can guide inquiry into the spiritual concerns of patients.

Markens, S., Fox, S. A., Taub, B. and Gilbert, M. L. [Department of Sociology, Temple University, Philadelphia, PA 19122-6089; markens@temple.edu]. **“Role of Black churches in health promotion programs: lessons from the Los Angeles Mammography Promotion in Churches Program.”** *American Journal of Public Health* 92, no. 5 (May 2002): 805-10.

[Abstract:] OBJECTIVES: This article assesses pastor-level factors that affect the successful recruitment and implementation of community-based health promotion programs in Black churches. METHODS: Semistructured interviews with 16 pastors of Black churches were analyzed for content. RESULTS: We found that although the involvement of Black pastors in an array of secular activities makes them open to participate in health programs, their overcommitment to other issues can negatively influence their ability to participate. Second, although Black pastors appreciate being included in and benefiting from health research, minorities' history of being underserved and exploited can lead to suspiciousness and reluctance to participate. CONCLUSIONS: Our findings suggest that those interested in developing church-based health programs in the Black community must be attuned to how the same factors can both facilitate and hinder a program's development.

Martin, J. C. and Sachse, D. S. [University of Tennessee Health Science Center, College of Nursing, Memphis, TN]. **“Spirituality characteristics of women following renal transplantation.”** *Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association* 29, no. 6 (Dec 2002): 577-81.

[Abstract:] End stage renal disease (ESRD) is a potentially terminal condition that causes patients to consider their mortality. Post research has shown that prayer and religious coping are associated with better posttransplant adjustment and that individuals with life-threatening illnesses have higher levels of spirituality than healthy individuals. Few studies, however, have examined the spirituality characteristics of kidney transplant recipients. This study examined the spiritual perspectives and spiritual well-being of 28 women who had a functioning allograft 18-24 months after receiving a first kidney transplant. Measurement by the Spiritual Perspective Scale (SPS) and Spiritual Well-Being (SWB) Scale scores indicated high levels of spirituality and moderate correlation between spiritual perspective and spiritual well-being. Although older participants had higher levels of spiritual perspective, there were no associations between age and spiritual well-being, nor difference in spiritual perspective and well-being by race, education, or employment status. Thus, particularly for the aging, spirituality may be a valuable psychological resource that should be supported in women posttransplant.

McBride, J. L. [Family Practice Residency Program, Floyd Medical Center, Rome, GA 30165]. **“Spiritual component of patients who experience psychological trauma: family physician intervention.”** *Journal of the American Board of Family Practice* 15, no. 2 (Mar-Apr 2002): 168-9.

In this brief essay, the author reflects as a family practitioner, offering specific suggestions to clinicians assessing and caring for patients who have spiritual issues related to trauma.

McCullough, M. E., Emmons, R. A. and Tsang, J. A. [Department of Psychology, Southern Methodist University, Dallas, TX 75275-0442; mikem@mail.smu.edu]. **“The grateful disposition: a conceptual and empirical topography.”** *Journal of Personality & Social Psychology* 82, no. 1 (Jan 2002): 112-27.

[Abstract:] In four studies, the authors examined the correlates of the disposition toward gratitude. Study 1 revealed that self-ratings and observer ratings of the grateful disposition are associated with positive affect and well-being, prosocial behaviors and traits, and religiousness/spirituality. Study 2 replicated these findings in a large nonstudent sample. Study 3 yielded similar results to Studies 1 and 2 and provided evidence that gratitude is negatively associated with envy and materialistic attitudes. Study 4 yielded evidence that these associations persist after controlling for Extraversion/positive affectivity, Neuroticism/negative affectivity, and Agreeableness. The development of the Gratitude Questionnaire, a unidimensional measure with good psychometric properties, is also described.

McSherry, W., Draper, P. and Kendrick, D. [Faculty of Health, School of Nursing, University of Hull, East Riding Campus, Beverley Road, Willerby, Hull HU10 6NS, UK; w.mcsherry@nursing.hull.co.uk]. **“The construct validity of a rating scale designed to assess spirituality and spiritual care.”** *International Journal of Nursing Studies* 39, no. 7 (Sep 2002): 723-34.

[Abstract:] A postal survey, containing a questionnaire and covering letter, was distributed to 1029 ward-based nurses, of all grades, in a Large NHS Trust in an attempt to establish how nurses perceived spirituality and spiritual care. A response rate of 55.3% (n = 549) was obtained. Part of the questionnaire contained "The Spirituality and Spiritual Care Rating Scale" (SSCRS) a newly constructed instrument to aid the investigation and measurement of Spirituality and Spiritual Care. Factor Analysis was performed in an attempt to establish construct validity and to identify any underlying associations between items in the scale. It suggested a 17-item instrument with four factor-based subscales: Spirituality, Spiritual Care, Religiosity and Personalised Care. The 17-item SSCRS demonstrated a reasonable level of internal consistency reliability, having a Cronbach's alpha coefficient of 0.64. Confirmatory Factor Analysis is recommended in order to cross-validate and refine this new Rating Scale.

McSherry, W. and Ross, L. [Dept. of Nursing and Applied Health Studies, Univ. of Hull, Willerby, UK; w.mcsherry@hull.ac.uk]. **“Dilemmas of spiritual assessment: considerations for nursing practice.”** *Journal of Advanced Nursing* 38, no. 5 (Jun 2002): 479-88. [Review, 72 refs.]

[Abstract:] BACKGROUND: Interest in the spiritual dimension of nursing has resulted in a proliferation of published research internationally that is very prescriptive, suggesting that nurses should be providing spiritual care. However, little research has been published that provides nurses with a potential framework for the assessment and subsequent delivery of spiritual care. It would appear that there is a consensus of opinion that nurses can and should be able to undertake an assessment of their patients' spiritual needs. However, such assumptions may be unfounded, inaccurate, misguided and potentially detrimental to patient care. AIM: This article explores the area of spiritual assessment, drawing on the international literature, highlighting potential dilemmas in conducting a spiritual assessment. A review of some of the currently available spiritual assessment tools is also undertaken. DESIGN: A debate is presented based on the authors' experiences and opinions with regard to this aspect of care. The debate is informed by a review of the literature specifically addressing spiritual assessment. The authors use United Kingdom policy to illustrate drivers and provide a context for the debate. However

the dilemmas presented and issues raised are of significance to a wider international audience. **CONCLUSION:** It is argued that the area of spiritual assessment needs careful consideration, both nationally and internationally, by those professionals involved in the provision of spiritual care so that potential dilemmas can be identified and reviewed. Such consideration may prevent the construction and subsequent use of inappropriate assessment tools within practice. The article incorporates some considerations for practice.

McSherry, W. and Watson, R. [Department of Nursing and Applied Health Studies, East Riding Campus, University of Hull, Hull, UK]. **"Spirituality in nursing care: evidence of a gap between theory and practice."** *Journal of Clinical Nursing* 11, no. 6 (Nov. 2002): 843-4.

This brief report of a study indicates that theories of spirituality in health care literature and education may not be congruent with understandings of spirituality by patients.

McVay, M. R. [Yankton Medical Clinic, Avera Sacred Heart Hospital, Yankton, SD]. **"Medicine and spirituality: a simple path to restore compassion in medicine."** *South Dakota Journal of Medicine* 55, no. 11 (Nov 2002): 487-91. [Review, 16 refs.]

[Abstract:] Medical science has achieved impressive accomplishments in the diagnosis and treatment of human disease. However, the emphasis on science and technology has created a generation of physicians who find it difficult to relate to their patients about their suffering. Time constraints and economic pressures also add to the challenge of giving meaningful time to patients. Patients want to talk to their physician about their concerns, but surveys indicate that this is not being accomplished. Medical educators are developing curricula to teach how care can be given compassionately. This article reviews the importance of addressing spiritual care in medicine. Spirituality is defined and the spiritual history is explained. Research on the role of spirituality in health care is also reviewed. The role of the physician as a healer, attending to mind, body and spirit is encouraged.

Meisenhelder, J. B. [MGH Institute of Health Professions at Massachusetts General Hospital, Boston, MA 02129; jmeisenhelder@mghihp.edu]. **"Terrorism, posttraumatic stress, and religious coping."** *Issues in Mental Health Nursing* 23, no. 8 (Dec 2002): 771-82. [Review, 32 refs.]

[Abstract:] The events of September 11, 2001 triggered a widespread national response that was two-fold: a posttraumatic stress reaction and an increase in attendance in religious services and practices immediately following the tragic events. The following discussion traces the existing research to distinguish this posttraumatic stress reaction from posttraumatic stress disorder as a recognized psychiatric diagnosis. This disaster reaction is then examined in light of the research on religious coping, delineating both its positive and negative aspects and the respective outcomes. A conceptual model illustrates the benefits in seeking religious comfort for managing a postdisaster stress response. Nursing implications for practice are discussed.

Mendelson, C. [College of Nursing, University of New Mexico Health Sciences Center]. **"Health perceptions of Mexican American women."** *Journal of Transcultural Nursing* 13, no. 3 (Jul 2002): 210-7.

[Abstract:] This article describes the health perceptions of a sample of moderately to highly acculturated Mexican American women. Using an ethnographic design, the author interviewed 13 women to determine their health perceptions. The interviews were guided by the domains of health described in the World Health Organization (WHO) definition of health. Three broad categories of health perceptions were identified: the physical body, the emotional component, and finding balance. With the addition of a spiritual component, the WHO definition was a useful tool for uncovering health perceptions. The process of in-depth ethnographic interviewing provided a contextual view of health in which the complexity of intrafamilial relationships was revealed, as were the importance of spirituality as a coping mechanism and the perception of health as an integrated, holistic experience.

Meraviglia, M. G. [University of Texas at Austin, School of Nursing; mmeraviglia@mail.utexas.edu]. **"Prayer in people with cancer."** *Cancer Nursing* 25, no. 4 (Aug 2002): 326-31.

[Abstract] The purpose of this study was to adapt an instrument to assess prayer activities, experiences, and attitudes for people with cancer. A cross-sectional correlational research design was used to study 32 adults (24 women and 8 men) at 3 urban oncology and 2 radiation clinics. The prayer scale was adapted for people with cancer by the author, reviewed by measurement and content experts, and tested by administration to 32 people with a variety of cancers. Expert review supported the content validity of the adapted instrument. Instrument subscales had acceptable reliability for internal consistency. The 3 prayer scale subscales were moderately correlated to perceived relationship with God. Results demonstrated that high scores on the frequency of prayer subscale were associated with low levels of education and functional status and high presence of metastasis at diagnosis. Reports of more prayer activity were related to low levels of functional status. Additionally, those reporting low levels of physical health status had more prayer experiences. The prayer scale is a sensitive instrument for assessing prayer activities, experiences, and attitudes of people with cancer. Prayer is a valuable internal resource, which can lessen the effect of cancer.

Messikomer, C. M. and DeCraemer, W. [The Acadia Institute, Exton, PA 19341; CarlaMessikomer@msn.com]. **"The spirituality of academic physicians: an ethnography of a scripture-based group in an academic medical center."** *Academic Medicine* 77, no. 6 (Jun 2002): 562-73.

[Abstract:] Whether acknowledged or not, spirituality is part of the human condition of physicians as well as patients, and of the distinctive work that doctors do. This paper presents a first-hand sociological account of a group of 20 academic physicians in a large, urban, East Coast academic medical center who met weekly to study theological concepts drawn from Christian Scripture. The principal method of inquiry was participant observation over the course of an academic year. In analyzing the "talk" and interaction that took place among them, the authors observed not only some of the implicit tensions between medicine, religion, and spirituality but also the complementarity between them. While the group's explicit purpose was to foster spiritual growth and connectedness, it also provided a venue in which members dealt openly with problems of uncertainty and meaning that the practice of medicine inevitably raises; with the meaning of physicianhood, given the growing corporatization of medicine; with an opportunity to engage in "worried consultation" with their spiritual-medical colleagues about their mutual patients; and to underscore for each other their dismay about the absence of spirituality in medicine, on the one hand, and their belief about its importance on the other. The authors also highlight some of the ways in which spirituality influenced these physicians' medical outlook, and conversely, how that outlook shaped their mode of spiritual reflection.

- Meyer, J. and Davis, E. [St. Cloud State University, St. Cloud, MN]. **“Workplace chaplains: filling a need traditional EAPs can't meet.”** *Benefits Quarterly* 18, no. 3 (2002): 22-6.
 [Abstract:] More organizations are finding secular counseling provided by employee assistance programs (EAPs) is inadequate for many employees. As a result, increasing numbers of employers are providing services of workplace chaplains. Chaplain services are not necessarily part of the recent fad toward "spirituality" in organizations, but rather address the needs of an increasingly non-churchgoing culture living in a more stressful world.
- Meyerhoff, H., van Hofwegen, L., Harwood, C. H., Drury, M. and Emblen J. [Trinity Western University, Langley, British Columbia]. **“Spiritual nursing interventions.”** *Canadian Nurse* 98, no. 3 (Mar 2002): 21-4.
 The authors offer a brief overview, emphasizing communication and prayer and illustrating these with a case.
- Miller, L., Weissman, M., Gur, M. and Greenwald, S. [Clinical Psychology Program, Teachers College, Columbia University, New York, NY 10027]. **“Adult religiousness and history of childhood depression: eleven-year follow-up study.”** *Journal of Nervous & Mental Disease* 190, no. 2 (Feb 2002): 86-93.
 [From the abstract:] This study investigates the association between childhood depression and the protective qualities of adult religiousness. Subjects were 146 (65 female and 81 male) adults with a history of childhood depression and 123 (61 female and 62 male) adults without a history of childhood depression interviewed as part of a long-term follow-up study (mean years of follow-up, 11.2; SD = 1.4). ...Findings showed adult personal importance of religion to be associated with a decreased risk for depression in women without a history of childhood depression but an increased risk for depression in women with a history of childhood depression. Adult Catholicism as compared with Protestantism was associated with a decreased risk for depression in male childhood depressives, but this association was not found in men without childhood depression. The findings potentially suggest a reciprocal-influence process between childhood pathology and the development of religiousness.
- Musgrave, C. F., Allen, C. E. and Allen, G. J. [Henrietta Szold Hadassah Hebrew University School of Nursing, Jerusalem, Israel]. **“Spirituality and health for women of color.”** *American Journal of Public Health* 92, no. 4 (Apr 2002): 557-60.
 [Abstract:] Spirituality among African American and Hispanic women has been associated with a variety of positive health outcomes. The purposes of this commentary are (1) to define spirituality, comparing it with religiosity, and briefly examine the historical, cultural, and contextual roots of spirituality among women of color; (2) to explore research data that support a relationship between spirituality and health, particularly among women of color; and (3) to present several examples of how spirituality may enhance public health interventions designed to promote health and prevention.
- Narayanasamy, A. [Trinity Care Spirituality Research Project, University of Nottingham, UK]. **“Spiritual coping mechanisms in chronically ill patients.”** *British Journal of Nursing* 11, no. 22 (Dec 12, 2002-Jan 8, 2003): 1461-70. [Review, 60 refs.]
 [Abstract:] Addressing spiritual needs is acknowledged as an essential component of holistic nursing care. Findings are emerging that suggest that chronic illness demands significant changes in patients' lifestyle. In such circumstances it is claimed that spiritual care can be therapeutic to patients (Cohen et al, 2000; Sherwood, 2000). This study was carried out in order to understand further the spiritual coping mechanisms of patients suffering from chronic illness. A qualitative methodology based on descriptive phenomenology was used to capture participants' lived experience. The main themes emerging from this study suggest that chronic illness led participants to use the following spiritual coping mechanisms: faith, prayer, and related sources of support. Patients coping with chronic illness were engaged in both a personal and private struggle. Patients may benefit from nursing interventions that are sensitive, supportive, and responsive to their spiritual needs.
- Narayanasamy, A., Gates, B. and Swinton, J. [School of Nursing, University of Nottingham, UK]. **“Spirituality and learning disabilities: a qualitative study.”** *British Journal of Nursing* 11, No. 14 (Jul 25-Aug 7, 2002): 948-57.
 [Abstract:] This article describes a unique empirical study where critical incidents were obtained from learning disability nurses to understand how they attempt to meet the spiritual needs of the people for whom they care. Following analysis, the nurses' approaches to meeting spiritual needs were categorized as 'personal' and 'procedural', and each of these is described in turn. There then follows a discussion on the effects of these nurses' interventions on both clients and their families, and nurses themselves. The findings of the study illuminate how these learning disability nurses attempted to meet the spiritual needs of people with learning disabilities in their care. The findings may help nurses ensure that spiritual needs are identified in the construction of the personal care plans of people with learning disabilities.
- Nelson, C. J., Rosenfeld, B., Breitbart, W. and Galietta, M. [Department of Psychology, Long Island University, Brooklyn, NY]. **“Spirituality, religion, and depression in the terminally ill.”** *Psychosomatics* 43, no. 3 (May-Jun 2002): 213-20.
 [From the abstract:] OBJECTIVE: This study examined the impact of spirituality and religiosity on depressive symptom severity in a sample of terminally ill patients with cancer and AIDS. METHODS: One hundred sixty-two patients were recruited from palliative-care facilities (hospitals and specialized nursing facilities), all of whom had a life expectancy <6 months. The primary variables used in this study were the FACIT Spiritual Well-Being Scale, a religiosity index similar to those used in previous research, the Hamilton Depression Rating Scale (HDRS), the Karnofsky Performance Rating Scale, the Memorial Symptom Assessment Scale, and the Duke-UNC Functional Social Support Questionnaire. RESULTS: A strong negative association was observed between the FACIT Spiritual Well-Being scale and the HDRS, but no such relationship was found for religiosity, because more religious individuals had somewhat higher scores on the HDRS. Similar patterns were observed for the FACIT subscales, finding a strong negative association between the meaning and peace subscale (which corresponds to the more existential aspects of spirituality) and HDRS scores, whereas a positive, albeit nonsignificant, association was observed for the faith subscale (which corresponds more closely to religiosity)....
- Newlin, K., Knafel, K. and Melkus, G. D. [Yale University School of Nursing, New Haven, CT]. **“African-American spirituality: a concept analysis.”** *Advances in Nursing Science* 25, no. 2 (Dec 2002): 57-70. [Review, 57 refs.]
 [Abstract:] Culturally competent care for African Americans requires sensitivity to spirituality as a component of the cultural context. To foster understanding, measurement, and delivery of the spiritual component of culturally competent care, this article presents an

evolutionary concept analysis of African-American spirituality. The analysis is based on a sample of multidisciplinary research studies reflecting spirituality of African Americans. Findings indicate that African-American spirituality involves quintessential, internal, external, consoling, and transformative attributive dimensions. Findings are considered in relation to previous conceptual analyses of spirituality and suggest that defining attributes of African-American spirituality are both global and culturally prominent. Implications for practice and research are discussed.

Northcott, N. "Nursing with dignity. Part 2: Buddhism." *Nursing Times* 98, no. 10 (Mar 7-13, 2002): 36-8.

This second part to a nine-part series addresses diversity issues for health care providers in the care of Buddhist patients.

O'Connor, T. S., McCarroll-Butler, P., Meakes, E., Davis, A. and Jadad, A. [Hamilton Health Sciences Corp., Hamilton, Ontario, Canada L8N 3Z5]. "Review of quantity and types of spirituality research in three health care databases (1962-1999): implications for the health care ministry." *The Journal of Pastoral Care & Counseling* 56, no. 3 (Fall 2002): 227-32.

[From the abstract:] Using computer technology to identify the term "spiritual," these researchers present results of the 2306 citations and compare five criteria discovered with research reported in four pastoral counseling journals....

O'Gorman, M. L. [St. Thomas Hospital, Nashville, TN 37212-3115; Mogorman@stthomas.org]. "Spiritual care at the end of life." *Critical Care Nursing Clinics of North America* 14, no. 2 (Jun 2002): 171-6, viii.

[Abstract:] Spiritual care at the end of life focuses on integration and peacemaking for patients and their families. This article will discuss the work of "letting go" for patients, families, and staff as well. Addressing these tasks honors commitments to significant relationships, both personal and professional, and provides healing and closure. Critical care nurses provide spiritual care when they participate in activities as diverse as story telling, advocating for their patients' wishes, addressing suffering and pain. Caring for the dying requires competence in all aspects of end of life care and the ability to build trusting relationships.

O'Hara, D. P. [Elliott Allen Institute for Theology and Ecology, University of St. Michael's College, Toronto, Ontario, Canada; dohara@sympatico.com]. "Is there a role for prayer and spirituality in health care?" *Medical Clinics of North America* 86, no. 1 (Jan 2002): 33-46, vi. [Review, 89 refs.]

[Abstract:] While most people will turn to prayer during serious illness or impending death, our healthcare system has tended to relegate prayer and spirituality to the periphery of medical care, if it is tolerated at all. Despite recent research that seemingly demonstrates a relationship between prayerful practices and health benefits, the integration of spirituality into the practice of medicine remains elusive. The research that purports to demonstrate the link between prayer and health is examined in an exploration of the place prayer and spirituality might have in the health care system.

O'Leary, U. "Psychosocial influences on pain perceptions in cancer." *Nursing Times* 98, no. 43 (Oct 22-28, 2002): 36-8.

The author addresses the subject generally, including the role of "beliefs, values and spirituality."

Oman, D., Kurata, J. H., Strawbridge, W. J. and Cohen, R. D. [Human Population Laboratory, Public Health Institute, Berkeley, CA 94704-1011; DougOman@post.harvard.edu]. "Religious attendance and cause of death over 31 years." *International Journal of Psychiatry in Medicine* 32, no. 1 (2002): 69-89.

[Abstract:] OBJECTIVE: Frequent attendance at religious services has been reported by several studies to be independently associated with lower all-cause mortality. The present study aimed to clarify relationships between religious attendance and mortality by examining how associations of religious attendance with several specific causes of death may be explained by demographics, socioeconomic status, health status, health behaviors, and social connections. METHOD: Associations between frequent religious attendance and major types of cause-specific mortality between 1965 and 1996 were examined for 6545 residents of Alameda County, California. Sequential proportional hazards regressions were used to study survival time until mortality from circulatory, cancer, digestive, respiratory, or external causes. RESULTS: After adjusting for age and sex, infrequent (never or less than weekly) attenders had significantly higher rates of circulatory, cancer, digestive, and respiratory mortality ($p < 0.05$), but not mortality due to external causes. Differences in cancer mortality were explained by prior health status. Associations with other outcomes were weakened but not eliminated by including health behaviors and prior health status. In fully adjusted models, infrequent attenders had significantly or marginally significantly higher rates of death from circulatory (relative hazard [RH] = 1.21, 95 percent confidence interval [CI] = 1.02 to 1.45), digestive (RH = 1.99, $p < 0.10$, 95 percent CI = 0.98 to 4.03), and respiratory (RH = 1.66, $p < 0.10$, 95 percent CI = 0.92 to 3.02) mortality. CONCLUSIONS: These results are consistent with the view that religious involvement, like high socioeconomic status, is a general protective factor that promotes health through a variety of causal pathways. Further study is needed to determine whether the independent effects of religion are mediated by psychological states or other unknown factors.

Otis-Green, S., Sherman, R., Perez, M. and Baird, R. P. [City of Hope National Medical Center, Supportive Care and Palliative Medicine Department, Duarte, CA 91010-3000]. "An integrated psychosocial-spiritual model for cancer pain management." *Cancer Practice* 10, Suppl 1 (May-Jun 2002): S58-65.

[From the abstract:] ...This article describes a multidisciplinary model for cancer pain management that focuses on the psychosocial and spiritual aspects of cancer pain and the needs of patients. DESCRIPTION OF PROGRAM: This multidisciplinary model has been organized to provide the most effective pain management to a variety of patients within a comprehensive cancer center....

Parker, M. W., Bellis, J. M., Bishop, P., Harper, M., Allman, R. M., Moore, C. and Thompson, P. [School of Social Work, Univ. of Alabama, Tuscaloosa, and Division of Gerontology and Geriatric Medicine, Univ. of Alabama at Birmingham; mwparker@sw.ua.edu]. "A multidisciplinary model of health promotion incorporating spirituality into a successful aging intervention with African American and white elderly groups." *Gerontologist* 42, no. 3 (Jun 2002): 406-15.

[Abstract:] PURPOSE: A community and faith-based intervention with elderly persons and their adult children involving religious, medical, and academic communities is described. DESIGN AND METHODS: Lifestyle changes and individual and corporate forms of spirituality were affirmed using an expanded Rowe and Kahn model of successful aging. Faculty from academic, medical, state, and religious institutions presented a variety of workshops at a multichurch-sponsored conference that hosted over 500 seniors. RESULTS:

Postconference surveys suggested extremely favorable satisfaction rates across all groups represented. The African American religious community provided critical leadership in achieving an excellent African American participation rate. IMPLICATIONS: The model described has the capacity to generate collaborations across denominational, racial, and class barriers, and has the potential of helping to unify the religious community around the important task of promoting successful aging.

Patel, S. S., Shah, V. S., Peterson, R. A. and Kimmel, P. L. [Department of Medicine, George Washington University, Washington, DC 20037]. **“Psychosocial variables, quality of life, and religious beliefs in ESRD patients treated with hemodialysis.”** *American Journal of Kidney Diseases* [Online] 40, no. 5 (Nov 2002): 1013-22.

[Abstract:] BACKGROUND: Religious and spiritual aspects of quality of life (QOL) have not been fully assessed in patients with end-stage renal disease (ESRD) treated with hemodialysis (HD), but psychosocial factors are associated with patient survival. METHODS: To investigate interrelationships between religious beliefs and psychosocial and medical factors, we studied 53 HD patients. Psychosocial and medical variables included perception of importance of faith (spirituality), attendance at religious services (religious involvement), the Beck Depression Inventory, Illness Effects Questionnaire, Multidimensional Scale of Perceived Social Support, McGill QOL Questionnaire scores, Karnofsky scores, dialysis dose, and predialysis hemoglobin and albumin levels. RESULTS: Eighty-seven percent of participants were African-American. Men had higher depression scores, perceived lower social support, and had higher religious involvement scores than women. No other parameters differed between sexes. Perception of spirituality and religiosity did not correlate with age, Karnofsky score, dialysis dose, or hemoglobin or albumin level. Greater perception of spirituality and religiosity correlated with increased perception of social support and QOL and less negative perception of illness effects and depression. A one-question global QOL measure correlated with depression, life satisfaction, perception of burden of illness, social support, and satisfaction with nephrologist scores, but not with age or Karnofsky score. CONCLUSION: Religious beliefs are related to perception of depression, illness effects, social support, and QOL independently of medical aspects of illness. Religious beliefs may act as coping mechanisms for patients with ESRD. The relationship between religious beliefs and clinical outcomes should be investigated further in patients with ESRD.

Pauls, M. and Hutchinson, R. C. [Queen Elizabeth II Health Sciences Centre and Department of Emergency Medicine, Dalhousie University, Halifax, NS; merril_pauls@yahoo.com]. **“Bioethics for clinicians: 28. Protestant bioethics.”** *CMAJ* 166, no. 3 (Feb 5, 2002): 339-43. [Review, 31 refs.] Comment in *CMAJ* 166, no. 9 (Apr 2002): 1135.

[From the abstract:] ...In this article we provide an overview of common Protestant beliefs and highlight concepts that have emerged from Protestant denominations that are particularly relevant to bioethics. These include the sovereignty of God, the value of autonomy and the idea of medicine as a calling as well as a profession....

Pendleton, S. M., Cavalli, K. S., Pargament, K. I. and Nasr, S. Z. [Division of Ambulatory Pediatrics, Department of Pediatrics, Wayne State University, Detroit, MI; spendlet@med.wayne.edu]. **“Religious/spiritual coping in childhood cystic fibrosis: a qualitative study.”** *Pediatrics* 109, no. 1 (Jan 2002): E8. [NOTE: The abstract appears in the print journal, but the article is found only in the journal's on-line pages.]

[Abstract:] OBJECTIVE: To understand the role of religiousness/spirituality in coping in children with cystic fibrosis (CF). METHODS: Participants were a convenience sample of 23 patients with CF, ages 5 to 12 years, and their parent(s) in an ambulatory CF clinic. The design was a focused ethnography including in-depth interviews with children and parent(s), children's drawings, and self-administered written parental questionnaires. Analysis used grounded theory. RESULTS: Main outcome measures were participants' views on religion/spirituality in coping with illness. Data included 632 quotes organized into 257 codes categorized into 11 themes. One overarching domain emerged from analysis of the 11 themes: Religious/Spiritual Coping, composed of 11 religious/spiritual coping strategies. CONCLUSIONS: Children with CF reported a variety of religious/spiritual coping strategies they nearly always associated with adaptive health outcomes. A preliminary conceptual framework for religious/spiritual coping in children with CF is presented. More study is needed to assess how variability in age, disease type, disease severity, religious/spiritual preference, and religious/spiritual intensity affect religious/spiritual coping in children with chronic illness. Future studies should also investigate whether physician attention to religious/spiritual coping could assist patients in coping with CF and strengthen the doctor-patient relationship.

Pesut, B. [Department of Nursing, Trinity Western University, 7600 Glover Road, Langley, BC, V2Y 1Y1, Canada; pesut@twu.ca]. **“The development of nursing students' spirituality and spiritual care-giving.”** *Nurse Education Today* 22, no. 2 (Feb 2002): 128-35.

[Abstract:] Nursing education programs are being increasingly challenged to incorporate spirituality and spiritual care-giving into the curriculum. The purposes of this study were to explore how students in a baccalaureate curriculum perceived their spirituality and spiritual health, and their perceptions of spiritual nursing care. Students in the first and fourth years of the program filled out a survey that included a spiritual well-being scale and several open-ended questions. Overall, students had a strong awareness of personal spirituality and a high level of spiritual health. They identified a number of behaviors and characteristics of the nurse that facilitated spiritual nursing care. Fourth year students demonstrated a more patient-centered approach to spiritual care. They placed less emphasis on the nurse's agenda and qualities and more on supporting the patient's beliefs.

Peterman, A. H., Fitchett, G., Brady, M. J., Hernandez, L. and Cella, D. [Northwestern University, Center on Outcomes, Research and Education, Evanston, IL 60201; a-peterman@northwestern.edu]. **“Measuring spiritual well-being in people with cancer: the functional assessment of chronic illness therapy—Spiritual Well-being Scale (FACIT-Sp).”** *Annals of Behavioral Medicine* 24, no. 1 (Winter 2002): 49-58.

[Abstract:] A significant relation between religion and better health has been demonstrated in a variety of healthy and patient populations. In the past several years, there has been a focus on the role of spirituality, as distinct from religion, in health promotion and coping with illness. Despite the growing interest, there remains a dearth of well-validated, psychometrically sound instruments to measure aspects of spirituality. In this article we report on the development and testing of a measure of spiritual well-being, the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp), within two samples of cancer patients. The instrument comprises two subscales—one measuring a sense of meaning and peace and the other assessing the role of faith in illness. A total score for spiritual well-being is also produced. Study 1 demonstrates good internal consistency reliability and a significant relation with quality of life in a large,

multiethnic sample. Study 2 examines convergent validity with 5 other measures of religion and spirituality in a sample of individuals with mixed early stage and metastatic cancer diagnoses. Results of the two studies demonstrate that the FACIT-Sp is a psychometrically sound measure of spiritual well-being for people with cancer and other chronic illnesses.

Peters, K. F., Kong, F., Hanslo, M. and Biesecker, B. B. [Department of Medicine, Center for Developmental and Health Genetics, and Department of Biobehavioral Health, Pennsylvania State University, University Park, PA.; kfp1@psu.edu]. **“Living with Marfan syndrome III. Quality of life and reproductive planning.”** *Clinical Genetics* 62, no. 2 (Aug 2002): 110-20.

[From the abstract:] ...In this study of 174 affected adults, the overall quality of life was reported to be adequate, although it was significantly decreased within the spiritual/psychological domain....

Peterson, J., Atwood, J. R. and Yates, B. [College of Nursing, University of Nebraska Medical Center, Omaha, NE; jpeterso@fhsu.edu]. **“Key elements for church-based health promotion programs: outcome-based literature review.”** *Public Health Nursing* 19, no. 6 (Nov-Dec 2002): 401-11. [Review, 57 refs.]

[From the abstract:] ...A renewed interest in church-based health promotion programs (CBHPP) is emerging. The purpose of this article is to propose seven key elements found in a literature review to be beneficial in establishing church-based community health promotion programs that demonstrated desired health promotion outcomes. Based on the outcomes of successful CBHPP, the following key elements have been identified: partnerships, positive health values, availability of services, access to church facilities, community-focused interventions, health behavior change, and supportive social relationships. An example of one program that embodies these elements is presented. The Heart and Soul Program, designed to increase physical activity in midlife women to reduce their risk of cardiovascular disease with advancing age, is discussed within the context of the elements for successful church-based programs. CBHPP have effectively promoted health behaviors within certain communities. To promote health and wellness in light of our diverse society and health needs, health promotion professionals and churches can be dynamic partners.

Pettus, M. C. [University of Massachusetts School of Medicine, Pittsfield, MA 01201]. **“Implementing a medicine-spirituality curriculum in a community-based internal medicine residency program.”** *Academic Medicine* 77, no. 7 (Jul 2002): 745.

[Abstract:] **OBJECTIVE:** To promote greater sensitivity to and heightened awareness of the relevance and therapeutic potential of integrating medicine and spirituality in the healing process of patients cared for by our medical residents. Strategies for clear, effective, and empathetic communication are integrated into the curriculum. **DESCRIPTION:** With the support of The University of Massachusetts Medical School Macy Initiative in health communication, funded by the Josiah Macy, Jr. Foundation, we have fully implemented a medicine-spirituality curriculum as an integral aspect of our residency program. Current strategies include (1) new house officers participate in the workshop "Communicating Bad News," which is based on a videotaped interaction and experiential role-play about the challenging "art" of sharing bad and often traumatic news; (2) a monthly lecture series that looks at various aspects of religious and spiritual practices and their implications on science and health with topics including the following: taking a spiritual history, exploring world religious views from a Judeo-Christian perspective, studying Eastern philosophies such as Buddhism and Hinduism, and discussing cultural diversity's effect on how people understand and cope with illness; (3) residents receive a comprehensive, evidence-based syllabus that encompasses all of the medical literature relating to spirituality, religion and health; (4) local hospice professionals give end-of-life care lectures about pain management, palliation, advanced directives, and ethical implications; (5) our residents spend one or two days per year with our pastoral care leaders and one to two days per year with our hospice team; (6) monthly ward rounds with a faculty member who emphasizes the spiritual dimension of a particular case and the faith-based resources in our hospital and community. **DISCUSSION:** Traditionally, graduate medical education has not emphasized the importance of spirituality as a "target" for routine inquiry, understanding, and sharing in the context of patient care. We are beginning to see that residents need to be aware of the relationship between spirituality and health, as a consequence of this curriculum. Because the curriculum is seamlessly integrated into a preexisting infrastructure (e.g., noon conferences, ambulatory off-site experiences, walk-rounds, etc.), it has been relatively easy to implement. Focusing on the literature has also provided a "scientific door" that has made this more palatable. Over time, we will foster a growing alliance of the medical and faith communities in our rural area. This has potent implications for community health initiatives. Two of our residents have already volunteered to give talks at local congregations. Spirituality and religion are sensitive and personal areas that can be awkward to embrace and openly discuss. By remaining sensitive and respectful of all views, we strive to diminish the obstacles and enable a more provocative, enlightening residency experience. As a consequence, we are forced to reconsider what it is to be a "healer" and what it is to be "healed." Annual verbal and written feedback will allow us to refine our curriculum. I anticipate this to be a permanent aspect of our residents' training.

Plotnikoff, G. A., Numrich, C., Wu, C., Yang, D. and Xiong, P. [Center for Spirituality and Healing, University of Minnesota]. **“Hmong shamanism. Animist spiritual healing in Minnesota.”** *Minnesota Medicine* 85, no. 6 (Jun 2002): 29-34.

[Abstract:] Hmong cultural attitudes, values, and behaviors influence when, where, why, and with whom a Hmong person will use Western medicine. Understanding the practices and importance of Hmong healing traditions will help majority-culture physicians provide respectful and effective health care to Hmong patients. The foremost Hmong traditional healer is the shaman (*tu txiv neeb*, pronounced "too tse neng"). There is no equivalent health professional in Western biomedicine, and the scope of the shaman as a healer extends beyond the capacities and expertise of physicians. Despite 25 years of Hmong acculturation in the United States and conversion to Christianity, Hmong shamanism maintains its traditional role in health and healing. Many Hmong who see physicians also rely on shamans for restoring health and balance to their body and soul. Thus, the Hmong shaman can be considered a powerful complement to Western health care professionals. This article presents the results of semistructured interviews with 11 Hmong shamans (5 males, 6 females, ranging in age from 35 to 85) and 32 nonrandomly selected Hmong patients (14 males, 18 females ranging in age from 21 to 85). The shamans described their spiritual perspectives, training and skills, and professional activities. Patients described their beliefs about spiritual healing and health care. These interviews suggest that Shamanism is considered effective care by many Hmong, irrespective of age, gender, or degree of acculturation. The article also includes summary charts of Hmong healing practices and concludes with a set of questions designed to help practicing physicians access the assumptions and beliefs of their Hmong patients so that they can provide efficient, effective, and satisfactory care.

Puchalski, C. M. [Departments of Medicine and Health Care Sciences, The George Washington Institute for Spirituality and Health, GWU Medical Center, 2300 K Street NW, Warwick Building #336, Washington, DC 20037; hcscmp@gwumc.edu].

- “**Spirituality and end-of-life care: a time for listening and caring.**” *Journal of Palliative Medicine* 5, no. 2 (Apr 2002): 289-94.
- Purdy, W. A. [wapurdy@aol.com]. “**Spiritual discernment in palliative care.**” *Journal of Palliative Medicine* 5, no. 1 (Feb 2002): 139-41.
- Raholm, M. B. [Tampere University Hospital, Finland]. “**Weaving the fabric of spirituality as experienced by patients who have undergone a coronary bypass surgery.**” *Journal of Holistic Nursing* 20, no. 1 (Mar 2002): 31-47.
[Abstract:] When one is faced with a life-threatening event, spiritual issues become extremely important. The depth of one person's suffering is a unique experience. The relationship that developed between the interpretation of the answers of the coronary artery bypass patients and self-interpretation were the two directions in which this hermeneutic research moved forward within the hermeneutic circle. Central implications of the concept of spirituality emerging from this study are spirituality as meaning through gaining a new appreciation of life and health, spirituality as an inner strength through love and faith and in an ontological sense, spirituality as an inner strength through suffering and desire. Suffering invites one into the spiritual domain. Indeed, this concept raises important considerations for the development of caring knowledge about spirituality.
- Raholm, M. B., Lindholm, L. and Eriksson, K. [Tampere University Hospital, Finland]. “**Grasping the essence of the spiritual dimension reflected through the horizon of suffering: an interpretative research synthesis.**” *Australian Journal of Holistic Nursing* 9, no. 1 (Apr 2002): 4-13. [Review, 43 refs.]
[Abstract:] The purpose of this research synthesis was to describe the essence of the spiritual dimension reflected through the horizon of suffering. The material reviewed consisted of 18 articles published between 1989 and 2000 in caring and nursing journals. A depth in the interpretation of the texts was discovered where four different themes emerged: undemanding communion, confirmation of dignity, the dialectic of suffering, and the creation of coherence of meaning.
- Rammohan, A., Rao, K. and Subbakrishna, D. K. [Department of Clinical Psychology, National Institute of Mental Health and Neuro Sciences (NIMHANS), Hosur Road, Bangalore 560 029, Karnataka, India]. “**Religious coping and psychological wellbeing in carers of relatives with schizophrenia.**” *Acta Psychiatrica Scandinavica* 105, no. 5 (May 2002): 356-62.
[Abstract:] OBJECTIVE: To examine the use of religious coping and its relation to psychological wellbeing in carers of relatives with schizophrenia. METHOD: Sixty carers of patients with an ICD-10 diagnosis of schizophrenia, were assessed on strength of religious belief, perceived burden, religious and other coping strategies and psychological wellbeing. RESULTS: Coping strategies of denial and problem solving, strength of religious belief and perceived burden were significant predictors of wellbeing. CONCLUSION: Strength of religious belief plays an important role in helping family members to cope with the stress of caring for a mentally ill relative. In addition to psychoeducation and problem solving coping, the role of religious coping in enhancing wellbeing of carers needs to be considered in family intervention programs.
- Robinson-Smith, G. [Villanova University]. “**Prayer after stroke. Its relationship to quality of life.**” *Journal of Holistic Nursing* 20, no. 4 (Dec 2002): 352-66.
[Abstract:] Research has documented that recovery from a stroke is stressful, often necessitating significant coping efforts. Difficult life events such as stroke may encourage patients to reexamine spiritual aspects of life, and the challenges associated with stroke can promote spiritual growth and development. Because of the life-changing experience of stroke, spiritual practices may assist patients in finding meaning and wholeness through the confidence they offer. The purpose of this article is to report how 8 patients used prayer after stroke as a coping strategy to improve self-efficacy and quality of life after stroke. A qualitative approach using the long interview method was employed to expand on spiritual practices expressed through prayer as a way of coping after stroke. Potential strategies are suggested for nurses that address patients' spiritual needs.
- Rossiter-Thornton, J. F. “**Prayer in your practice.**” *Complementary Therapies in Nursing & Midwifery* 8, no. 1 (Feb 2002): 21-8.
[Review, 17 refs.] Comment on pp. 1-6. [The article is paired with Targ, E., “Research methodology for studies of prayer and distant healing,” also noted in this bibliography.]
[Abstract:] This article is intended for anyone interested in introducing prayer into his or her practice. It outlines the reasons for using prayer and addresses some of the objections put forward by certain professionals. The paper then describes The Prayer Wheel, a practical non-denominational way to pray and provides instructions on how to present it as an adjunct in health care.
- Ruhl, T. S. “**Spiritual informed consent for CAM.**” *Archives of Internal Medicine* 162, no. 8 (Apr 22, 2002): 943-4.
This brief comment raises an interesting issue of informed consent in cases of research involving a spiritual intervention.
- Salari, S. [Department of Family and Consumer Studies, University of Utah, Salt Lake City, UT 84112; sonia.salari@fcs.utah.edu]. “**Invisible in aging research: Arab Americans, Middle Eastern immigrants, and Muslims in the United States.**” *Gerontologist* 42, no. 5 (Oct 2002): 580-8.
[Abstract:] Recent worldwide events have focused greater attention on the Middle East. Little is known about the diverse populations of older persons living in the United States who have Middle Eastern origins and/or practice Islam. Stereotypes and backlash can negatively influence the quality of life for mid- and later-life individuals and their families. Gerontologists can improve conditions by incorporating new knowledge of these groups into research, policy, and practice to dispel stereotypes and provide appropriate services. This article focuses on the demographic characteristics and diversity among mid- and later-life Arab Americans, Muslims, and Middle Eastern immigrants and their descendants. Further research is needed to shed light on the family support, social patterns, housing environments, health care needs, service utilization, and quality of life among immigrants and their descendants across the life course.
- Schoenberger, N. E., Matheis, R. J., Shiflett, S. C. and Cotter, A. C. [Kessler Medical Rehabilitation Research and Education Corp., West Orange, NJ; nancysholland@bellsouth.net]. “**Opinions and practices of medical rehabilitation professionals regarding prayer and meditation.**” *Journal of Alternative & Complementary Medicine* 8, no. 1 (Feb 2002): 59-69.

[From the abstract:] OBJECTIVE: To assess the attitudes and practices of professionals in the field of physical medicine and rehabilitation (PM&R) regarding prayer and meditation. DESIGN: A national mail survey that included questions about the use of a number of complementary and alternative therapies. PARTICIPANTS: The survey was mailed to 7,479 physicians, nurses, physical therapists, and occupational therapists who specialize in PM&R, and 1221 (17%) returned completed surveys. RESULTS: Although the majority of respondents endorsed prayer as a legitimate health care practice, there was greater belief in the benefits of meditation. Older respondents were more likely to recommend meditation to their patients and more likely to meditate themselves. Gender differences that were observed in opinions and practices are better interpreted as differences in professional specialty. In general, nurses and occupational therapists responded more positively toward meditation and prayer than did physicians and physical therapists. Personal use of a technique was the strongest predictor of professional behaviors. Attitude was a stronger predictor of professional use or referral for prayer than meditation, but correlations between attitude and behavior were generally weak for both techniques. Despite their acceptance of these techniques, the vast majority of rehabilitation professionals did not refer their patients for meditation or religious consultation....

Shahabi, L., Powell, L. H., Musick, M. A., Pargament, K. I., Thoresen, C. E., Williams, D., Underwood, L. and Ory, M. A. [Department of Preventive Medicine, Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL 60612]. **“Correlates of self-perceptions of spirituality in American adults.”** *Annals of Behavioral Medicine* 24, no. 1 (Winter 2002): 59-68.

[Abstract:] To advance knowledge in the study of spirituality and physical health, we examined sociodemographic, behavioral, and attitudinal correlates of self-perceptions of spirituality. Participants were a nationally representative sample of 1,422 adult respondents to the 1998 General Social Survey. They were asked, among other things, to rate themselves on the depth of their spirituality and the depth of their religiousness. Results indicated that, after adjustment for religiousness, self-perceptions of spirituality were positively correlated with being female ($r = .07$, $p < .01$), having a higher education ($r = .12$, $p < .001$), and having no religion ($r = .10$, $p < .001$) and inversely correlated with age ($r = -.06$, $p < .05$) and being Catholic ($r = -.08$, $p < .01$). After adjustment for these sociodemographic factors, self-perceptions of spirituality were associated with high levels of religious or spiritual activities (range in correlations = .12-.38, all $p < .001$), low cynical mistrust, and low political conservatism (both $r = -.08$, $p < .01$). The population was divided into 4 groups based on their self-perceptions of degree of spirituality and degree of religiousness. The spiritual and religious group had a higher frequency of attending services, praying, meditating, reading the Bible, and daily spiritual experience than any of the other 3 groups (all differences $p < .05$) and had less distress and less mistrust than the religious-only group ($p < .05$ for both). However, they were also more intolerant than either of the nonreligious groups ($p < .05$ for both) and similar on intolerance to the religious-only group. We conclude that sociodemographic factors could confound any observed association between spirituality and health and should be controlled. Moreover, individuals who perceive themselves to be both spiritual and religious may be at particularly low risk for morbidity and mortality based on their good psychological status and ongoing restorative activities.

Shannon, S. E. and Tatum, P. [Department of Family and Community Medicine, University of Missouri-Columbia]. **“Spirituality and end-of-life care.”** *Missouri Medicine* 99, no. 10 (Nov-Dec 2002): 571-6.

[Abstract:] As dying patients adjust to the irreversible nature of their illness, their needs and focus of care changes. Spiritual issues may become a central concern for them, and addressing these issues can be key to relieving suffering. Physicians, unfortunately, have little training in this area and are often uncomfortable discussing spirituality. In this article, we address the role of spirituality in end-of-life care, and discuss a format for spiritual assessment. We hope this will encourage more comprehensive patient-centered, end-of-life care.

Siegel, B., Tenenbaum, A. J., Jamanka, A., Barnes, L., Hubbard, C. and Zuckerman, B. [Dept. of Pediatrics, Boston Medical Center, Boston Univ. School of Medicine, Boston, MA 02118; bsiegel@bu.edu]. **“Faculty and resident attitudes about spirituality and religion in the provision of pediatric health care.”** *Ambulatory Pediatrics* 2, no. 1 (Jan-Feb 2002): 5-10.

[Abstract:] OBJECTIVE: To characterize pediatricians' attitudes toward spirituality/religion (S/R) in relationship to the practice of pediatrics. METHODS: Pediatric faculty ($n = 100$) and residents ($n = 65$) in an urban academic medical center completed a questionnaire about their attitudes toward and clinical practices related to S/R. Study variables included the strength of personal S/R orientation, attitudes toward S/R, clinicians' discussion of S/R with patients and families, self-reported S/R behaviors, the medical conditions that warrant discussion of S/R, and attitudes toward praying with patients if asked to do so. RESULTS: Sixty-five percent of pediatricians felt that faith plays a role in healing, and 76% reported feeling comfortable praying with a patient if asked to do so. Ninety-three percent would ask about S/R when discussing a life-threatening illness, and 96% when discussing death and dying. A strong personal S/R orientation was associated with beliefs that the pediatrician should discuss S/R with the patient ($P < .01$); beliefs that faith plays a role in healing ($P < .01$); and feelings that patients would like to discuss S/R with their pediatrician ($P < .01$), that the doctor-patient relationship would be strengthened by discussion of S/R ($P < .01$), and that physicians should call on an S/R leader for an illness or death ($P < .01$). Personal S/R orientation was not related to whether physicians reported that they discuss S/R issues with their patients ($P = .08$). Residents were more likely than faculty to state that it is appropriate to pray with patients if asked to do so ($P < .05$), and compared with pediatricians who were science majors in college, pediatricians who were nonscience majors in college felt more comfortable praying with patients if asked to do so ($P < .01$). CONCLUSIONS: In an urban, inner-city, academic medical center, pediatric residents and faculty have an overall positive attitude toward the integration of S/R into the practice of pediatrics.

Simpson, J. [Queen Margaret Hospital, Fife Acute Hospitals NHS Trust, Dunfermline]. **“Nursing with dignity. Part 9: Jehovah's Witnesses.”** *Nursing Times* 98, no. 17 (Apr 23-29, 2002): 36-7, 2002. Comment on p. 19.

[Abstract:] This article describes the main teachings and customs of Jehovah's Witnesses. It offers some guidelines to enable nurses to provide sensitive and appropriate care to patients who are Jehovah's Witnesses.

Smith, S. H. [Rutgers, The State University School of Social Work, Camden, NJ; sash@crab.rutgers.edu]. **“‘Fret no more my child ... for I'm all over heaven all day': religious beliefs in the bereavement of African American, middle-aged daughters coping with the death of an elderly mother.”** *Death Studies* 26, no. 4 (May 2002): 309-23.

[Abstract:] This article examines the ways in which religious beliefs of 30 African American, middle-aged daughters help them cope with the death of their elderly mothers. This qualitative, exploratory study found that daughters use their beliefs to move through states of grief that allow them to prepare, relinquish control, accept death, and maintain a connection to their mothers beyond death. Important themes identified in this study include the belief in an after life and the reunification of family members there. Findings suggest that religious

beliefs provide a means for adult daughters to cope with the tasks of living in the present yet maintain a tie with their deceased mothers that serves to enhance their religious beliefs and fortitude in daily living.

Soothill, K., Morris, S. M., Harman, J. C., Thomas, C., Francis, B. and McIlmurray, M. B. [Dept. of Applied Social Science, Lancaster University, Lancaster, UK; k.soothill@lancaster.ac.uk]. **“Cancer and faith. Having faith—Does it make a difference among patients and their informal carers?”** *Scandinavian Journal of Caring Sciences* 16, no. 3 (Sep 2002): 256-63.

[Abstract:] This research considers the impact of having a religious faith on the cancer experience of patients and informal carers, focusing primarily on the association between faith and psychosocial needs. A questionnaire survey of 1000 patients in the north-west of England returned 402 completed questionnaires; around two-thirds of patients indicated they had an informal carer. Using logistic regression analysis, we examine the relationship between the importance of 48 needs and faith for 189 paired patients and carers, while controlling for the effect of eight socio-demographic and clinical variables. Patients with expressed faith identified fewer psychosocial needs than those without faith. In contrast, carers with expressed faith identified more needs than those without faith in relation to support from family and neighbors. Carers also needed more help with finding a sense of purpose and meaning, and help in dealing with unpredictability. Not surprisingly, both patients and carers with faith identified a greater need for opportunities for personal prayer, support from people of their own faith and support from a spiritual adviser. Various explanations of these differences between patients and carers are proposed. The crucial point is that one should not too readily assume that the cancer experience is shared in the same way by patients and carers. In understanding the faith dimension, one needs to consider both the spiritual and secular aspects of having a religious faith.

Spaniol, L. **“Spirituality and connectedness.”** *Psychiatric Rehabilitation Journal* 25, no. 4 (Spring 2002): 321-2.

The author puts forward the concept of “connectedness” as a central quality of spirituality.

Stanton, A. L., Danoff-Burg, S. and Huggins, M. E. [Department of Psychology, University of Kansas, Lawrence 66045-2160; astanton@ku.edu]. **“The first year after breast cancer diagnosis: hope and coping strategies as predictors of adjustment.”** *Psycho-Oncology* 11, no. 2 (Mar-Apr 2002): 93-102.

Among the findings [from the abstract]: ...The hypothesis that coping through turning to religion would be more effective for less hopeful women was supported....

Stutts, A. and Schloemann, J. [St. Francis Medical Center, Cape Girardeau, MO]. **“Life-sustaining support: ethical, cultural, and spiritual conflicts. Part II: Staff support—a neonatal case study.”** *Neonatal Network - Journal of Neonatal Nursing* 21, no. 4 (Jun 2002): 27-34.

[From the abstract:] As medical knowledge and technology continue to increase, so will the ability to provide life-sustaining support to patients who otherwise would not survive. Along with these advances comes the responsibility of not only meeting the clinical needs of our patients, but also of understanding how the family's culture and spirituality will affect their perception of the situation and their decision-making process. As the U.S. continues to become a more culturally diverse society, health care professionals will need to make changes in their practice to meet the psychosocial needs of their patients and respect their treatment decisions. Part I of this series...[Stutts, A. and Schloemann, J. “Life Sustaining Support: Ethical, Cultural, and Spiritual Conflicts Part I: Family Support—A Neonatal Case Study.” *Neonatal Network - Journal of Neonatal Nursing* 21, no. 3 (April 2002): 23-9.]...discussed how the cultural and spiritual belief systems of Baby S's family affected their decision-making processes and also their ability to cope with the impending death of their infant. The development of a culturally competent health care team can help bridge the gap between culturally diverse individuals....

Sulmasy, D. P. [The Bioethics Institute of New York Medical College and The John J Conley Department of Ethics, Saint Vincent's Manhattan, New York, NY 10011; daniel_sulmasy@nycmc.edu]. **“A biopsychosocial-spiritual model for the care of patients at the end of life.”** *Gerontologist* 42, Spec No. 3 (Oct 2002): 24-33. [Review, 84 refs.]

[Abstract:] PURPOSE: This article presents a model for research and practice that expands on the biopsychosocial model to include the spiritual concerns of patients. DESIGNS AND METHODS: Literature review and philosophical inquiry were used. RESULTS: The healing professions should serve the needs of patients as whole persons. Persons can be considered beings-in-relationship, and illness can be considered a disruption in biological relationships that in turn affects all the other relational aspects of a person. Spirituality concerns a person's relationship with transcendence. Therefore, genuinely holistic health care must address the totality of the patient's relational existence-physical, psychological, social, and spiritual. The literature suggests that many patients would like health professionals to attend to their spiritual needs, but health professionals must be morally cautious and eschew proselytizing in any form. Four general domains for measuring various aspects of spirituality are distinguished: religiosity, religious coping and support, spiritual well-being, and spiritual need. A framework for understanding the interactions between these domains is presented. Available instruments are reviewed and critiqued. An agenda for research in the spiritual aspects of illness and care at the end of life is proposed. IMPLICATIONS: Spiritual concerns are important to many patients, particularly at the end of life. Much work remains to be done in understanding the spiritual aspects of patient care and how to address spirituality in research and practice.

Tang, T. S., White, C. B. and Gruppen, L. D. [Department of Medical Education, University of Michigan Medical School, Ann Arbor, MI 48109-0201]. **“Does spirituality matter in patient care? Establishing relevance and generating skills.”** *Academic Medicine* 77, no. 5 (May 2002): 470-1.

This is a brief report of a Spirituality and Medicine program for second-year medical students at the University of Michigan.

Tanyi, R. A. [Orthopedics and Spine, Regions Hospital, Saint Paul, MN; rtanyi@yahoo.com]. **“Towards clarification of the meaning of spirituality.”** *Journal of Advanced Nursing* 39, no. 5 (Sept 2002): 500-9.

[Abstract:] BACKGROUND: Rhetoric about spirituality and nursing has greatly increased, as scientific-based approaches are not fully able to address many human problems, such as persistent pain. Despite the renewed interest and growing literature on spirituality, there is no consensus on a definition of this concept. There is also ambiguity on how this concept is incorporated into nursing practice, research, and education. AIM: This paper aims to contribute toward clarification of the meaning of spirituality in relevance to health and nursing today through a conceptual analysis process. METHODS: Information was obtained through dictionary definitions and electronic database

searches of literature on spirituality spanning the past 30 years. The criteria for selection included scholarly articles and books with a definition of spirituality, and research studies that investigated the meaning of spirituality to individuals' health. A total of 76 articles and 19 books were retrieved for this analysis. FINDINGS: Spirituality is an inherent component of being human, and is subjective, intangible, and multidimensional. Spirituality and religion are often used interchangeably, but the two concepts are different. Spirituality involves humans' search for meaning in life, while religion involves an organized entity with rituals and practices about a higher power or God. Spirituality may be related to religion for certain individuals, but for others, such as an atheist, it may not be. CONCLUSION: In order to provide clarity and enhance understanding of this concept, this analysis delineates antecedents, attributes, constructed case examples, empirical referents, and consequences of spirituality. A proposed definition of spirituality emerged from this process, which may be applied broadly. Implications for nursing practice, education, and research are discussed.

Targ, E. [Complementary Medical Research Institute, California Pacific Medical Center, San Francisco, CA 94115]. **“Research methodology for studies of prayer and distant healing.”** *Complementary Therapies in Nursing & Midwifery* 8, no. 1 (Feb 2002): 29-41. [Review, 35 refs.] [The article is paired with Rossiter-Thornton, J. F., “Prayer in your practice,” also noted in this bibliography.]

[Abstract:] The double-blind randomized clinical trial is the gold standard for trials of prayer and distant healing. Adequate blinding and randomization procedures should be followed and documented. The intervention must be well defined (include frequency, amount of time and training and/or experience level of healers). Subjects should have risks and benefits of study participation explained to them and sign informed consent before enrollment. Populations should be homogeneous. Consider stratification for smaller samples. Baseline information, including psychological status, beliefs about prayer and healing and other sources of prayer and healing, should be collected from subjects in clinical trials. This should be examined as part of the final data analysis for contribution to outcomes. Objectively measurable outcomes with adequate variability should be chosen. Subject study participation activities such as clinical interviews, traveling to special sites, journaling or meditation should be minimized to avoid washing out a small effect. In clinical trials subjects should be asked if they believed they were in the treatment group and this information should be entered as a co-variate for data analysis. Healers/prayers should be treated in a collegial and respectful way. Their healing efforts (time, location, method) should be documented in a log and they should be periodically contacted and encouraged by experimenters if the study is taking place over an extended period of time. Observational and outcomes research can add an important dimension to healing research. Qualitative studies may also make an important contribution and help guide development of future controlled trials.

Tarpley, J. L. and Tarpley, M. J. [Surgical Service, Veterans Affairs Medical Center, Vanderbilt University School of Medicine, Nashville, TN 37232-2730]. **“Spirituality in surgical practice.”** *Journal of the American College of Surgeons* 194, no. 5 (May 2002): 642-7. [Review, 38 refs.]

This overview and commentary addresses the importance of patient spirituality and notes the beginnings of “scientific scrutiny of the mechanisms.”

Tate, D. G. and Forchheimer, M. [University of Michigan Model Spinal Cord Injury Program, Ann Arbor, MI]. **“Quality of life, life satisfaction, and spirituality: comparing outcomes between rehabilitation and cancer patients.”** *American Journal of Physical Medicine & Rehabilitation* 81, no. 6 (Jun 2002): 400-10.

[Abstract:] OBJECTIVE: To determine differences in quality of life, life satisfaction, and spirituality across different patient groups and to determine what factors may relate to these three outcomes across rehabilitation and cancer patients. DESIGN: Subjects were first stratified by five diagnostic groupings. Patient data were then regrouped for additional analytic purposes into two large cohorts. All subjects completed questionnaires once. Differences in scores and correlations were computed, and regression models were specified. RESULTS: Group differences were found across the quality of life measures used in the study. There were also differences in life satisfaction and spiritual well-being. Spirituality was found to be associated with both quality of life and life satisfaction, although it was not a significant predictor in a multivariate context. CONCLUSIONS: In general, subjects with prostate cancer reported higher scores across all measures. Spirituality showed a strong association with both life satisfaction and quality of life, and it was a significant predictor of life satisfaction among rehabilitation subjects. Factors such as age, marital status, and work status, in addition to specific dimensions of quality of life, such as social functioning and functional well-being, were found to be associated with total quality of life.

Taylor, E. J. and Outlaw, F. H. [School of Nursing, Loma Linda University, Los Angeles, CA]. **“Use of prayer among persons with cancer.”** *Holistic Nursing Practice* 16, no. 3 (Apr 2002): 46-60.

[Abstract:] This study explored how persons use prayer to cope with cancer. Employing phenomenologic methods, 30 informants were interviewed in depth about why, when, and how they prayed, as well as what they prayed for and the outcomes expected. Findings detail how patients use prayer to ease the physical, emotional, and spiritual distresses of illness. A range of approaches to prayer and topics for prayer was observed, often determined by illness circumstances. The article provides a discussion that begins to suggest how these data can inform clinical practice and future research.

Thompson, I. **“Mental health and spiritual care.”** *Nursing Standard* 17, No. 9 (Nov 13-19, 2002): 33-8.

[Abstract:] BACKGROUND: Achieving holistic care is an important goal for nurses. While much is made of the bio-psychosocial model of holistic care, reflecting the allopathic bias inherent in the Western medical model, the issue of spirituality is mostly neglected. Where acknowledged, spirituality is often limited to recording the client's religion. This article asserts that religion and spirituality are not synonymous, although spirituality might sometimes be reflected through religious practices. CONCLUSION: With the move towards provision of modern mental health services in the community, the community mental health nurse will increasingly care for individuals for whom the spiritual is part of their daily lives and not a symptom of their illness. This is set against the backdrop of a multicultural society and as such will call for holistic nursing skills.

Thoresen, C. E. and Harris, A. H. [School of Education, Stanford University; cthor@stanford.edu]. **“Spirituality and health: what's the evidence and what's needed?”** *Annals of Behavioral Medicine* 24, no. 1 (Winter 2002): 3-13. [Review, 80 refs.]

[Abstract:] In this article, we familiarize readers with some recent empirical evidence about possible associations between religious and/or spiritual (RS) factors and health outcomes. In considering this evidence, we believe a healthy skepticism is in order. One needs to remain

open to the possibility that RS-related beliefs and behaviors may influence health, yet one needs empirical evidence based on well-controlled studies that support these claims and conclusions. We hope to introduce the dismissing critic to suggestive data that may create tempered doubt and to introduce the uncritical advocate to issues and concerns that will encourage greater modesty in the making of claims and drawing of conclusions. We comment on the following questions: Do specific RS factors influence health outcomes? What possible mechanisms might explain a relation, if one exists? Are there any implications for health professionals at this point in time? Recommendations concern the need to improve research designs and measurement strategies and to clarify conceptualizations of RS factors. RS factors appear to be associated with physical and overall health, but the relation appears far more complex and modest than some contend. Which specific RS factors enhance or endanger health and well-being remains unclear.

Tloczynski, J. and Fritzsche, S. [Psychology Department, Bloomsburg University, PA 17815; jptloczyn@prolog.net]. **“Intercessory prayer in psychological well-being: using a multiple-baseline, across-subjects design.”** *Psychological Reports* 91, no. 3, pt. 1 (Dec 2002): 731-41.

[Abstract:] Undergraduates from an upper-level psychology course were volunteer participants in the study. The 8 participants were to be prayed for in a Multiple Baseline Across Subjects research design, which included a 1-week minimum baseline period for all subjects followed by the sequential presentation of the independent variable so that every two weeks, two additional subjects were being prayed for until all but 2 participants, who maintained baseline, were exposed to being prayed for at 7 weeks. All participants were prayed for by one of the experimenters using a nondirective method of prayer where no specific requests were made. All subjects completed the Taylor Manifest Anxiety Scale on a daily basis for 5 weeks and the Minnesota Multiphasic Personality Inventory-2 on a weekly basis for 7 weeks. Analysis of data identified significant reductions in anxiety scores on both the tests for subjects who were prayed for but not for those who were not prayed for. Subjects' lower mean anxiety scores somewhat matched the sequential timing of being prayed for.

Treloar, L. L. [Scottsdale Community College, Scottsdale, AZ 85256; linda.treloar@sccmail.maricopa.edu]. **“Disability, spiritual beliefs and the church: the experiences of adults with disabilities and family members.”** *Journal of Advanced Nursing* 40, no. 5 (Dec 2002): 594-603.

[From the abstract:] AIMS: This paper reports the findings of a qualitative interpretive study that explored how people with disabilities and family members use their spiritual beliefs to establish meaning for disability, and to respond to the challenges of lived experience with disability. The participants' perceptions of the evangelical Christian church's influence on their spiritual experiences related to disability suggest recommendations for improved integration by the church. Applications are drawn for helping professionals and religious leaders who provide holistic care. ...DESIGN/METHODS: The author interviewed 30 persons, comprising two major groups: 13 parents of children with mixed developmental disabilities and nine adults with physical disabilities. Predominantly white, the participants lived in a south-western metropolitan area in the United States of America (USA) in 1998. FINDINGS: Trial or difficulty contributed to spiritual challenge, the breaking of self, reliance on God, and strengthened faith in God. The participants chose to live with thankfulness and joy despite difficulties common to experience with disability. The participants' spiritual beliefs stabilized their lives, providing meaning for the experience of disability, assistance with coping and other benefits. The participants' recommendations include increased assistance by the church in promoting theological understanding of disability, and religious support using a continuing model of caring....

Tsuang, M. T., Williams, W. M., Simpson, J. C. and Lyons, M. J. [Harvard Institute of Psychiatric Epidemiology and Genetics, Harvard Medical School Department of Psychiatry, Massachusetts Mental Health Center, Boston, MA 02115; Ming_Tsuang@hms.harvard.edu]. **“Pilot study of spirituality and mental health in twins.”** *American Journal of Psychiatry* 159, no. 3 (Mar 2002): 486-8.

[Abstract:] OBJECTIVE: The goal of this study was to investigate associations between empirically defined dimensions of spirituality, personality variables, and psychiatric disorders in Vietnam era veterans. METHOD: One hundred pairs of male twins from the Vietnam Era Twin Registry were administered the self-report Spiritual Well-Being Scale and a pilot Index of Spiritual Involvement. Correlation analyses were supplemented with regression analyses that examined the relative influence of genetic and environmental factors on aspects of spirituality. RESULTS: Existential well-being was significantly associated with seven of 11 dimensions of personality and was significantly negatively associated with alcohol abuse or dependence and with two of three clusters of personality disorder symptoms. Associations between mental health variables and religious well-being or spiritual involvement were much more limited. CONCLUSIONS: Useful distinctions can be made between major dimensions of spirituality in studies of spirituality, religious coping, and mental health.

Underwood, L. G. and Teresi, J. A. [Fetzer Institute, Kalamazoo, MI 49009; info@fetzer.org]. **“The Daily Spiritual Experience Scale: development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health-related data.”** *Annals of Behavioral Medicine* 24, no. 1 (Winter 2002): 22-33.

[Abstract:] Spirituality and religiousness are gaining increasing attention as health research variables. However, the particular aspects examined vary from study to study, ranging from church attendance to religious coping to meaning in life. This frequently results in a lack of clarity regarding what is being measured, the meaning of the relationships between health variables and spirituality, and implications for action. This article describes the Daily Spiritual Experience Scale (DSES) and its development, reliability, exploratory factor analyses, and preliminary construct validity. Normative data from random samples and preliminary relationships of health-related data with the DSES also are included. Detailed data for the 16-item DSES are provided from two studies; a third study provided data on a subset of 6 items, and a fourth study was done on the interrater reliability of the item subset. A 6-item version was used in the General Social Survey because of the need to shorten the measure for the survey. A rationale for the conceptual underpinnings and item selection is provided, as are suggested pathways for linkages to health and well-being. This scale addresses reported ordinary experiences of spirituality such as awe, joy that lifts one out of the mundane, and a sense of deep inner peace. Studies using the DSES may identify ways in which this element of life may influence emotion, cognition and behavior, and health or ways in which this element may be treated as an outcome in itself a particular component of well-being. The DSES evidenced good reliability across several studies with internal consistency estimates in the .90s. Preliminary evidence showed that daily spiritual experience is related to decreased total alcohol intake, improved quality of life, and positive psychosocial status.

- Unruh, A. M., Versnel, J. and Kerr, N. [School of Occupational Therapy, Dalhousie University, Halifax, NS B3H 3J5; anita.unruh@dal.ca]. **“Spirituality unplugged: a review of commonalities and contentions, and a resolution.”** *Canadian Journal of Occupational Therapy - Revue Canadienne d'Ergotherapie* 69, no. 1 (Feb 2002): 5-19.
 [Abstract:] Spirituality is an important and essential component of occupational therapy, but recent publications in occupational therapy literature also raise questions about the adequacy of the Canadian Association of Occupational Therapists' definition of spirituality and the relationship of spirituality to occupational performance. Re-examination of spirituality and occupation is needed to better understand the role of occupational therapists with respect to spirituality. In this paper, the authors examine the common themes that are inherent in definitions of spirituality from diverse professional perspectives. The commonalities and contentions inherent in these definitions are then contrasted with the perspectives of occupational therapists. This discussion is followed by a challenge for re-examination of spirituality in the Canadian Model of Occupational Performance, and an argument that occupational identity rather than spirituality should have a central position. The implications of spirituality and occupational identity for evidence-based occupational therapy are considered.
- Van Ness, P. H. and Larson, D. B. [Department of Epidemiology and Public Health, Yale University School of Medicine, New Haven, CT 06520-8034; peter.vanness@yale.edu]. **“Religion, senescence, and mental health: the end of life is not the end of hope.”** *American Journal of Geriatric Psychiatry* 10, no. 4 (Jul-Aug 2002): 386-97. [Review, 97 refs.]
 [Abstract:] The authors review epidemiological and survey research relevant to the relationships between religiousness/spirituality and mental health in people at the end of life, with the end of helping psychiatrists, psychologists, and other mental health professionals dealing with older Americans. They give special attention to well-being, religious coping, cognitive dysfunction, anxiety, depression, and suicide, and consider the extent to which hope is a mediator of the purported salutary effects of religiousness. Studies were selected from the comprehensive and systematic review of 20th-century scientific literature concerning religion and health. Authors also review current studies relevant to religion and end-of-life issues. Religious persons reported generally higher levels of well-being. The review also found fairly consistent inverse associations of religiousness with rates of depression and suicide. There was some negative association between religious participation and cognitive dysfunction, but the association with anxiety was inconsistent, with some studies showing a correlation between higher levels of religion and anxiety. Religion's effects on mental health are generally protective in direction but modest in strength.
- Walach, H., Bosch, H., Haraldsson, E., Marx, A., Tomasson, H., Wiesendanger, H. and Lewith, G. [Institute of Environmental Medicine and Hospital Epidemiology, University Hospital Freiburg, Germany; walach@ukl.uni-freiburg.de]. **“Efficacy of distant healing—a proposal for a four-armed randomized study (EUHEALS).”** *Forschende Komplementarmedizin und Klassische Naturheilkunde* 9, no. 3 (Jun 2002): 168-76.
 [Abstract:] BACKGROUND: Distant healing as a treatment modality is frequently used by patients and healers. Some preliminary evidence suggests possible effects. Since patients suffering from multiple chemical sensitivity and chronic fatigue syndrome have only few effective treatment options, distant healing will be offered as a treatment within a formal trial of distant healing. DESIGN AND METHOD: A four-armed randomized trial will include 400 patients with self-attributed, environmental problems who fulfil the diagnostic criteria of severe idiopathic chronic fatigue, chronic fatigue syndrome or multiple chemical sensitivity. Patients will be recruited by specialized general practitioners and environmental clinics. They will be treated by healers distributed all over Europe, coming from various healing traditions and nationalities. Each patient will be treated by 3 healers. Healers will have no contact with the patients and will only be provided with the patient's Christian name and a photograph. The patients will be randomized to one of 4 groups in a 2 x 2 factorial design. They will either receive (distant) healing or not, and either know or not know this decision. Thereby the effects of expectation and of time can be disentangled from the specific effects of healing. OUTCOME MEASURE: Primary outcome measure will be the mental health summary scale of the MOS SF-36. The measure will be taken at the beginning and at the end of a 6- month treating or waiting period, respectively. A variety of moderator variables will be considered to evaluate which of these may be predictive of outcome.
- Wallace, D. C., Tuck, I., Boland, C. S. and Witucki, J. M. [UNCG School of Nursing, University of North Carolina-Greensboro, 210 Moore Building, Greensboro, NC 27402; debra_wallace@uncg.edu]. **“Client perceptions of parish nursing.”** *Public Health Nursing* 19, no. 2 (Mar-Apr 2002): 128-35.
 [From the abstract:] ...The convenience sample included clients from two congregations in a southeastern Appalachian area served by parish nurses. Face-to-face client interviews were conducted, and the Spradley's ethnographic approach to data analysis of transcripts was used. Each interview was analyzed separately by the research group for patterns and meanings reflecting [themic] perspective. Five themes of client perception of parish nursing emerged from the data: (1) being available, (2) integrating spirituality and health, (3) helping us help ourselves, (4) exploring parish nursing, and (5) evaluating parish nursing. Clients perceived having a parish nurse as positive and beneficial for individuals, the congregation, the church, and community. Parish nursing was viewed as a useful, meaningful, and effective health intervention and setting, and parish nurses were viewed as effective and meaningful health providers....
- Walter, T. [Department of Sociology, University of Reading, UK; j.a.walter@reading.ac.uk]. **“Spirituality in palliative care: opportunity or burden?”** *Palliative Medicine* 16, no. 2 (Mar 2002): 133-9.
 [Abstract:] The article questions an assumption in palliative care literature, namely that all patients have a spiritual dimension and that all staff can offer spiritual care. The article identifies spirituality as a particular kind of discourse. In late-modern Anglophone societies, this discourse arises from the experience of a particular generation and a particular segment of the population, namely those moving beyond formal religion; this segment is probably better represented among caring professionals than among dying patients. A four-fold typology of patients' approaches to religion/spirituality is developed, indicating the potential of differentiating between actual patients, rather than presuming a universal 'search for meaning'. This alternative approach may enhance opportunities for team working and reduce the likelihood of any one member of staff feeling spiritual care to be an unwelcome burden.
- Walsh, K., King, M., Jones, L., Tookman, A. and Blizard, R. [Department of Psychiatry and Behavioural Science, Royal Free Campus, Royal Free and University College Medical School, London NW3 2PF]. **“Spiritual beliefs may affect outcome of bereavement: prospective study.”** *BMJ* 324, no. 7353 (Jun 29, 2002): 1551-5.

[Abstract:] OBJECTIVE: To explore the relation between spiritual beliefs and resolution of bereavement. DESIGN: Prospective cohort study of people about to be bereaved with follow up continuing for 14 months after the death. SETTING: A Marie Curie centre for specialist palliative care in London. PARTICIPANTS: 135 relatives and close friends of patients admitted to the centre with terminal illness. MAIN OUTCOME MEASURE: Core bereavement items, a standardized measure of grief, measured 1, 9, and 14 months after the patients' death. RESULTS: People reporting no spiritual belief had not resolved their grief by 14 months after the death. Participants with strong spiritual beliefs resolved their grief progressively over the same period. People with low levels of belief showed little change in the first nine months but thereafter resolved their grief. These differences approached significance in a repeated measures analysis of variance ($F=2.42$, $P=0.058$). Strength of spiritual belief remained an important predictor after the explanatory power of relevant confounding variables was controlled for. At 14 months the difference between the group with no beliefs and the combined low and high belief groups was 7.30 (95% confidence interval 0.86 to 13.73) points on the core bereavement items scale. Adjusting for confounders in the final model reduced this difference to 4.64 (1.04 to 10.32) points. CONCLUSION: People who profess stronger spiritual beliefs seem to resolve their grief more rapidly and completely after the death of a close person than do people with no spiritual beliefs.

Walton, J. [St. Peter's Hospital, Helena, MT]. **"Discovering meaning and purpose during recovery from an acute myocardial infarction."** *Dimensions of Critical Care Nursing* 21, no. 1 (Jan-Feb 2002): 36-43.

[Abstract:] Spirituality can play a powerful role in recovery. This article explores spirituality in patients recovering from acute myocardial infarction (AMI). By understanding the influence of spirituality on recovery, nurses can help patients discover meaning and purpose in life after AMI and be a positive influence on patient recovery.

Walton, J. [Helena and Hospice Chaplain, St. Peter's Hospital, Helena, MT]. **"Finding a balance: a grounded theory study of spirituality in hemodialysis patients."** *Nephrology Nursing Journal: Journal of the American Nephrology Nurses' Association* 29, no. 5 (Oct 2002): 447-56; discussion on p. 457.

[Abstract:] The purpose of this study was to discover what spirituality means to hemodialysis patients and how it influences their lives. Grounded theory qualitative research method was used to discover meaning, provide understanding, and create a beginning substantive theory of spirituality. Four men and 7 women, 36 to 78 years of age, receiving outpatient hemodialysis in the northwestern United States, volunteered to participate in this study. Demographic data were collected and indepth interviews were completed. The Glaserian method of grounded theory was used for data collection and analysis. The central core category of this study was finding a balance, which occurred in the following four phases: (a) confronting mortality, (b) reframing, (c) adjusting to dialysis, and (d) facing the challenge. Categories of spirituality were faith, presence, and receiving and giving back. Participants described spirituality as a life-giving force from within, full of awe, wonder, and solitude, that inspires one to strive for balance in life. Participants validated the description of spirituality, categories, and phases to assure that it captured their person experiences. A focus group of hemodialysis staff validated the results for clarity, understanding, and application to clinical practice. The results of this study provide a theoretical framework to guide nursing practice as well as an understanding of what spirituality means to hemodialysis patients and how it influences their lives.

Weaver, A. J., Flannelly, K. J., Larson, D. B., Stapleton, C. L. and Koenig, H. G. [HealthCare Chaplaincy, New York, NY 10022]. **"Mental health issues among clergy and other religious professionals: a review of research."** *The Journal of Pastoral Care & Counseling: JPCC* 56, no. 4 (Winter 2002): 393-403. [Review, 74 refs.]

[Abstract:] The authors reviewed the literature on mental health issues among clergy and other religious professionals, using electronic searches of databases of medical (Medline), nursing (CINAHL), psychology (PsycINFO), religious (ATLA), and sociological research (Sociofile). The existing research indicates the Protestant clergy report higher levels of occupational stress than Catholic priests, brothers, or sisters. Catholic sisters repeatedly reported the lowest work-related stress, whereas women rabbis reported the highest stress levels in various studies. Occupational stress appears to be a source of family stress among Protestant clergy—a factor which clergy and their spouses believe the denominational leadership should address. High levels of stress also have been found to be associated with sexual misconduct among clergy. The authors make several recommendations based on these and other findings they report in their review.

Weis, D. M., Schank, M. J., Coenen, A. and Matheus, R. [Marquette University College of Nursing, Clark Hall, P.O. Box 1881, Milwaukee, WI 53201-1881; darlene.weis@marquette.edu]. **"Parish nurse practice with client aggregates."** *Journal of Community Health Nursing* 19, no. 2 (Summer 2002): 105-13.

[Abstract:] The purpose of this study was to describe 1 aspect of parish nurses' practice: working with client aggregates. Nineteen parish nurses practicing in 22 faith communities collected data using 2 standardized nursing classification systems—North American Nurses Diagnosis Association Taxonomy and Nursing Intervention Classification. Nurses recorded 77 group encounters for services provided over a 5-month period. The most frequent nursing diagnoses and nursing interventions are reported and emphasize health promotion and illness prevention. The parish nurse roles of educator, counselor, referral agent, and advocate-facilitator described in the literature were consistent with the findings of this study. In addition, the parish nurse as a member of the ministerial team is discussed. A focus group of the parish nurses provided validation of the results of aggregate practice.

Wenzel, L. B., Donnelly, J. P., Fowler, J. M., Habbal, R., Taylor, T. H., Aziz, N. and Cella, D. [Epidemiology Division, College of Medicine, University of California, Irvine, CA 92697-7555]. **"Resilience, reflection, and residual stress in ovarian cancer survivorship: a gynecologic oncology group study."** *Psycho-Oncology* 11, no. 2 (Mar-Apr): 142-53.

[From the abstract:] ...The purpose of this study is to describe the quality of life (QOL) concerns and survivorship sequelae of long-term (>5 yr) early-stage ovarian cancer survivors accrued through the clinical cooperative Gynecologic Oncology Group. Forty-nine ovarian cancer survivors with a mean age at diagnosis of 55.9 yr (range 30-76) completed a telephone interview assessing QOL, psychosocial status, sexual functioning and late-effects of treatment. ...Spiritual well-being was significantly positively associated with personal growth and mental health, and negatively associated with a declining health status....

Whitfield, W. **"Research in religion and mental health: naming of parts—some reflections."** *International Journal of Psychiatric Nursing Research* 8, no. 1 (Oct 2002): 891-6.

[From the abstract:] The editor considers some definitions of research, mental health, religion and religiosity. Reviews some studies of the benefits of religion to mental and physical health. Discusses nursing aspects and invites readers to contribute to this relatively underdeveloped area of knowledge....

Whooley, M. A., Boyd, A. L., Gardin, J. M. and Williams, D. R. [Department of Veterans Affairs Medical Center and Department of Medicine, University of California, San Francisco, CA 94121; whooley@itsa.ucsf.edu]. “**Religious involvement and cigarette smoking in young adults: the CARDIA study (Coronary Artery Risk Development in Young Adults) study.**” *Archives of Internal Medicine* 162, no. 14 (Jul 22, 2002): 1604-10.

[From the abstract:] BACKGROUND: Results of previous studies have suggested that involvement in religious activities may be associated with lower rates of smoking. We sought to determine whether frequent attendance at religious services is associated with less smoking among young adults. ...RESULTS: Of 4544 participants who completed the tobacco questionnaire in 1987/1988, 34% (891/2598) who attended religious services less than once per month or never and 23% (451/1946) who attended religious services at least once per month reported current smoking (odds ratio [OR], 1.7; 95% confidence interval [CI], 1.5-2.0; P<.001). This association between less frequent attendance at religious services and current smoking was found in most denominations and remained significant after adjusting for potential confounding variables (OR, 1.5; 95% CI, 1.3-1.8; P<.001). During 3-year follow-up, nonsmokers who reported little or no religious involvement had an increased risk of smoking initiation (adjusted OR, 1.9; 95% CI, 1.3-2.7; P<.001). CONCLUSIONS: Young adults who attend religious services have lower rates of current and subsequent cigarette smoking. The potential health benefits associated with religious involvement deserve further study.

Williams, L., Reed, S., Nelson, C. and Brose, A. [University of North Texas, Denton, TX 76203-1280]. “**Relations of intrinsic spirituality with health status and symptom interference.**” *Psychological Reports* 91, no. 2 (Oct 2002): 618-26.

[Abstract:] The purpose of this study was to examine the relationships between spiritual experience and current health status and between spiritual experience and subjective experience of symptom interference. Symptom interference is the extent to which symptoms of physical or psychological illness limited participants' activities of daily living. Participants were 49 volunteers who were enrolled in a spiritual fitness class at a variety of denominational Christian churches in Plano, Texas. The sample ranged in age from 22 to 65 years, and 84% were women. The Index of Core Spiritual Experiences and the Medical Symptoms Checklist were administered. Current health status and symptom interference were utilized from the self-report checklist. It was predicted that Index scores would be significantly different based on participants' health status and that Index scores would correlate significantly with participants' ratings of symptom interference. Analysis indicated that Index scores were significantly higher ($p = .02$) for participants with no current medical diagnosis than for those currently experiencing either a life-threatening or a chronic medical or psychological disorder. Also, the percentage-bend correlation between Index scores and scores for interference of symptoms in daily life was significant ($(r)Pb = -.33, p = .02$). These results suggest that the report of core spiritual experiences may be related to better current health status. These findings have implications for understanding the role of spirituality in the prevention of illness and in an individual's ability to cope with illness.

Wright, M. C. [Doncaster Royal and Montagu Hospitals NHS Trust, Doncaster, UK; m.c.wright@sheffield.ac.uk]. “**The essence of spiritual care: a phenomenological enquiry.**” *Palliative Medicine* 16, no. 2 (Mar 2002): 125-32.

[Abstract:] This study used a phenomenological approach, founded on the Husserlian tradition, to discover the spiritual essence of palliative care in the lived experience of stakeholders. Semistructured interviews were conducted with 16 participants who held a variety of roles linked to palliative care, and were of different religions and none. Amongst these participants, spiritual care is based on the assumption that all people are spiritual beings. It recognizes the relationship between illness and the spiritual domain and acknowledges the possibility of a search for meaning in the big questions of life and death. It responds to religious and humanistic needs by meeting both the requirements of faith and the desire for another human being to 'be there'. Fundamentally, spiritual care seeks to affirm the value of each and every person based on non-judgmental love.

Wright, S. G. [Faculty of Health, St Martin's College, Lancaster]. “**Examining the impact of spirituality on nurses and health-care provision.**” *Professional Nurse* 17, no. 12 (Aug 2002): 709-11. [Review, 19 refs.]

[Abstract:] The spiritual needs of patients are often neglected by health-care professionals who are already over-stretched by the 'physical' demands of their role. However, there is also ignorance of the spiritual needs of health-care professionals, especially nurses, who may have personal uncertainties about their own spirituality. This lack of understanding can lead to burnout.

Yick, A. G. and Gupta, R. [School of Human Services, Capella University, Minneapolis, MN; ayick@videosymphony.com]. “**Chinese cultural dimensions of death, dying, and bereavement: focus group findings.**” *Journal of Cultural Diversity* 9, no. 2 (Summer 2002): 32-42.

Among the findings of this focus group study of care providers working with Chinese Americans in New York City is that elements of Confucianism, Buddhism, Taoism, and local folklore appear to be embedded in the death attitudes and practices of Chinese Americans. The authors make recommendations to care providers regarding cultural sensitivity.